	In-Class Alcohol and Other Drug Pre						· · ·												Community, One School, (	One Student At A Time
Program Name	Program Description  Positive Family Support-Family Check-Up is an adaptive, family-based intervention that targets adolescent problem behavior at the universal, selected, and indicated levels. It can be adapted based on the different family prodes including differing intervention targets and deces that can be most effective to a particular family. This often recults in a more effective was of recourses and greater treatment.	Continuum of Intervention	ion Selected Outcomes	Program Setting	Target Age	Date Last Reviewed	d Program Contact	Origin of Program	Origin Type	Core Program Components	End Audience	Risk Factors	Protective Factors	Participation for Successful Implementation	Participant Contribution	People Implementing	Organizations Implementing	Communities Implementing	Program Expansion	Enabling Program Expansion
Adolescent Transitions Program (ATP) now called Positive Family Support-Family Check- Up	the different family needs, including differing intervention targets and doses that can be most effective to a particular family. This often results in a more effective use of resources and greater treatment compliance. There are three levels to the overall program:  Level 1: Family Resource Center - The first, universal level involves the creation of a Family Resource Center (FRC). A parent consultant is trained in techniques of operating the FRC, which provides a structured place for school staff and parents to communicate and collaborate. Parent Consultants help set norms for protective parenting practices and distribute information on prosocial family management practices. They also deliver a universal-level prevention program to students in their school's homeroom class. This program, called Success, Health, and Peace (SHAPe) is a 6-week program that seeks to improve each child's chances of success, promote health and abstinence and nonviolence. Students participate in one program session per week and are assigned a parent-child interaction homework activity each week. Each activity covers one family management skill that is paired with the class topic from that week: a) school success, b) health decisions, c) building positive peer groups, d) the cycle of respect, e) coping with stress and anger, and f) solving problems peacefully. Upon program completion, families receive a newsletter that summarizes the parenting practices and class	Universal Prevention Selective Prevention Indicated Prevention	Alcohol Depression Tobacco	School	Early Adolescence (12-14) - Middle School	Fosco et al 2013 (Blueprints)	Kevin Moore, Ph.D. Child and Family Center University of Oregon 195 West 12th Avenue Eugene, OR 97401-3408 Phone: (541) 346-4805 Kmoore2@uoregon.edu cfc.uoregon.edu	Tom Dishion, Ph.D. University of Oregon	University-Based Program	Level 1: Family Resource Center with a 6 week in-class program called "success, health and peace"  Level 2: Family Check-Up  Level 3: The Family Intervention Menu	Middle School students	Individual: Early initiation of antisocial behavior Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use Rebelliousness Substance use  Peer: Interaction with antisocial peers Peer substance use  Family: Family conflict/violence Parental attitudes favorable to antisocial behavior Parental attitudes favorable to drug use Poor family management  School: Low school commitment and attachment	Individual: Problem solving skills  Peer: Interaction with prosocial peers  Family: Attachment to parents Opportunities for prosocial involvement with parents Parent social support Parental involvement in education Rewards for prosocial involvement with parents  School: Opportunities for prosocial involvement in education Rewards for prosocial involvement in school	Schools that already have a substance abuse program (e.g., PDIF or RTI (response to intervention) or Comprehensive Integrated Three-Tiered Programming).	Staff (.5 FTE) and faciltiies (Family Resource Room), plus programming for substance abuse that can dovetail. 'We are looking for places where we can lower costs for implementing evidence-based prevention programs. We need a footprint to go into; they must have a program ir place for us to come in and we add a family component to what they are already doing.'	n	"I have a 2-3 places in mind that are doing all three levels particularly well. The tertierary levels most difficult as it takes the most staff, and most of these staff were lost during recent bud cuts."  In brief, (1) Madison Middle School in Eugene C (2) Small rural school near Eugene OR, (3) large middle school in Eastern OR, (4) school out in Portland, (5) good example of first year implementation in Churchville, IL, (6) Colorado.	et  "Lastly, we are just starting in Pennsylvania they have a really nice infrastructure to support these sort of implementationstheir advocate / cus-	"I'm interested in expanding the program because research money is much harder to get these days."	"Turn-over in schools makes implementation difficult unless you have implementation at the District or State level. Training budgets are not ongoing, so can't keep up with turn-over. Our response is to start a Train-the-Trainer program to help with that continuity. If there were foundations that help backfill FTE position (contractors) to support these programs; grant support specific training programs and the like, but don't pay for full time dedicated staff."
ig Brothers Big Sisters (BBBS) Community-Based Mentoring Program)	Big Brothers Big Sisters of America is a community mentoring program which matches a volunteer adult mentor to a child, with the expectation that a caring and supportive relationship will develop. The most important component in this program is the match. Once matches are made, they are continually monitored and supervised by a professional BBBS staff member. Relationships between mentor and child are one-to-one, they meet three to five hours per week, on a weekly basis, over the course of a year or longer. Generalized activities of the relationship are related to the goals that are set initially when the match is made. These goals are identified from the extensive case manager interview held with the parent/guardian and with the child. Beyond the establishment of a close relationship between mentor and child, other goals might relate to school attendance and academic performance, relationships with other children and siblings, general hygiene, learning new skills or developing a hobby. These goals are updated by the case manager as progress is made and circumstances change over time. Case managers are there for guidance, and suggest rather than dictate activities in which matched pairs are to engage. Case managers use the Standards and Required Procedures for One-To-One Service to outline the schedule of contacts made with the volunteer, as well as with the parent and/or child. More frequent contact is made with the mentor and parent during the early stages of the match (once a month) and then tapers to once every three months after one year and throughout the rest of the duration of the match. At least quarterly, the case manager is in touch with the child to learn of the youth's experiences, in order to determine how the relationship is developing and to provide an opportunity to give advice and guidance around any issues the volunteer might have, as well as to encourage and support various activities. Most contacts are made over the phone.	Selective Prevention	Alcohol Antisocial-aggressive Behavior Close Relationships with Parents Close Relationships with Peers Illicit Drug Use Positive Social/Prosocial Behavior Truancy - School Attendance	Community (e.g., religious, recreation)	Late Childhood (5-11) - K/Elementary Early Adolescence (12-14) - Middle School Late Adolescence (15-18) - High School	8/2011 (NREPP)	Vanessa Marks Vice President, Research, Innovation & Growth  Big Brothers Big Sisters of America 261 Madison Avenue, 9th Floor, New York NY 10016  Cell: 202.494.3182 venessa.marks@bbbs.org	Program began in 1904 with Clerk in New York Courts	n Non-University Affiliated Non-Profit	1:1 Mentoring Program is THE core component. They publish a Service Delivery Model that guides affiliates. This Service Delivery Model includes standards (for matching, for screeing, case management, evaluations, etc.) and guidelines (for different types of matches, site-based programs - for example at a corporate envrionment, YMCA or school).	to address specific ages and populations (mili- tary = any age, over 18	Individual: Early initiation of antisocial behavior Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use  Peer: Interaction with antisocial peers  Family: Family conflict/violence Family history of problem behavior  School: Low school commitment and attachment Poor academic performance  Community: Extreme economic disadvantage	Individual: Academic self-efficacy Prosocial behavior Prosocial involvement  Family: Attachment to parents  Community: Opportunities for prosocial involvement Rewards for prosocial involvement	The Mentor and Mentee meet unsupervised; as such the family is most important. If we can't reach the parent every month to make sure they are comfortable then we close the match. Most matches are through community-based programs This can be a challenge because there are a lot of children who have parents we can't reach (incarceration, for example).  Our site-based meetings are supervised meetings so we don't need monhtly contact with the parents. If it is a site-based program the most important member is whoever is hosting the program. Most site-based programs are school-based, though some are based in community partners.	Communities: Provide volunteer recruitment  Schools: Provide space and supervision for site-based programs  Families: Provide sign-off for unsupervised matches through community programs.	"We have a common database that all agencies are required to use, so have real-time data on who is doing what. Namely they track 'strength of relationship' at 3 month marks, then annuall Then a 'Youth Outcome Survey' pre-match and then annually."	"Affiliates each are incorporated separately and have their own board of directors. National Offily. is headquartered in Dallas and satellite offices in the control of the	e "We have 337 affiliates across the country who serve 5,000 communities across all 50 states."	"We talk about growing our youth services. We have over 30,000 kids on our waitlist at any given time. So we are never able to meet the need and demand for our services. So when we talk about growth we talk about growing our youth services. We are also very interested in research and innovation. We have the networks, the number and the desire to lead the field on mentorship research. Lastly, we are interested in collaboration - how can we partner with other service providers to leverage additional socio-emotional outcomes."	"The two biggest barriers for growth we face are those that most face: (1) the need to raise more money to support more matches, and (2) volunteer recruitment/engagement/retention is huge part of our work - especially getting diver volunteers."
ARE to Be You	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.	Universal Prevention Selective Prevention	Parental Self-efficacy Use of Harsh Punishment Child's Developmental Level Satisfaction With Social Support Syster	Community (e.g., religious, recreation)	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	11/2006 (NREPP)	Jan Miller-Heyl (970) 565-3606 jan.miller-heyl@colostate.edu	David MacPhee (970) 491-5503 david.macphee@colostate.ed	University-Based Program	DARE TO BE YOU HAS NOT RESPONDED TO REQUESTS FOR INFORMATION										
Functional Family Therapy (FFT)	Functional Family Therapy (FFT) is a prevention/intervention program for youth who have demonstrated a range of maladaptive, acting out behaviors and related syndromes. Intervention services consist primarily of direct contact with family members, in person and telephone; however, services may be coupled with supportive system services such as remedial education, job training and placement, and school placement. Some youth are also assigned trackers who advocate for these youth for a period of at least three months after release.  FFT should be implemented with a team of master's level therapists, with oversight by a licensed clinical therapist. FFT is a phasic program with steps which build upon each other. These phases consist of:  Engagement, designed to emphasize within youth and family factors that protect youth and families from early program dropout;  Motivation, designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for lasting change;  Assessment, designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they relate to change techniques;  Behavior Change, which consists of communication training, specific tasks and technical aids, parenting skills, contracting and response-cost techniques, and youth compliance and skill building;  Generalization, during which family case management is guided by individualized family functional needs, their interface with environmental constraints and resources, and the alliance with the FFT Therapist/Family Case Manager.	Indicated Prevention	Delinquency and Criminal Behavior Illicit Drug Use	Juvenile Justice Setting Mental Health/Treatment Center Social Services Transitional Between Contexts	Early Adolescence (12-14) - Middle School Late Adolescence (15-18) - High School	Celinska, Furrer, & Cheng 2013 (Blueprints)	Holly DeMaranville FFT Communications Director 1251 NW Elford Dr. Seattle, WA 98177 Phone: (206) 369-5894 - cell Fax: (206) 453-3631 Email: hollyfft@comcast.net Website: www.fftinc.com	James F. Alexander, Ph.D University of Utah	University-Based Program	Engagement: Designed to emphasize within youth and family factors that protect youth and families from early program dropout  Motivation: Designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope and motivation for lasting change  Assessment: Designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they relate to change techniques  Behavior Change: Consists of communication training, specific tasks and technical aids, parenting skills, contracting and response-cost techniques, and youth compliance and skill building  Generalization: During which family case management is guided by individualized family functional needs, their interface with environmental constraints and resources, and the alliance with the FFT Therapist/Family Case Manager	10-18 year olds	Individual: Antisocial/aggressive behavior Early initiation of antisocial behavior Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use Hyperactivity Rebelliousness Substance use  Peer: Interaction with antisocial peers Peer substance use  Family: Family conflict/violence Family history of problem behavior Neglectful parenting Parental attitudes favorable to antisocial behavior Parental attitudes favorable to drug use Poor family management Violent discipline	Individual: Clear standards for behavior Problem solving skills Prosocial behavior Prosocial involvement Skills for social interaction  Peer: Interaction with prosocial peers  Family: Attachment to parents Non-violent discipline Opportunities for prosocial involvement with parents Parent social support Rewards for prosocial involvement with parents	"Family is mandatory; will not work without famil involvement."	"The whole basis of FFT is that the family is making changes in their lives that impacts what happens in the youth. And so the family MUST be involved in all components. (1) Time, they need to show up and be there, but that is just the star they need to be involved in ALL apects of the family. And, you know, family could be whoever the primary caregiver is - it doesn't have to be the mother and father."	"We have close to 350 sites that do FFT in 48 states across 11 countries (see map on website I can't say that there is any one group that doe it better than anyone else. They all do it in different ways but they all do their best. The sites that are the most successful are the sites that have people as champions, that make sure that FFT is part of their overall structure, that it is incorporated into their everyday business - who really champion it."	The person we spoke with didn't want to single any one location out as being better than the others.  "They are certified by us for a reason; we wouldn't certify them unless we thought they defer the control of the c	"Our longest standing site is a site in Dayton, Ohio that has been operating for approximately 13 years".  The California Institute for Health Operates approximately 45 programs overseas.  In total there are over 75 sites who have been doing FFT for over 8 years.	"We expand daily, but we don't actively market; referrals only. We don't have any growth goals and simply don't look at our program in this way."	
uiding Good Choices	Guiding Good Choices (GGC) is a family skills-training program for parents and their middle-school aged children. The program is based on the social development model and its primary objectives are to enhance protective parent-child interactions and to reduce child risk for early substance use initiation. GGC consists of a five-session, multimedia drug resistance and education program for adolescents and their parents. Adolescent participants are required to attend one session which teaches pere isstance skills. The parents receive four sessions of instruction including material on the (a) identification of risk factors for adolescent substance abuse and a strategy to enhance protective family processes; (b) development of effective parenting practices, particularly regarding substance use issues; (c) family conflict management; and (d) use of family meetings as a vehicle for improving family management and positive child involvement. Each session runs approximately two hours in length.  Specifically, Session 1 creates opportunities for involvement and interaction in the family and rewarding children's participation in the family. Session 2 establishes clear family rules about substance use, monitoring the behavior of children, and disciplining children. Session 3 teaches children skills needed to resist peer influences to use drugs. Session 4 focuses on reducing and managing anger and family conflict. Session 5 focuses on expressing positive feelings and developing bonding.	Universal Prevention	Alcohol Delinquency and Criminal Behavior Depression Illicit Drug Use	School	Early Adolescence (12-14) - Middle School	7/2012 (NREPP)	Guiding Good Choices Channing Bete Company, Inc.  One Community Place South Deerfield, MA 01373-0200  Phone: (800) 477-4776  Email: custsvcs@channing-bete.com  Website: www.channing-bete.com/prevention-programs/guiding-good-choices	J. David Hawkins, Ph.D. University of Washington	For Profit Organizatio	Five, two-hour multimedia-supported educational sessions for teens and their parents that include family activities and discussion topics, as well as skill-building exercises and information on positive parenting.	Daranta and shildren	Individual: Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use  Peer: Interaction with antisocial peers  Family: Family conflict/violence Neglectful parenting Parent aggravation Parental attitudes favorable to drug use Poor family management	Individual: Clear standards for behavior Refusal skills, Skills for social interaction  Peer: Interaction with prosocial peers  Family: Attachment to parent Opportunities for prosocial involvement with parents Rewards for prosocial involvement with parents	"Community. If we get all aspects fo the community to work together (public services, education, juvenile justice) then we can make it work. Putting on a parent training workshop is hard work, and it won't work without someone in the commnity spearheading the effort to pull togethe the stakeholders. Then, the family are the end users of the information; they are the ones who need to take it home and practice these skills with their children, and continually hold family meetings (etc.); the family has a really big job here too, but they don't get trained unless someone in the community takes lead."	practice skills  Schools: Mailing lists and distribution to parents	are giving the workshops to the parents."	Arizona: Attorney General's implementation is newer but it is large: https://www.azag.gov/good-choices  Navasota, TX: Implementation has been cited it the U.S. Dept. of Education: http://www.esc6.net/info/spotlight/info.aspx?id=447. It contains suite of programs under the Raising Healthy Chdren (based on the Seattle Social Development Project), including Guiding Good Choices  San Diego, CA: Unified School District—Implementation is noted on a couple of their Web pages: http://www.sandi.net/site/default.aspx?PageID=1699, http://www.sandi.net/site/default.aspx?PageID=26842  Columbus, IN: http://www.therepublic.com/view/local_story/Column-Guiding-program-helps-m_1391828220  Watsonville, CA: http://www.mercurynews.combreaking-news/ci_20375278/watsonville-gets-250-000-state-grant-gang-prevention	a I- See left.	"Funding having been reduced for our customers, and continuing to look very tight, we are realistic about our customers' ability to expand their programs."	
ifeSkills Training (LST) Sometimes called Botvin's LST)	LifeSkills Training (LST) is a three-year universal prevention program for middle/junior high school students targeting the use of gateway substances (tobacco, alcohol, and marijuana) and violence. The program provides students with training in personal self-management, social skills, and social resistance skills. LST consists of 15 core sessions in the first year, ten booster sessions in the second year, and five booster sessions in the third year. Each year also contains optional violence prevention sessions (three in year one, and two for both years two and three). Sessions are taught sequentially and delivered primarily by classroom teachers. Each unit in the curriculum has a specific major goal, measurable student objectives, lesson content, and classroom activities.  The LST program includes two generic skills training components that foster overall competence and a domain-specific component to increase resistance to social pressures to smoke, drink, or use illicit drugs. The Personal Self-Management Skills component teaches students to examine their self-image and its effects on behavior; set goals and keep track of personal progress; identify everyday decisions and how they may be influenced by others; analyze problem situations, and consider the consequences of each alternative solution before making decisions; reduce stress and anxiety, and look at personal challenges in a positive light. The Social Skills component teaches students the necessary skills to overcome shyness, communicate effectively and avoid misunderstandings, initiate and carry out conversations, handle social requests, utilize both verbal and nonverbal assertiveness skills to make or refuse requests, and recongize that they have choices other than aggression or passivity when faced with tough situations. The Resistance Skills component teaches students to recognize and challenge common misconceptions about tobacco, alcohol, other drug use, and other risk behaviors such as violence and delinquency. The main goal of this component is t	Universal Prevention	Alcohol Delinquency and Criminal Behavior Illicit Drug Use Sexual Risk Behaviors STIs Tobacco Violence	School	Early Adolescence (12-14) - Middle School	9/2008 (NREPP)	National Health Promotion Associates, Inc.  711 Westchester Avenue, 3rd Floor White Plains, NY 10604  (914) 421-2525 (914) 421-2007 fax  Istinfo@nhpamail.com  www.lifeskillstraining.com	Gilbert J. Botvin, Ph.D.  Weill Cornell Medical College	For Profit Organizatio	Curricula for 30 core sessions over three years with optional boosters (focused on violence).	Middle and high school students focus, with extensions down to 3rd grade and up into college/workplace	Individual: Early initiation of drug use Favorable attitudes towards drug use Substance use  Peer: Interaction with antisocial peers Peer substance use  Neighborhood/Community: Laws and norms favorable to drug use/crime	Individual: Clear standards for behavior Perceived risk of drug use Problem solving skills Refusal skills Skills for social interaction	"Schools. That's were students are most of the day, and that's where our program is implemented out of necessity or access."	Schools: Provide access Community  Organizations: Oftentimes provide funding	Nominated by school or community-based organization	Community-based organizations implement in schools, or schools implement themselves.	"The most successful sites start from a planning process that engages the most stakeholders. They are in all 50 states and internationally as well."	"We started just in the middle school and expanded down to the third-grade and up into college/work-place trainings. We talk about expansion mostly in terms of updating and expanding programming. We view it as expanding the LST continum."	"Policy that moved prevention to the forefront. Child Left Behind did well at that, but otherwis it's up to us to get the word out, which we do a lot of, but policy priority for evidence-based pr vention as a whole would help as it would bring more dedicated funding towards programs that are proven as effective."
fultidimensional Family Therapy	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 of viice 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).	Indicated Prevention	Alcohol Illicit Drug Use Abstinence From Substance Use Treatment Retention Recovery From Substance Use Risk Factors For Continued Substance Use And Other Problem Behaviors School Performance Delinquency	Outpatient Correctional Use Home	6-12 (Childhood) 13-17 (Adolescent)	6/2008 (NREPP)	Gayle A. Dakof, Ph.D. (305) 749-9332 gdakof@mdft.org	Howard A. Liddle, Ed.D., ABF (305) 243-6860 hliddle@med.miami.edu	PP University Affiliated Non-Profit	Train-the-trainer for program staff to deliver 12-16, 60-90 minute manual-driven assessment and treatment modules that target four areas of social interaction:  1. Social skills: the youth's interpersonal functioning with parents and peers  2. Parenting skills: the parents' parenting practices and level of adult functioning independent of their parenting role  3. Mental health: parent-adolescent interactions in therapy sessions  4. Juvenile justice: communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice)	Parent-Child Relationship	Individual: Early initiation of antisocial behavior Early initiation of drug use Rebelliousness Substance use  Peer: Interaction with antisocial peers Peer substance use  Family: Conflict/violence Neglectful parenting Parent stress Parental attitudes favorable to antisocial behavior Parental attitudes favorable to drug use Poor family management Violent discipline	Individual: Clear standards for behavior Prosocial involvement Rewards for prosocial involvement.  Peer: Resistence to peer pressue.  Family: Attachment to parents Non-violent discipline Opportunities for prosocial involvement with parents Parent social support Parental involvement in education Rewards for prosocial involvement with parents  School: Opportunities for prosocial involvement in education Rewards for prosocial involvement in school  Community: Opportunities for prosocial involvement Rewards for prosocial involvement Rewards for prosocial involvement	"Community. We target four domains (parents, adolescents, schools, and community relatinoships). The commnity is most important because they initiate the programs; they may already be doing a bootstrap intervention, and are looking for something evidence-based."	"Funding and staff. We only provide the model; they provide the funding, staff, and site for implementation."		"Our website has tabs with contact information for everywhere that the program is happening; these are clinical supervisors or CEO's or Progra Directors. They sometimes initiate, but are alw the ones implementing."		"We are a non-profit whose goal is to disseminate the Multidimensional Family Therapy Model. There are now over 100 progarams in U.S. and Europe; we want more. Most people find out about us through our publications, through registries and evaluators."	re "Training takes time. We do a train-the-trainer
Aultidimensional Treatment Foster Care	Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers. MFTC utilizes a behavior modification program based on a three-level point the youth are provided with structured daily feedback. As youth accumulate points, they are given more freedom from adult supervision. Individual and family therapy is provided, and case managers closely supervise and support the youths and their foster families through daily phone calls and weekly foster parent group meetings. There is a learning emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically last for about six months. Aftercare services remain in place for as long as the parents want, but typically last about one year.	Indicated Prevention	Delinquency and Criminal Behavior Illicit Drug Use Teen Pregnancy Tobacco Violence	Community (e.g., religious, recreation) Home School Transitional Between Contexts	Early Adolescence (12-14) - Middle School Late Adolescence (15-18) - High School	October 2009 (NREPP)	Gerard J. Bouwman (541) 343-2388 gerardb@mtfc.com	Patricia Chamberlain, Ph.D. (541) 485-2711 pattic@oslc.org	Non-University Affiliated Non-Profit	Four key elements are targeted during foster care placement and aftercare:  Providing youth with a consistent reinforcing environment where they are mentored and encouraged to develop academic and positive living skills  Providing youth with daily structure that includes clear expectations and limits and well-specified consequences delivered in a teaching-oriented manner  Providing close supervision  Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships		Individual: Antisocial/aggressive behavior Early initiation of antisocial behavior Favorable attitudes towards antisocial behavior Physical violence  Peer: Interaction with antisocial peers  Family: Poor family management  School: Poor academic performance	Individual: Clear standards for behavior Problem solving skills Prosocial behavior Prosocial involvement Rewards for prosocial involvement Skills for social interaction  Peer: Interaction with prosocial peers  Family: Attachment to parents Opportunities for prosocial involvement with parents Parent social support Rewards for prosocial involvement with parents  School: Rewards for prosocial involvement in school  Neighborhood/Community: Opportunities for prosocial involvement Rewards for prosocial involvement	MULTIDIMENSIONAL TREATMENT FOSTER CARE HAS NOT RESPONDED TO REQUESTS FOR INFOR MATION						
fultisystemic Therapy (MST)	Multisystemic Therapy® (MST®) is an intensive family- and community-based treatment that addresses the multiple causes of serious antisocial behavior across key settings, or systems within which youth are embedded (family, peers, school, and neighborhood). Because MST emphasizes promoting behavior change in the youth's natural environment, the program aims to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising teenagers, and to empower youth to cope with the family, peer, school, and neighborhood problems they encounter.  Within a context of support and skill building, the therapist places developmentally appropriate demands on adolescents and their families to reduce problem behavior. Initial therapy sessions identify the strengths and weaknesses of the adolescent, the family, and their transactions with extrafamilial systems (e.g., peers, friends, school, parental workplace). Problems identified by both family members and the therapists are explicitly targeted for change by using the strengths in each system to facilitate such change. Treatment approaches are derived from well-validated strategies such as strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavioral therapy.  While MST focuses on addressing the known causes of delinquency on an individualized comprehensive basis, several types of interventions are typically identified for serious juvenile offenders and their families. At the family level, MST interventions into tremove barriers to effective parenting (e.g., parental substance abuse, parental psychopathology, low social support, high stress, and marital conflict), to enhance parenting competencies, and to promote affection and communication among familiation members. Interventions in the school domain may foreward, and discipline systems; prompting parents to communicate effectively with each other about adolescent problems; problems solving day-to-day conflicts; and developi	Indicated Prevention	Close Relationships with Parents Delinquency and Criminal Behavior Illicit Drug Use Internalizing Mental Health - Other Positive Social/Prosocial Behavior Violence	Home Juvenile Justice Setting Mental Health/Treatment Center School Social Services Transitional Between Contexts	Early Adolescence (12-14) - Middle School Late Adolescence (15-18) - High School	Weiss et al 2013 (Blueprints)	Marshall Swenson, MSW, MBA  MST Services, Inc. 710 J. Dodds Boulevard, Suite 200 Mount Pleasant, SC 29464  Phone: (843) 856-8226  marshall.swenson@mstservices.com  www.mstservices.com or www.mstinstitute.org	Scott W. Henggeler, Ph.D.  Medical University of South Carolina	For Profit Organizatio	on 1:1 Therapy sessions	Families	Individual: Early initiation of antisocial behavior Early initiation of drug use Rebelliousness Substance use  Peer: Interaction with antisocial peers Peer substance use  Family: Family conflict/violence Neglectful parenting Parent history of mental health difficulties Parent stress Parental attitudes favorable to antisocial behavior Parental attitudes favorable to drug use Poor family management Violent discipline  School: Low school commitment and attachment Poor academic performance  Community: Community: Community disorganization Laws and norms favorable to drug use/crime Low neighborhood attachment	Individual: Clear standards for behavior Problem solving skills Prosocial involvement Rewards for prosocial involvement Skills for social interaction  Peer: Interaction with prosocial peers  Family: Attachment to parents Non-violent discipline Opportunities for prosocial involvement with parents Parent social support Parental involvement in education Rewards for prosocial involvement with parents  School: Opportunities for prosocial involvement in education Rewards for prosocial involvement in school  Community: Opportunities for prosocial involvement Rewards for prosocial involvement	Family	"Although the combination is different from one community to another, funding is at the community level, referrals come from multiple sources depending on the program, and time for case collaboration is needed from all systems relevant to a given youth."	"A list of all implementing agencies is listed on our website at www.mstservices.com."			"Not expanding. The treatment model is heavily researched and has been generally stable for more than two decades."	"We would consider our expansion planning pr prietary, but we do have specific well-designed strategic plans in place that employ all availab social networks. A link to these networks is a available on our website www.mstservices.com
Nurse-Family Partnership	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.	Selective Prevention	Alcohol Child Maltreatment Delinquency and Criminal Behavior Early Cognitive Development Employment Healthy Gestation and Birth Illicit Drug Use Mental Health - Other Physical Health and Well-Being Post Secondary Education Reciprocal Parent-Child Warmth Teen Pregnancy Tobacco	Home	0-5 (Early childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)	7/2008 (NREPP)	Nurse-Family Partnership National Service Office  1900 Grant Street, Suite 400 Denver, Colorado 80203  Direct phone: 303-327-4240 Toll free: 866-864-5226 Fax: 303-327-4260  email: info@nursefamilypartnership.org www.nursefamilypartnership.org/	David L. Olds, Ph.D.  University of Colorado Health Sciences Center	Non-University h Affiliated Non-Profit	18 Model Elements.	Registered Profession- al Nurses / First time mothers	31 3 ,	Family: Attachment to parents Breastfeeding Non-violent discipline Opportunities for prosocial involvement with parents Parent social support Rewards for prosocial involvement with parents	Family and Community	"Families - because participation is voluntary.  Communities - they require a long-standing community advisory board. One of their goals is to connect families to community resources, so this is another reason."	Independent Agencies hire Registered Nurses	"Independent agencies are both grown organic and come to us as customers. Agencies vary in size and structure (NFP, for-profit, government, nursing associations, hospitals), but generally i run through maternal health services. Supporte by federal."	"We are in 43 States and the US Virgin Islands.  We have a locations tab on our website"  is http://www.nurrofamilynartnership.org/locations/	"Yes we are expanding. Our primary indicator is # of families served. We know that there are ~600,000 first time moms each year, and our goal is to increase the percentage of those we serve."	"We have had very significant growth over th past five years, and as long as we continue to cultivate our funding sources we will continue grow. We work hard to access maternal and e childhood funding to support and expand our agencies."
ositive Action	Positive Action (PA) is a school-based program that includes a detailed curriculum with lessons 2-4 times a week—approximately 140 15-minute lessons - pre-grade through 12, and 82 15-20 minute lessons per grade 7 and 8. The content of the classroom curriculum is taught through six units, which teach the following:  The Positive Action Philosophy and the Thoughts-Actions-Feelings about Self Circle This unit provides the conceptual foundation for the content of the program delivered in Units 2-6 and teaches generally about positive and negative actions and their meaning for and application to life. The remaining units teach the specific positive actions for the whole self: the physical, intellectual, social and emotional. Positive Actions for Body and Mind – This unit focuses on nutrition, exercises, sleep, hygiene and other good health habits for the physical area, and thinking skills, problem solving, decision making, memorizing, reasoning, thinking creatively, curiosity study skills and the value of learning for the intellectual area.  Social/Emotional Positive Actions for Managing Yourself Responsibly - Students are taught to manage their personal resources like time, energy, thoughts, actions, feelings, money, talents and possessions, including basic self-control or self-regulation skills.  Social/Emotional Positive Actions for Getting Along with Others - Students are taught to the honest with themselves and others by responsibility taking, learning how to be truthful, admitting to mistakes, not blaming others, knowing their own strengths and weaknesses, and following through with commitments.  Social/Emotional Positive Actions for Improving Yourself Continuously - Students are taught to be honest with themselves and others by responsibility taking, learning how to be truthful, admitting to mistakes, not blaming others, knowing their own strengths and weaknesses, and following through with commitments.  Social/Emotional Positive Actions for Improving Yourself Continuously - Students are taught to be honest w	Universal Prevention	Academic Performance Alcohol Anxiety Bullying Conduct Problems Delinquency and Criminal Behavior Depression Emotional Regulation Illicit Drug Use Physical Health and Well-Being Sexual Risk Behaviors Tobacco Truancy - School Attendance Violence Violent Victimization	School	Late Childhood (5-11) - K/Elementary Early Adolescence (12-14) - Middle School	12/2006 (NREPP)	Carol Gerber Allred  264 4th Avenue Twin Falls, Idaho 83303-2347  (800) 345-2974  carol@positiveaction.net  www.positiveaction.net	Carol Allred	For Profit Organizatio	"Curricula (e.g., pre-K-12 and family classes), and Kits (e.g., family kit, community kit, substance abuse prevention kit, bulemia kit, conflict resolution kit, counseling kit). The school-based program is the heart of it (Tier 1), and then Tier 2 / Tier 3 (more intensive cases) grow out of that."  "The other components, such as community, family, and counselor kits; these are available but we've never done any trainings or much research to support these components. There is one philosphy that guides everything (you feel good about yourself when you do positive actions). It's a focus on the 'whole self' and personal devlelpment on the individual level."	Students Pre-K - 12	Individual: Antisocial/aggressive behavior Bullies others Early initiation of antisocial behavior Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use Physical violence Rebelliousness Substance use Victim of bullying  Peer: Interaction with antisocial peers Peer substance use  School: Low school commitment and attachment Poor academic performance Repeated a grade	Individual: Academic self-efficacy Clear standards for behavior Exercise Perceived risk of drug use Problem solving skills Prosocial behavior Prosocial involvement Refusal skills Rewards for prosocial involvement Skills for social interaction  Peer: Interaction with prosocial peers  Family: Attachment to parents Opportunities for prosocial involvement with parents Rewards for prosocial involvement with parents School: Opportunities for prosocial involvement in education Rewards for prosocial involvement in school	well. We do not have any on community. We don't have any sites where people do all three (use kits or curricula from all three areas); it's an aspiration we have, but we are not there yet."	"Schools provide the people to deliver the program i.e. teachers. Sometimes we have service providers (nonprofits or for profits) that come into schools, in which case schools only provide the permission, space and studentsnot money - the budget for outside actors coming in comes from prevention groups, often funded by block grant money."	"We have around 14,000 in our customer conta database, which is not everybody either. But in terms of people we use for references, we do keep them organized in different ways, but it do pends what kind of reference you are looking for	to you. Private companies too; Orange County, California are service providers who go into large	Schools, so there are some Charter Schools there that are using Positive ActionThe first place that comes to mind is actually in Peoria IL, where were are not exactly using as a school-based program, but more on a Tier 2 and Tier 3 treatment setting so you can see how this is used in more severe cases. East L.A is a good example of a unified	"We talk about people touched; we are expanding into schools, into intervention/treatment facilities. We've been in every state for over 15 years; we just want to do more everywhere. We are also international, so are expanding internationally as well. Because we have outcomes that cross over so many areas *academic, violence, socio-emotional, mental-physical, substance, etc) we can look at different markets to expand into. So part of what we do is decide to expand into this market or that market."	1 and Tier 2 programs. After school is big to Then prevention is big too; we do a lot of wo Texas where service providers go in to schoo described to the left). Being able to expand r keting would help us to grow our progams m quickly. We know the education market, and
Project Northland	Project Northland provides six years of comprehensive programming for students beginning in sixth grade. Phase I provides programming for 8th, 7th, and 8th graders. Each of the three years of programming has a specific thems and incorporates individual, parent, peer, and community pericipation. The students receive skills training in communicating with their parents about alcohol (6th grade), dealing with peer influence and normative expectations about alcohol (7th grade), and understanding methods that bring about community-level changes in atcohol-related programs and policles (8th grade).  Phase II of the program is designed to help maintain the effects through high school. Phase II intervention strategies include community-level changes in atcohol-related programs and policles (8th grade).  Sixth grades: The "Slick Iracy Home learn Program" consists of four weekly sessions of activity-story books which the students complete as homework with their parents. The books also include information on young adolescent alcohol use for parents. Small group discussions about the books are held during school, and an evening fair at which students' posters and projects are displayed. Community-white leaks fromes are cross section of the cummunities: government officials, school and buildings, activities and projects are displayed. Community-white leaks fromes are cross section of the cummunities: government officials, school and buildings, school and buildings, and activities on the project of the schools are held during school, and an evening fair at which students' posters and projects are displayed. Community works, parents, concerned citizens, charged and buildings and schools are participation for parents and advisels for parents and citizens are considered in the project of the schools and attendance and the project and activities for parents and citizens to schools and attendance and advisels of the project and projects and advisels to project and activities for parents and citizens for parents and citizens for pa	Universal Prevention	Alcohol	School	Early Adolescence (12-14) - Middle School Late Adolescence (15-18) - High School	3/2007 (NREPP)	Project Northland  Hazelden Publishing and Education P. O. Box 176 Center City, MN 55012-0176 Phone: 1-800-328-9000 ext. 4324 Email: kmcelfresh@hazelden.org www.hazelden.org/web/go/projectnorthland	Cheryl L. Perry, Ph.D.  University of Texas School of Public Health	Non-University  Affiliated Non-Profit	PROJECT NORTHLAND HAS NOT RESPONDED TO REQUESTS FOR INFORMATION										
roject STAR (formerly Midwest Prevention roject)	The Midwestern Prevention Project (MPP) is a comprehensive community-based, multifaceted program for adolescent drug abuse prevention. The treatment consists of five components (mass media, school, parent, community, and health policy) introduced sequentially over a five year period. The mass media component is introduced with the school component during the first year and continues for almost five years. This component consists of approximately 31 television, radio, and print broadcasts per year, ranging from one-hour talk shows to 15-second commercials and public service announcements.  The school program, which is the central program channel, initiated in grades 6 or 7, consists of a 10-session youth educational program on skills training for resistance of drug use given in school, 10 homework sessions involving active interviews and role-plays with parents and family members. Booster sessions are provided in the second year (grades 7 or 8). The youth educational program includes topics such as the psychosocial consequences of drug use, correction of beliefs about the prevalence of drug use, recognition and counteraction of adult, media, and community influences on drug use, peer and environmental pressure resistance, assertiveness in practicing pressure resistance, problem solving for difficult situations that involve potential drug use, and statement of public commitment to avoid drug use. Prevention skills are delivered via modeling and rehearsal of resistance skills, feedback with peer reinforcement through Socratic Discussion, peer leader facilitation, and discussion of homework results.  The parent program, initiated in year 2, strives to develop family support and modeling for a non-drug use norm within the family as well as in the school and neighborhood and includes parent education and organization throughout middle school. This is accomplished by the creation of a group consisting of the principal, 4-6 parents, and 2 student peer leaders from each school who meet throughout the school year to refi	Universal Prevention (Entire Population)	Tobacco Alcohol Marijuana	Community (e.g., religious, recreation) School	Middle Childhood (9-12) Adolescence (13-18)	12/2011 (Promising Practices Network)	Chih-Ping Chou Professor, Preventive Medicine  Joint Appointment in Social Work, University of Southern California Soto Street Building, SSB, 2001 N. Soto Street, Room 302X, MC 9239 Los Angeles CA 90032–3628  Phone: 323.442.8239  cchou@usc.edu	Mary Ann Pentz, Ph.D.  USC Norris Comprehensive Cancer Center University of Southern Califo 1441 Eastlake Avenue, MS-4 Los Angeles, CA 90089-9175 Phone: (626) 457-6691 Fax: (626) 457-4012 Email: pentz@usc.edu	44 University-Based	PROJECT STAR HAS NOT RESPONDED TO REQUESTS FOR INFORMATION										
oject Toward No Drug Abuse	Project TND is a drug prevention program for high school youth who are at-risk for drug use and violence-related behavior. It originally consisted of nine sessions designed to address issues of substance abuse and violence: 1) Communication and Active Listening, 2) Stereotyping, 3) Myths and Denial, 4) Chemical Dependency, 5) Talk Show, 6) Stress, Health and Goals, 7) Self Control, 8) Perspectives, and 9) Decision Making and Commitment. Three new sessions were added from the third trial on; that is, most trials utilized a 12-session program. These three newer sessions are the 1) Marijuana Panel, 2) Positive and Negative Thought Loops and Subsequent Behavior, and 3) Smoking Cessation. Classes are taught by trained health educators, who administer the curriculum over a 3-week period. Each session lasts 40 minutes and is conducted during the class period. The current version of TNO contains twelve 40-minute interactive sessions. The sessions should be taught as written. Those students who are absent on days that a lesson is implemented should be provided with single-page summaries of the material from each lesson that they can utilize as a means to "make-up" learning of missed lesson material.  The Socratic method is used throughout the curriculum. Thus, the emphasis is on interactions between the students and the teacher and the students with each other. The teacher's use of questioning leads students to generate the answers based on the reasoning that information is internalized more readily when it is not imposed from someone else.  Classroom management in Project TND involves development of positive norms of classroom behavior. Although interaction among the youth is encouraged, the course is primarily teacher-directed and highly structured. In Project TND, the teacher's role is to actively develop and maintain peer group support in the class by modeling support, positively reinforcing it among group members, and negatively reinforcing deviant peer bonds and activities. The teacher creates and structures inter	Universal Prevention Selective Prevention	Alcohol Illicit Drug Use Tobacco Violent Victimization	School	Late Adolescence (15-18) - High School	9/2006 (NREPP)	Leah Meza  USC Institute for Prevention Research Soto Street Bldg., 302A 201 N. Soto Street Los Angeles, CA 90032  Phone: (800) 400-8461 for orders Fax: (323) 442-7254  Email: leahmedi@usc.edu  Website: tnd.usc.edu	Steve Sussman, Ph.D. University of Southern Califo	University-Based ornia Program	Curricula for 12, 40-minute classes:  1. Communication and Active Listening 2. Stereotyping 3. Myths and Denial 4. Chemical Dependency 5. Talk Show 6. Stress, Health, and Goals 7. Self Control 8. Perspectives 9. Decision Making and Commitment 10. Marijuana Panel 11. Positive and Negative Thought Loops and Subsequent Behavior 12. Smoking Cessation	At-risk adolescents	Individual: Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use Substance use  Peer: Interaction with antisocial peers, Peer substance use  Family: Family history of problem behavior	Individual: Perceived risk of drug use Problem solving skills Prosocial behavior Prosocial involvement Skills for social interaction	School	"Schools deliver the program; it usually becomes part of a class (PE, health, science). They provide the students, teachers, and space. Some provide elective credit for these courses, some do not. Some schools have their own grant funding, and become the purchasers themselves."	timewhere these teachers work, we don't know	"Country and state level of education; they have a pretty good idea on where this is, and can give an idea based on State."	"They can show us what organizations are big purchasers and that tells us that they are doing this class again and again, across many classrooms. Those continuing to purchase year after year we can assume are having a successful implementation (e.g., Orange Valley, CA)."	"We are mostly stable - not really expanding right now. Not interested in expanding programming - 12 components is enough to manage."	
Promoting Alternative Thinking Strategies (PATHS)	The PATHS curriculum is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children (grades PreK-6) while simultaneously enhancing the educational process in the classroom.  PATHS is now available by grade level in the following grades: PreK/Kindergarten, Grade 1, Grade 2, Grade 3, Grade 4, and Grade 5/6. The original multi-year version is also available from the publisher. The grade level versions maintain all key elements of the original version and now organize them more discretely by grade levels. Blueprints has not certified the PreK/K version of the program.  PATHS targets five major conceptual domains: (1) self control; (2) emotional understanding; (3) positive self-esteem; (4) relationships; and (5) interpersonal problem solving skills. In addition, a 30-lesson non-mandatory supplementary unit reviews and extends PATHS concepts that are covered in other units.  The PATHS curriculum is designed for use by regular classroom teachers. Lessons are sequenced according to increasing developmental difficulty and designed for implementation in approximately 20-30 minutes 2 to 3 times per week. The curriculum provides detailed lesson plans, exact scripts, suggested guidelines, and general and specific objectives for each lesson. However, the curriculum has considerable flexibility so that it can also be integrated with an individual teacher's style. Lessons include such activities as dialoguing, role-playing, story-telling by teachers and peers, social and self-reinforcement, attribution training, and verbal mediation. Learning is promoted in a multi-method manner through the combined use of visual, verbal, and kinesthetic modalities.	Universal Prevention	Antisocial-aggressive Behavior Conduct Problems Depression Emotional Regulation Externalizing Internalizing	School	Late Childhood (5-11) - K/Elementary	5/2007 (NREPP)	Channing-Bete Company  One Community Place South Deerfield, MA 01373-0200  Phone: (800) 477-4776 Fax: (800) 499-6464  custsvcs@channing-bete.com  www.channing-bete.com/prevention-programs/paths/paths.html	Co-developers	For Profit Organiza- tion/University-Based Program	PATHS HAS NOT RESPONDED TO REQUESTS FOR INFORMATION										
Strengthening Families Program: For Parents and Youth 10-14	The seven-session program for families with young adolescents is based on the biopsychosocial model and targets enhancement of family protective and resiliency processes and family risk reduction. Sessions are conducted once weekly for seven weeks. The first six are two-hour sessions including separate one-hour parent and child skills-building followed by a one-hour family session where parents and children practice the skills they have learned independently, work on conflict resolution and communication, and engage in activities to increase family cohesiveness and positive involvement of the child in the family. The final session is a one-hour family interaction session without the concurrent parent and child training sessions. Parents are taught means of clarifying expectations based on child development norms of adolescent substance use, using appropriate disciplinary practices, managing strong emotions regarding their children, and effective communication. Essential program content for the parent skills training sessions is contained on videotapes that include family interactions illustrating key concepts. Children are taught refusal skills for dealing with peer pressure and other personal and social interactional skills. During the family sessions, family members practice conflict resolution and communication skills and engage in activities designed to increase family cohesiveness and positive involvement of the child in the family. These sessions are led by three-person teams and include an average of eight families per session.	Universal Prevention	Alcohol Antisocial-aggressive Behavior Close Relationships with Parents Illicit Drug Use Internalizing Tobacco	Community (e.g., religious, recreation) School	Early Adolescence (12-14) - Middle School	4/2008 (NREPP)	Cathy Hockaday, Ph.D.  Iowa State University 1087 Lebaron Hall Ames, IA 50011-4380  Phone: (515) 294-7601 Fax: (515) 294-5507  Email: hockaday@iastate.edu  Website: www.extension.iastate.edu/sfp	Virginia Molgaard, Ph.D. Iowa State University	Non-University Affiliated Non-Profit	A curriculum that covers seven (7) two-hour sessions to teach parenting skills and child resistance to peer pressure (in separate sessions) plus one-hour family session where parents and children practice communication together.	10-14 year old adoles-	Family: Family conflict/violence Neglectful parenting Parental attitudes favorable to drug use	Skills for social interaction  Family: Attachment to parents Non-violent discipline Opportunities for prosocial involvement with parents	the adolescents are. Community organization are equally important because they provide the funding. The program would work without both."	"Schools give class lists and contact to parents and function as the recruitment pool. Community organizations provide the funding. Families drive ongoing attendance, support, and sustainability."	has good facilitation skills. They are nominated the community or implementing organization, a	"University extension offices, substance abuse offices (for treatment), schools or school district and state juvenile courts, community-based organizations and agencies who deliver prevention programs."	s, good recruitment rates and does well. The Ari-	"We are expanding by trying to reach more people; the Prosper program is one of our efforts to expand. We track expansions by th number of trainings that we deliver - each training goes along with a new program or existing program expansion. We've had 20 trainings across the country so far this year; last year we had 20 in total all year long."	"Awareness. Money to travel to talk to differer states and coalitions, to attend conferences, or run a targeted marketing campaign. Any medanisms where folks in the community could fininformation on us."
Strong African American Families (SAAF)	The Strong African American Families (SAAF) project is a 7-week interactive educational program for African American parents and their early adolescent children. The intervention program is based on an empirical model of the processes linked to psychological adjustment, substance use and high-risk behavior in rural African American youth. Early adolescence is the period in which children gain increasing control over their behavior, begin forming frendships based on similarities and common interests, and develop attitudes toward substances use. The earling of the processes inked to psychological adjustment, substance use. The SAAF program is designed to strengthen positive family interactions and to enhance parents' efforts to help their children establish and reach positive goals during this critical transition between childhood and adolescence.  The SAAF curriculum is based on data collected in two other studies, Families In It Together (FIIT) and the Family and Community Health Study (FACHS). These studies survey large numbers of African American families residing in rural areas about the kinds of things that parents and children do that foster competence. The SAAF program targets the following predictors of child competence: (1) family routines, parent-child relationship quality, no-nonsense discipline, monitoring and communication, parental involvement with the child's school, racial socialization; (2) goal setting, self-regulation, resistance skill development; and (3) the cognitive antecedents of adolescent risk behavior, including the formation of prototypes of drinking youths and willingness to drink in risk-conducive situations.  The SAAF includes a curriculum organized around seven sessions. Each session includes there modules - Caregiver, Youth, and Family. SAAF modules are an hour each. Parent and youth meet separately for their modules that occur simultaneously. During the second hour, everyone comes together for a group meeting with all of the families. Thus, all parents and youths receive a total	Universal Prevention	Alcohol Close Relationships with Parents Delinquency and Criminal Behavior Truancy - School Attendance	Community (e.g., religious, recreation) School	Late Childhood (5-11) - K/Elementary	3/2011 (NREPP)	Tracy Anderson Dissemination Specialist tnander@uga.edu 706 425 2992  Center for Family Research University of Georgia 1095 College Station Road Athens, GA 30602-4527  www.cfr.uga.edu/saaf1#mission	Gene H. Brody, Ph.D. University of Georgia	University-Based Program	Curricula with 7 classes, each with three one hour modules (Caregiver, Youth, and Family)	African American parents with children in early adolescence	Individual: Early initiation of drug use Favorable attitudes towards antisocial behavior Favorable attitudes towards drug use Substance use  Peer: Interaction with antisocial peers Peer substance use  Family: Family conflict/violence Low socioeconomic status Parent stress Parental attitudes favorable to antisocial behavior Parental attitudes favorable to drug use Poor family management  School: Low school commitment and attachment Neighborhood/Community: Community disorgan zation, Extreme economic disadvantage Laws and norms favorable to drug use/crime Perceived availability of drugs	Individual: Clear standards for behavior, Perceived risk of drug use, Problem solving skills, Prosocial beha ior, Prosocial involvement, Refusal skills Family: Attachment to parents, Opportunities for prosocial involvement with parents, Parent social support, Parental involvement in education	"As far as adoption goes, it would be schools because if they have an interest they can provide and promote the program. They are also important for sustainability - if families have a good relationship with the schools then they are more likely to attend. Next it's community organizations because provention is not the school's job	"Schools bring the staff, space, and students.  Community organizations bring the funding and expertise. Famililes bring the attendance, and are what sustains the program."	"Varies; usually hired by school or a partnering organization. Not usually teachers but Mental Health staff, counselors, etc"	"Universities, CBOs, School Systems, Juvenile Justice Departments, (state level), interested in early interventions, and more recently, Behavio Health groups who have started to see the valu of prevention (even though their funding is still billed as treatment)."	is getting great response. The first organization to adopt SAAF is called Senate Bill 94 is a state-ini-	base of our growth; it's hard to expand if you don't have people coming. Our training model is also expanding right now, which provides better technical assistance pre and post adoption."	