**100 EBP’s**

**http://www.nrepp.samhsa.gov/ViewAll.aspx**

**A Woman's Path to Recovery (Based on A Woman's Addiction Workbook)**

Date of Review: December 2007

A Woman’s Path to Recovery is a clinician-led program for women with substance use disorders. The model uses chapters from "A Woman's Addiction Workbook: Your Guide to In-Depth Healing” as the basis for 12 90-minute sessions conducted by clinicians over 8 weeks. The workbook is divided into two main sections: exploration and healing. The “exploration” section helps women look at their lives in relation to gender and addiction issues. It provides background information on the relationship between gender and addiction, differences between women and men in addiction and recovery, historical barriers to treatment faced by women, and subgroups of women at risk for addiction. It then encourages women to identify their life themes in five key areas relevant to women and addiction: body and sexuality, stress, relationships, trauma and violence, and thrill-seeking. They can also evaluate their addiction and co-occurring mental disorders. The “healing” section of the book guides women through methods of recovery. It is organized into four domains--relationships, beliefs, actions, and feelings--and includes a series of exercises for each domain. The book conveys a supportive tone for the journey to healing and provides specific recovery resources. Overall, the model addresses social and emotional problems unique to women. Difficult areas in a woman’s life are explored through the psychology that underlies female addictive behavior.

The research to date on A Woman’s Path to Recovery has been conducted with women addicted to opiates and other substances; however, the intervention can also be used to address nonsubstance addictions, such as addiction to shopping and eating. In addition, session length and program duration can be modified, depending on the setting or group of women. The workbook was originally created as a self-help model for women and adolescent girls and can be used in a self-help format (i.e., without the involvement of a clinician). This self-help model was not reviewed by NREPP.

**Learn More by Visiting: http://www.seekingsafety.org**

**Across Ages**

Date of Review: June 2008

Across Ages is a school- and community-based substance abuse prevention program for youth ages 9 to 13. The unique feature of Across Ages is the pairing of older adult mentors (55 years and older) with young adolescents, specifically those making the transition to middle school. The overall goal of the program is to increase protective factors for high-risk students to prevent, reduce, or delay the use of alcohol, tobacco, and other drugs and the problems associated with substance use. The four intervention components are (1) a minimum of 2 hours per week of mentoring by older adults who are recruited from the community, matched with youth, and trained to serve as mentors; (2) 1-2 hours of weekly community service by youth, including regular visits to frail elders in nursing homes; (3) monthly weekend social and recreational activities for youth, their families, and mentors; and (4) 26 45-minute social competence training lessons taught weekly in the classroom using the Social Problem-Solving Module of the Social Competence Promotion Program for Young Adolescents developed by Roger Weissberg and colleagues. Implementing Across Ages requires a full-time project coordinator, a part-time outreach coordinator, and one mentor for every one or two students.

**Learn More by Visiting: http://www.acrossages.org**

**Active Parenting Now**

Date of Review: May 2008

Active Parenting Now is a video-based education program targeted to parents of 2- to 12-year-olds who want to improve their parenting skills. It is based on the application of Adlerian parenting theory, which is defined by mutual respect among family members within a democratically run family. The program teaches parents how to raise a child by using encouragement, building the child's self-esteem, and creating a relationship with the child based upon active listening, honest communication, and problem solving. It also teaches parents to use natural and logical consequences to reduce irresponsible and unacceptable behaviors.

Active Parenting Now is conducted in one 2-hour class per week for 6 weeks. The program features a video that contains vignettes of a variety of typical family situations depicted by professional actors. Each scene provides an example of how an autocratic or permissive parenting technique fails to handle a situation and then models the alternative authoritative (or “active”) skills. The Leader's Guide aids the leader, a professional facilitator, in organizing the sessions. The guide contains session organizers, questions and answers to help parents process the video, instructions for all group activities, brief explanations to be made by the leader, and home activity assignments. The Parent's Guide contains all the information covered in Active Parenting Now, giving parents their first exposure to the information and skills they will be learning. It also includes additional reading material, practice activities, and homework assignments that provide information and opportunities to practice using the skills. A poster, called the Job Performance Aid, describes the goals of children's behavior and misbehavior, information on how to analyze the purpose of a child's behavior, and actions the parent can take to solve problems.

**Learn More by Visiting:**

* **http://www.activeparenting.com**

**Active Parenting of Teens: Families in Action**

Date of Review: February 2010

Active Parenting of Teens: Families in Action is a school- and community-based intervention for middle school-aged youth designed to increase protective factors that prevent and reduce alcohol, tobacco, and other drug use; irresponsible sexual behavior; and violence. Family, school, and peer bonding are important objectives. The program includes a parent and teen component. The parent component uses the curriculum from Active Parenting of Teens. This curriculum is based on Adlerian parenting theory, which advocates mutual respect among family members, parental guidance, and use of an authoritative (or democratic) style of parental leadership that facilitates behavioral correction. A teen component was developed to complement the parent component.

Active Parenting of Teens: Families in Action uses a family systems approach in which families attend sessions and learn skills. Each of the sessions includes time during which parents and youth meet in separate groups and time during which all family members meet together. Modules address parent-child communication, positive behavior management, interpersonal relationships for adolescents, ways for families to have fun together, enhancement of the adolescent’s self-esteem, and factors that promote school success. Youth are taught about the negative social and physical effects of substance use, they learn general life skills and social resistance skills, and they are provided opportunities to practice these skills. Parents are taught skills to help reinforce their teen’s skills training. During the portion of each session involving the youth and parents together, they participate in a family enrichment activity and receive a homework assignment to complete before the next session.

The program is offered in six weekly 2-hour sessions. Typical groups consist of 5 to 12 families. Sessions use videos, group discussion, and role-plays, plus high-energy activities for the teens. Two leaders are needed, one for the parent portion and one for the teen portion, with one of the two leaders also leading the parents and teens combined.

**Learn More by Visiting:**

* **http://www.activeparenting.com**

**Adolescent Community Reinforcement Approach (A-CRA)**

Date of Review: March 2008

The Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with prosocial activities and behaviors that support recovery. This outpatient program targets youth 12 to 22 years old with DSM-IV cannabis, alcohol, and/or other substance use disorders. A-CRA includes guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together. According to the adolescent's needs and self-assessment of happiness in multiple areas of functioning, therapists choose from among 17 A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in prosocial activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Role-playing/behavioral rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in prosocial leisure activities.

A-CRA has been adapted for use with Assertive Continuing Care (ACC), which provides home visits to youth following residential treatment for alcohol and/or other substance dependence. It also has been adapted for use in a drop-in center for street-living, homeless youth to reduce substance use, increase social stability, and improve physical and mental health. These adaptations are reviewed in this summary.

**Learn More by Visiting:**

* **http://www.chestnut.org/LI/acra-acc/index.html**

**Adolescent Coping With Depression (CWD-A)**

Date of Review: July 2007

The Adolescent Coping With Depression (CWD-A) course is a cognitive behavioral group intervention that targets specific problems typically experienced by depressed adolescents. These problems include discomfort and anxiety, irrational/negative thoughts, poor social skills, and limited experiences of pleasant activities. CWD-A consists of 16 2-hour sessions conducted over an 8-week period for mixed-gender groups of up to 10 adolescents. Each participant receives a workbook that provides structured learning tasks, short quizzes, and homework forms. To encourage generalization of skills to everyday situations, adolescents are given homework assignments that are reviewed at the beginning of the subsequent session.

The CWD-A course was originally adapted from the adult version of the Coping With Depression course. In modifying the course for use with adolescents, in-session material and homework assignments were simplified, experiential learning opportunities (e.g., role-plays) were enhanced, and problem-solving skills were added to the curriculum.

**Learn More by Visiting:**

* **http://www.kpchr.org/public/acwd/acwd.html**
* **http://www.ori.org**

**Aggressors, Victims, and Bystanders: Thinking and Acting To Prevent Violence**

Date of Review: January 2009

Aggressors, Victims, and Bystanders: Thinking and Acting To Prevent Violence (AVB) is a curriculum designed to prevent violence and inappropriate aggression among middle school youth, particularly those living in environments with high rates of exposure to violence. Based on research demonstrating the role of cognitive patterns in mediating aggressive behavior, AVB addresses the differing roles that individuals typically play in promoting or preventing violence.

The core objectives of AVB are to encourage young people to examine their roles as aggressors, victims, and bystanders; develop and practice problem-solving skills; rethink beliefs that support the use of aggression; and generate new ways of thinking about and responding to conflict in each of these roles. A central feature of the curriculum is its four-step Think-First Model of Conflict Resolution. This model helps students pause and reflect when confronted with a conflict so they can define the situation in ways that lead to effective, positive solutions. The curriculum is presented in 12 45-minute classroom sessions conducted 1 to 3 times per week over 4 to 12 weeks. AVB can be taught by health educators, language arts teachers, police officers, school resource/safety officers, or physical education instructors.

**Learn More by Visiting:**

* **http://www.thtm.org**

**Alcohol Behavioral Couple Therapy**

Date of Review: January 2009

Alcohol Behavioral Couple Therapy (ABCT) is an outpatient treatment for individuals with alcohol use disorders and their intimate partners. ABCT is based on two assumptions: Intimate partner behaviors and couple interactions can be triggers for drinking, and a positive intimate relationship is a key source of motivation to change drinking behavior. Using cognitive-behavioral therapy, ABCT aims to identify and decrease the partner’s behaviors that cue or reinforce the client’s drinking; strengthen the partner’s support of the client’s efforts to change; increase positive couple interactions by improving interpersonal communication and problem-solving skills as a couple; and improve the client’s coping skills and relapse prevention techniques to achieve and maintain abstinence.

The treatment program consists of 2-3 hours of assessment for treatment planning, followed by 12-20 weekly, 90-minute therapy sessions for the client with his or her partner. The number of treatment sessions may be increased if sessions of less than 90 minutes are desired. Treatment follows cognitive-behavioral principles applied to couples therapy and specific therapeutic interventions for alcohol use disorders. The optimal implementation of ABCT occurs in the context of an existing clinic or private practice with certified/licensed mental health or addictions professionals who have a background in treating alcohol use disorders and knowledge of cognitive-behavioral therapy.

The NREPP review of this intervention was funded by the [Center for Substance Abuse Treatment (CSAT)](http://www.samhsa.gov/about/csat.aspx).

**AlcoholEdu for High School**

Date of Review: May 2008

AlcoholEdu for High School is an online, interactive, alcohol education and prevention course designed to increase alcohol-related knowledge, discourage acceptance of underage drinking, and prevent or decrease alcohol use and its related negative consequences. Although high schools typically administer the course to their entire freshman class each year, the course can be used with other high school populations as well. By implementing the program at the population level, schools expose students to a consistent message, ultimately creating a common body of knowledge and a shared experience that helps establish a social safety net among students. The program includes a precourse assessment measuring knowledge, attitudes, and behaviors, followed by three 30-minute lessons, a postcourse assessment, and a 30-day (or more) follow-up review of key course concepts and follow-up assessment. The three lessons address alcohol's effects on the body and impairments produced at various blood alcohol concentrations; alcohol's effects on the mind, including brain development, blackouts, hangovers, and risk taking; and factors that influence decisions about drinking and strategies for making healthy choices. Brief lecture formats present current research, and interactive exercises personalize and reinforce the information. The course, which requires minimal teacher involvement, may be assigned as an outside project or completed in a school’s computer lab.

Students can progress through the program at their own pace. Although students have unlimited access to the course materials throughout the academic year, schools are encouraged to tie the course to something that is meaningful to the students, such as a test or project grade, access to a school event, or participation in extracurricular activities. The three lessons are typically completed within 1 to 3 weeks. Students may use their accounts throughout the academic year to access alcohol-related Web links or revisit any of the different interactive exercises.

**Learn More by Visiting:**

* **http://www.outsidetheclassroom.com/solutions/high-school/alcoholedu-for-high-school.aspx**

**All Stars**

Date of Review: June 2007

All Stars is a multiyear school-based program for middle school students (11 to 14 years old) designed to prevent and delay the onset of high-risk behaviors such as drug use, violence, and premature sexual activity. The program focuses on five topics important to preventing high-risk behaviors: (1) developing positive ideals that do not fit with high-risk behavior; (2) creating a belief in conventional norms; (3) building strong personal commitments; (4) bonding with school, prosocial institutions, and family; and (5) increasing positive parental attentiveness. The All Stars curriculum includes highly interactive group activities, games and art projects, small group discussions, one-on-one sessions, a parent component, and a celebration ceremony. The All Stars Core program consists of 13 45-minute class sessions delivered on a weekly basis by teachers, prevention specialists, or social workers. The All Stars Booster program is designed to be delivered 1 year after the core program and includes nine 45-minute sessions reinforcing lessons learned in the previous year. Multiple program packages are available to support implementation by either regular teachers or prevention specialists.

**Learn More by Visiting:**

* **http://www.allstarsprevention.com**

**Al's Pals: Kids Making Healthy Choices**

Date of Review: July 2008

Al's Pals: Kids Making Healthy Choices is a school-based prevention program that seeks to develop social-emotional skills such as self-control, problem-solving, and healthy decisionmaking in children ages 3-8 in preschool, kindergarten, and first grade. The program fosters both the personal traits of resilience and the nurturing environments children need to overcome difficulties and fully develop their talents and capabilities. Through fun lessons, engaging puppets, original music and materials, and appropriate teaching approaches, the Al's Pals curriculum helps young children regulate their own feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other drugs; and builds children's abilities to make healthy choices and cope with life's difficulties. The program consists of a year-long, 46-session interactive curriculum delivered by trained classroom teachers who use Al’s Pals teaching approaches to infuse the concepts into daily interactions with the children. Ongoing communication with parents is also part of Al’s Pals. Teachers regularly send parents letters to update them about the skills the children are learning, suggest home activities to reinforce these concepts, and inform parents about their child's progress.

**Learn More by Visiting:**

* **http://www.wingspanworks.com/educational\_programs**

**American Indian Life Skills Development/Zuni Life Skills Development**

Date of Review: June 2007

Suicide is the second leading cause of death among American Indians 15 to 24 years old, according to Centers for Disease Control and Prevention data. The estimated rate of completed suicides among American Indians in this age group is about three times higher than among comparably aged U.S. youth overall (37.4 vs. 11.4 per 100,000, respectively). American Indian Life Skills Development (the currently available version of the former Zuni Life Skills Development program) is a school-based suicide prevention curriculum designed to address this problem by reducing suicide risk and improving protective factors among American Indian adolescents 14 to 19 years old.

The curriculum includes anywhere from 28 to 56 lesson plans covering topics such as building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behavior, learning about suicide, role-playing around suicide prevention, and setting personal and community goals. The curriculum typically is delivered over 30 weeks during the school year, with students participating in lessons 3 times per week. Lessons are interactive and incorporate situations and experiences relevant to American Indian adolescent life, such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons include brief, scripted scenarios that provide a chance for students to employ problem solving and apply the suicide-related knowledge they have learned.

Lessons are delivered by teachers working with community resource leaders and representatives of local social services agencies. This team-teaching approach ensures that the lessons have a high degree of cultural and linguistic relevance even if the teachers are not Native American or not of the same tribe as the students. For example, the community resource leaders can speak to students in their own language to explain important concepts and can relate curriculum materials and exercises to traditional and contemporary tribal activities, beliefs, and values. A school counselor (typically of the same tribe) serves as the on-site curriculum coordinator.

The Zuni Life Skills Development curriculum was developed with cultural components relevant to the people of the Zuni Pueblo in New Mexico and was tested and evaluated with that population. The Zuni curriculum served as the basis for the broader American Indian Life Skills Development curriculum that is now in use, which can be used with other American Indian populations when implemented with appropriate and culturally specific modifications.

**ATHENA (Athletes Targeting Healthy Exercise & Nutrition Alternatives)**

Date of Review: January 2007

The ATHENA (Athletes Targeting Healthy Exercise & Nutrition Alternatives) program uses a school-based, team-centered format that aims to reduce disordered eating habits and deter use of body-shaping substances among middle and high school female athletes. The intervention includes a balanced presentation concerning the consequences of substance use and other unhealthy behaviors and the beneficial effects of appropriate sport nutrition and effective exercise training. In addition to its learning goals related to nutrition, ATHENA incorporates cognitive restructuring appropriate to a sport team setting to address mood-related risk factors for diet pill use.

The ATHENA program is delivered using scripted lessons in small learning clusters, each led by one coach-designated athlete squad leader. The intervention includes eight 45-minute classroom sessions integrated into a team’s usual practice activities. Each participant receives a workbook and a pocket-sized sport nutrition and training guide.

**Learn More by Visiting:**

* **http://www.athenaprogram.com**
* **http://www.ohsu.edu/hpsm/**
* **ATLAS (Athletes Training and Learning To Avoid Steroids)**
* Date of Review: February 2007
* Athletes Training and Learning To Avoid Steroids (ATLAS) is a school-based drug prevention program. ATLAS was designed for male high school athletes to deter drug use and promote healthy nutrition and exercise as alternatives to drugs. The curriculum consists of 10 45-minute interactive classroom sessions and 3 exercise training sessions facilitated by peer educators, coaches, and strength trainers. Program content includes (1) discussion of sports nutrition; (2) exercise alternatives to anabolic steroids and sports supplements; and (3) the effects of substance abuse in sports, drug refusal role-playing, and the creation of health promotion messages.

**Learn More by Visiting:**

* **http://www.ohsu.edu/hpsm/**

**Behavioral Couples Therapy for Alcoholism and Drug Abuse**

Date of Review: October 2006

Behavioral Couples Therapy for Alcoholism and Drug Abuse (BCT) is a substance abuse treatment approach based on the assumptions that (1) intimate partners can reward abstinence and (2) reducing relationship distress lessens risk for relapse. In BCT, the therapist works with both the person who is abusing substances and his or her partner to build a relationship that supports abstinence. Program components include a recovery or sobriety contract between the partners and therapist; activities and assignments designed to increase positive feelings, shared activities, and constructive communication; and relapse prevention planning. Partners generally attend 15-20 hour-long sessions over 5-6 months. A typical session follows this sequence: (1) the therapist asks about any substance use since the last session; (2) the couple discusses compliance with the recovery contract; (3) the couple presents and discusses homework assigned at the last session; (4) the couple discusses any relationship problems since the last session; (5) the therapist presents new material; and (6) the therapist assigns new homework.

**Border Binge-Drinking Reduction Program**

Date of Review: November 2006

The Border Binge-Drinking Reduction Program provides a process for changing the social and community norms associated with underage and binge drinking that has proven effective at reducing alcohol-related trauma caused by young American's binge drinking across the U.S.-Mexican border. The program is a binational effort to curb irresponsible drinking practices, employing environmental management techniques including (1) regular surveys of youths returning from a night of drinking with anonymous blood alcohol concentration (BAC) breath tests; (2) strong media advocacy, using information from the surveys to characterize the problem, mobilize the community to action, and reframe the issue from an accepted norm to a health and safety issue for the binational community; (3) formation of the Binational Policy Council, which recommends policy changes on both sides of the border and provides spokespeople for the media advocacy and community organizing components; (4) increased enforcement of existing laws and policies, such as ID checks at border crossings and in bars in Tijuana, Mexico; and (5) implementation of policies and practices that impact the environment where dangerous cross-border drinking occurs.

**Learn More by Visiting:**

* **http://www.publicstrategies.org**
* **http://www.pire.org**

**Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women**

Date of Review: August 2009

The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women (BCM) program provides a fully integrated set of substance abuse treatment and trauma-informed mental health services to low-income, minority women with co-occurring alcohol/drug addiction, mental disorders, and trauma histories. BCM was developed by a consortium of urban substance abuse and mental health treatment programs as an enhancement to existing substance abuse treatment based on the Trauma Recovery and Empowerment Model (TREM). TREM uses a psychoeducational and skills-building approach to increase a woman's understanding of the associations among addiction, trauma, mental health disorders, and sexual risk behaviors. It teaches positive and protective coping skills to help women heal from past abuse and avoid future abuse, along with behavioral strategies for reducing trauma symptoms, substance use relapse, and sexual risk.

BCM begins with a diagnostic assessment for mental disorders and trauma administered by a trained mental health/trauma service (MHTS) coordinator/case manager. The MHTS coordinator/case manager develops an integrated, trauma-informed treatment plan for the client, links her to the appropriate mental health services, and works collaboratively as the primary point of contact with the client's mental health and substance abuse treatment service teams. Additionally, BCM uses five manual-driven, skills-building group modules. One of these modules is a modified version of the TREM curriculum adapted to include 3 group sessions on HIV/AIDS prevention for a total of 25 sessions. The four other modules are:

* Women's Leadership Training Institute (3 sessions, 15 hours total), delivered by staff with a personal history of alcohol or drug abuse, mental health problems, and/or interpersonal violence, focuses on leadership and communication skills and aims to reverse the silencing effects of trauma and help clients regain their voice.
* Economic Success in Recovery (8 sessions, 16 hours total) assists clients, who often have a history of economic dependence on abusive partners, in gaining the skills to effectively manage money issues and draw associations between their past substance use and current economic situation.
* Pathways to Family Reunification and Recovery (10 sessions, 15 hours total) focuses on building skills, knowledge, and support related to child custody issues.
* Nurturing Program for Families in Substance Abuse Treatment and Recovery (12 sessions, 24 hours total) focuses on enhancing parenting skills and family communication.

**Brief Alcohol Screening and Intervention for College Students (BASICS)**

Date of Review: April 2008

Brief Alcohol Screening and Intervention for College Students (BASICS) is a prevention program for college students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems. Following a harm reduction approach, BASICS aims to motivate students to reduce alcohol use in order to decrease the negative consequences of drinking. It is delivered over the course of two 1-hour interviews with a brief online assessment survey taken by the student after the first session. The first interview gathers information about the student's recent alcohol consumption patterns, personal beliefs about alcohol, and drinking history, while providing instructions for self-monitoring any drinking between sessions and preparing the student for the online assessment survey. Information from the online assessment survey is used to develop a customized feedback profile for use in the second interview, which compares personal alcohol use with alcohol use norms, reviews individualized negative consequences and risk factors, clarifies perceived risks and benefits of drinking, and provides options to assist in making changes to decrease or abstain from alcohol use. Based on principles of motivational interviewing, BASICS is delivered in an empathetic, nonconfrontational, and nonjudgmental manner and is aimed at revealing the discrepancy between the student's risky drinking behavior and his or her goals and values. The intervention is delivered by trained personnel proficient in motivational interviewing and may be tailored for use with young adults in settings other than colleges.

**Learn More by Visiting:**

* **http://depts.washington.edu/abrc/basics.htm**

**Brief Marijuana Dependence Counseling**

Date of Review: February 2007

Brief Marijuana Dependence Counseling (BMDC) is a 12-week intervention designed to treat adults with a diagnosis of cannabis dependence. Using a client-centered approach, BMDC targets a reduction in the frequency of marijuana use, thereby reducing marijuana-related problems and symptoms. BMDC is based on the research protocol used by counselors in the Center for Substance Abuse Treatment's Marijuana Treatment Project conducted in the late 1990s. A treatment manual provides guidelines for counselors, social workers, and psychologists in both public and private settings. BMDC is implemented as a 9-session multicomponent therapy that includes elements of motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), and case management.

**Brief Strategic Family Therapy**

Date of Review: April 2008

Brief Strategic Family Therapy (BSFT) is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention.

BSFT considers adolescent symptomatology to be rooted in maladaptive family interactions, inappropriate family alliances, overly rigid or permeable family boundaries, and parents’ tendency to believe that a single individual (usually the adolescent) is responsible for the family’s troubles. BSFT operates according to the assumption that transforming how the family functions will help improve the teen’s presenting problem. BSFT’s therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially “joins” the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interactions. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction.

**Brief Strengths-Based Case Management for Substance Abuse**

Date of Review: June 2009

Brief Strengths-Based Case Management (SBCM) for Substance Abuse is a one-on-one social service intervention for adults with substance use disorders that is designed to reduce the barriers and time to treatment entry and improve overall client functioning. The intervention is a time-limited version of SBCM that focuses on substance abuse. SBCM differs from conventional case management in its use of a strengths perspective. This perspective defines how to carry out the five functions of SBCM's case management component: assessment, planning, linkage, monitoring, and advocacy. The case manager helps the client identify personal skills, abilities, and assets through discussion; supports client decisionmaking so that the client sets treatment goals and determines how the goals will be met; encourages client participation in seeking informal sources of assistance; and works to resolve any client-identified barriers to treatment, such as lack of transportation, child care, and social support. Although broad system change is not the intent, the case manager also advocates with treatment providers and seeks system accommodation on behalf of the client. The case manager strives to develop a strong working alliance with the client, which is considered central to the process of linking with and using substance abuse treatment services effectively. Unlike SBCM, which is usually structured over many months and sometimes years, Brief SBCM for Substance Abuse is delivered in a maximum of five sessions over a limited, predetermined period. Sessions typically average 90 minutes, with some requiring more than 2 hours. Each session is flexible, providing an opportunity to develop and implement a personal, client-driven plan that improves the individual's overall functioning and/or addresses specific barriers to linking with treatment.

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Date of Review: June 2009

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**Broad Spectrum Treatment (BST) and Naltrexone for Alcohol Dependence**

Date of Review: November 2009

Broad Spectrum Treatment (BST) and Naltrexone for Alcohol Dependence is a 3- to 6-month program that uses manual-guided cognitive behavioral therapy in combination with naltrexone pharmacotherapy (50 mg daily) to treat adults with alcohol dependence. BST therapists deliver 8-14 individual sessions incorporating components of motivational enhancement therapy (MET), community reinforcement, and 12-step approaches.

BST begins with two MET sessions. MET is an individualized, nonconfrontational counseling approach that seeks to maximize a client's motivation to become abstinent by emphasizing the client's own control over drinking behavior. The first MET session, conducted in 90 minutes, is used to review the client's level of functioning across six psychosocial domains (cognitive, marital or significant other relationship, family, work, residential stability, and social network) and provide feedback on tests of liver function and neuropsychological performance. This session emphasizes the effects of drinking on the client's life as a motivational basis for change to achieve a goal of abstinence from alcohol. The session concludes with a planned change worksheet that becomes the basis for the second MET session, conducted in 30 minutes, that focuses on reviewing goals and redefining them if necessary.

Following these two MET sessions are sessions that increase support for abstinence by teaching skills for accessing and using available intrapersonal and community resources. Based on the specific needs of the client, these 60-minute sessions are selected from 24 modules related to the 6 psychosocial domains. Examples of these sessions include contingency management; reciprocity marriage counseling; family supportive therapy; involvement with Alcoholics Anonymous (AA) and Al-Anon; family contingency contracting; disengagement from prior social network; establishment of sober supports; vocational counseling and rehabilitation, job location, and employment contingencies; assertiveness training and drink refusal training; and cognitive restructuring.

The dissemination materials reviewed for this summary guide only the psychosocial component of the intervention. Naltrexone should be administered under medical supervision as an adjunct to treatment.

**Building Assets--Reducing Risks (BARR)**

Date of Review: January 2009

Building Assets--Reducing Risks (BARR) is a multifaceted school-based prevention program designed to decrease the incidence of substance abuse (tobacco, alcohol, and other drugs), academic failure, truancy, and disciplinary incidents among 9th-grade youth. BARR encourages students to make healthy behavior choices and achieve academic success using a set of strategies that includes delivery of a manual-based class on social competency known as the “I-Time” curriculum. This curriculum consists of 33 sequential, 30-minute group activities delivered weekly throughout the school year by teachers and/or school staff. The curriculum includes 10 general content areas--building a connected community, goals, leadership, communication, assets, grief and loss, bullying, diversity, risky behavior, and dreams--with the following objectives:

* Building social competency by strengthening positive interpersonal relationships with peers and teachers/school staff
* Increasing student engagement in the high school academic experience
* Preventing substance abuse by reinforcing a “no use” message (i.e., any use of drugs is illegal, against school policy, and unhealthy for minors)

Other program strategies include the early identification of youth at elevated risk for substance abuse and school failure and the appropriate referral of youth to strengths-based counseling interventions, both of which are achieved through weekly risk review meetings with the school's program coordinator, counselor, staff person overseeing discipline, and student services staff. Monthly teacher/staff meetings are also conducted. BARR relies on making strengths-based support interventions available during, after, and outside school, with ongoing mandated training for all 9th-grade teachers, administrators, and staff. Parental involvement in the program is encouraged through an orientation session for parents when their children start the 9th grade and a parent advisory group that meets periodically throughout the school year.

**Learn More by Visiting:**

* **http://www.search-institute.org/BARR**

**CARE (Care, Assess, Respond, Empower)**

Date of Review: February 2007

CARE (Care, Assess, Respond, Empower)--formerly called Counselors CARE (C-CARE) and Measure of Adolescent Potential for Suicide (MAPS)--is a high school-based suicide prevention program targeting high-risk youth. CARE includes a 2-hour, one-on-one computer-assisted suicide assessment interview followed by a 2-hour motivational counseling and social support intervention. The counseling session is designed to deliver empathy and support, provide a safe context for sharing personal information, and reinforce positive coping skills and help-seeking behaviors. CARE expedites access to help by connecting each high-risk youth to a school-based caseworker or a favorite teacher and establishing contact with a parent or guardian chosen by the youth. The program also includes a follow-up reassessment of broad suicide risk and protective factors and a booster motivational counseling session 9 weeks after the initial counseling session.

The goals of CARE are threefold: to decrease suicidal behaviors, to decrease related risk factors, and to increase personal and social assets. CARE assesses the adolescent’s needs, provides immediate support, and then serves as the adolescent’s crucial communication bridge with school personnel and the parent or guardian of choice. The CARE program is typically delivered by school or advanced-practice nurses, counselors, psychologists, or social workers who have completed the CARE implementation training program and certification process.

Although CARE was originally developed to target high-risk youth in high school--particularly those at risk of school dropout or abusing substances--its scope has been expanded to include young adults (ages 20 to 24) in settings outside of schools, such as health care clinics.

**Learn More by Visiting:**

* **http://www.reconnectingyouth.com**

**Caring School Community**

Date of Review: February 2008

Caring School Community (CSC), formerly called the Child Development Project, is a universal elementary school (K-6) improvement program aimed at promoting positive youth development. The program is designed to create a caring school environment characterized by kind and supportive relationships and collaboration among students, staff, and parents. The CSC model is consistent with research-based practices for increasing student achievement as well as the theoretical and empirical literature supporting the benefits of a caring classroom community in meeting students’ needs for emotional and physical safety, supportive relationships, autonomy, and sense of competence. By creating a caring school community, the program seeks to promote prosocial values, increase academic motivation and achievement, and prevent drug use, violence, and delinquency. CSC has four components designed to be implemented over the course of the school year: (1) Class Meeting Lessons, which provide teachers and students with a forum to get to know one another and make decisions that affect classroom climate; (2) Cross-Age Buddies, which help build caring cross-age relationships; (3) Homeside Activities, which foster communication at home and link school learning with home experiences and perspectives; and (4) Schoolwide Community-Building Activities, which link students, parents, teachers, and other adults in the school. Schoolwide implementation of CSC is recommended because the program builds connections beyond the classroom.

**Learn More by Visiting:**

* **http://www.devstu.org/csc/videos/index.shtml**

**CASASTART**

Date of Review: May 2007

CASASTART (Striving Together to Achieve Rewarding Tomorrows, formerly known as Children at Risk), is a community-based, school-centered substance abuse and violence prevention program developed by the National Center on Addiction and Substance Abuse at Columbia University (CASA). CASASTART targets youths between 8 and 13 years old who have a minimum of four identified risk factors. Youth participants may remain in the program up to 2 years. Specific program objectives of CASASTART include reducing drug and alcohol use, reducing involvement in drug trafficking, decreasing associations with delinquent peers, improving school performance, and reducing violent offenses. CASASTART’s intervention model is informed by the research literature on social learning theory, social strain theory, social control theory, and positive youth development. Its eight fundamental components are community-enhanced policing, intensive case management, juvenile justice intervention, family services, after-school and summer activities, education services, mentoring, and the use of incentives to encourage youth development activities. Each site brings together key stakeholders in schools, law enforcement agencies, and social services and health agencies to develop tailored approaches to the delivery of the core service components consistent with local culture and practice. At all sites, CASASTART is staffed by case managers and requires the cooperation of area police departments and local social service and juvenile crime agencies.

**Learn More by Visiting:**

* **http://www.casacolumbia.org**

**CAST (Coping And Support Training)**

Date of Review: February 2007

CAST (Coping And Support Training) is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as CARE (Care, Assess, Respond, Empower), but other evidence-based suicide risk screening instruments can be used.

CAST’s skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group-generated implementation plan for the CAST leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decisionmaking skills, better management of anger and depression, “school smarts,” control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with “Lifework” assignments that call for the youth to practice the session’s skills with a specific person in their school, home, or peer-group environment.

**Learn More by Visiting:**

* **http://www.reconnectingyouth.com/cast**

**Celebrating Families!**

Date of Review: April 2008

Celebrating Families! (CF!) is a parenting skills training program designed for families in which one or both parents are in early stages of recovery from substance addiction and in which there is a high risk for domestic violence and/or child abuse. The CF! program uses a cognitive behavioral theory (CBT) model to achieve three primary goals:

* Break the cycle of substance abuse and dependency within families,
* Decrease substance use and reduce substance use relapse, and
* Facilitate successful family reunification.

The CBT model defines substance use as a learned social behavior that is acquired through modeling or imitation of the observed behavior in others with whom one has some type of social relationship. In this model, addiction is considered a disease. The CF! program provides weekly instruction focusing on a healthy lifestyle free from drugs and alcohol, addressing risk and protective factors as well as developmental assets of family members. Following a family dinner, parents and children participate in separate 90-minute instructional group sessions devoted to a particular theme. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance. Themes include (1) healthy living, (2) nutrition, (3) communication, (4) feelings and defenses, (5) anger management, (6) facts about alcohol, tobacco, and other drugs, (7) chemical dependency as a disease, (8) the effects of chemical dependency on the whole family, (9) goal setting, (10) making healthy choices, (11) healthy boundaries, (12) healthy friendships and relationships, and (13) individual uniqueness. Originally designed for the Family Treatment Drug Court (FTDC) system, CF! is currently used by drug courts, dependency courts, faith-based organizations, residential and outpatient treatment services, and social service agencies serving parents and children ages 4-17. Started in the mid-1990s, the FTDC is the most recent and the fastest growing type of drug court in the United States. It provides a setting for all the participants in the child protection system to come together to determine the individual treatment needs of substance-abusing parents whose children are wards of the court. The goal of the FTDC is to rehabilitate the parents as competent caretakers so that their children can be safely returned to their parents' care.

**Learn More by Visiting:**

* **http://www.celebratingfamilies.net**

**Challenging College Alcohol Abuse**

Date of Review: January 2007

Challenging College Alcohol Abuse (CCAA) is a social norms and environmental management program aimed at reducing high-risk drinking and related negative consequences among college students (18 to 24 years old). The intervention was developed at the University of Arizona based on work previously done at Northern Illinois University. CCAA uses a campus-based media campaign and other strategies to address misperceptions about alcohol and make the campus environment less conducive to drinking. Studies have shown that college students tend to perceive their peers’ level of drinking to be higher than it actually is, which in turn influences their own drinking behavior. CCAA’s media campaign addresses these misperceptions by (1) communicating norms using data from surveys conducted at the university, (2) educating students on less-known or less-understood facts related to alcohol, and (3) offering an opportunity to change the “public conversation” around alcohol use among students, staff, and the local community. Advertisements and articles in the school newspaper, press releases, campus displays, and other media are used to communicate factual information about alcohol and drugs and related topics such as health and wellness, sexual assault, and sexually transmitted diseases. CCAA provides small grants to fund and promote non-alcohol social events that compete with traditional drinking occasions. Some media coverage is targeted to higher-risk groups such as fraternity and sorority chapters, freshmen, women, and students living in residence halls. CCAA also includes components aimed at faculty and staff, parents, and the local community, such as encouraging increased restrictions and monitoring of on-campus and off-campus alcohol use.

**Learn More by Visiting:**

* **http://www.socialnorms.campushealth.net**
* **http://www.health.arizona.edu**

**Chestnut Health Systems - Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model**

Date of Review: June 2007

The Chestnut Health Systems-Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model is designed for youth between the ages of 12 and 18 who meet the American Society of Addiction Medicine's criteria for Level I or Level II treatment placement. The Bloomington model incorporates outpatient and intensive outpatient programs and is based on a blended therapeutic approach, drawing on four theoretical frameworks (Rogerian, behavioral, cognitive, and reality) for behavioral and emotional change. The program emphasizes an individualized treatment plan that includes the family unit as well as the adolescent.

The two primary treatment approaches in this model are skill-building and counseling groups:

* Skill-building is offered in a group format and covers fourteen different topics weekly. Topics include relapse prevention, life skills, self-esteem, family issues, recovery lifestyle, and recreation/leisure. Assignment to the number and type of skill-building groups is based on an individualized Master Treatment Plan (MTP) for each adolescent. Each type of group is comprised of at least 12 different presentations that are 35-40 minutes long and repeat in a continuous cycle.
* Group counseling sessions provide an opportunity for adolescents to discuss personal issues in a group format. Adolescents are encouraged to focus on how they can effectively deal with problems and issues in their lives, with peers providing feedback and relating the issues discussed to their own personal experiences. Group counseling sessions occur weekly and are 35-40 minutes long.

Group sessions are offered both in the evening and in the morning to accommodate adolescent school and work schedules. All staff members who provide direct services to adolescents are licensed (e.g., LCPC or LCSW), certified (e.g., Certified Alcohol and Drug Counselor), or working towards licensure or certification, which must be obtained by the end of their second year of employment. The Chestnut-Bloomington OP/IOP Program is offered at various dose levels with different components depending on the needs of the individual client.

**Learn More by Visiting:**

* **http://www.chestnut.org**
* **Children in the Middle**
* Date of Review: August 2006
* Children in the Middle (CIM) is an educational intervention for divorcing families that aims to reduce the parental conflict, loyalty pressures, and communication problems that can place significant stress on children. CIM consists of one to two 90- to 120-minute classroom sessions and can be tailored to meet specific needs. The intervention teaches specific parenting skills, particularly good communication skills, to reduce the familial conflict experienced by children. Each parent attending classes typically receives two CIM booklets ("What About the Children" and "Children in the Middle") that give advice for reducing the stress of divorce/separation on children and promote practice of the skills taught in the course. Each parent also watches the CIM video, which illustrates how children often feel caught in the middle of their parents’ conflicts.

**Learn More by Visiting:**

* **http://www.divorce-education.com**

**Children's Summer Treatment Program (STP)**

Date of Review: September 2008

The Children's Summer Treatment Program (STP) is a comprehensive intervention for children with attention-deficit/hyperactivity disorder (ADHD) and related disruptive behaviors. The program focuses on the child's peer relations, the child's academic/classroom functioning, and the parents' parenting skills--three domains that drive outcomes in children with these conditions. The STP is based on the premise that combining an intensive summer treatment program with a follow-up program during the school year is more likely to provide an effective intervention for ADHD than clinic-based treatment alone. Children entering grades 1-6 are treated for 6-9 hours daily, 5 days per week, in a camp-like setting in which they engage in a variety of recreational and classroom activities. During the 8-week program, multiple strategies are implemented, including a point system with associated rewards and consequences, sports skills training and practice, group problem solving and social skills training, and a Daily Report Card for assessing each child's targeted behaviors. Ideally, treatment is conducted by a team of undergraduate interns (4 or 5 per group of 12-16 children) trained and supervised by staff with STP experience from the implementing organization, but staff may provide the treatment themselves if the use of interns is not possible. Parents attend weekly evening sessions in which they learn behavior management skills to apply to their children in the home setting. A teen version of the program also has been developed for adolescents entering grades 7-10.

**Learn More by Visiting:**

* **http://ccf.buffalo.edu/STP.php**

**Class Action**

Date of Review: April 2007

Class Action is the second phase of the Project Northland alcohol-use prevention curriculum series. Class Action (for grades 11-12) and Project Northland (for grades 6-8) are designed to delay the onset of alcohol use, reduce use among youths who have already tried alcohol, and limit the number of alcohol-related problems experienced by young drinkers. Class Action draws upon the social influence theory of behavior change, using interactive, peer-led sessions to explore the real-world legal and social consequences of substance abuse. The curriculum consists of 8-10 group sessions in which students divide into teams to research, prepare, and present mock civil cases involving hypothetical persons harmed as a result of underage drinking. Using a casebook along with audiotaped affidavits and depositions, teens review relevant statutes and case law to build legal cases they then present to a jury of their peers. Case topics include drinking and driving, fetal alcohol syndrome, drinking and violence, date rape, drinking and vandalism, and school alcohol policies. Students also research community issues around alcohol use and become involved in local events to support community awareness of the problem of underage drinking. Class Action can be used as a booster session for the Project Northland series or as a stand-alone program.

**Learn More by Visiting:**

* **http://www.hazelden.org/**
* **http://www.hazelden.org/bookstore**

**Clinician-Based Cognitive Psychoeducational Intervention for Families**

Date of Review: October 2006

The Clinician-Based Cognitive Psychoeducational Intervention is intended for families with parents with significant mood disorder. Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression. The intervention consists of 6-11 sessions that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals. Sessions are conducted by trained psychologists, social workers, and nurses. The core elements of the intervention are (1) an assessment of all family members, (2) teaching information about affective disorders and risks and resilience in children, (3) linking information to the family's life experience, (4) decreasing feelings of guilt and blame in children, and (5) helping children to develop relationships within and outside the family to facilitate their independent functioning in school and in activities outside the home. In family meetings, parents talk about their own sessions, their treatment, and how they are working to build resilience and protect their children.

**Cocaine-Specific Coping Skills Training**

Date of Review: March 2008

Cocaine-Specific Coping Skills Training (CST), an adaptation of a treatment approach used for alcoholism, teaches cocaine users how to identify high-risk situations associated with past episodes of cocaine use and modify their behavior to avoid or counteract those influences in the future. Topics covered by this manualized treatment technique include frustration, anger, and other negative feelings; social pressure to use; internal pressure to use based on urges; assertiveness skills; and methods for enhancing positive moods. Working individually or in a group with a trained psychologist, participants describe a situation in which they used cocaine, analyze antecedents and consequences, learn anticipatory and reactive coping skills for that type of event, and role-play when possible. Coping skills are linked to specific points in the sequence of actions, or “behavior chain,” whenever possible. For example, participants learn ways to escape, avoid, or modify the trigger situation; use cognitive restructuring to change their thoughts and affect; use alternative behaviors to attain desired consequences; and imagine the consequences of using versus not using while in the situation. CST is delivered in up to eight 45-minute sessions three to five times per week.

**Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**

Date of Review: March 2010

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina.

CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.

**Cognitive Behavioral Social Skills Training**

Date of Review: November 2006

Cognitive Behavioral Social Skills Training (CBSST) is a program for middle-aged and older outpatients with chronic schizophrenia. The program teaches cognitive and behavioral coping techniques, social functioning skills, problem-solving, and compensatory aids for neurocognitive impairments. Consisting of 24 to 36 weeks of 2-hour group psychotherapy sessions (1 session per week), CBSST targets the range of multidimensional deficits that can lead to disability in middle-aged and older people with schizophrenia. The social skills training component is based on modules for symptom management, communication role-play, and problem-solving social skills developed by Psychiatric Rehabilitation Consultants, a group of clinicians and researchers from the University of California, Los Angeles. The cognitive behavioral training component of CBSST was specifically developed for patients with schizophrenia. The compensatory aids are designed to address the cognitive impairment associated with both aging and schizophrenia. The program incorporates modifications specific to this target population, such as identifying and challenging ageist beliefs (e.g., "I'm too old to learn"), age-relevant role-play situations (e.g., talking to a doctor about eyeglasses), and age-specific problem-solving (e.g., finding transportation, coping with hearing and vision problems).

**Cognitive Behavioral Therapy for Adolescent Depression**

Date of Review: November 2006

Cognitive Behavioral Therapy (CBT) for Adolescent Depression is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs. To adapt CBT for adolescents, more emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration autonomy and trust issues, (4) focus on cognitive distortions and affective shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills. As teens frequently do not complete detailed thought logs, internal experiences such as monitoring cognitions associated with in-session affective shifts are used to illustrate the cognitive model. To match the more concrete cognitive style of younger adolescents, therapists summarize session content frequently. Abstraction is kept to a minimum, and concrete examples linked to personal experience are used when possible. The treatment program is delivered in 12 to 16 weekly sessions.

**Learn More by Visiting:**

* **http://www.starcenter.pitt.edu/DownloadManuals/54/Default.aspx**

**Cognitive Behavioral Therapy for Late-Life Depression**

Date of Review: December 2006

Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching patients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.

**Learn More by Visiting:**

* **http://oafc.stanford.edu**

**Communities Mobilizing for Change on Alcohol (CMCA)**

Date of Review: April 2007

Communities Mobilizing for Change on Alcohol (CMCA) is a community-organizing program designed to reduce teens’ (13 to 20 years of age) access to alcohol by changing community policies and practices. CMCA seeks both to limit youths’ access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable. It employs a range of social-organizing techniques to address legal, institutional, social, and health issues related to underage drinking. The goals of these organizing efforts are to eliminate illegal alcohol sales to minors, obstruct the provision of alcohol to youth, and ultimately reduce alcohol use by teens. The program involves community members in seeking and achieving changes in local public policies and the practices of community institutions that can affect youths’ access to alcohol.

CMCA is based on established research that has demonstrated the importance of the social and policy environment in facilitating or impeding drinking among youth. CMCA community-organizing methods draw on a range of traditions in organizing efforts to deal with the social and health consequences of alcohol consumption.

**Learn More by Visiting:**

* **http://www.yli.org/servicesoffered/6/cmca**
* **Community Trials Intervention To Reduce High-Risk Drinking**
* Date of Review: February 2008
* Community Trials Intervention To Reduce High-Risk Drinking is a multicomponent, community-based program developed to alter the alcohol use patterns and related problems of people of all ages. The program incorporates a set of environmental interventions that assist communities in (1) using zoning and municipal regulations to restrict alcohol access through alcohol outlet density control; (2) enhancing responsible beverage service by training, testing, and assisting beverage servers and retailers in the development of policies and procedures to reduce intoxication and driving after drinking; (3) increasing law enforcement and sobriety checkpoints to raise actual and perceived risk of arrest for driving after drinking; (4) reducing youth access to alcohol by training alcohol retailers to avoid selling to minors and those who provide alcohol to minors; and (5) forming the coalitions needed to implement and support the interventions that address each of these prevention components. The program aims to help communities reduce alcohol-related accidents and incidents of violence and the injuries that result from them. The program typically is implemented over several years, gradually phasing in various environmental strategies; however, the period of implementation may vary depending on local conditions and goals.
* **Learn More by Visiting:**

**http://www.pire.org/communitytrials/index.htm**

**Computer-Assisted System for Patient Assessment and Referral (CASPAR)**

Date of Review: November 2009

The Computer-Assisted System for Patient Assessment and Referral (CASPAR) is a comprehensive assessment and services planning process used by substance abuse clinicians to conduct an initial assessment, generate a treatment plan, and link clients admitted to a substance abuse treatment program to appropriate health and social services available either on site within the program or off site in the community. The intervention relies on the CASPAR software package, downloaded to a personal computer, that consists of two Microsoft Windows-based applications designed to work sequentially.

The first application is an electronic version of the widely used Addiction Severity Index (ASI) called the Drug Evaluation Network System (DENS) ASI. The ASI is a research-derived problem assessment interview that measures the type and severity of difficulty across seven domains: medical, employment, alcohol use, drug use, legal status, family/social relationships, and psychiatric functioning. The computer-assisted DENS ASI provides item-by-item instructions for the interviewing counselor, including coding and probing suggestions. There are 150 automated consistency checks built into the program to ensure accurate coding fidelity to the ASI interview, and all items are range checked. The software also generates narrative reports and client-level treatment plan problem lists on a form that can be used to manually draft a treatment plan.

After the DENS ASI is used to assess the client and generate a treatment plan problem list, the clinician can use the list to prioritize the client's problems as part of the treatment planning process. The clinician then uses the second application, the CASPAR Resource Guide, to identify off-site health and social services to address these problems. These are often specialized or "wrap-around" services outside the scope or resources of the admitting treatment program. Those implementing CASPAR use a Resource Guide "skeleton" to create an extensive guide tailored to their local community. The Resource Guide used in the study reviewed by NREPP contained electronic information on 1,524 agencies in southeastern Pennsylvania, sorted by agency name, services provided, and 131 keywords. The guide was based on the electronic edition of First Call for Help, a local resource directory of free or low-cost health and social service providers published by the United Way of Southeastern Pennsylvania. The Resource Guide skeleton enables users to capture provider-specific information such as services available, fee structure, eligibility criteria, and all necessary contact information.

**Learn More by Visiting:**

* **http://www.tresearch.org**

**Contracts, Prompts, and Reinforcement of Substance Use Disorder Continuing Care (CPR)**

Date of Review: February 2010

Contracts, Prompts, and Reinforcement of Substance Use Disorder Continuing Care (CPR) is an aftercare intervention for adults that begins in the final week of residential substance abuse treatment. CPR aims to help clients after discharge to participate in aftercare treatment (individual and group therapy) and self-help support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), maintain alcohol and drug abstinence, and reduce the problems they have experienced as a result of their substance use. Based on a cognitive-behavioral model, CPR uses aftercare contracts, written and telephone reminder prompts, and a series of social reinforcers, such as letters, certificates, and medallions. Although the intervention is not gender specific and has been used in multiple settings, the study reviewed in this summary was conducted with predominantly male clients in a Department of Veterans Affairs (VA) medical center.

CPR begins with a written aftercare contract between the therapist and client established during the final week of residential substance abuse treatment. The contract outlines a commitment to participate in weekly group therapy and AA/NA meetings as well as monthly individual therapy for at least 8 weeks after discharge from the treatment program. Recontracting occurs after 8 weeks to reinforce continuing aftercare treatment and AA/NA participation for the next 9 months. Throughout aftercare, CPR clients receive personal letters, appointment cards, and automated telephone reminder prompts to facilitate their attendance at therapy sessions and AA/NA meetings, and written and phone follow-ups let them know when they have missed sessions. Using principles of contingency management, CPR also provides clients with social reinforcers in the form of handwritten congratulatory letters for aftercare attendance, a certificate 90 days after entry into residential substance abuse treatment, a medallion after 3 months of aftercare, and a certificate and medallion 1 year after entry into residential treatment. These reinforcers are given during regularly scheduled therapy sessions. Both the full CPR intervention and its individual components (aftercare contracting, attendance prompts, and social reinforcement) have been used with clients following discharge from residential substance abuse treatment.

**Learn More by Visiting:**

* **http://vaww.national.cmop.va.gov/MentalHealth/SUD/Forms/Allltems.aspx**

**Coping Cat**

Date of Review: October 2006

Coping Cat is a cognitive behavioral treatment that assists school-age children in (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying cognition in anxiety-provoking situations (i.e., unrealistic expectations); (3) developing a plan to help cope with the situation (i.e., determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement as appropriate. The intervention uses behavioral training strategies with demonstrated efficacy, such as modeling real-life situations, role-playing, relaxation training, and contingent reinforcement. Throughout the sessions, therapists use social reinforcement to encourage and reward the children, and the children are encouraged to verbally reinforce their own successful coping. Coping Cat consists of 16 sessions. The first eight sessions are training sessions in which each of the basic concepts are introduced individually and then practiced and reinforced. In the second set of eight sessions, the child practices the new skills in both imaginary and real-life situations varying from low stress/low anxiety to high stress/high anxiety, depending on what is appropriate for each child.

**Learn More by Visiting:**

* **http://www.workbookpublishing.com**

**Coping With Work and Family Stress**

Date of Review: October 2007

Coping With Work and Family Stress is a workplace preventive intervention designed to teach employees 18 years and older how to deal with stressors at work and at home. The model is derived from Pearlin and Schooler’s hierarchy of coping mechanisms as well as Bandura’s social learning theory. The 16 90-minute sessions, typically provided weekly to groups of 15-20 employees, teach effective methods for reducing risk factors (stressors and avoidance coping) and enhancing protective factors (active coping and social support) through behavior modification (e.g., methods to modify or eliminate sources of stress), information sharing (e.g., didactic presentations, group discussions), and skill development (e.g., learning effective communication and problem-solving skills, expanding use of social network). The curriculum emphasizes the role of stress, coping, and social support in relation to substance use and psychological symptoms. The sessions are led by a facilitator who typically has a master’s-level education; is experienced in group dynamics, system theory, and cognitive and other behavior interventions; and is able to manage group process. Facilitator training in the program curriculum is required.

**Learn More by Visiting:**

* **http://www.theconsultationcenter.org/index.php?/coping-with-work-a-family-stress.html**

**Creating Lasting Family Connections (CLFC)/Creating Lasting Connections (CLC)**

Date of Review: June 2007

Creating Lasting Family Connections (CLFC), the currently available version of Creating Lasting Connections (CLC), is a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their alcohol and other drug (AOD) use. CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings. The six modules of the CLFC curriculum, administered to parents/guardians and youth in 18-20 weekly training sessions, focus on imparting knowledge and understanding about the use of alcohol and other drugs, including tobacco; improving communication and conflict resolution skills; building coping mechanisms to resist negative social influences; encouraging the use of community services when personal or family problems arise; engendering self-knowledge, personal responsibility, and respect for others; and delaying the onset and reducing the frequency of AOD use among participating youth. The program emphasizes early intervention services for parents and youth and follow-up case management services for families. Manuals for trainers, notebooks for participants, and other materials are available, but the program is intended to be modified with each implementation to reflect the needs of the participants and the skill level of the trainers.

Creating Lasting Connections was an experimental program implemented and evaluated in church communities with the families of high-risk 11- to 14-year-old youth. CLC served as the basis for CLFC, which is now in use.

**Learn More by Visiting:**

* **http://www.copes.org**

**Critical Time Intervention**

Date of Review: August 2006

Critical Time Intervention (CTI) is designed to prevent recurrent homelessness and other adverse outcomes among persons with severe mental illness. It aims to enhance continuity of care during the transition from institutional to community living. The intervention, which lasts roughly 9 months following institutional discharge, involves two components: (1) strengthening the individual’s long-term ties to services, family, and friends; and (2) providing emotional and practical support during the transition. Postdischarge services are delivered by workers who have established relationships with patients during their institutional stay. CTI is intended to be used with individuals leaving institutions such as shelters, hospitals, and jails. The intervention is delivered in three main phases: (1) transition to the community, which focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers; (2) tryout, which involves testing and adjusting the systems of support that were developed in the first phase; and (3) transfer of care, which completes the transfer of care to community resources that will provide long-term support.

**Learn More by Visiting:** **http://www.criticaltime.org**

**Curriculum-Based Support Group (CBSG) Program**

Date of Review: April 2010

The Curriculum-Based Support Group (CBSG) Program is a support group intervention designed to increase resiliency and reduce risk factors among children and youth ages 4-15 who are identified by school counselors and faculty as being at elevated risk for early substance use and future delinquency and violence (e.g., they are living in adverse family situations, displaying observable gaps in coping and social skills, or displaying early indicators of antisocial attitudes and behaviors).

Based on cognitive-behavioral and competence-enhancement models of prevention, the CBSG Program teaches essential life skills and offers emotional support to help children and youth cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and other drugs; and reduce antisocial attitudes and rebellious behavior. Delivered in 10-12 weekly, 1-hour support group sessions, the curriculum addresses topics such as self-concept, anger and other feelings, dreams and goal setting, healthy choices, friends, peer pressure, life challenges, family chemical dependency, and making a public commitment to staying drug free and true to life goals. Lesson content and objectives are essentially the same for all participants but are tailored for age and developmental status.

Groups are formed with 6-10 participants no more than 2 years apart in age and are led by trained adult facilitators and cofacilitators who follow the program facilitator's manual. Students ages 8-11 participated in the study reviewed for this summary.

**Learn More by Visiting:**

* **http://www.rdikids.org**

**Customized Employment Supports**

Date of Review: March 2008

Customized Employment Supports (CES, formerly known as Comprehensive Employment Supports) was developed to help methadone treatment patients, who are likely to have irregular work histories, attain rapid placement in paid jobs and increase their legitimate earnings. CES counselors work intensively with a small caseload of unemployed and underemployed patients (15-18 in the initial period) to help them overcome the barriers that hinder their employment. This intervention extends to an addiction population the principles of the Individual Placement and Support (IPS) model of vocational counseling for persons with disabilities. CES has six stages of service delivery: assessment, engagement, enhancement of self-efficacy to reduce barriers, focused employment skills teaching, preparation for interviewing, and job retention. CES is implemented in two settings: first in the program/clinic to practice interviewing and prepare a resume, and then in the community to help the individual secure and retain a job. Sessions in the community involve active engagement techniques to build a therapeutic alliance with the patient. Vocationally relevant learning activities take place in the community on "neutral turf" to promote the development of patient trust and openness. Master's-level vocational rehabilitation counselors meet with patients individually up to three times per week during an intensive phase of up to 6 months until employment is obtained, followed by continuing job retention support.

**Learn More by Visiting:**

* **http://www.ndri.org/ctrs/itsr/ces.html**

**DARE to be You**

Date of Review: November 2006

DARE to be You (DTBY) is a multilevel prevention program that serves high-risk families with children 2 to 5 years old. Program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse, including parental self-efficacy, effective child rearing, social support, and problem-solving skills. Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, providing knowledge of appropriate child management strategies, improving parents' and children's relationships with their families and peers, and contributing to child developmental advancement.

**Learn More by Visiting:**

* **http://www.colostate.edu/Depts/CoopExt/DTBY/**

**Dialectical Behavior Therapy**

Date of Review: October 2006

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. “Dialectical” refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

**Learn More by Visiting:**

* **http://www.behavioraltech.org**
* **http://depts.washington.edu/brtc/about/dbt**
* **Double Trouble in Recovery**
* Date of Review: December 2007
* Double Trouble in Recovery (DTR) is a mutual aid, self-help program for adults ages 18-55 who have been dually diagnosed with mental illness and a substance use disorder. In a mutual aid program, people help each other address a common problem, usually in a group led by consumer facilitators rather than by professional treatment or service providers. DTR is adapted from the Twelve Steps of Alcoholics Anonymous. DTR meetings follow the traditional 12-step format, which includes group member introductions, a presentation by a speaker with experiences similar to those of the meeting attendees, and time for all attendees to share their experiences with the group. Meetings typically last 60-90 minutes. DTR encourages members to discuss their addiction, mental illness, psychotropic medications, and experiences with formal treatment without the stigma they might encounter in traditional 12-step programs, which have a single focus. DTR groups are structured to create an environment in which people with an active addiction and psychiatric diagnosis can identify with other members and explore their dual recovery needs.

**Learn More by Visiting:**

* **http://www.doubletroubleinrecovery.org**

**Drinker's Check-up**

Date of Review: February 2008

Drinker’s Check-up (DCU) is a computer-based brief intervention designed to help problem drinkers reduce their alcohol use and alcohol-related consequences. The program targets individuals along the continuum of problem drinking from hazardous use (e.g., binge-drinking college students) to alcohol dependence (e.g., individuals presenting for specialized alcohol treatment). DCU is based on the principles of brief motivational interviewing and is sensitive to the individual’s readiness to change. DCU’s core elements are characterized by the acronym FRAMES: Feedback is personalized, Responsibility for changing is left with the individual, Advice to change is given, a Menu of options for changing is offered, information is provided in an Empathetic style, and Self-efficacy is emphasized. The program consists of integrated assessment, feedback, and decisionmaking modules. Following the completion of the assessment and feedback modules, users are prompted to review information and exit the program, complete a second decisional balance exercise, or negotiate goals and develop a plan for change, depending on the individual’s reported readiness to change. DCU is available as a Windows program for use by health care providers, therapists, and treatment programs and as a Web application for use by the general public. The Windows version includes a companion Follow-up DCU (FDCU) program for conducting follow-up data collection and evaluating treatment outcomes. DCU can be used as a stand-alone intervention or as a precursor to more intensive alcohol treatment.

**Learn More by Visiting:**

* **http://www.drinkerscheckup.com/**

**Early Risers "Skills for Success"**

Date of Review: May 2007

Early Risers “Skills for Success” is a multicomponent, developmentally focused, competency-enhancement program that targets 6- to 12-year-old elementary school students who are at high risk for early development of conduct problems, including substance use. Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions to move high-risk children onto a more adaptive developmental pathway.

A “family advocate” (someone with a bachelor's degree and experience working with children/parents) coordinates the child- and family-focused components. The child-focused component has three parts: (1) Summer Day Camp, offered 4 days per week for 6 weeks and consisting of social-emotional skills education and training, reading enrichment, and creative arts experiences supported by a behavioral management protocol; (2) School Year Friendship Groups, offered during or after school and providing advancement and maintenance of skills learned over the summer; and (3) School Support, which occurs throughout each school year and is intended to assist and modify academic instruction, as well as address children’s behavior while in school, through case management, consultation, and mentoring activities performed by the family advocate at school. The family-focused component has two parts: (1) Family Nights with Parent Education, where children and parents come to a center or school five times per year during the evening, with children participating in fun activities while their parents meet in small groups for parenting-focused education and skills training; and (2) Family Support, which is the implementation of an individually designed case plan for each family to address their specific needs, strengths, and maladaptive patterns through goal setting, brief interventions, referral, continuous monitoring, and, if indicated, more intensive and tailored parent skills training.

**Emergency Department Means Restriction Education**

Date of Review: March 2010

Emergency Department Means Restriction Education is an intervention for the adult caregivers of youth (aged 6 to 19 years) who are seen in an emergency department (ED) and determined through a mental health assessment to be at risk for committing suicide. Studies show that the presence of a gun in the household increases suicide risk, yet parents who take their adolescent to an ED for a suicide attempt are often not warned about restricting their child’s access to firearms and other lethal means. ED Means Restriction Education is designed to help parents and adult caregivers of at-risk youth recognize the importance of taking immediate, new action to restrict access to firearms, alcohol, and prescription and over-the-counter drugs in the home. The intervention also gives parents and caregivers specific, practical advice on how to dispose of or lock up firearms and substances that may be used in a suicide attempt. Examples are using firearm locking devices or locked medicine cabinets, turning in firearms to local police, or moving the item to another location outside the home. By encouraging reduced access to these means, the intervention also aims to lessen the risk of violence directed at others, including homicide.

The intervention is designed to be delivered in a brief period consistent with the demands of busy EDs. The intervention consists of three components or messages that can be delivered by a trained health care professional, such as a physician, nurse, social worker, or mental health specialist. The three components are (1) informing parents, when their child is not present, that the child is at increased suicide risk and why (e.g., “Adolescents who have made a suicide attempt are at risk for another attempt”); (2) telling parents they can reduce this risk by limiting their child’s access to lethal means; and (3) educating parents and problem solving with them about how to limit access to lethal means.

**Emergency Room Intervention for Adolescent Females**

Date of Review: October 2007

Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts. A review of the literature suggests that factors related to treatment noncompliance following a suicide attempt include family discord, maternal psychopathology, attempter depression, and negative experiences with emergency room staff. The intervention consists of three components designed to improve the emergency room experience for the adolescent and family, thereby changing the family’s conceptualization of the suicidal behavior and expectations about therapy. First, a 2-hour training is conducted separately with each of the six groups of staff working with adolescents who have attempted suicide. Second, the adolescents and their families watch a 20-minute videotape, filmed in Spanish and dubbed in English, that portrays the emergency room experience of two adolescents who have attempted suicide. Last, a bilingual crisis therapist delivers a brief family treatment in the emergency room.

**Learn More by Visiting:**

* **http://chipts.ucla.edu/interventions/manuals/interer.html**

**EnhanceWellness**

Date of Review: August 2010

EnhanceWellness is an outpatient intervention for older adults with chronic health conditions such as heart disease, high blood pressure, arthritis, and rheumatism. The program's goal is to help men and women better manage their illnesses and minimize related problems such as unnecessary use of prescription psychoactive medications, physical inactivity, depression, and social isolation. The individually tailored service is delivered through health care providers at senior centers and other community locations and is designed to complement medical intervention provided by the participant's primary medical team. Following a referral from their primary care physician or a community-based provider, participants meet with an EnhanceWellness provider, typically a registered nurse (RN) or social worker who has been trained in motivational interviewing and transtheoretical behavior change. The provider coaches the participant in developing a tailored health action plan that identifies risk factors the participant has chosen to work on as well as goals for making changes in those risk factors. Participants are encouraged to enroll in any or all of the three core offerings:

* EnhanceFitness (formerly the Lifetime Fitness Program), an evidence-based exercise class provided at various community locations. (In the initial randomized trial reviewed in this summary, the class was provided at the senior center.) Alternatively, participants can opt to follow an exercise regimen at home or with another group.
* The Chronic Illness Self-Management Course, a series of 2.5-hour classes offered weekly for 6 weeks. (In the initial trial, classes were 2 hours and held weekly for 7 weeks.) The course combines peer support with health promotion information and disease self-management concepts. As part of the course, participants use the accompanying self-management workbook, Living a Healthy Life With Chronic Conditions.
* Peer support provided by a trained volunteer (health mentor).

After the initial meeting, the RN or social worker monitors the participant's progress toward health goals through follow-up visits and telephone calls and informs the primary care physician of the participant's progress. In the initial trial, the number of in-person visits ranged from 1 to 8, with an average of 3, and the number of phone contacts ranged from 1 to 22, with an average of 9. EnhanceWellness participants typically remain in the program for 6 months, graduating once they reach the goals outlined in their health action plan.

**Learn More by Visiting:**

* **http://www.projectenhance.org**

**Familias Unidas**

Date of Review: October 2009

Familias Unidas is a family-based intervention for Hispanic families with children ages 12-17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning. Familias Unidas is guided by ecodevelopmental theory, which proposes that adolescent behavior is affected by a multiplicity of risk and protective processes operating at different levels (i.e., within family, within peer network, and beyond), often with compounding effects. The program is also influenced by culturally specific models developed for Hispanic populations in the United States.

The intervention is delivered primarily through multiparent groups, which aim to develop effective parenting skills, and family visits, during which parents are encouraged to apply those skills while interacting with their adolescent. The multiparent groups, led by a trained facilitator, meet in weekly 2-hour sessions for the duration of the intervention. Each group has 10 to 12 parents, with at least 1 parent from each participating family. Sessions include problem posing and participatory exercises. Group discussions aim to increase parents' understanding of their role in protecting their adolescent from harm and to facilitate parental investment.

The intervention proceeds in three stages:

* Stage 1: The facilitator aims to engage parents in the intervention and create cohesion among the parents in the group.
* Stage 2: The facilitator introduces three primary adolescent "worlds" (i.e., family, peers, school), elicits parents' specific concerns within each world (e.g., disobedience within the family, unsupervised association with peers, problems at school), and assures parents that the intervention will be tailored to address these concerns.
* Stage 3: The facilitator fosters the parenting skills necessary to decrease adolescent problem behavior and increase adolescent school bonding and academic achievement. In this third stage, group sessions are interspersed with home visits, during which facilitators supervise parent-adolescent discussions to encourage bonding within the family and help parents implement the skills related to each of the three worlds (e.g., discussing behavior management, peer supervision issues, and homework). Each family receives up to eight home visits

Familias Unidas also involves meetings of parents with school personnel, including the school counselor and teachers, to connect parents to their adolescent's school world. Family activities involving the parents, the adolescent, and his or her peers and their parents allow parents to connect to their adolescent's peer network and practice monitoring skills.

The duration of the intervention ranges from 3 to 5 months depending on the target population. Facilitators must be Spanish speaking and bicultural, with a minimum of a bachelor's degree in psychology and 3 years of clinical experience, or a master's degree and 1 year of clinical experience.

**Families and Schools Together (FAST)**

Date of Review: December 2008

Families and Schools Together (FAST) is a multifamily group intervention designed to build relationships between families, schools, and communities to increase well-being among elementary school children. The program’s objectives are to enhance family functioning, prevent school failure, prevent substance misuse by the children and other family members, and reduce the stress that children and parents experience in daily situations. Participants in the multifamily group work together to enhance protective factors for children, including parent-child bonding, parent involvement in schools, parent networks, family communication, parental authority, and social capital, with the aim of reducing the children’s anxiety and aggression and increasing their social skills and attention spans.

FAST includes three components: outreach to parents, eight weekly multifamily group sessions, and ongoing monthly group reunions for up to 24 months to support parents as the primary prevention agents for their children. Collaborative teams of parents/caregivers, professionals (e.g., substance abuse or mental health professionals), and school personnel facilitate the groups, which meet at the school at the end of the school day. With each cycle of FAST implementation, 30 to 50 students in one grade level and their families can participate.

Although versions of FAST have been developed for families with children of all ages (babies through teens), the research reviewed for this summary included only elementary school children.

**Learn More by Visiting:**

* **http://familiesandschools.org**
* **http://cfsproject.wceruw.org/fastprogram.html**

**Family Behavior Therapy**

Date of Review: October 2006

Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. This treatment approach owes its theoretical underpinnings to the Community Reinforcement Approach and includes a validated method of improving enlistment and attendance. Participants attend therapy sessions with at least one significant other, typically a parent (if the participant is under 18) or a cohabitating partner. Treatment typically consists of 15 sessions over 6 months; sessions initially are 90 minutes weekly and gradually decrease to 60 minutes monthly as participants progress in therapy. FBT includes several interventions, including (1) the use of behavioral contracting procedures to establish an environment that facilitates reinforcement for performance of behaviors that are associated with abstinence from drugs, (2) implementation of skill-based interventions to assist in spending less time with individuals and situations that involve drug use and other problem behaviors, (3) skills training to assist in decreasing urges to use drugs and other impulsive behavior problems, (4) communication skills training to assist in establishing social relationships with others who do not use substances and effectively avoiding substance abusers, and (5) training for skills that are associated with getting a job and/or attending school.

**Learn More by Visiting:**

* **http://www.unlv.edu/centers/achievement**

**Family Matters**

Date of Review: October 2006

Family Matters is a family-directed program to prevent adolescents 12 to 14 years of age from using tobacco and alcohol. The intervention is designed to influence population-level prevalence and can be implemented with large numbers of geographically dispersed families. The program encourages communication among family members and focuses on general family characteristics (e.g., supervision and communication skills) and substance-specific characteristics (e.g., family rules for tobacco and alcohol use and media/peer influences). The program involves successive mailings of four booklets to families and telephone discussions between the parent and health educators. Two weeks after family members read a booklet and carry out activities intended to reinforce its content, a health educator contacts a parent by telephone. A new booklet is mailed when the health educator determines that the prior booklet has been completed. The program can be implemented by many different types of organizations and people, such as health promotion practitioners in health departments, school health educators and parent-teacher groups, volunteers in community-based programs, and national nonprofit organizations.

**Learn More by Visiting:**

* **http://familymatters.sph.unc.edu/index.htm**

**Family Support Network (FSN)**

Date of Review: July 2008

Family Support Network (FSN) is an outpatient substance abuse treatment program targeting youth ages 10-18 years. FSN includes a family component along with a 12-session, adolescent-focused cognitive behavioral therapy--called Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT12)--and case management. The family component attempts to engage adolescents and their parents in a joint commitment to the treatment and recovery process. It establishes a support system, encourages family communication, and teaches parents behavioral management skills with the ultimate goal of improving the quality of family interrelationships. The family component includes:

* Six biweekly, multifamily education meetings addressing teen beliefs, adolescent development, adolescent drug use patterns, drugs and adolescents, the recovery process, and family management issues such as boundaries, parental discipline, and communication
* Four monthly home visits to reinforce the family's commitment to treatment and help the adolescent and his or her family individualize the skills they learned

The MET/CBT12 component provides 2 individual sessions of MET that explore and resolve the youth's ambivalence about changing substance abuse behaviors and 10 group sessions of CBT that teach youth specific cognitive behavioral skills. These skills include refusing cannabis, problem solving, anger awareness and management, dealing with criticism, managing depression, coping with cravings, managing thoughts about marijuana, planning for emergencies, building a better social network, engaging in activities unrelated to drug use, and coping with relapse.

The case management component addresses barriers to treatment participation and can include weekly phone calls to discuss attendance, transportation, and child care, as well as mediating support among the adolescent, parents, and social institutions (e.g., school, social services, juvenile court system). Families with more complex needs, such as those related to housing, school, and employment, are provided more intensive case management services for 2 months, after which they receive standard case management.

The family component, MET/CBT12, and case management are administered concurrently using different providers trained in each specialty.

**Forever Free**

Date of Review: December 2006

Forever Free is a drug treatment program for women who abuse drugs and are incarcerated. The intervention aims to reduce drug use and improve behaviors of women during incarceration and while they are on parole. While they are incarcerated, women participate in individual substance abuse counseling, special workshops, educational seminars, 12-step programs, parole planning, and urine testing. Counseling and educational topics include self-esteem, anger management, assertiveness training, information about healthy versus dysfunctional relationships, abuse, posttraumatic stress disorder, codependency, parenting, and sex and health. The program lasts 4-6 months. Women participate in 4 hours of program activities 5 days per week. After graduation and discharge to parole, women may voluntarily enter community residential treatment. Residential treatment services include individual and group counseling. Some women also participate in family counseling, vocational training/rehabilitation, and recreational or social activities.

**Friends Care**

Date of Review: January 2008

Friends Care is a stand-alone aftercare program for probationers and parolees exiting mandated outpatient substance abuse treatment. The aftercare program is designed to maintain and extend the gains of court-ordered outpatient treatment by helping clients develop and strengthen supports for drug-free living in the community. Program goals include reduced drug use and criminal activity. Friends Care offers individual counseling to explore and resolve issues in maintaining a drug-free and productive life and to support efforts to continue drug-free functioning; case management to assist in obtaining needed services; skills building in job seeking and appropriate workplace demeanor; family relationship strengthening; education on HIV prevention; crisis intervention; and a peer support group. The program provides services for up to 6 months following discharge from an outpatient facility.

**Functional Adaptation Skills Training (FAST)**

Date of Review: March 2007

Functional Adaptation Skills Training (FAST) is an intervention for adult patients 40 years and older living in board-and-care facilities who have been diagnosed with schizophrenia or schizoaffective disorder. The goal of FAST is to improve patients’ independence and quality of life. The intervention is manualized and based on social cognitive theory and independent living skills programs. FAST targets six areas of everyday functioning: medication management, social skills, communication skills, organization and planning, transportation, and financial management. Participants in FAST meet once per week, in a group format, over the course of 24 weeks. Each session lasts approximately 2 hours and is led by a master’s- or doctoral-level therapist or by a nursing paraprofessional in the board-and-care facility.

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**Guiding Good Choices**

Date of Review: April 2007

Guiding Good Choices (GGC) is a drug use prevention program that provides parents of children in grades 4 through 8 (9 to 14 years old) with the knowledge and skills needed to guide their children through early adolescence. It seeks to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding within the family, and teach skills that allow children to resist drug use successfully. GGC is based on research that shows that consistent, positive parental involvement is important to helping children resist substance use and other antisocial behaviors. Formerly known as Preparing for the Drug Free Years, this program was revised in 2003 with more family activities and exercises. The current intervention is a five-session curriculum that addresses preventing substance abuse in the family, setting clear family expectations regarding drugs and alcohol, avoiding trouble, managing family conflict, and strengthening family bonds. Sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback, and use video-based vignettes to demonstrate parenting skills. Families also receive a Family Guide containing family activities, discussion topics, skill-building exercises, and information on positive parenting.

**Learn More by Visiting: http://www.channing-bete.com/ggc**

* **Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention Program for African American Women (HWFD)**
* Date of Review: May 2010
* Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention Program for African American Women (HWFD) targets African American women who are 13 to 55 years old and at risk of contracting HIV/AIDS and transmitting HIV through unsafe sexual activity and substance abuse. Program participants are referred from agencies that provide services in primarily urban areas with high poverty and unemployment rates. The curriculum is based on African-centered precepts, values, and beliefs tied with a conceptual framework called "culturecology," which poses that an understanding of African American culture is central to behavior and behavioral change. Through a process of resocialization, or "culturalization," HWFD seeks to instill traditional African and African American health-promoting values that can help participants overcome negative social influences. Goals of the intervention include increasing motivation and sense of self-efficacy, decreasing depression and feelings of hopelessness, increasing knowledge about HIV/AIDS, and promoting less risky sexual practices.
* HWFD has four core components: (1) the African Centered Behavioral Change HIV/AIDS & Substance Abuse Prevention Curriculum, (2) the Zola Ngolo Healing Ritual; (3) the Self-Healing Practice: Loving Oneself; and (4) Journaling. HWFD’s strategies address women as whole persons in the context of family and community. These strategies include self- and collective-directed veneration, rituals of reflection and healing, and cultural realignment. The intervention is conducted by trained professional and paraprofessional women assisted by a licensed mental health professional and delivered in 16 weekly 2-hour modules. The content of the modules is fixed but can be augmented with input from the participants. The modules incorporate individual sessions and group discussions, behavioral skills practice, lectures, role-playing, viewing of prevention videos, and take-home exercises.

**Healthy Alternatives for Little Ones (HALO)**

Date of Review: April 2010

Healthy Alternatives for Little Ones (HALO) is a 12-unit holistic health and substance abuse prevention curriculum for children ages 3-6 in child care settings. HALO is designed to address risk and protective factors for substance abuse and other health behaviors by providing children with information on healthy choices. The program aims to help children understand the complexities of "health" and "healthy choices" by putting these abstract concepts into concrete terms they can understand. In HALO, health is defined as "growing bigger, stronger, and better able to think." The curriculum encourages healthy eating, exercise, and emotion recognition and educates children about the harmful effects of alcohol, tobacco, and other drugs (ATOD) on the body. HALO provides learning opportunities for children through teacher-led, developmentally appropriate, and fun hands-on activities that involve educational songs, videos, group activities, and books. Parental involvement is facilitated through introductory and unit-specific letters that encourage at-home discussion and the practice of identifying and making healthy choices.

**Learn More by Visiting:**

* **http://haloforkids.org**

**Healthy Living Project for People Living With HIV**

Date of Review: March 2010

The Healthy Living Project for People Living With HIV promotes protective health decisionmaking among individuals with HIV--heterosexual women, heterosexual men, gay men, and injection drug users--to reduce substance use and the risk of transmitting HIV. The Healthy Living Project is based on social action theory and targets the interactive psychosocial domains of the community environment, internal affective states, and self-regulation. Using a cognitive-behavioral approach, this manual-driven intervention is delivered by facilitators functioning as “life coaches” who work with clients individually to help them make changes in their health behavior, become active participants in their ongoing medical care, and achieve desired personal goals. The Healthy Living Project consists of 15 sessions, each 90 minutes in duration, presented in 3 modules: Stress, Coping, and Adjustment; Safer Behaviors; and Health Behaviors. During tailored counseling sessions, the client is encouraged to identify a life project and work with the coach to set attainable goals and build self-confidence, self-esteem, and motivation to increase protective health behaviors. Intervention strategies include psychosocial education, skills building to improve coping, and problem-solving training involving role-play exercises.

**Learn More by Visiting:**

* **http://chipts.ucla.edu/projects/chipts/hlp.asp**
* **http://www.cch.ucla.edu/research/hlp.htm**

**Healthy Workplace**

Date of Review: April 2008

Healthy Workplace is a set of substance abuse prevention interventions for the workplace that are designed for workers who are not substance-dependent and still have the power to make choices about their substance use. The five Healthy Workplace interventions--SAY YES! Healthy Choices for Feeling Good, Working People: Decisions About Drinking, the Make the Connection series, Healthy Life 2000 (formerly Prime Life 2000), and Power Tools--target unsafe drinking, illegal drug use, prescription drug use, and the healthy lifestyle practices of workers. Cast in a health promotion framework and grounded in social-cognitive principles of behavior change, Healthy Workplace interventions integrate substance abuse prevention materials into popular health promotion programs, thereby defusing the stigma of substance abuse and reducing barriers to help-seeking behavior. Intervention materials are designed to raise awareness of the hazards of substance use and the benefits of healthy behaviors and to teach techniques to live healthier lives. The interventions are delivered in small group sessions using videos and print materials that can be used in any order and are selected based on the organization’s goals and workforce composition (construction workers, office workers, technical/professional staff, etc.).

**Learn More by Visiting:**

* **http://www.centerforworkforcehealth.com**

**HighScope Curriculum**

Date of Review: May 2009

The HighScope Curriculum is an early childhood education program for children ages birth to 5 years. Designed for children with or without special needs and from diverse socioeconomic backgrounds and ethnicities, the program aims to enhance children’s cognitive, socioemotional, and physical development, imparting skills that will help children succeed in school and be more productive and responsible throughout their lives. The curriculum is based on the view that children are active learners who learn from what they do as well as what they hear and see. It offers a balance of activities planned by children (e.g., playing with toys, games) and those planned by adults (e.g., group time, field trips, special events). The classroom is arranged into various areas, such as house, art, block, and book areas, allowing children to independently find, use, and return the materials they need to carry out their chosen activities. In their daily routine, children plan what they will do, carry out their plans, and review their activities with adults and other children. They engage in individual and social play and in small-group and whole-group activities, thereby developing initiative, a sense of responsibility, social cooperation, and individual competence. The curriculum has a version for infants and toddlers (birth to 3 years) and a version for preschool children (3 to 5 years). Studies of the preschool curriculum were reviewed for this summary. Children participate in the preschool program for 1 to 3 years, with each year's teaching practices and curriculum content being developmentally and age appropriate.

**Learn More by Visiting:**

* **http://www.highscope.org**

**Hip-Hop 2 Prevent Substance Abuse and HIV (H2P)**

Date of Review: November 2009

Hip-Hop 2 Prevent Substance Abuse and HIV (H2P) is designed to improve knowledge and skills related to drugs and HIV/AIDS among youth ages 12-16 with the aim of preventing or reducing their substance use and risky sexual activity. The program incorporates aspects of hip-hop culture--including language, arts, and history--as a social, cultural, and contextual framework for addressing substance use and HIV risk behaviors.

H2P uses a curriculum consisting of 10 modules, called "ciphers," delivered in 10 2-hour sessions. Through the curriculum's use of hip-hop culture, an interactive, multimedia CD, and a mix of traditional teaching methods, students learn information about drugs, HIV/AIDS, and sexual behavior; resistance and refusal skills; effective communication and negotiation skills; information about healthy alternatives to sex and drugs; and prevention self-efficacy skills.

School staff (e.g., teachers, counselors) deliver the first four modules in after-school or in-school sessions and the remaining modules at H2P camp, a 3-day retreat offering students structured learning and recreational activities, team-building experiences, mentoring, and opportunities for creative expression. Prior to serving as instructors, school staff participate in a 1-day training to learn about the genesis, ideology, and cultural components of hip-hop.

**Learn More by Visiting:**

* **http://www.hiphop2prevent.org**
* **http://www.ypci.org/**

**I'm Special**

Date of Review: June 2010

I'm Special is a substance abuse prevention program for 3rd and 4th graders. The primary goal of the program is to develop and nurture each child's sense of uniqueness and self-worth. It further enhances the protective and resiliency factors of children by teaching them appropriate ways for dealing with feelings; steps for making decisions; and skills for healthy living, effective group interactions, and resisting drugs, as provided through the program's "no use" message. The program is administered by trained facilitators through eight 50- to 60-minute group sessions, which are designed to be enjoyable for children and include a variety of hands-on activities. To become a trained facilitator, an individual with group leadership experience (e.g., a teacher, youth leader, counselor, prevention specialist) must complete a 2-day training. I'm Special has been implemented with both universal and at-risk populations in school classrooms and in after-school settings as well as with youth groups (e.g., clubs, Scouts).

**Learn More by Visiting:**

* **http://www.preventionservices.org**

**IMPACT (Improving Mood--Promoting Access to Collaborative Treatment)**

Date of Review: August 2007

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for patients 60 years or older who have major depression or dysthymic disorder. The intervention is a 1-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment. Intervention participants receive a 20-minute educational videotape and a booklet about late-life depression and are encouraged to have an initial visit with a depression care manager (DCM). During the first visit, the DCM completes an initial assessment, provides education about treatments, and discusses the patient's preference for depression treatment (i.e., antidepressant medications and psychotherapy). All patients are encouraged to engage in behavioral activation such as physical activity or pleasant events scheduling. The IMPACT treatment algorithm suggests an initial choice of an antidepressant medication or a course of Problem Solving Treatment in Primary Care (PST-PC), six to eight sessions of brief structured psychotherapy delivered by a DCM in the primary care setting. For patients already taking antidepressant medications who are still depressed, the recommendation typically is to increase the dose, augment the antidepressant with a trial of PST-PC, or switch to a different medication or PST-PC. New cases and cases needing treatment plan adjustment are discussed with a supervising team psychiatrist during weekly team meetings. The DCM then works with the patient and his or her primary care provider to establish a treatment plan according to the recommended treatment algorithm; the patient and primary care provider make the actual treatment choices. The DCM follows up with patients in person or by telephone approximately every 2 weeks during acute phase and approximately monthly during the continuation phase.

**Learn More by Visiting:**

* **http://impact-uw.org**

**Incredible Years**

Date of Review: August 2007

Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2- to 12-year-old children and their parents and teachers. The parent, child, and teacher training interventions that compose Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The three program components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children.

The parent training intervention focuses on strengthening parenting competencies and fostering parents’ involvement in children’s school experiences to promote children’s academic and social skills and reduce delinquent behaviors. The Dinosaur child training curriculum aims to strengthen children’s social and emotional competencies, such as understanding and communicating feelings, using effective problem-solving strategies, managing anger, practicing friendship and conversational skills, and behaving appropriately in the classroom. The teacher training intervention focuses on strengthening teachers’ classroom management strategies, promoting children’s prosocial behavior and school readiness, and reducing children’s classroom aggression and noncooperation with peers and teachers. The intervention also helps teachers work with parents to support their school involvement and promote consistency between home and school. In all three training interventions, trained facilitators use videotaped scenes to structure the content and stimulate group discussions and problem solving.

**Learn More by Visiting:**

* **http://www.incredibleyears.com**

**Interim Methadone Maintenance**

Date of Review: October 2008

Interim Methadone Maintenance, also known as Interim Maintenance or IM, is a simplified methadone treatment program for opioid-dependent adults who are on waiting lists for comprehensive methadone treatment. IM consists of a daily, individually determined methadone dose, administered by a nurse, plus emergency counseling for up to 120 days. U.S. Federal regulations permit methadone treatment programs (MTPs) to provide IM to adults who seek treatment but, due to limited program capacity, cannot be admitted within 14 days. The regulations specify that (1) only public or nonprofit MTPs can provide IM; (2) patients receive counseling with IM only for emergencies or during times of crisis (e.g., serious medical problem, relationship issues, temporary loss of housing), although this occurs on an infrequent basis; and (3) patients must undergo limited drug testing. IM aims to facilitate entry into MTPs and reduce heroin use and criminal behavior by capitalizing on the motivation of the individual seeking treatment and providing help at the time of the request.

**JOBS Program**

Date of Review: April 2010

The JOBS Program is intended to prevent and reduce negative effects on mental health associated with unemployment and job-seeking stress, while promoting high-quality reemployment. Structured as a job search seminar, the program teaches participants effective strategies for finding and obtaining suitable employment as well as for anticipating and dealing with the inevitable setbacks they will encounter. The program also incorporates elements to increase participants' self-esteem, sense of control, and job search self-efficacy. By improving their job-seeking skills and sense of personal mastery, the program inoculates participants against feelings of helplessness, anxiety, depression, and other stress-related mental health problems.

JOBS seminars use interactive methods to engage participants, such as small- and large-group discussions and modeling and role-playing techniques. The sessions include exercises to identify and convey one's job-related skills, use social networks to obtain job leads, contact potential employers, prepare job applications and resumes, and go through a job interview. Problem-solving exercises help participants prepare for and cope with the stresses of unemployment, the job search process, and setbacks.

The JOBS Program is delivered during five half-day sessions in employment offices, social service settings, community settings, and outplacement programs. Participants can be recruited from central organizational settings such as State employment offices or outplacement programs in corporate human resources departments. Seminars are provided to groups of 12-20 participants by a pair of trainers who receive approximately 160 hours of formal training, during which they learn about group processes and the theoretical bases of the intervention, undergo extensive rehearsal, and practice the delivery of the intervention.

**Learn More by Visiting:**

* **http://www.isr.umich.edu/src/seh/mprc/**

**Keep A Clear Mind (KACM)**

Date of Review: May 2007

Keep a Clear Mind (KACM) is a take-home drug education program for elementary school students in grades 4-6 (ages 9-11) and their parents. KACM is designed to help children develop specific skills to refuse and avoid use of “gateway” drugs. The program consists of four weekly lessons based on a social skills training model: Alcohol, Tobacco, Marijuana, and Tools To Avoid Drug Use. Each lesson introduces the topic for the week and is followed by a sequence of five activities to be completed at home with a parent. The activities include answering a simple question about drugs, listing reasons not to use specific drugs, writing “No” statements to resist social pressure to use drugs, selecting from a list of alternatives the best ways to refuse and avoid drugs, and completing contracts to refuse and avoid drugs. Small incentives such as folders, stickers, and bookmarks are provided to students who return their completed lessons within the indicated period. Parent newsletters prompt parents to reinforce their children for practicing saying no to drugs and provide specific behavior tips for communicating with children about how to avoid drug use. KACM can be facilitated by schools, private practice counselors, community-based youth organizations, and recreation centers.

**Descriptive Information**

**Learn More by Visiting:**

* **http://www.keepaclearmind.com**

**Keepin' it REAL**

Date of Review: December 2006

Keepin’ it REAL is a multicultural, school-based substance use prevention program for students 12-14 years old. Keepin’ it REAL uses a 10-lesson curriculum taught by trained classroom teachers in 45-minute sessions over 10 weeks, with booster sessions delivered in the following school year. The curriculum is designed to help students assess the risks associated with substance abuse, enhance decisionmaking and resistance strategies, improve antidrug normative beliefs and attitudes, and reduce substance use. The narrative and performance-based curriculum draws from communication competence theory and a culturally grounded resiliency model to incorporate traditional ethnic values and practices that protect against substance use. The curriculum places special emphasis on resistance strategies represented in the acronym REAL: Refuse offers to use substances, Explain why you do not want to use substances, Avoid situations in which substances are used, and Leave situations in which substances are used.

**Learn More by Visiting:**

* **http://www.dare.org**
* **http://www.discoveryeducation.com/products/health/resources.cfm**
* **http://www.kir.psu.edu/index.shtml**
* **Lifelines Curriculum**
* Date of Review: June 2009
* Lifelines is a comprehensive, schoolwide suicide prevention program for middle and high school students. The goal of Lifelines is to promote a caring, competent school community in which help seeking is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret. Lifelines seeks to increase the likelihood that school staff and students will know how to identify at-risk youth when they encounter them, provide an appropriate initial response, and obtain help, as well as be inclined to take such action.
* Lifelines includes a set of components to be implemented sequentially: a review of resources and establishment of administrative guidelines and procedures for responding to a student at risk; training for school faculty and staff to enhance suicide awareness and an understanding of the role they can play in identifying and responding to a student with suicidal behavior; a workshop and informational materials for parents; and implementation of a curriculum for students, the Lifelines Curriculum, to inform students about suicidal behavior and discuss their role in suicide prevention.
* The research reviewed for this summary assessed only the Lifelines Curriculum, the last component to be implemented in the larger Lifelines program. It consists of four 45-minute or two 90-minute lessons that incorporate elements of the social development model and employ interactive teaching techniques, including role-play. Health teachers and/or guidance counselors teach the lessons within the regular school health curriculum. The Lifelines Curriculum was developed specifically for students in grades 8-10 but can be used with students through 12th grade.

**Learn More by Visiting:**

* **http://www.hazelden.org/web/public/lifelines.page**
* **http://www.state.me.us/suicide**

**Media Detective**

Date of Review: June 2010

Media Detective is a media literacy education program for 3rd- to 5th-grade students. The goal of the program is to prevent or delay the onset of underage alcohol and tobacco use by enhancing the critical thinking skills of students so they become adept in deconstructing media messages, particularly those related to alcohol and tobacco products, and by encouraging healthy beliefs and attitudes about abstaining from alcohol and tobacco use. The program consists of 10 45-minute lessons based on established models of decisionmaking and research on the message interpretation process. Students are taught to deconstruct product advertisements by looking for five "clues": (1) the product, (2) the target audience, (3) the ad hook, (4) the hidden message, and (5) missing information about the health-related consequences of using the product. The program uses a range of pedagogical techniques and can be adapted to a variety of classroom settings and skill levels of students. The Media Detective program kit contains the main materials needed to teach the program, including a teacher manual, poster flipchart, and CD with media examples. Individual student workbooks that accompany the activities taught in each lesson are sold separately. Also available is a comprehensive online training workshop, which provides an introduction to the theory and research underlying the program model and instructions for facilitating each program activity. Those who finish this training and successfully complete assessment tests receive certification as program teachers. Media Detective is related to Media Ready, a media literacy education program for 6th- to 8th-grade students. Media Ready has been reviewed separately by NREPP.

**Learn More by Visiting:**

* **http://www.irtinc.us/products/mediadetective/index.html**

**Mendota Juvenile Treatment Center Program**

Date of Review: January 2010

The Mendota Juvenile Treatment Center (MJTC) program offers intensive mental health treatment to the most violent male adolescents held in secured correctional facilities. Primary themes of the program include helping youth accept responsibility for their behavior, teaching social skills, resolving mental health issues, and helping to build positive relationships with families. Originally established by the Wisconsin legislature as part of broad juvenile justice reform, the program has a unique clinical-correctional hybrid structure. It is operated under the administrative code of the Department of Corrections as a secured correctional facility but housed on the grounds of a State mental health facility. The ratio of clinical staff to residents is about twice that of more typical juvenile corrections units. Youth who are transferred to MJTC are selected by the staff of juvenile corrections institutions based on failure in the rehabilitative programming, nearly always because of aggressive or disruptive behavior.

The MJTC program relies on a variation of the “Decompression” treatment model combined with Aggression Replacement Training, a cognitive-behavioral treatment approach. The Decompression treatment model assumes that defiant behavior can become cyclic when the defiant response to a sanction is itself sanctioned, resulting in more defiance and increasing sanctions. Increased sanctions further disenfranchise youth from conventional goals and values and may result in a “compressed,” or actively and antagonistically defiant, behavior pattern. Inside the juvenile correctional institution, the typical outcome of this cycle of behavior and sanctions is extended periods of segregation or other controls permitted under the juvenile administrative code. The MJTC model attempts to erode aggressive adolescent offenders’ antagonistic defiance of authority figures. Staff are trained to give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior.

The MJTC program provides school services and group therapy focused on anger management, improved social skills and problem solving, and issues of substance abuse and sexual offenses. Youth in the program typically have several individual counseling sessions each week with a psychologist, psychiatrist, or social worker. A cornerstone of the intervention is the Today-Tomorrow Program, a behavioral point system that closely monitors the youth’s behavior and is highly responsive to changes in his behavior. Adolescents earn privileges following relatively short periods of positive behavior.

Across the three studies reviewed, the average length of time in treatment at MJTC ranged from 45 to 83 weeks.

**Modified Therapeutic Community for Persons With Co-Occurring Disorders**

Date of Review: March 2008

The Modified Therapeutic Community (MTC) for Persons With Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use disorders and mental disorders. MTC is a structured and active program based on community-as-method (that is, the community is the treatment agent) and mutual peer self-help. A comprehensive treatment model, MTC adapts the traditional therapeutic community (TC) in response to the psychiatric symptoms, cognitive impairments, and reduced level of functioning of the client with co-occurring disorders. Treatment encompasses four stages (admission, primary treatment, live-in reentry, and live-out reentry) that correspond to stages within the recovery process. The stage format allows gradual progress, rewarding improvement with increased independence and responsibility. Goals, objectives, and expected outcomes are established for each stage and are integrated with goals specific to each client in an individual treatment plan. Staff members function as role models, rational authorities, and guides.

The MTC model retains most of the key components, structure, and processes of the traditional TC but makes three key adaptations for individuals with co-occurring disorders: It is more flexible, less intense, and more personalized. For example, MTC reduces the time spent in each activity, deemphasizes confrontation, emphasizes orientation and instruction, uses fewer sanctions, is more explicit in acknowledging achievements, and accommodates special developmental needs.

When used in prison settings, MTC has included additional programmatic and operational adaptations to address the particular circumstances of offenders with co-occurring disorders. Programmatic alterations have included an emphasis on criminal thinking and behavior that recognizes the interrelationships of substance abuse, mental illness, and criminality, while operational adjustments have included adding security personnel to the treatment team and making other changes to comply with the security requirements of correctional facilities. In other community applications, outpatient substance abuse treatment programs have adopted certain features of the MTC model to improve services for their clients who have co-occurring disorders.

**Learn More by Visiting:**

* **http://www.ndri.org/ctrs/cirp.html**

**Moral Reconation Therapy**

Date of Review: May 2008

Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months.

**Learn More by Visiting:**

* **http://www.ccimrt.com**
* **http://www.moral-reconation-therapy.com**

**Motivational Enhancement Therapy**

Date of Review: September 2007

Motivational Enhancement Therapy (MET) is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly nonconfrontational manner. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence and achieve lasting changes for a range of problematic behaviors. This intervention has been extensively tested in treatment evaluations of alcohol and other drug use/misuse. MET uses an empathic but directive approach in which the therapist provides feedback that is intended to strengthen and consolidate the client’s commitment to change and promote a sense of self-efficacy. MET aims to elicit intrinsic motivation to change substance abuse by resolving client ambivalence, evoking self-motivational statements and commitment to change, and "rolling with resistance" (responding in a neutral way to the client's resistance to change rather than contradicting or correcting the client).

**Learn More by Visiting:**

* **http://motivationalinterview.org**

**Motivational Interviewing**

Date of Review: December 2007

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Although many variations in technique exist, the MI counseling style generally includes the following elements:

* Establishing rapport with the client and listening reflectively.
* Asking open-ended questions to explore the client’s own motivations for change.
* Affirming the client’s change-related statements and efforts.
* Eliciting recognition of the gap between current behavior and desired life goals.
* Asking permission before providing information or advice.
* Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
* Encouraging the client’s self-efficacy for change.
* Developing an action plan to which the client is willing to commit.

Adaptations of the MI counseling approach that are reviewed in this summary include a brief intervention for college-age youth visiting hospital emergency rooms after an alcohol-related event; a brief intervention for adult patients with histories of heavy drinking presenting to primary medical care settings for routine care; and a brief intervention for cocaine and heroin users presenting to urban walk-in medical clinics. Community-based substance abuse treatment clinics also have incorporated an MI counseling style into the initial intake/orientation session to improve program retention (also reviewed below).

**Learn More by Visiting:**

* **http://www.motivationalinterview.org**

**Multidimensional Family Therapy (MDFT)**

Date of Review: June 2008

Multidimensional Family Therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decisionmaking and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems.

Delivered across a flexible series of 12 to 16 weekly or twice weekly 60- to 90-minute sessions, MDFT is a manual-driven intervention with specific assessment and treatment modules that target four areas of social interaction: (1) the youth’s interpersonal functioning with parents and peers, (2) the parents’ parenting practices and level of adult functioning independent of their parenting role, (3) parent-adolescent interactions in therapy sessions, and (4) communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

**Learn More by Visiting:**

* **http://www.med.miami.edu/ctrada**

**Multidimensional Treatment Foster Care (MTFC)**

Date of Review: October 2009

Multidimensional Treatment Foster Care (MTFC) is a community-based intervention for adolescents (12-17 years of age) with severe and chronic delinquency and their families. It was developed as an alternative to group home treatment or State training facilities for youths who have been removed from their home due to conduct and delinquency problems, substance use, and/or involvement with the juvenile justice system. Youths are typically referred to MTFC after previous family preservation efforts or other out-of-home placements have failed. Referrals primarily come from juvenile courts and probation, mental health, and child welfare agencies. MTFC aims to help youth live successfully in their communities while also preparing their biological parents (or adoptive parents or other aftercare family), relatives, and community-based agencies to provide effective parenting and support that will facilitate a positive reunification with the family.

MTFC is based on social learning theory. Four key elements are targeted during foster care placement and aftercare:

1. Providing youth with a consistent reinforcing environment where they are mentored and encouraged to develop academic and positive living skills
2. Providing youth with daily structure that includes clear expectations and limits and well-specified consequences delivered in a teaching-oriented manner
3. Providing close supervision
4. Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships

Youths are individually placed with highly trained and supervised foster parents and are provided with intensive support and treatment in a setting that closely mirrors normative life. MTFC typically lasts 6-9 months and relies on coordinated, multimethod interventions conducted in the MTFC foster home, with the youth's biological or aftercare family, and with the youth. Involvement of the youth's family is emphasized from the outset of treatment to facilitate the youth's return to the family and maximize training and preparation for posttreatment care. Progress is tracked through daily telephone calls with the foster parents.

A program supervisor with a caseload of 10 or fewer youth oversees and coordinates the interventions and supervises and supports the foster parents throughout treatment through the daily telephone calls and weekly foster parent group meetings. The program supervisor also coordinates the work of family and individual therapists (for therapy conducted with the youth and his or her parents), skills trainers, and a foster parent liaison/trainer.

**Multisystemic Therapy (MST) for Juvenile Offenders**

Date of Review: March 2007

Multisystemic Therapy (MST) for juvenile offenders addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth’s social network that are contributing to his or her antisocial behavior. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST is delivered in the natural environment (in the home, school, or community). The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.

**Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)**

Date of Review: December 2009

Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB) is a clinical adaptation of Multisystemic Therapy (MST) that is specifically targeted to adolescents who have committed sexual offenses and demonstrated other problem behaviors. MST-PSB is suitable for use with male and female youth, although the youth included in the studies reviewed for this summary were primarily male. The primary objectives of MST-PSB are to decrease problem sexual and other antisocial behaviors and out-of-home placements. Based in principle on an ecological model, the intervention is directed at youth and their families, with the collaboration of community-based resources such as case workers, probation/parole officers, and school professionals.

Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth’s behavior but typically address deficits in overall family relations and the youth’s cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks.

MST-PSB is delivered in the youth’s natural environment (i.e., home, school, community) by master’s-level therapists trained in a clinical area of the human service field. Each therapist provides approximately 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.

**Learn More by Visiting:**

* **http://mstpsb.com**
* **http://www.mstservices.com/**

**Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)**

Date of Review: November 2008

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. Like standard MST, on which it is based, MST-Psychiatric has its foundation in social-ecological and social learning systems theories. It includes specific clinical and training components for staff designed to address (1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.

MST-Psychiatric teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in prosocial activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family’s natural environment (e.g., home, school, community) daily when needed and for approximately 6 months. A MST-Psychiatric team consists of a full-time doctoral-level supervisor, four master’s-level therapists, a part-time psychiatrist, and a bachelor’s-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.

**Learn More by Visiting:**

* **http://www.mstservices.com**
* **http://www.mstinstitute.org**

**Network Therapy**

Date of Review: February 2007

Network Therapy is a substance-abuse treatment approach that engages members of the patient’s social support network to support abstinence. Key elements of the approach are: (1) a cognitive-behavioral approach to relapse prevention in which patients learn about cues that can trigger relapse and behavioral strategies for avoiding relapse; (2) support from the patient’s natural social network; and (3) community reinforcement techniques engaging resources in the social environment to support abstinence. Network Therapy patients typically participate in outpatient treatment twice per week for 12 to 24 weeks. The patient participates in weekly individual therapy sessions and weekly sessions attended by network members approved by the therapist. Patients agree to contingency contracts agreeing to aversive consequences if they use targeted drugs. Some practitioners ask patients to submit urine samples for testing.

**New Beginnings Program**

Date of Review: March 2007

The New Beginnings Program (NBP) is designed for divorced parents who have children between the ages of 3 and 17. The goal of NBP is to promote resilience of children following parental divorce. The NBP consists of 10 weekly group sessions and two individual sessions. The parents learn skills to improve parent-child relationship quality and effectiveness of discipline, reduce exposure to interparental conflict, and decrease barriers to nonresidential parent-child contact. Each session includes a short lecture, skill demonstration, and skill practice. Participants are assigned homework after each session; difficulties and successes in implementing the skills at home are discussed in subsequent sessions. Each group is co-led by two master’s-level clinicians. The two individual sessions are timed to occur after the third and sixth group sessions.

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**New York University Caregiver Intervention (NYUCI)**

Date of Review: July 2007

New York University Caregiver Intervention (NYUCI) is a counseling and support intervention for spouse caregivers that is intended to improve the well-being of caregivers and delay the nursing home placement of patients with Alzheimer’s disease. The program also aims to help spouse caregivers mobilize their social support network and help them better adapt to their caregiving role. The program consists of four components, the first two of which are delivered within 4 months of enrollment in the study: (1) two individual counseling sessions of 1 to 3 hours tailored to each caregiver’s specific situation, (2) four family counseling sessions with the primary caregiver and family members selected by that caregiver, (3) encouragement to participate in weekly, locally available support groups after participation in the intervention, and (4) ad hoc counseling, counseling provided by telephone to caregivers and families whenever needed to help them deal with crises and the changing nature of their relative’s symptoms. The program is delivered by counselors with advanced degrees in social work or allied professions.

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**Not On Tobacco (N-O-T)**

Date of Review: February 2008

Not On Tobacco (N-O-T) is a school-based smoking cessation program designed for youth ages 14 to 19 who are daily smokers. N-O-T is based on social cognitive theory and incorporates training in self-management and stimulus control; social skills and social influence; stress management; relapse prevention; and techniques to manage nicotine withdrawal, weight, and family and peer pressure. The program consists of 50-minute group sessions conducted weekly for 10 consecutive weeks, plus four optional booster sessions. The sessions are delivered in gender-specific groups of 10-12 teens by same-gender facilitators. N-O-T can be implemented by schools or other community organizations using teachers, school nurses, counselors, and other staff and volunteers who are trained to facilitate group sessions.

**Learn More by Visiting:**

* **http://www.notontobacco.com**

**Nurse-Family Partnership**

Date of Review: July 2008

Nurse-Family Partnership (NFP) is a prenatal and infancy nurse home visitation program that aims to improve the health, well-being, and self-sufficiency of low-income, first-time parents and their children. NFP was founded on concepts of human ecology, self-efficacy, and human attachment. Its program activities are designed to link families with needed health and human services, promote good decisionmaking about personal development, assist families in making healthy choices during pregnancy and providing proper care to their children, and help women build supportive relationships with families and friends. Nurses follow a detailed, visit-by-visit guide that provides information on tracking dietary intake; reducing cigarette, alcohol, and illegal drug use; identifying symptoms of pregnancy complications and signs of children's illnesses; communicating with health care professionals; promoting parent-child interactions; creating safe households; and considering educational and career options. Program objectives include decreased substance use, improved maternal economic self-sufficiency, fewer subsequent unintended pregnancies, reduced child abuse and neglect, and improved school readiness of the children. Individual programs serve a minimum of 100-200 families and are supported by 4-8 trained registered nurse home visitors (each carrying a caseload of 25 families), a nurse supervisor, and administrative support. Nurse home visits begin early in pregnancy and continue until the child's second birthday. The frequency of home visits changes with the stages of pregnancy and infancy and is adapted to the mother's needs, with a maximum of 13 visits occurring during pregnancy and 47 occurring after the child's birth.

**Learn More by Visiting:**

* **http://www.nursefamilypartnership.org**

**Nurturing Parenting Programs**

Date of Review: April 2010

The Nurturing Parenting Programs (NPP) are family-based programs for the prevention and treatment of child abuse and neglect. The programs were developed to help families who have been identified by child welfare agencies for past child abuse and neglect or who are at high risk for child abuse and neglect. The goals of NPP are to:

* Increase parents’ sense of self-worth, personal empowerment, empathy, bonding, and attachment.
* Increase the use of alternative strategies to harsh and abusive disciplinary practices.
* Increase parents’ knowledge of age-appropriate developmental expectations.
* Reduce abuse and neglect rates.

NPP instruction is based on psychoeducational and cognitive-behavioral approaches to learning and focuses on "re-parenting," or helping parents learn new patterns of parenting to replace their existing, learned, abusive patterns. By completing questionnaires and participating in discussion, role-play, and audiovisual exercises, participants learn how to nurture themselves as individuals and in turn build their nurturing family and parenting skills as dads, moms, sons, and daughters. Participants develop their awareness, knowledge, and skills in five areas: (1) age-appropriate expectations; (2) empathy, bonding, and attachment; (3) nonviolent nurturing discipline; (4) self-awareness and self-worth; and (5) empowerment, autonomy, and healthy independence. Participating families attend sessions either at home or in a group format with other families. Group sessions combine concurrent separate experiences for parents and children with shared "family nurturing time." In home-based sessions, parents and children meet separately and jointly during a 90-minute lesson once per week for 15 weeks.

Two group facilitators are recommended for every seven adults participating in the program. Two additional group facilitators are recommended for every 10 children participating. NPP can be implemented by professionals or paraprofessionals in fields such as social work, education, recreation, and psychology who have undergone NPP facilitator training and have related experience.

Multiple NPPs have been developed for various age groups and family circumstances (see the Adaptations section below for more information). The studies reviewed for this summary involved the NPPs designed for (1) parents and their children 0-5 years and (2) parents and their school-age children 5-12 years.

**Learn More by Visiting:**

* **http://nurturingparenting.com**
* **http://nurturingtraining.com**

**OQ-Analyst**

Date of Review: August 2008

The OQ-Analyst (OQ-A) is a computer-based feedback and progress tracking system designed to help increase psychotherapy treatment effectiveness. By assessing the attainment of expected progress during therapy, the tracking system provides feedback to therapists on whether patients are staying on track toward positive treatment outcomes. This information may be shared with the patient at the therapist's discretion. In addition, the OQ-A can provide decision support to the therapist to maximize the likelihood of a positive outcome for the client.

Prior to therapy sessions, patients complete the Outcome Questionnaire 45 (OQ-45), a 45-item self-report instrument. Responses are entered into a computer with OQ-A software, and a report is generated for use by the therapist. The OQ-A uses these responses to measure the quality of the therapeutic alliance, client motivation/expectation, quality of social supports, negative life events, and possible need for medication referral. The OQ-A then suggests an appropriate course of treatment.

The OQ-A is designed to detect treatment effectiveness regardless of treatment modality, diagnosis, or discipline of the treating professional. It is suitable for use in inpatient and outpatient settings.

**Learn More by Visiting:**

* **http://www.oqmeasures.com**

**Parent-Child Interaction Therapy**

Date of Review: March 2009

Parent-Child Interaction Therapy (PCIT) is a treatment program for young children with conduct disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT was developed for children ages 2-7 years with externalizing behavior disorders. In PCIT, parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior. This treatment has two phases, each focusing on a different parent-child interaction: child-directed interaction (CDI) and parent-directed interaction (PDI). In each phase, parents attend one didactic session to learn interaction skills and then attend a series of coaching sessions with the child in which they apply these skills. During the CDI phase, parents learn nondirective play skills similar to those used in play therapy and engage their child in a play situation with the goal of strengthening the parent-child relationship. During the PDI phase, parents learn to direct the child’s behavior with clear, age-appropriate instructions and consistent consequences with the aim of increasing child compliance. Ideally, during coaching sessions, the therapist observes the interaction from behind a one-way mirror and provides guidance to the parent through a “bug-in-the-ear” hearing device. PCIT is generally administered in 15 weekly, 1-hour sessions in an outpatient clinic by a licensed mental health professional with experience working with children and families. The treatment manual provides written outlines in checklist form for each session. The program has been used with families with a history of physical abuse, children with prenatal substance exposure, and children with developmental disabilities.

**Learn More by Visiting:**

* **http://www.pcit.org**
* **http://www.okpcit.org**

**Parenting Through Change**

Date of Review: October 2006

Parenting Through Change (PTC) is a theory-based intervention to prevent internalizing and externalizing conduct behaviors and associated problems and promote healthy child adjustment. Based on the Parent Management Training--Oregon Model (PMTO), PTC provides recently separated single mothers with 14 weekly group sessions to learn effective parenting practices including skill encouragement, limit-setting, problem-solving, monitoring, and positive involvement. PTC also includes strategies to help parents decrease coercive exchanges with their children and use contingent positive reinforcements (e.g., praise, incentives) to promote prosocial behavior. Topics are presented in an integrated, step-by-step approach and are typically introduced in one or more sessions, then reviewed and revisited throughout the remainder of the program.

**Parenting Wisely**

Date of Review: February 2008

Parenting Wisely is a set of interactive, computer-based training programs for parents of children ages 3-18 years. Based on social learning, cognitive behavioral, and family systems theories, the programs aim to increase parental communication and disciplinary skills. The original Parenting Wisely program, American Teens, is designed for parents whose preteens and teens are at risk for or are exhibiting behavior problems such as substance abuse, delinquency, and school dropout. Parents use this self-instructional program on an agency’s personal computer or laptop, either on site or at home, using the CD-ROM or online format. During each of nine sessions, users view a video enactment of a typical family struggle and then choose from a list of solutions representing different levels of effectiveness, each of which is portrayed and critiqued through interactive questions and answers. Each session ends with a quiz. All nine sessions can be completed in 2 to 3 hours. Parents also receive workbooks containing program content and exercises to promote skill building and practice.

Adaptations of the original Parenting Wisely program have been created for various groups of youth. One of these adaptations, Young Children, targets children ages 3-9 years. Although the studies reviewed in this summary primarily evaluated the original version of Parenting Wisely, the Young Children version was also evaluated, as were adaptations created to be implemented with groups of parents.

**Learn More by Visiting:**

* **http://www.familyworksinc.com**

**Parenting with Love and Limits (PLL)**

Date of Review: June 2008

Parenting with Love and Limits (PLL) combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. The program also has been used with teenagers with less extreme behaviors. PLL teaches families how to reestablish adult authority through consistent limits while reclaiming a loving relationship. It includes six multifamily sessions, conducted by two facilitators, that employ group discussions, videotapes, age-specific breakout sessions, and role-play. Individual families also receive intensive 1- to 2-hour therapy sessions in an outpatient or home-based setting to practice the skills learned in the group setting. Three or four family therapy sessions are recommended for low- to moderate-risk adolescents; up to 20 sessions may be recommended for those with more severe problems such as involvement with the juvenile or criminal justice system. PLL’s integration of group sessions and family therapy is designed to help families apply skills and concepts to real-life situations and prevent relapse.

**Learn More by Visiting:**

* **http://www.gopll.com**

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**Learn More by Visiting:**

* **http://www.gopll.com**

**Partners in Care**

Date of Review: November 2009

Partners in Care (PIC) is an intervention for use in managed primary care settings to improve the treatment of depression. PIC is based on collaborative care models, in which mental health is integrated with primary care. The program supports the detection, assessment, treatment choice, and management of patients with major depression or dysthymia by increasing collaboration among primary care clinicians, mental health specialists, nurses, and patients. For the managed care provider, the intervention goal is to increase the percentage of patients receiving appropriate treatment for depression. For patients, the program aims to improve quality of life and reduce depression symptoms. PIC is suitable for use with most age groups, from teenagers through older adults, although the study reviewed for this summary included only individuals 18 and older.

The core elements of PIC include teamwork between specialists and generalists, case management by nurses, and patient education and empowerment. The intervention educates clinicians on the treatment of depression in the primary care setting while also giving them access to psychotherapists who can provide consultation on difficult cases and take referrals when needed. Health care organizations participating in PIC receive a package of materials designed to help them implement their own collaborative care model. These materials include:

* The Clinician Guide to Depression Assessment and Management in Primary Care, which gives primary care physicians the information they need to assess and treat patients, as well as key references on patient education, medications, and psychotherapy
* Pocket-sized Quick Reference Cards, which summarize key points from the Guide and include information on antidepressants, including doses, side effects, and typical costs
* Individual and group cognitive-behavioral therapy (CBT) manuals
* Guidelines and Resources for the Depression Nurse Specialist, containing instructions, forms, and materials needed to carry out case management
* Patient education brochures, suitable for use with patients with major depression as well as patients who feel sad but do not have the full-blown illness

Health care organizations implementing PIC should nominate a set of individuals who will serve as depression care improvement leaders, including a primary care provider, a mental health specialist, and a nursing clinician. At least one of these individuals should have experience in practice redesign or quality improvement methods. This leadership team uses the PIC materials to educate primary care and mental health specialist clinicians about the program, hires and trains nurse care managers, and provides the necessary space, support, and monitoring to conduct the program. Nurse care managers are usually experienced registered nurses; they can also be clinical nurse specialists or social workers who are willing to do brief, targeted, proactive care for a large caseload rather than carry out psychotherapy.

**Learn More by Visiting:**

* **http://www.rand.org/health/projects/pic/**

**Partners with Families and Children: Spokane**

Date of Review: April 2008

Partners with Families and Children: Spokane (Partners) provides services to families with children under 30 months old who are referred by child protective services, law enforcement, or other public health agencies due to chronic child neglect or risk of child maltreatment. These families generally are low income, marginally integrated into conventional life and family structures, and present multiple needs across life domains. Partners is a multidisciplinary intervention based on wraparound service principles and attachment theory. Its characteristic features are intensive case management using an integrated system of care approach; on-site resources for gender-specific, integrated parental substance abuse and mental health services; parental coaching to improve parent-child interactions and relationships; and a commitment to provide services as long as the family wants and benefits from services.

Families who enter Partners are assigned to a Family Team Coordinator, who completes an initial formal assessment and develops a team of professionals and family members to participate in service plan development and delivery. Based on family need, collaborations are routinely developed with schools, Head Start, and local public health and other agencies to ensure service coordination. When a family enters Partners, the Coordinator arranges an initial home visit, begins a planning process for evaluation, and consults with core team members. The Coordinator continues to provide intensive case management services. Family team meetings typically occur at least once a month and include the professional team as well as individuals personally involved with and identified by the family. Family teams place a strong emphasis on the quality of the parent-child relationship and the quality of interactions, using infant psychotherapy principles to guide treatment goals. Meetings focus on informal modeling of appropriate relationship and behavior with the child, progressive encouragement and support of increasingly competent behavior, and parental self-reflection regarding the parent-child relationship.

**Learn More by Visiting:**

* **http://www.partnerswithfamilies.org**

**Pathways' Housing First Program**

Date of Review: November 2007

Housing First, a program developed by Pathways to Housing, Inc., is designed to end homelessness and support recovery for individuals who are homeless and have severe psychiatric disabilities and co-occurring substance use disorders. Pathways’ Housing First model is based on the belief that housing is a basic right and on a theoretical foundation that emphasizes consumer choice, psychiatric rehabilitation, and harm reduction. The program addresses homeless individuals’ needs from a consumer perspective, encouraging them to define their own needs and goals, and provides immediate housing (in the form of apartments located in scattered sites) without any prerequisites for psychiatric treatment or sobriety. Treatment and support services are provided through an Assertive Community Treatment (ACT) team consisting of social workers, nurses, psychiatrists, vocational and substance abuse counselors, peer counselors, and other professionals. These services may include psychiatric and substance use treatment, supported employment, illness management, and recovery services. While ACT is the preferred support for persons with severe mental illness, less intensive modalities can be used. Consumers who are recovering or who participate in smaller programs may receive support through an intensive case management approach, obtaining services both directly from their own program and through referrals to other agencies.

Consistent with the principles of consumer choice, Housing First uses the harm reduction approach in its clinical services to address both substance abuse and psychiatric issues. The treatment team recognizes that consumers can be at different stages of recovery and that interventions should be tailored to each consumer’s stage. Consumers’ tenancy is not dependent on their adherence to clinical treatment, although they must meet the obligations of a standard lease. The team works with consumers through housing loss, hospitalization, or incarceration and helps consumers obtain housing after these episodes. While consumers can refuse formal clinical services, the program requires them to meet with a team member at least four to six times per month to ensure their safety and well-being.

**Learn More by Visiting:**

* **http://www.pathwaystohousing.org**
* **Peaceful Alternatives to Tough Situations (PATTS)**
* Date of Review: March 2008
* Peaceful Alternatives to Tough Situations (PATTS) is a school-based aggression management program designed to help students increase positive conflict resolution skills, increase the ability to forgive transgressions, and reduce aggressive behavior. PATTS features three separate curricula (for kindergarten through grade 2, grades 3 through 5, and middle and high school), each of which is delivered in nine weekly, 1-hour sessions. The program teaches cognitive skills, peer refusal skills, appropriate conflict resolution skills, identification and verbalization of emotions, recognition of anger cues, calming techniques, and forgiveness. Sessions are highly interactive and use group discussion, role-playing, games, and skills review. In addition, parents and teachers receive training informing them about the skills taught to students and encouraging them to support the use of the skills at home and in the classroom. PATTS is designed to be delivered by teachers, guidance counselors, and graduate or undergraduate mental health counselors.

**Learn More by Visiting:**

* **http://www.patts.info**

**Penn Resilience Training for College Students**

Date of Review: March 2007

Penn Resilience Training for College Students is a brief prevention program for freshmen university students at risk for depression. The program teaches a range of techniques based on the work of Beck and colleagues on cognitive therapy for depression. The manual-based program helps participants to acquire the following skills: (1) learn the relationship between thoughts, feelings, and behaviors; (2) identify automatic negative thoughts and underlying beliefs; (3) use evidence to question and dispute automatic negative thoughts and irrational beliefs; (4) replace automatic negative thoughts with more constructive interpretations, beliefs, and behaviors; (5) apply behavioral activation strategies; (6) build interpersonal skills; (7) manage stress; and (8) generalize these skills to new and relevant situations. The program is delivered to 10 to 12 freshmen participants per group by a trainer and a cotrainer through 1- to 2-hour weekly meetings over 8 weeks. The workshop meetings consist of rapport-building, lectures and audiovisual presentations, role-play, games and activities, group discussion, and homework reviews. Detailed participant notebooks are used along with homework and written materials to review major points of the workshop. Trainers (trained cognitive specialists) meet with participants individually on six occasions to review the skills the participants learned in the workshop and to discuss any questions they have about applying the skills to their lives.

**Learn More by Visiting:**

* **http://www.ppc.sas.upenn.edu/**

**Phoenix House Academy**

Date of Review: December 2007

Phoenix House Academy (formerly known as Phoenix Academy) is a therapeutic community (TC) model enhanced to meet the developmental needs of adolescents ages 13-17 with substance abuse and other co-occurring mental health and behavioral disorders. The Phoenix House Academy model integrates residential treatment with an on-site public junior high and high school (grades 8-12). Some Phoenix House Academy programs also include trade or technical training sponsored by local community colleges. The community campus receives most of its referrals from juvenile probation, family, and self-referrals, with the remaining youth coming from social service agencies (e.g., departments of mental health, children and family services), health care providers, and educational institutions. Professional program staff include psychiatrists, psychologists, social workers, and counselors, many of whom are in recovery themselves.

The Phoenix House Academy TC model maintains that substance abuse is an outward manifestation of a broad set of personal and developmental problems in the adolescent and that successful recovery is built upon change involving the whole person--psychologically, socially, and behaviorally. Participants learn to embrace honesty, focus on effective living in the present moment (rather than in the past), accept personal responsibility for their own actions, develop a strong work ethic, and adhere to a strict moral code known as right living. The process for change is behavioral social learning, which takes place in a community of supportive peers and staff who model and support the rehearsal of effective behaviors. Each residential member earns status promotions and other privileges by complying with program rules and expectations and demonstrating specific behaviors toward attaining treatment goals, such as attending school. Behavior that deviates from the community's sober-living norms results in sanctions or loss of previously earned privileges. During treatment, youth progress through treatment phases with increasing program privileges and responsibilities. Days are highly structured, with most waking hours spent in school, community meetings, lectures, groups, individual and family counseling, community service, aftercare services, and recreation. In some programs, other types of scientifically sound and empirically tested interventions may be incorporated into treatment as well. Phoenix House Academy programs offer gender-specific services, and some can provide treatment for individuals up to 20 years of age.

**Learn More by Visiting:**

* **http://www.phoenixhouse.org**

**Positive Action**

Date of Review: December 2006

Positive Action is an integrated and comprehensive program that is designed to improve academic achievement; school attendance; and problem behaviors such as substance use, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior. It is also designed to improve parent-child bonding, family cohesion, and family conflict. Positive Action has materials for schools, homes, and community agencies. All materials are based on the same unifying broad concept (one feels good about oneself when taking positive actions) with six explanatory subconcepts (positive actions for the physical, intellectual, social, and emotional areas) that elaborate on the overall theme. The program components include grade-specific curriculum kits for kindergarten through 12th grade, drug education kits, a conflict resolution kit, sitewide climate development kits for elementary and secondary school levels, a counselor’s kit, a family kit, and a community kit. All the components and their parts can be used separately or in any combination and are designed to reinforce and support one another.

**Learn More by Visiting:**

* **http://www.positiveaction.net**

**Prevention and Relationship Enhancement Program (PREP)**

Date of Review: September 2006

The goal of the Prevention and Relationship Enhancement Program (PREP) is to modify or enhance those dimensions of couples' relationships that research and theory have linked to effective marital functioning, such as communication, problem-solving skills, and protecting positive connections and expectations. Using techniques of cognitive-behavioral marital therapy and communication-oriented marital enhancement programs, PREP aims to help couples maintain high levels of functioning and prevent marital problems from developing. Topics covered include communication, conflict management, commitment, friendship, sensuality, problem-solving, and emotional supportiveness, among others. The program can be delivered in a variety of formats. Six 2-hour session are typical; other formats include a weekday session followed by a weekend retreat. Homework assignments are completed between sessions that require couples to practice skills, read chapters, and complete exercises. PREP is usually conducted with groups of three to eight couples and can also be delivered with larger groups. A trained consultant (or coach) ideally works with each couple throughout the program.

**Learn More by Visiting:**

* **http://www.prepinc.com**
* **http://www.withinmyreach.com**

**Primary Project**

Date of Review: February 2007

Primary Project (formerly the Primary Mental Health Project, or PMHP) is a school-based program designed for early detection and prevention of school adjustment difficulties in children 4-9 years old (preschool through 3rd grade). The program begins with screening to identify children with early school adjustment difficulties (e.g., mild aggression, withdrawal, and learning difficulties) that interfere with learning. Following identification, children are referred to a series of one-on-one sessions with a trained paraprofessional who utilizes developmentally appropriate child-led play and relationship techniques to help adjustment to the school environment. Children generally are seen weekly for 30-40 minutes for 10-14 weeks. During the session, the trained child associate works to create a nonjudgmental atmosphere while establishing limits on the length of sessions, aggression toward self or others, and destruction of property. Targeted outcomes for children in Primary Project include increased task orientation, behavior control, assertiveness, and peer social skills. The program is suitable for implementation in a specially designed place on a school campus equipped with expressive toys and materials (art media, building toys, imaginative toys).

**Learn More by Visiting:**

* **http://www.childrensinstitute.net**

**PRIME For Life**

Date of Review: November 2009

PRIME For Life (PFL) is a motivational intervention used in group settings to prevent alcohol and drug problems or provide early intervention. PFL has been used primarily among court-referred impaired driving offenders, as in the two studies reviewed for this summary. It also has been adapted for use with military personnel, college students, middle and high school students, and parents. Different versions of the program, ranging from 4.5 to 20 hours in duration, and optional activities are available to guide use with various populations.

Based on the Lifestyle Risk Reduction Model, the Transtheoretical Model, and persuasion theory, PFL emphasizes changing participants’ perceptions of the risks of drug and alcohol use and related attitudes and beliefs. Risk perception is altered through the carefully timed presentation of both logical reasoning and emotional experience. Instructors use empathy and collaboration (methods consistent with motivational interviewing) to increase participants’ motivation to change behavior to protect what they value most in life. Participants are guided in self-assessing their level of progression toward or into dependence or addiction. PFL also assists participants in developing a detailed plan for successfully following through with behavior change. Multimedia presentations and extensive guided discussion help motivate participants to reduce their substance use or maintain low-risk choices. Individual and group activities are completed using participant workbooks.

**Learn More by Visiting:**

* **http://www.primeforlife.org**

**Prize Incentives Contingency Management for Substance Abuse**

Date of Review: August 2007

Prize Incentives Contingency Management for Substance Abuse is a variation of contingency management, or reinforcement, that awards prizes for abstinence and treatment compliance. It is based on a construct central to behavioral psychology known as operant conditioning, or the use of consequences to modify the occurrence and form of behavior. The program augments existing, usual care services in community-based treatment settings for adults who primarily abuse stimulants (especially cocaine) or opioids (especially heroin) or who have multiple substance use problems. Over a period of 3 months, urine and breath samples are collected two or three times a week for at least the first 6 weeks and once or twice weekly thereafter. For each sample that tests negative for the target drug (stimulants or opioids), clients can draw slips of paper or plastic chips from a bowl for the chance of winning a prize valued from $1 to $100. Clients may also receive draws from the prize bowl for attending counseling/group therapy sessions and completing weekly goal-related activities. The number of draws from the prize bowl increases from 1 to as many as 15 with consecutive negative test results and/or attendance at consecutive sessions. A drug-positive sample or an unexcused absence resets the number of draws to one. Bonus draws may be awarded to clients on a predetermined schedule. Although the original trials of Prize Incentives were conducted over 3 months, the intervention can be used with urine and breath samples collected one to three times weekly for longer durations.

**Program of All-Inclusive Care for the Elderly (PACE)**

Date of Review: June 2007

The Program of All-Inclusive Care for the Elderly (PACE) features a comprehensive and seamless service delivery system and integrated Medicare and Medicaid financing. Eligible individuals are age 55 years or older and meet the clinical criteria to be admitted to a nursing home but choose to remain in the community. An array of coordinated services is provided to support PACE participants to prevent the need for nursing home admission. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants’ needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts. PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the “PACE center,” and supplement this care with in-home and referral services in accordance with the participants’ needs. Each participant can receive all Medicare- and Medicaid-covered services, as well as other care determined necessary by the interdisciplinary team.

**Important note about implementation requirements:**
For a health care organization to be approved as a PACE program, the State must elect PACE as a voluntary State option under its Medicaid plan. In addition, the prospective PACE organization and the State must work together in the development of the PACE provider application. On behalf of the prospective provider, the State submits the application to the Centers for Medicare and Medicaid Services (CMS) with assurance of the State’s support of the application and its contents. Each approved PACE program receives a fixed amount of money per PACE participant regardless of the services the participant utilizes.

**Learn More by Visiting:**

* **http://www.npaonline.org**

**Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)**

Date of Review: March 2007

The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS provides eight 50-minute sessions with a trained social service worker in the client’s home over 19 weeks. Counselors use three depression management techniques: (1) problem-solving treatment, in which clients are taught to recognize depressive symptoms, define problems that may contribute to depression, and devise steps to solve these problems; (2) social and physical activity planning; and (3) planning to participate in pleasant events. Counselors encourage participants to use existing community services and attend local events.

**Learn More by Visiting:**

* **http://www.pearlsprogram.org**

**Project ACHIEVE**

Date of Review: April 2009

Project ACHIEVE is a comprehensive school reform and improvement program for preschool through high school (students ages 3-18 years) that focuses on students’ academic, social-emotional/behavioral, and social skills outcomes; schoolwide positive behavioral support systems and school safety; positive classroom and school climates; and community and parent outreach and involvement. For students, the aim is to improve resilience, protective factors, and effective self-management skills so youth are better able to resist unhealthy and maladaptive behaviors. The aim for staff is to ensure effective instruction and classroom management as well as supports and services to students not responding with academic and behavioral success. The school aim is to help schools to be successful for all students.

Based on social learning theory and effective approaches to school reform and improvement, this schoolwide program uses professional development and ongoing technical consultation to target and reinforce critical staff skills and intervention approaches. The program incorporates a continuum of student services, including prevention, strategic intervention, and crisis management, and consists of seven interdependent components implemented over 3 years:

* Strategic planning and organizational analysis and development
* Problem-solving, response-to-intervention, teaming, and consultation processes
* Effective school, schooling, and professional development
* Academic instruction linked to academic assessment, intervention, and achievement (i.e., Positive Academic Supports and Services)
* Age-appropriate social skills instruction (i.e., Stop & Think Social Skills Program) linked to behavioral assessment, intervention, and self-management (i.e., Positive Behavioral Support System)
* Parent and community training, support, and outreach
* Data management, evaluation, and accountability

Project ACHIEVE involves the school's entire instructional, administrative, and support staff and, following training, can be implemented with resources available in most schools. Training typically involves in-service training, classroom-based demonstrations, and technical consultation and follow-up.

Project ACHIEVE has been used in public schools, alternative schools, special education centers, psychiatric and juvenile justice facilities, Head Start programs, and specialized charter schools. The research study reviewed for this summary involved kindergarten through grade 6 in public schools.

**Learn More by Visiting:**

* **http://www.projectachieve.info**

**Project ALERT**

Date of Review: December 2006

Project ALERT is a school-based prevention program for middle or junior high school students that focuses on alcohol, tobacco, and marijuana use. It seeks to prevent adolescent nonusers from experimenting with these drugs, and to prevent youths who are already experimenting from becoming more regular users or abusers. Based on the social influence model of prevention, the program is designed to help motivate young people to avoid using drugs and to teach them the skills they need to understand and resist prodrug social influences. The curriculum is comprised of 11 lessons in the first year and 3 lessons in the second year. Lessons involve small-group activities, question-and-answer sessions, role-playing, and the rehearsal of new skills to stimulate students’ interest and participation. The content focuses on helping students understand the consequences of drug use, recognize the benefits of nonuse, build norms against use, and identify and resist prodrug pressures.

**Learn More by Visiting:**

* **http://www.projectalert.com**

**Project EX**

Date of Review: November 2006

Project EX is a school-based smoking-cessation clinic program for adolescents that stresses motivation, coping skills, and personal commitment. Consisting of eight 40- to 45-minute sessions delivered over a 6-week period, the program curriculum includes strategies for coping with stress, dealing with nicotine withdrawal, and avoiding relapses. Project EX uses engaging and motivating activities such as games and yoga to reduce or stop smoking among adolescents and teach self-control, anger management, mood management, and goal-setting techniques. Adolescents are provided with accurate information about the social, emotional, environmental, and physiological consequences of tobacco use. The first four sessions are intended to prepare students for an attempt at quitting smoking, which should take place between sessions 4 and 6. The remaining sessions are designed to maintain quit status and enhance quit attempts. Project EX clinics operate during school hours. Each clinic group can accommodate 8 to 15 students.

**Learn More by Visiting:**

* **http://tnd.usc.edu/ex**

**Project Northland**

Date of Review: March 2007

Project Northland is a multilevel intervention involving students, peers, parents, and community in programs designed to delay the age at which adolescents begin drinking, reduce alcohol use among those already drinking, and limit the number of alcohol-related problems among young drinkers. Administered to adolescents in grades 6-8 on a weekly basis, the program has a specific theme within each grade level that is incorporated into the parent, peer, and community components. The 6th-grade home-based program targets communication about adolescent alcohol use utilizing student-parent homework assignments, in-class group discussions, and a communitywide task force. The 7th-grade peer- and teacher-led curriculum focuses on resistance skills and normative expectations regarding teen alcohol use, and is implemented through discussions, games, problem-solving tasks, and role-plays. During the first half of the 8th-grade Powerlines peer-led program, students learn about community dynamics related to alcohol use prevention through small group and classroom interactive activities. During the second half, they work on community-based projects and hold a mock town meeting to make community policy recommendations to prevent teen alcohol use.

**Learn More by Visiting:**

* **http://www.hazelden.org/web/go/projectnorthland**

**Project SUCCESS**

Date of Review: November 2007

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse. In recent years, Project SUCCESS has been used in regular middle and high schools for a broader range of high-risk students. The intervention includes four components:

* The Prevention Education Series (PES), an eight-session alcohol, tobacco, and other drug program conducted by Project SUCCESS counselors (local staff trained by the developers) who help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use.
* Schoolwide activities and promotional materials to increase the perception of the harm of substance use, positively change social norms about substance use, and increase enforcement of and compliance with school policies and community laws.
* A parent program that includes informational meetings, parent education, and the formation of a parent advisory committee.
* Individual and group counseling, in which the Project SUCCESS counselors conduct time-limited counseling for youth following their participation in the PES and an individual assessment. Students and parents who require more intensive counseling, treatment, or other services are referred to appropriate agencies or practitioners in the community.

**Learn More by Visiting:**

* **http://www.sascorp.org**

**Project Towards No Drug Abuse**

Date of Review: September 2006

Project Towards No Drug Abuse (Project TND) is a drug use prevention program for high school youth. The current version of the curriculum is designed to help students develop self-control and communication skills, acquire resources that help them resist drug use, improve decisionmaking strategies, and develop the motivation to not use drugs. It is packaged in 12 40-minute interactive sessions to be taught by teachers or health educators. The TND curriculum was developed for high-risk students in continuation or alternative high schools. It has also been tested among traditional high school students.

**Learn More by Visiting:**

* **http://tnd.usc.edu**

**Project Towards No Tobacco Use**

Date of Review: September 2007

Project Towards No Tobacco Use (Project TNT) is a classroom-based curriculum that aims to prevent and reduce tobacco use, primarily among 6th- to 8th-grade students. The intervention was developed for a universal audience and has served students with a wide variety of risk factors. Designed to counteract multiple causes of tobacco use simultaneously, Project TNT is based on the theory that youth will be better able to resist tobacco use if they are aware of misleading information that facilitates tobacco use (e.g., pro-tobacco advertising, inflated estimates of the prevalence of tobacco use), have skills that counteract the social pressures to obtain approval by using tobacco, and appreciate the physical consequences of tobacco use.

Project TNT comprises 10 core lessons and 2 booster lessons, all 40-50 minutes in duration. The core lessons are designed to be taught over a 2-week period but may be spread out over as long as 4 weeks. Booster lessons, which are taught 1 year afterward, are intended to be delivered over 2 consecutive days but may be taught 1 week apart. The curriculum uses a wide variety of activities to encourage student involvement and participation. Activities include games, videos, role-plays, large and small group discussion, use of student worksheets, homework assignments, activism letter writing, and a videotaping project. The two-lesson booster program summarizes previously learned material and discusses how this material might be used in daily living.

**Learn More by Visiting:**

* **http://tnd.usc.edu/tnt/**

**Project Venture**

Date of Review: October 2007

Project Venture is an outdoor experiential youth development program designed primarily for 5th- to 8th-grade American Indian youth. It aims to develop the social and emotional competence that facilitates youths' resistance to alcohol, tobacco, and other drug use. Based on traditional American Indian values such as family, learning from the natural world, spiritual awareness, service to others, and respect, Project Venture’s approach is positive and strengths based. The program is designed to foster the development of positive self-concept, effective social interaction skills, a community service ethic, an internal locus of control, and improved decisionmaking and problem-solving skills. The central components of the program include a minimum of 20 1-hour classroom-based activities, such as problem-solving games and initiatives, conducted across the school year; weekly after-school, weekend, and summer skill-building experiential and challenge activities, such as hiking and camping; 3- to 10-day immersion summer adventure camps and wilderness treks; and community-oriented service learning and service leadership projects throughout the year.

**Learn More by Visiting:**

* **http://www.niylp.org**

**Prolonged Exposure Therapy for Posttraumatic Stress Disorders**

Date of Review: December 2007

Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) psychoeducation about common reactions to trauma and the cause of chronic posttrauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the traumatic memory, and (3) in vivo exposure, gradually approaching trauma reminders (e.g., situations, objects) that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90 minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.

**Learn More by Visiting:**

* **http://www.med.upenn.edu/ctsa/workshops\_pet.html**

**Promoting Alternative THinking Strategies (PATHS), PATHS Preschool**

Date of Review: May 2007

Promoting Alternative THinking Strategies (PATHS) and PATHS Preschool are school-based preventive interventions for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. The elementary school PATHS Curriculum is available in two units: the PATHS Turtle Unit for kindergarten and the PATHS Basic Kit for grades 1-6. The curriculum includes 131 20- to 30-minute lessons designed to be taught by regular classroom teachers approximately 3 times per week over the course of a school year. PATHS Preschool, an adaptation of PATHS for children 3 to 5 years old, is designed to be implemented over a 2-year period. Its lessons and activities highlight writing, reading, storytelling, singing, drawing, science, and math concepts and help students build the critical cognitive skills necessary for school readiness and academic success. The PATHS Preschool program can be integrated into existing learning environments and adapted to suit individual classroom needs.

**Learn More by Visiting:**

* **http://www.channing-bete.com/paths**
* **http://www.channing-bete.com/pathspreschool**
* **http://www.prevention.psu.edu/projects/paths.html**

**PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)**

Date of Review: March 2007

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. The intervention components are: (1) recognition of depression and suicide ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists). The treatment algorithm assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment. Health specialists collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.

Implementation of the program relies on educating primary care physicians to recognize symptoms and apply a clinical algorithm based on depression treatment guidelines for older patients from the American Psychiatric Association, the Agency for Healthcare Research and Quality, and the Texas Department of Mental Health. The recommended first line of treatment is citalopram, a selective serotonin reuptake inhibitor (SSRI). If citalopram does not achieve the desired result, other medications may be added or substituted. Interpersonal psychotherapy may also be used in addition to or instead of pharmacological treatment.

**Protecting You/Protecting Me**

Date of Review: March 2008

Protecting You/Protecting Me (PY/PM) is a 5-year classroom-based alcohol use prevention and vehicle safety program for elementary school students in grades 1-5 (ages 6-11) and high school students in grades 11 and 12. The program aims to reduce alcohol-related injuries and death among children and youth due to underage alcohol use and riding in vehicles with drivers who are not alcohol free. PY/PM consists of a series of 40 science- and health-based lessons, with 8 lessons per year for grades 1-5. All lessons are correlated with educational achievement objectives. PY/PM lessons and activities focus on teaching children about (1) the brain--how it continues to develop throughout childhood and adolescence, what alcohol does to the developing brain, and why it is important for children to protect their brains; (2) vehicle safety, particularly what children can do to protect themselves if they have to ride with someone who is not alcohol free; and (3) life skills, including decisionmaking, stress management, media awareness, resistance strategies, and communication. Lessons are taught weekly and are 20-25 minutes or 45-50 minutes in duration, depending on the grade level. A variety of ownership activities promote students’ ownership of the information and reinforces the skills taught during the lesson. Parent take-home activities are offered for all 40 lessons. PY/PM's interactive and affective teaching processes include role-playing, small group and classroom discussions, reading, writing, storytelling, art, and music. The curriculum can be taught by school staff or prevention specialists. PY/PM also has a high school component for students in grades 11 and 12. The youth-led implementation model involves delivery of the PY/PM curriculum to elementary students by trained high school students who are enrolled in a peer mentoring, family and consumer science, or leadership course for credit. The program’s benefits to high school students are derived from learning about the brain and how alcohol use can impact adolescents, serving as role models to the elementary school participants, and taking coursework in preparation for delivering the curriculum.

**Learn More by Visiting:**

* **http://www.pypm.org**
* **http://www.hazelden.org/pypm**

**Psychoeducational Multifamily Groups**

Date of Review: December 2006

Psychoeducational Multifamily Groups (PMFG) is a treatment modality designed to help individuals with mental illness attain as rich and full participation in the usual life of the community as possible. The intervention focuses on informing families and support people about mental illness, developing coping skills, solving problems, creating social supports, and developing an alliance between consumers, practitioners, and their families or other support people. Practitioners invite five to six consumers and their families to participate in a psychoeducation group that typically meets every other week for at least 6 months. “Family” is defined as anyone committed to the care and support of the person with mental illness. Consumers often ask a close friend or neighbor to be their support person in the group. Group meetings are structured to help people develop the skills needed to handle problems posed by mental illness.

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**Real Life Heroes**

Date of Review: December 2007

Real Life Heroes (RLH) is based on cognitive behavioral therapy models for treating posttraumatic stress disorder (PTSD) in school-aged youth. Designed for use in child and family agencies, RLH can be used to treat attachment, loss, and trauma issues resulting from family violence, disasters, severe and chronic neglect, physical and sexual abuse, repeated traumas, and posttraumatic developmental disorder. RLH focuses on rebuilding attachments, building the skills and interpersonal resources needed to reintegrate painful memories, fostering healing, and restoring hope. These goals are accomplished using nonverbal creative arts, narrative interventions, and gradual exposure to help children process their traumatic memories and bolster their adaptive coping strategies.

The protocol components include safety planning, trauma psychoeducation, skill building in affect regulation and problem solving, cognitive restructuring of beliefs, nonverbal processing of events, and enhanced social support. Practitioners use an activity-based workbook and manual. The workbook, built around the metaphor of heroes, provides a structured, phased approach to help children and caring adults rebuild the sense of safety and hope, the attachments, and the skills and resources necessary for trauma therapy. Activities promote the repair of breaks in caring adult-child trust and attunement. The intervention involves anywhere from 6 to 18 months of weekly therapy sessions, the overall duration depending on the child's individual needs and circumstances. Clinicians, typically having an M.S.W. degree, attend a 2-day workshop and participate in consultation groups every other week. Child care staff and foster parents are also involved in training as team members and caring adults.

**Learn More by Visiting:**

* **http://www.reallifeheroes.net**
* **http://www.routledgementalhealth.com**

**Reconnecting Youth: A Peer Group Approach to Building Life Skills**

Date of Review: September 2009

Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is a school-based prevention program for students ages 14-19 years that teaches skills to build resiliency against risk factors and control early signs of substance abuse and emotional distress. RY targets youth who demonstrate poor school achievement and high potential for school dropout. Eligible students must have either (1) fewer than the average number of credits earned for all students in their grade level at their school, high absenteeism, and a significant drop in grades during the prior semester or (2) a record of dropping out of school. Potential participants are identified using a school's computer records or are referred by school personnel if they show signs of any of the above risk factors. Eligible students may show signs of multiple problem behaviors, such as substance abuse, aggression, depression, or suicidal ideation.

RY also incorporates several social support mechanisms for participating youth: social and school bonding activities to improve teens' relationships and increase their repertoire of safe, healthy activities; development of a crisis response plan detailing the school system's suicide prevention approaches; and parent involvement, including active parental consent for their teen's participation and ongoing support of their teen's RY goals.

The course curriculum is taught by an RY Leader, a member of the school staff or partnering agency who has abilities as a "natural helper," has healthy self-esteem, is motivated to work with high-risk youth, and is willing to comply with implementation requirements.

**Descriptive Information**

**Learn More by Visiting:**

* **http://www.reconnectingyouth.com**

**Recovery Training and Self-Help**

Date of Review: April 2008

Recovery Training and Self-Help (RTSH) is a group aftercare program for individuals recovering from opioid addiction. RTSH is based on the supposition that opioid addiction, regardless of a person's original reasons for using substances, stems from conditioning due to the reinforcing effects of repeated opioid use. RTSH is designed to deactivate addiction by teaching and supporting alternative responses to stimuli previously associated with opioid use. Program goals include reducing the occurrence and frequency of relapse and readdiction and helping unemployed participants obtain employment. RTSH features 6 months of twice weekly meetings, regular weekend recreational activities, and a support network for clients. Each RTSH group is co-led by a professional therapist and a group leader in recovery. At one of the weekly meetings, the professional therapist delivers the Recovery Training (RT) curriculum, a preplanned series of didactic sessions that systematically addresses predictable threats to abstinence from illicit opiates. The second weekly meeting, a self-help session conducted by the group leader in recovery, is devoted to sharing experiences, discussing personal issues, addressing group business, and planning for weekend recreational and community service activities.

**Red Cliff Wellness School Curriculum**

Date of Review: October 2010

The Red Cliff Wellness School Curriculum is a substance abuse prevention intervention based in Native American tradition and culture. Designed for grades K-12, the curriculum aims to reduce risk factors and enhance protective factors related to substance use, including school bonding, success in school, increased perception of risk from substances, and identification and internalization of culturally based values and norms. The Red Cliff program is taught by teachers who have been trained in interactive, cooperative learning techniques and facilitation. The manualized curriculum has separate components for grades K-3, 4-6, and 7-12. Each component includes 20-30 developmentally appropriate lessons and activities designed to enhance the values of sharing, respect, honesty, and kindness and to assist students in understanding their emotions. Small-group discussions (described as "talking circles" in Native American terms) are extensively used, along with small-group process activities, independent workbook activities, and collaborative projects for older students.

The school curriculum was created by the First American Prevention Center, an arm of the Red Cliff Band of Lake Superior Chippewa. The curriculum is part of a broader wellness initiative that includes a community curriculum and home wellness kit. Since its initial development for Native American youth, the tribally based curriculum has been used in schools with a wide range of populations, including some with only a small percentage of non-Native students.

The research reviewed in this summary involved only the elementary school component (grades 4-6) of the K-12 program.

**Learn More by Visiting:**

* **http://www.firstamericanprevention.org**

**Reinforcement-Based Therapeutic Workplace**

Date of Review: August 2007

Reinforcement-Based Therapeutic Workplace is a practical application of voucher-based abstinence reinforcement therapy. Abstinence reinforcement procedures are historically based on a construct central to behavioral psychology known as operant conditioning, or the use of consequences to modify the occurrence and form of behavior. In voucher-based abstinence reinforcement therapy for cocaine abuse, cocaine-abusing outpatients in ongoing methadone maintenance treatment programs receive escalating monetary vouchers for successive cocaine-free urine samples. These vouchers can be exchanged for goods and services purchased by staff on behalf of the patients. When this voucher-based reinforcement is applied to a Therapeutic Workplace, the patients are hired, trained, and paid to work in a supportive environment. They earn escalating base-pay vouchers while they remain abstinent from cocaine (and sometimes opiates) as verified by negative urine samples. Eligibility for participation in the Therapeutic Workplace is dependent on a client providing evidence of enrollment in either a community methadone treatment program or a comprehensive drug abuse treatment program for pregnant and postpartum women.

**Relapse Prevention Therapy (RPT)**

Date of Review: September 2008

Relapse Prevention Therapy (RPT) is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training is the cornerstone of RPT, teaching clients strategies to:

* Understand relapse as a process
* Identify and cope effectively with high-risk situations such as negative emotional states, interpersonal conflict, and social pressure
* Cope with urges and craving
* Implement damage control procedures during a lapse to minimize negative consequences
* Stay engaged in treatment even after a relapse
* Learn how to create a more balanced lifestyle

Coping skills training strategies include both cognitive and bevarioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client’s overall coping capacity.

**Residential Student Assistance Program (RSAP)**

Date of Review: June 2009

The Residential Student Assistance Program (RSAP) is designed to prevent and reduce alcohol and other drug (AOD) use among high-risk multiproblem youth ages 12 to 18 years who have been placed voluntarily or involuntarily in a residential child care facility (e.g., foster care facility, treatment center for adolescents with mental health problems, juvenile correctional facility). Based on the Employee Assistance Program (EAP) model, the intervention focuses on wellness and addresses factors that hinder adolescents from being free from AOD use, such as emotional problems and mental disabilities, parental abuse and neglect, and parental substance abuse. The program is delivered in residential facilities by masters-level counselors who use a combination of strategies, including assessment of each youth entering the facility, an eight-session prevention education series, group and/or individual counseling for youth who have chemically dependent parents and/or are using substances, and referral to substance abuse treatment programs. These services are delivered over 20-24 weeks and are fully integrated into the adolescent’s overall experience at the residential facility. The counselors also conduct facility-wide awareness activities, provide training and consultation on AOD prevention to facility staff, and lead a task force for staff and one for residents, both of which aim to change the facility’s culture and norms around substance use and facilitate referrals to the program.

**Learn More by Visiting:**

* **http://www.sascorp.org/residesap.htm**

**Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)**

Date of Review: May 2007

Resources for Enhancing Alzheimer’s Caregiver Health II (REACH II) is a multicomponent psychosocial and behavioral training intervention for caregivers (21 years and older) of patients with Alzheimer’s disease or dementia. The intervention is designed to reduce caregiver burden and depression, improve caregivers’ ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients. REACH II participants are provided with educational information, skills to manage care recipient behaviors, social support, cognitive strategies for reframing negative emotional responses, and strategies for enhancing healthy behaviors and managing stress. Methods used in the intervention include didactic instruction, role-playing, problem-solving tasks, skills training, stress management techniques, and telephone support groups.

In the randomized controlled trial of REACH, the intervention was delivered over 6 months by certified interventionists holding at least a bachelor’s degree. The protocol included 12 individual sessions (9 at home and 3 by telephone) and 5 structured support-group sessions by telephone. Participants were supplied with resource notebooks that contained educational materials and telephones with visual display screens linked to a computer-integrated telephone system to support conference calling.

**Learn More by Visiting:**

* **http://www.edc.pitt.edu/reach2**

**Responding in Peaceful and Positive Ways (RiPP)**

Date of Review: January 2007

Responding in Peaceful and Positive Ways (RiPP) is a school-based violence prevention program for middle school students. RiPP is designed to be implemented along with a peer mediation program. Students practice using a social-cognitive problem-solving model to identify and choose nonviolent strategies for dealing with conflict. RiPP emphasizes behavioral repetition and mental rehearsal of the social-cognitive problem-solving model, experiential learning techniques, and didactic learning modalities. RiPP sessions are taught in the classroom by a school-based prevention specialist and are typically incorporated into existing social studies, health, or science classes. The intervention is offered in three grade-specific modules:

* RiPP-6 (6th grade): 16 sessions over the school year, focusing broadly on violence prevention
* RiPP-7 (7th grade): 16 sessions at the beginning of the school year, focusing on using conflict resolution skills in friendships
* RiPP-8 (8th grade): 16 sessions at the end of the school year, focusing on making a successful transition to high school

**Learn More by Visiting:**

* **http://www.preventionopportunities.org**

**Reward & Reminder**

Date of Review: December 2008

Reward & Reminder, a population-level intervention targeting whole communities, counties, or States, is designed to promote the community norm of not selling tobacco to minors. By using rapid and public rewards and recognition for clerks and retailers/outlets that do not sell tobacco to minors, Reward & Reminder aims to reduce illegal sales of tobacco, perceived access to tobacco, and tobacco use prevalence rates. The intervention emerged from a contextual analysis of factors affecting the behavior of store clerks, retailers, and the tobacco industry overall. At the core of the program is the use of "mystery shoppers," teams of youth who--with parental permission and under the supervision of adults--enter stores and try to buy tobacco products. They provide immediate recognition and rewards, such as gift certificates, to clerks who do the "right thing" and give reminders to those who do not. The results of the mystery shopper visits are entered into a Web-based system where they are made publicly visible, and the results are communicated to local media to promote the positive norm. The mystery shopper visits are scheduled across the year to maximize the immediate and sustained impact. Using on-site or Web-based training, community adults who pass background checks can be trained as supervisors in about 3 hours, and approved youth can be trained as shoppers in about an hour. Quality control is maintained using a Web-based data entry system that facilitates data collection and guides implementation and fidelity activities.

**Learn More by Visiting:**

* **http://www.rewardandreminder.com**

**Safe Dates**

Date of Review: August 2006

Safe Dates is a program designed to stop or prevent the initiation of emotional, physical, and sexual abuse on dates or between individuals involved in a dating relationship. Intended for male and female 8th- and 9th-grade students, the goals of the program include: (1) changing adolescent dating violence and gender-role norms, (2) improving peer help-giving and dating conflict-resolution skills, (3) promoting victim and perpetrator beliefs in the need for help and seeking help through the community resources that provide it, and (4) decreasing dating abuse victimization and perpetration. Safe Dates consists of five components: a nine-session curriculum, a play script, a poster contest, parent materials, and a teacher training outline. In some studies, the program incorporated a booster session.

**Learn More by Visiting:**

* **http://www.hazelden.org/safedates**

**SAFEChildren**

Date of Review: October 2007

Schools And Families Educating Children (SAFEChildren) is a family-focused preventive intervention designed to increase academic achievement and decrease risk for later drug abuse and associated problems such as aggression, school failure, and low social competence. SAFEChildren targets 1st-grade children and their families living in inner-city neighborhoods. The intervention has two components. The first component is a multiple-family group approach that focuses on parenting skills, family relationships, understanding and managing developmental and situational challenges, increasing parental support, skills and issues in engaging as a parent with the school, and managing issues such as neighborhood problems (e.g., violence). Families participate in 20 weekly sessions (2 to 2.5 hours each) led by a trained, professional family group leader. Each session includes a review of the previous week’s homework, discussion about a focused topic, and in-session role-plays and activities. The second component is a reading tutoring program for the child. Tutoring is provided twice weekly (one 30-minute and one 20-minute session) over 20 weeks, using a modified version of the Wallach program. Each tutoring session involves segments on phonics, sound and word activities, and reading books.

**Learn More by Visiting:**

* **http://www.psych.uic.edu/fcrg/safe.html**

**Second Step**

Date of Review: December 2006

Second Step is a classroom-based social-skills program for children 4 to 14 years of age that teaches socioemotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others’ emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decisionmaking process when emotionally aroused. The curriculum is divided into two age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years). Each curriculum contains five teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways. Group decisionmaking, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.

**Learn More by Visiting:**

* **http://www.cfchildren.org**

**Seeking Safety**

Date of Review: October 2006

Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

**Learn More by Visiting:**

* **http://www.seekingsafety.org**

**Service Outreach and Recovery (SOAR)**

Date of Review: June 2009

Service Outreach and Recovery (SOAR), a multicomponent program for indigent and residentially unstable clients, aims to reduce drug and alcohol use and increase participation in formal substance abuse treatment programs and 12-step self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. SOAR targets individuals at soup kitchens who acknowledge current or past substance abuse problems. The program sequentially delivers two manual-driven group counseling modules--Motivational Enhancement for Recovery (MER) followed by Education and Skills for Recovery (ESR)--to a group of 3-10 clients. The 12 1-hour sessions of MER and 36 1-hour sessions of ESR are delivered thrice weekly over a period of 4 months in a trailer at the conclusion of the soup kitchen’s lunchtime meal service. During MER sessions, participants learn about addiction, recovery, and readiness for change. They are encouraged to (1) discuss the ways in which substance use affects their lives by contrasting their current situation with the way they would like things to be, (2) review the options available for effecting the desired change, and (3) decide on treatment strategies they feel ready to adopt. ESR focuses on building skills for relapse prevention that include coping strategies for stress-provoking situations and painful emotions, methods to reduce the health risks associated with injection drug use (e.g., HIV infection), and identification and avoidance of emotional and situational triggers for drinking and drug use. ESR sessions also use cognitive restructuring to identify and offer alternatives to negative practices such as blaming, malingering, emotion blunting, deceiving, and dwelling on thoughts that trigger the desire to use drugs and alcohol.

Another component of SOAR is the use of peer advocates, individuals who are either in recovery from substance abuse or were raised in drug- or HIV-affected families. Peer advocates renew friendly contact whenever SOAR clients return to the soup kitchen, assist the counselor at each group session, and maintain telephone and/or mail contact with each client between sessions. Peer advocates also help clients schedule appointments and complete required treatment forms, and they are available twice weekly to either escort clients to nearby self-help meetings or meet them at the meetings.

Modest incentives (i.e., food coupon books, public transit passes) are given to clients for attendance at each MER and ESR session, attendance at each self-help meeting, and enrollment in a formal treatment program. Clients also may win a raffle prize or small gift when they graduate from SOAR. There are minimal requirements for program enrollment and participation.

**Learn More by Visiting:**

* **http://www.ndri.org/ctrs/itsr/soar.asp**

**SMARTteam**

Date of Review: November 2006

SMARTteam (Students Managing Anger and Resolution Together) is a multimedia, computer-based violence prevention intervention designed for 6th through 9th graders (11-15 years of age). The program is based on social learning theory as well as a skill acquisition model that approaches learning as a five-stage process ranging from novice to expert, with learners at each stage having different needs. The software's eight modules use games, graphics, simulations, cartoons, and interactive interviews to teach conflict resolution skills in three categories: anger management, dispute resolution, and perspective-taking. Anger management focuses on anger-control training; dispute resolution assists students in learning and using negotiation and compromise skills to resolve disputes; perspective-taking allows students to understand that others may have views and feelings different from their own. The various modules can be used separately or together in a sequential manner. Once installed on computers, SMARTteam is easy to use, requiring only rudimentary computer skills on the part of the students.

**Learn More by Visiting:**

* **http://www.lmssite.com/SMARTteam.html**

**SOS Signs of Suicide**

Date of Review: September 2006

SOS Signs of Suicide is a 2-day secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in others. They are taught that the appropriate response to these signs is to acknowledge them, let the person know you care, and tell a responsible adult (either with the person or on that person’s behalf). Students also participate in guided classroom discussions about suicide and depression. The intervention attempts to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes toward suicide and depression, and increase help-seeking behavior.

**Learn More by Visiting:**

* **http://www.mentalhealthscreening.org/highschool**

**SPORT**

Date of Review: November 2008

SPORT is a brief, multiple behavior program integrating substance abuse prevention and fitness promotion to help adolescents minimize and avoid substance use while increasing physical activity and other health-promoting habits. It is based on the Behavior-Image Model, which asserts that social and self-images are key motivators for the development of healthy behavior. The intervention promotes the benefits of an active lifestyle with positive images of youth as active and fit, and emphasizes that substance use is counterproductive in achieving positive image and behavior goals. SPORT involves a short, self-administered health behavior screen survey measuring physical activity and sport behaviors and norms, healthy nutrition, sleep, and alcohol use. Participants then receive a 10- to 12-minute personally tailored consultation from a written script, along with a key facts handout. A simple fitness prescription goal plan is completed by participants to motivate positive behavior and image change. In addition, parent/caregiver communication cards addressing key content are provided during the consultation and then sent or mailed home to adolescents for 3 to 5 consecutive weeks.

**Learn More by Visiting:**

* **http://www.briefhealthprograms.com/**

**STARS for Families**

Date of Review: March 2008

Start Taking Alcohol Risks Seriously (STARS) for Families is a health promotion program that aims to prevent or reduce alcohol use among middle school youth ages 11 to 14 years. The program is founded on the Multi-Component Motivational Stages (McMOS) prevention model, which is based on the stages of behavioral change found within the Transtheoretical Model of Change. The McMOS model posits a continuum of five stages in the initiation of alcohol use: precontemplation (has not tried alcohol in the past year), contemplation (is thinking about trying alcohol soon), preparation (is planning to start drinking soon), action (started drinking in the past 6 months), and maintenance (has been drinking for longer than 6 months). STARS for Families intervention materials are tailored to the individual’s stage of alcohol use initiation.

STARS for Families has three components. Youth who participate in the program receive brief individual consultations in school or in after-school programs about why and how to avoid alcohol use, and they may also receive a follow-up consultation. These standardized sessions are provided by trained adults guided by protocols. A series of eight postcards are mailed to parents/guardians providing key facts about how to talk to their children about avoiding alcohol. In addition, the family completes four take-home lessons designed to enhance parent-child communication regarding prevention skills and knowledge. These three components can be implemented separately or in various combinations. In addition to its implementation in school and after-school settings, the program also has been used in health clinics, youth organizations, and homes.

**Learn More by Visiting:**

* **http://nimcoinc.com**

**Stay on Track**

Date of Review: April 2010

Stay on Track is a school-based substance abuse prevention curriculum conducted over a 3-year period with students in grades 6 through 8. The intervention is designed to help students assess the risks associated with substance abuse; enhance decisionmaking, goal-setting, communication, and resistance strategies; improve antidrug normative beliefs and attitudes; and reduce substance use. The program empowers youth by providing knowledge and life skills relevant to health-promoting behavior.

Based on the health belief model and social development model, Stay on Track provides youth at each grade level with 12 45- to 50-minute lessons taught by classroom teachers. Motorsports is a motivational theme, with each lesson relating program objectives to professional racing activities and personalities. Special emphasis is given to tobacco, alcohol, club drugs, hallucinogens, prescription drugs, marijuana, and inhalants.

Program materials include a teacher handbook (Crew Chief’s Handbook), with 12 prepared lesson plans for each grade level and a CD; a student handbook (Driver’s Manual); and a take-home book (Your Turn at the Wheel) to encourage parent and family involvement. The materials are interactive, encouraging group participation, group discussions, role-playing, and brainstorming.

**Learn More by Visiting:**

* **http://www.ncprs.org/sotHome.htm**

**Storytelling for Empowerment**

Date of Review: July 2008

Storytelling for Empowerment is a school-based, bilingual (English and Spanish) intervention for teenagers at risk for substance abuse, HIV, and other problem behaviors due to living in impoverished communities with high availability of drugs and limited health care services. The program primarily targets Latino/Latina youth and uses cognitive decisionmaking, positive cultural identity (cultural empowerment), and resiliency models of prevention as its conceptual underpinnings. Storytelling for Empowerment aims to decrease alcohol, tobacco, and other drug (ATOD) use by identifying and reducing factors in the individual, family, school, peer group, neighborhood/community, and society/media that place youth at high risk for ATOD use, while enhancing factors that may strengthen youth resiliency and protect against ATOD use. The core components of the intervention include the Storytelling PowerBook and the Facilitator's Guide. The PowerBook is a series of activity workbooks that include the following sections:

* Knowledge Power: brain physiology, physical effects of drugs
* Skill Power: decisionmaking strategies, role-playing
* Personal Power: multicultural stories, symbol making
* Character Power: multicultural historical figures, character traits
* Culture Power: defining culture, biculture, subculture; cultural symbols
* Future Power: multicultural role models, choosing a role model, goal setting

Other available adaptations of the PowerBook include the (1) StoryBook for HIV, with sections on science, risk factors, relationships, and self-efficacy, and (2) Stories To Live or Die By: Inhalants, Meth, Ecstasy, which teaches facts and myths about methamphetamine, ecstasy, and club drugs. Storytelling for Empowerment also uses fotonovelas--a comic book-like print medium popular in Mexico and Latin America--to facilitate discussion between parents and their children on specific behaviors. Lesson plans are self-explanatory and can be implemented by teachers, program staff, or youth facilitators. Options for the number and timing of sessions are available.

**Learn More by Visiting:**

* **http://www.wheelcouncil.org**

**Strengthening Families Program**

Date of Review: December 2007

The Strengthening Families Program (SFP) is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3-16 years old. SFP comprises three life-skills courses delivered in 14 weekly, 2-hour sessions. The Parenting Skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. The Children’s Life Skills sessions are designed to help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. In the Family Life Skills sessions, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together. Participation in ongoing family support groups and booster sessions is encouraged to increase generalization and the use of skills learned.

**Learn More by Visiting:**

* **http://www.strengtheningfamiliesprogram.org**

**Strengthening Families Program: For Parents and Youth 10-14**

Date of Review: April 2008

The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) is a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. It is theoretically based on several etiological and intervention models including the biopsychosocial vulnerability, resiliency, and family process models. The program includes seven 2-hour sessions and four optional booster sessions in which parents and youth meet separately for instruction during the first hour and together for family activities during the second hour. The sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences to use substances. Sessions, which are typically held once a week, can be taught effectively by a wide variety of staff.

**Learn More by Visiting:**

* **http://www.extension.iastate.edu/sfp**

**Supportive-Expressive Psychotherapy**

Date of Review: October 2007

Supportive-Expressive Psychotherapy (SE) is an analytically oriented, time-limited form of focal psychotherapy that has been adapted for use with individuals with heroin and cocaine addiction. Particular emphasis is given to themes related to drug dependence, the role of drugs in relation to problem feelings and behaviors, and alternative, drug-free means of resolving problems. SE comprises two main components. The first component uses supportive techniques designed to allow patients to feel comfortable in discussing their own personal experiences. In this phase, the therapist focuses on developing a helping relationship with the patient and on identifying and bolstering the patient's strengths and areas of competence. The second component involves the use of expressive techniques to assist the patient in understanding his or her problematic relationship patterns, so that the patient can work through these themes within the context of the patient-therapist relationship. To achieve this goal, the therapist employs unreflective listening, evaluative understanding, and responding to identify the problematic relationship themes. SE helps patients explore the meanings they attach to their drug dependence and address their relationship problems more directly, thus allowing the patients to find better solutions to life problems than drug use.

**Surviving Cancer Competently Intervention Program**

Date of Review: December 2008

The Surviving Cancer Competently Intervention Program (SCCIP) is an intensive, 1-day family group treatment intervention designed to reduce the distress associated with posttraumatic stress symptoms (PTSS) in teenage survivors of childhood cancer (ages 11-18) and their parents/caregivers and siblings (ages 11-19). By reframing cancer-related beliefs and consequences in a positive context using open communication of thoughts, fears, feelings, and memories, SCCIP aims to promote individual and family coping, competence, and resilience.

Four sequential group sessions are conducted on a Saturday or Sunday with six to eight participating families. The two morning sessions emphasize the use of cognitive-behavioral skills to reduce persisting distress around the cancer experience. These sessions are conducted separately for teenage survivors, mothers, fathers, and teenage siblings. Session 3, the first session of the afternoon, starts with separate group conversations with survivors, mothers, fathers, and siblings about the cancer experience and concludes with the sharing of these discussions with the whole group. The final session asks the families to identify what they have learned about the impact of cancer on different family members and how this knowledge can help place the cancer experience into a historical context that allows them to move on with their lives individually and as a family unit. Although the research on SCCIP used eight interventionists (one lead and one trainee/assistant per discussion group), the intervention requires only four, with one being a lead. The lead interventionist should be an experienced mental health professional familiar with cognitive-behavioral and family therapy approaches and the sequelae associated with survival of childhood cancer. All interventionists should be comfortable working with groups and have a basic knowledge of cognitive-behavioral therapy. The intervention also can be implemented without the siblings of survivors, which would eliminate the need for the fourth interventionist.

**Learn More by Visiting:**

* **http://www.chop.edu/consumer/jsp/division/generic.jsp?id=77763**

**Systematic Training for Effective Parenting (STEP)**

Date of Review: January 2010

Systematic Training for Effective Parenting (STEP) provides skills training for parents dealing with frequently encountered challenges with their children that often result from autocratic parenting styles. STEP is rooted in Adlerian psychology and promotes a more participatory family structure by fostering responsibility, independence, and competence in children; improving communication between parents and children; and helping children learn from the natural and logical consequences of their own choices. Although STEP was designed for use with parents facing typical parenting challenges, all the studies reviewed for this summary targeted families with an abusive parent, families at risk for parenting problems and child maltreatment, or families with a child receiving mental health treatment.

There are four current versions of STEP: Early Childhood STEP for parents of children up to age 6; STEP for parents of children ages 6 through 12; STEP/Teen for parents of teens; and Spanish STEP, a complete translation of the STEP program for parents of children ages 6 through 12.

STEP is presented in a group format, with optimal group sizes ranging from 6 to 14 parents. The program is typically taught in 8 or 9 weekly, 1.5-hour study groups facilitated by a counselor, social worker, or individual who has participated in a STEP workshop. Using the STEP multimedia kit (including the Leader’s Resource Guide, Parent’s Handbook, DVDs, and an 11-point drug prevention educational component), the leader teaches lessons to parents on how to understand child behavior and misbehavior, practice positive listening, give encouragement (rather than praise), explore alternative parenting behaviors and express ideas and feelings, develop their child’s responsibilities, apply natural and logical consequences, convene family meetings, and develop their child’s confidence. Parents engage in role-plays, exercises, discussions of hypothetical parenting situations, and the sharing of personal experiences. Videos demonstrate the concepts covered each week with examples of ineffective and effective parent-child interactions.

**Learn More by Visiting:**

* **http://www.steppublishers.com/**

**TCU (Texas Christian University) Mapping-Enhanced Counseling**

Date of Review: July 2008

TCU (Texas Christian University) Mapping-Enhanced Counseling is a communication and decision-making technique designed to support delivery of treatment services by improving client and counselor interactions through graphic visualization tools that focus on critical issues and recovery strategies. As a therapeutic tool, it helps address problems more clearly than when relying strictly on verbal skills. Mapping-Enhanced Counseling is the cognitive centerpiece for an adaptive approach to addiction treatment that incorporates client assessments of needs and progress with the planning and delivery of interventions targeted to client readiness, engagement, and life-skills building stages of recovery. The technique centers on the use of “node-link” maps to depict interrelationships among people, events, actions, thoughts, and feelings that underlie negative circumstances and the search for potential solutions. There are three types of maps: (1) information maps are produced by a counselor or content expert to communicate important ideas (e.g., causes and consequences of HIV); (2) guide maps are predrawn “fill-in-the-node” displays completed by the client (either with assistance from the counselor or as homework); and (3) free style maps are drawn “from scratch” on paper or a marker board while a session progresses. These map types can be used independently or in combination to capitalize on the cognitive advantages of graphical representation while augmenting the flexibility and power of a verbal dialog between clients and counselors/therapists. They also document process and progress across sessions.

TCU Mapping-Enhanced Counseling training relies on manuals and/or workshops to emphasize the importance of integrating applications into the unique styles of counselors and client circumstances. Guidelines are provided for sequencing and timing of mapping activities, but flexibility permits modifications to fit unique situations. This technique has been evaluated across diverse outpatient and residential treatment settings, using both individual and group counseling. Its applications address common treatment issues (e.g., motivation, anger management, thinking errors, relationships) as well as how to facilitate organizational changes within treatment systems.

**Learn More by Visiting:**

* **http://www.ibr.tcu.edu**

**Teaching Kids to Cope (TKC)**

Date of Review: February 2010

Teaching Kids to Cope (TKC) is a cognitive-behavioral health education program, based on stress and coping theory, for adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation. This group treatment program teaches adolescents a range of skills designed to improve their coping with stressful life events and decrease their depressive symptoms. Participants are guided through a process to discover their distorted thinking patterns and to test their thinking against reality using suggested approaches. They also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways of reacting. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks. Activities also include group discussion, role-play, group projects, and the use of worksheets, handouts, films, and audiotapes. Homework assignments provide an opportunity for the adolescents to practice using new skills.

Ten 1-hour group sessions are delivered weekly by a professional with a bachelor’s degree in education, social work, child development, nursing, psychology, or other health-related field, and 1 year of experience working with children or adolescents. TKC can be implemented in schools, hospitals, outpatient clinics, churches, summer camps, or other community-based settings.

**Learn More by Visiting:**

* **http://www.pitt.edu/~krp12/**

**Teaching Students To Be Peacemakers**

Date of Review: June 2009

Teaching Students To Be Peacemakers (TSP) is a school-based program that teaches conflict resolution procedures and peer mediation skills. The program, based on conflict resolution theory and research, aims to reduce violence in schools, enhance academic achievement and learning, motivate prohealth decisions among students, and create supportive school communities. Students learn to be peacemakers in four steps. First, students are taught that conflicts are inevitable but can be desirable and can have positive outcomes when managed constructively. Second, they learn how to negotiate “integrative agreements” to conflicts of interests using a six-step negotiation procedure:

1. Describing what you want
2. Describing how you feel
3. Describing the reasons for your wants and feelings
4. Taking the other's perspective and summarizing your understanding of what the other person wants, how the other person feels, and the reasons underlying both
5. Inventing three optional plans to resolve the conflict that maximize joint benefits
6. Choosing the wisest course of action to implement and formalizing the agreement with a hand shake

Third, students are taught how to mediate their classmates' conflicts, so that they begin to assume a stake in each other's well-being and in the future of their own relationships with others. These first three steps constitute the conflict resolution training part of the program and typically require 10-20 hours of classroom instruction (which may be integrated with academic subjects) over several weeks. Fourth, teachers implement the peer mediation component in which each student gets experience serving as a mediator.

TSP is primarily designed for use in kindergarten through middle school but also has been used with high school students. Teachers deliver the program using lessons that include case studies, role-playing activities, and simulations. Students engage in intellectual conflicts, researching and preparing positions to make persuasive arguments supporting their views, which promotes academic achievement and a higher level of reasoning. Each year, as students proceed to the next grade, the program is retaught at an appropriately more complex and sophisticated level.

**Learn More by Visiting:**

* **http://www.co-operation.org**

**Team Awareness**

Date of Review: June 2007

Team Awareness is a customizable worksite prevention training program that addresses behavioral risks associated with substance abuse among employees, their coworkers, and, indirectly, their families. The training seeks to promote social health and increased communication between workers; improve knowledge about and attitudes toward alcohol- and drug-related protective factors in the workplace, such as company policy and Employee Assistance Programs (EAPs); and increase peer referral behaviors. To achieve these objectives, the training focuses on six components: the importance of substance abuse prevention; team ownership of policy (embracing policy as a useful tool for enhancing safety and well-being for the whole workgroup); stress, including stressors, individual coping styles, and other methods for coping; tolerance and how it can become a risk factor for groups; the importance of appropriate help-seeking and help-giving behavior; and access to resources for preventive counseling or treatment (e.g., EAPs, local community resources, 12-step programs, wellness programs). Training is highly interactive and includes group discussions, videos, role-playing, quizzes, games, communication exercises, and optional homework assignments.

Six to 8 weeks prior to training delivery, facilitators conduct focus groups with employees and interviews with key personnel, and they obtain copies of relevant documents (e.g., policies, EAP promotional materials, previous training materials) for use in the training. The preferred method for training delivery consists of two 4-hour sessions spaced 2 weeks apart and a supervisory module. Team Awareness-SB, a 4-hour version of Team Awareness created for small businesses, is also available.

**Learn More by Visiting:**

* **http://www.organizationalwellness.com**
* **http://www.ibr.tcu.edu**

**Teen Intervene**

Date of Review: August 2007

Teen Intervene is an early intervention program targeting 12- to 19-year-olds who display the early stages of alcohol or drug use problems (e.g., using or possessing drugs during school) but do not use these substances daily or demonstrate substance dependence. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, this intervention aims to help teens reduce and ultimately eliminate their alcohol and other drug use.

The program is administered in a school setting by a trained professional in two or three 1-hour sessions conducted 10 days apart. During session 1, an individual session with the adolescent, the therapist elicits information about the adolescent's substance use and related consequences, examines the benefits and costs of behavior change, and helps the adolescent set goals. In session 2, the therapist assesses the adolescent's progress, discusses strategies for overcoming barriers, and negotiates the adolescent's continued work toward meeting goals. Session 3, an optional individual counseling session with the teenager's parent (or guardian), addresses the adolescent's substance use and the need for the parent to demonstrate healthy attitudes and behaviors related to substance use and to monitor and supervise the adolescent. This session also includes a brief wrap-up conversation with both the parent and the adolescent.

**Learn More by Visiting:**

* **http://www.hazelden.org/bookstore**

**TeenScreen**

Date of Review: February 2007

The Columbia University TeenScreen Program identifies middle school- and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program’s main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors’ offices, juvenile justice settings, shelters, or any other youth-serving setting. Typically, all youth in the target age group(s) at a setting are invited to participate.

The screening involves the following stages:

1. Before any screening is conducted, parents’ active written consent is required for school-based screening sites and strongly recommended for non-school-based sites. Teens must also agree to the screening. Both the teens and their parents receive information about the process of the screening, confidentiality rights, and the teens’ rights to refuse to answer any questions they do not want to answer.
2. Each teen completes a 10-minute paper-and-pencil or computerized questionnaire covering anxiety, depression, substance and alcohol abuse, and suicidal thoughts and behavior.
3. Teens whose responses indicate risk for suicide or other mental health needs participate in a brief clinical interview with an on-site mental health professional. If the clinician determines the symptoms warrant a referral for an in-depth mental health evaluation, parents are notified and offered assistance with finding appropriate services in the community. Teens whose responses do not indicate need for clinical services receive an individualized debriefing. The debriefing reduces the stigma associated with scores indicating risk and provides an opportunity for the youth to express any concerns not reflected in their questionnaire responses.

**Learn More by Visiting:**

* **http://www.teenscreen.org**

**Telemedicine-Based Collaborative Care**

Date of Review: January 2010

Telemedicine-Based Collaborative Care is designed to improve patient depression outcomes (response and remission) in rural primary care practices that lack on-site mental health specialists. The intervention is an adaptation of the collaborative care model for rural Department of Veterans Affairs (VA) primary care practices using telemedicine technologies including telephone, interactive video, Internet, and electronic medical records. In the collaborative care approach to depression treatment, primary care providers work in conjunction with a depression care team that consists of nonphysicians (e.g., nurses, pharmacists) and mental health specialists (e.g., psychologists, psychiatrists).

Three types of providers are required to implement the intervention: on-site primary care providers, off-site telephone nurse care managers (CMs), and off-site telepsychiatrists. The on-site primary care providers screen all patients for depression, make diagnoses, and prescribe antidepressants, which are supplied to patients through the VA pharmacy. The CMs conduct biweekly telephone discussions with patients diagnosed with depression. During the discussions, the CMs are guided by a Web-based decision support system (NetDSS) that includes evidence-based instruments and scripts. The CMs provide patient education; assess barriers, preferences, and comorbidities; assist with patient self-management; and monitor symptoms, adherence, and side effects. The off-site telepsychiatrists provide clinical supervision for CMs during weekly meetings to discuss new patients and patients failing treatment. The telepsychiatrists also make treatment recommendations to primary care providers and conduct consultations with patients via interactive video. Telepharmacists and telepsychologists also may be involved in care. Telepharmacists conduct medication histories, address side effects of medications and nonadherence to protocols, and assess issues when patients do not respond to antidepressant therapy. Telepsychologists provide evidence-based psychotherapy via interactive video.

Intervention duration ranges from 8 months (2 months acute phase and 6 months continuation phase) to 12 months (for patients not responding in the acute phase or relapsing in the continuation phase). The intervention uses a stepped-care model in which treatment intensity is increased for patients failing to respond to lower levels of care by involving a greater number of intervention personnel with increasing mental health expertise. The sequence is as follows: (1) the patient and provider choose either watchful waiting or antidepressant therapy; (2) if the patient does not respond to antidepressant therapy, the telepharmacist conducts a medication history and provides pharmacotherapy recommendations to the primary care provider; and (3) if the patient still does not respond to antidepressant therapy, a telepsychiatrist provides a patient consultation followed by additional treatment recommendations to the primary care provider.

**Learn More by Visiting:**

* **https://www.netdss.net**

**Telephone Monitoring and Adaptive Counseling (TMAC)**

Date of Review: June 2010

Telephone Monitoring and Adaptive Counseling (TMAC) is a telephone-based continuing care intervention for alcohol and cocaine dependence that is designed to follow a client’s initial stabilization in a 3- to 4-week intensive outpatient treatment program. The goals of TMAC are to reinforce abstinence, lengthen the time to possible relapse, and shorten relapse episodes when they do occur. TMAC is manual-driven and combines elements of low-intensity monitoring, social support, and adaptive levels of motivational interviewing (MI) counseling and cognitive-behavioral therapy (CBT) in response to a client’s risk level for relapse measured at the start of each session by a structured 10-item interview. Drawing heavily from Wagner’s Chronic Care Model, TMAC focuses on supporting patient self-management, linking patients to community resources, using cognitive-behavioral strategies to increase self-confidence and skill levels, setting goals, identifying barriers to achieving goals, and developing strategies to overcome these barriers.

Initial contact between a TMAC counselor and client is face-to-face and occurs during the third or fourth week of primary substance abuse treatment. The purpose of this first meeting is to introduce the intervention and provide a bridge from in-person substance use counseling sessions to telephone-based, 15- to 30-minute counseling sessions. Subsequent TMAC sessions are initiated either by the client using a toll-free number or by the counselor, depending on which method the client and counselor feel will produce the highest contact rate. The intervention is delivered weekly for the first 8 weeks, twice monthly for up to another 10 months, and monthly thereafter. When clients are at high risk for substance use relapse, phone sessions are more frequent; if the risk level does not decrease, the sessions are followed by one-on-one, clinic-based MI counseling and CBT sessions. Designed to be at least 3 months in duration, TMAC can be used for as long as 18 months.

**Learn More by Visiting:**

* **http://www.med.upenn.edu/ccc/overview.html**

**The Leadership Program's Violence Prevention Project (VPP)**

Date of Review: August 2010

The Leadership Program's Violence Prevention Project (VPP) is a school-based intervention for early and middle adolescents. VPP is designed to prevent conflict and violence by improving conflict resolution skills, altering norms about using aggression and violence (including lowering tolerance for violence), and improving behavior in the school and community.

VPP lessons, taught in the classroom, are based on the experiential learning cycle, an interactive, learner-centered approach that encourages participation, communication, and group work. A trained facilitator guides students through options for conflict resolution and aids them in broadening their adoption of conflict resolution strategies through the use of improved communication skills (e.g., active listening, I-messages). The aim is to reduce students' use of verbally aggressive, physically aggressive, and antisocial conflict resolution strategies and to increase their use of prosocial verbal and other nonaggressive conflict resolution strategies. VPP also targets elements of the classroom environment in which conflict occurs, such as peer relationships and normative beliefs about aggressive behavior. The intervention includes core components for both middle and high school students, including introduction to leadership, vision and imagination, and conflict management. In addition, middle school students receive self-affirmation and cooperation components, and high school students receive self-concept, group dynamics, and social responsibility components. The program concludes with an arts-based final project cooperatively created by all members of each class.

The facilitator implements 12 weekly lessons following the written curriculum, with lessons in the core components adapted to meet participant and school needs. Each 45-minute lesson includes an icebreaker or other team-building exercise; the main activity, which involves the whole group or small groups participating in role-plays, trust games, cooperative work, or a group discussion; and a closing to reflect on the day's activities.

**Learn More by Visiting:**

* **http://www.theleadershipprogram.com/**

**The Seven Challenges**

Date of Review: January 2009

The Seven Challenges is designed to treat adolescents with drug and other behavioral problems. Rather than using prestructured sessions, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the seven challenges into the conversation. The challenges include (1) talking honestly about themselves and about alcohol and other drugs; (2) looking at what they like about alcohol and other drugs and why they are using them; (3) looking at the impact of drugs and alcohol on their lives; (4) looking at their responsibility and the responsibility of others for their problems; (5) thinking about where they are headed, where they want to go, and what they want to accomplish; (6) making thoughtful decisions about their lives and their use of alcohol and other drugs; and (7) following through on those decisions. These concepts are woven into counseling to help youth make decisions and follow through on them. Skills training, problem solving, and sometimes family participation are integrated into sessions that address drug problems, co-occurring problems, and life skills deficits. The Seven Challenges reader, a book of experiences told from the perspective of adolescents who have been successful in overcoming problems, is used by clients to generate ideas and inspiration related to their own lives. In addition to participating in counseling sessions, youth write in a set of nine Seven Challenges Journals, and counselors and youth engage in a written process called cooperative journaling. The program is flexible and can be implemented in an array of settings, including inpatient, outpatient, home-based, juvenile justice, day treatment, and school. The number, length, and frequency of sessions depend on the setting. Counselors with various levels of experience in working with mental health and substance abuse problems are trained in program implementation.

**Learn More by Visiting:**

* **http://www.sevenchallenges.com**

**Too Good for Drugs**

Date of Review: January 2008

Too Good for Drugs (TGFD) is a school-based prevention program for kindergarten through 12th grade that builds on students’ resiliency by teaching them how to be socially competent and autonomous problem solvers. The program is designed to benefit everyone in the school by providing needed education in social and emotional competencies and by reducing risk factors and building protective factors that affect students in these age groups. TGFD focuses on developing personal and interpersonal skills to resist peer pressures, goal setting, decisionmaking, bonding with others, having respect for self and others, managing emotions, effective communication, and social interactions. The program also provides information about the negative consequences of drug use and the benefits of a nonviolent, drug-free lifestyle. TGFD has developmentally appropriate curricula for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-8 curricula each include 10 weekly, 30- to 60-minute lessons, and the high school curriculum includes 14 weekly, 1-hour lessons plus 12 1-hour “infusion” lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in subject areas such as English, social studies, and science/health. Ideally, implementation begins with all school personnel (e.g., teachers, secretaries, janitors) participating in a 10-hour staff development program, which can be implemented either as a series of 1-hour sessions or as a 1- or 2-day workshop.

Too Good for Drugs is a companion program to Too Good for Violence (TGFV), reviewed by NREPP separately. At the high school level, the programs are combined in one volume under the name Too Good for Drugs & Violence High School.

**Learn More by Visiting:**

* **http://www.mendezfoundation.org**

**Too Good for Violence**

Date of Review: April 2008

Too Good for Violence (TGFV) is a school-based violence prevention and character education program for students in kindergarten through 12th grade. It is designed to enhance prosocial behaviors and skills and improve protective factors related to conflict and violence. TGFV has a developmentally appropriate curriculum for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-5 curricula each include seven weekly, 30- to 60-minute lessons, and the curricula for grades 6-8 each include nine weekly, 30- to 45-minute lessons. The high school curriculum includes 14 weekly, 1-hour lessons, plus 12 1-hour "infusion" lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in various subject areas. Trained teachers, counselors, and prevention specialists deliver the program. The research presented in this review involved only students in the 3rd grade.

Too Good for Violence is a companion program to Too Good for Drugs (TGFD). At the high school level, the programs are combined in one volume under the name Too Good for Drugs & Violence High School. Outcomes for TGFD and the combined high school version have been reviewed by NREPP in another summary.

**Learn More by Visiting:**

* **http://www.mendezfoundation.org**

**Transtheoretical Model (TTM)-Based Stress Management Program**

Date of Review: October 2007

The Transtheoretical Model (TTM)-Based Stress Management Program targets adults who have not been practicing effective stress management for 6 months or longer. TTM is a theory of behavior change that can be applied to single, multiple, and complex behavioral targets. TTM’s premise is that behavior change is a process and that as a person attempts to change a behavior, he or she moves through five stages: precontemplation (not intending to begin in the next 6 months), contemplation (intending to begin in the next 6 months), preparation (intending to begin in the next 30 days), action (practicing the behavior for less than 6 months), and maintenance (practicing the behavior for at least 6 months). This application of TTM to stress management focuses on increased regular relaxation, exercise, and social support activities. The intervention helps participants develop new strategies that can promote progress to the next stage of change in the adoption of effective stress management practices. The program uses a computerized expert system to provide individualized feedback reports on stress management behaviors at the beginning of the intervention and 3 and 6 months afterward. Participants receive feedback about themselves compared with their peers that includes stage of change, processes of change, self-efficacy, decisional balance responses, and their use of stress management behaviors. Because the intervention uses a self-directed computer program, no training is needed for implementation. A user manual provides answers to frequently asked questions, instructions on how to extract data, and technical support.

**Learn More by Visiting:**

* **http://www.prochange.com**

**Trauma Affect Regulation: Guide for Education and Therapy (TARGET)**

Date of Review: October 2007

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is a strengths-based approach to education and therapy for survivors of physical, sexual, psychological, and emotional trauma. TARGET teaches a set of seven skills (summarized by the acronym FREEDOM--Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution) that can be used by trauma survivors to regulate extreme emotion states, manage intrusive trauma memories, promote self-efficacy, and achieve lasting recovery from trauma. TARGET can be adapted to assist men and women from various age groups, cultures, and ethnicities who have had a variety of traumatic experiences. This program can be offered in 10-12 individual or group counseling or psychoeducational sessions conducted by clinicians, case managers, rehabilitation specialists, or teachers.

**Learn More by Visiting:**

* **http://www.advancedtrauma.com/**

**Trauma Recovery and Empowerment Model (TREM)**

Date of Review: December 2006

The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24- to 29-session group emphasizes the development of coping skills and social support. It addresses both short-term and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.

**Learn More by Visiting:**

* **http://www.ccdc1.org**

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Date of Review: June 2008

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.

**Descriptive Information**

**Learn More by Visiting:**

* **http://tfcbt.musc.edu/**

**Triple P--Positive Parenting Program**

Date of Review: January 2008

The Triple P--Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13 to 16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels:

* Level 1 (Universal Triple P) is a media-based information strategy designed to increase community awareness of parenting resources, encourage parents to participate in programs, and communicate solutions to common behavioral and developmental concerns.
* Level 2 (Selected Triple P) provides specific advice on how to solve common child developmental issues (e.g., toilet training) and minor child behavior problems (e.g., bedtime problems). Included are parenting tip sheets and videotapes that demonstrate specific parenting strategies. Level 2 is delivered mainly through one or two brief face-to-face 20-minute consultations.
* Level 3 (Primary Care Triple P) targets children with mild to moderate behavior difficulties (e.g., tantrums, fighting with siblings) and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, typically in the form of four 20-minute sessions.
* Level 4 (Standard Triple P and Group Triple P), an intensive strategy for parents of children with more severe behavior difficulties (e.g., aggressive or oppositional behavior), is designed to teach positive parenting skills and their application to a range of target behaviors, settings, and children. Level 4 is delivered in 10 individual or 8 group sessions totaling about 10 hours.
* Level 5 (Enhanced Triple P) is an enhanced behavioral family strategy for families in which parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression or high levels of stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. Enhanced Triple P extends Standard Triple P by adding three to five sessions tailored to the needs of the family.

Variations of some Triple P levels are available for parents of young children with developmental disabilities (Stepping Stones Triple P) and for parents who have abused (Pathways Triple P).

**Learn More by Visiting:**

* **http://www.triplep-america.com**

**Twelve Step Facilitation Therapy**

Date of Review: January 2008

Twelve Step Facilitation Therapy (TSF) is a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems. TSF is implemented with individual clients over 12 to 15 sessions. The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These principles include acknowledging that willpower alone cannot achieve sustained sobriety, that surrender to the group conscience must replace self-centeredness, and that long-term recovery consists of a process of spiritual renewal. Therapy focuses on two general goals: (1) acceptance of the need for abstinence from alcohol and other drug use and (2) surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. The TSF counselor assesses the client’s alcohol or drug use, advocates abstinence, explains the basic 12-step concepts, and actively supports and facilitates initial involvement and ongoing participation in AA. The counselor also discusses specific readings from the AA/NA literature with the client, aids the client in using AA/NA resources in crisis times, and presents more advanced concepts such as moral inventories.

The Twelve Step Facilitation manual reviewed for this summary incorporates material originally developed for Project MATCH, an 8-year, national clinical trial of alcoholism treatment matching funded by the National Institute on Alcohol Abuse and Alcoholism. Project MATCH included two independent but parallel matching study arms, one with clients recruited from outpatient settings, the other with patients receiving aftercare treatment following inpatient care. Patients were randomly assigned to Twelve Step Facilitation, Cognitive-Behavioral Therapy, or Motivational Enhancement Therapy. Findings from Project MATCH are included in this summary.

**Learn More by Visiting:**

* **http://www.hazelden.org/bookstore**

**United States Air Force Suicide Prevention Program**

Date of Review: July 2006

The United States Air Force Suicide Prevention Program (AFSPP) is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

* Leadership Involvement
* Suicide Prevention in Professional Military Education
* Guidelines for Use of Mental Health Services
* Community Preventive Services
* Community Education and Training
* Investigative Interview Policy
* Critical Incident Stress Management
* Integrated Delivery System (IDS)
* Limited Privilege Suicide Prevention Program
* Behavioral Health Survey
* Suicide Event Surveillance System

**Wellness Outreach at Work**

Date of Review: June 2008

Wellness Outreach at Work provides comprehensive risk reduction services to workplace employees, offering cardiovascular and cancer risk screening and personalized follow-up health coaching that addresses alcohol and tobacco use. Wellness Outreach at Work begins with outreach to all employees through voluntary, worksite-wide health risk screening, including biometric measures of health status, delivered as near to workstations as is practical. The screening directs employees' attention to health issues and to their own health risks and provides baseline information about the health risks of the total workforce. The screening takes approximately 20 minutes per employee and includes immediate feedback on health risks and first steps that might improve them. After the screening, employees are triaged for follow-up based on the number and severity of the health risks identified. Within the context of personalized, one-on-one coaching for cardiovascular health improvement and cancer risk, wellness coaches provide employees with education and counseling on alcohol use, tobacco use, weight control, and health management. Employees attend one to four 20-minute individual sessions per year thereafter. Computerized records allow employees to track their own health status and to access tools and information that can help them sustain their progress. Individual employees' health information is confidential, but profiles of changing risk factors for the workforce as a whole are made available periodically to employees and to management. The program includes long-term support for employees, both directly and through the corporate environment (e.g., alcohol-free public functions, peer encouragement of health promotion).

**Learn More by Visiting:**

* **http://www.ilir.umich.edu/wellness/**