

A. ANNOTATED "LISTS" OF EMPIRICALLY SUPPORTED/EVIDENCE BASED INTERVENTIONS FOR SCHOOL-AGED CHILDREN AND ADOLESCENTS

The following table provides a list of lists, with indications of what each list covers, how it was developed, what it contains, and how to access it.

I. Universal Focus on Promoting Healthy Development

A. *Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs* (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

1. *How it was developed:* Contacts with researchers and literature search yielded 250 programs for screening; 81 programs were identified that met the criteria of being a multiyear program with at least 8 lessons in one program year, designed for regular ed classrooms, and nationally available.
2. *What the list contains:* Descriptions (purpose, features, results) of the 81 programs.
3. *How to access:* CASEL (<http://www.casel.org>)

B. *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs* (2002). Social Develop. Res. Group, Univ. of Wash.

1. *How it was developed:* 77 programs that sought to achieve positive youth development objectives were reviewed. Criteria used: research designs employed control or comparison group and had measured youth behavior outcomes.
2. *What the list contains:* 25 programs designated as effective based on available evidence.
3. *How to access:* Online journal *Prevention & Treatment* (<http://journals.apa.org/prevention/volume5/pre0050015a.html>)

II. Prevention of Problems; Promotion of Protective Factors

A. *Blueprints for Violence Prevention* (1998). Center for the Study and Prevention of Violence, Institute of Behavioral Science, University Colorado, Boulder.

1. *How it was developed:* Review of over 450 delinquency, drug, and violence prevention programs based on a criteria of a strong research design, evidence of significant deterrence effects, multiple site replication, sustained effects.
2. *What the list contains:* 10 model programs and 15 promising programs.
3. *How to access:* Center for the Study and Prevention of Violence (<http://www.colorado.edu/cspvblueprints/model/overview.html>)

B. *Exemplary Substance Abuse Prevention Programs* (2001). Center for Substance Abuse Prevention (SAMHSA).

1. *How it was developed:* (a) Model Programs: implemented under scientifically rigorous conditions and demonstrating consistently positive results. These science-based programs underwent an expert consensus review of published and unpublished materials on 15 criteria (theory, fidelity, evaluation, sampling, attrition, outcome measures, missing data, outcome data, analysis, threats to validity, integrity, utility, replications, dissemination, cultural/age appropriateness. (b) Promising Programs: those that have positive initial results but have yet to verify outcomes scientifically.
2. *What the list contains:* 30 substance abuse prevention programs that may be adapted and replicated by communities.
3. *How to access:* SAMHSA (<http://www.modelprograms.samhsa.gov>)

C. Preventing Drug Use Among Children & Adolescents. Research Based Guide (1997).
National Institute on Drug Abuse (NIDA).

1. *How it was developed:* NIDA and the scientists who conducted the research developed research protocols. Each was tested in a family/school/community setting for a reasonable period with positive results.
2. *What the list contains:* 10 programs that are universal, selective, or indicated.
3. *How to access:* NIDA (<http://www.nida.nih.gov/prevention/prevopen.html>)

D. Safe, Disciplined, and Drug-Free Schools Expert Panel Exemplary Programs (2001).
U.S. Dept. of Educ. Safe & Drug Free Schools

1. *How it was developed:* Review of 132 programs submitted to the panel. Each program reviewed in terms of quality, usefulness to others, and educational significance.
2. *What the list contains:* 9 exemplary and 33 promising programs focusing on violence, alcohol, tobacco, and drug prevention.
3. *How to access:* U.S. Dept. of Education – (http://www.ed.gov/offices/OERI/ORAD/KAD/expert_panel/drug-free.html)

III. Early Intervention: Targeted Focus on Specific Problems or at Risk Groups

A. The Prevention of Mental Disorders in School-Aged Children: Current State of the Field (2001). Prevention Research Center for the Promotion of Human Development, Pennsylvania State University.

1. *How it was developed:* Review of scores of primary prevention programs to identify those with quasi-experimental or randomized trials and been found to reduce symptoms of psychopathology or factors commonly associated with an increased risk for later mental disorders.
2. *What the list contains:* 34 universal and targeted interventions that have demonstrated positive outcomes under rigorous evaluation and the common characteristics of these programs.
3. *How to access:* Online journal *Prevention & Treatment* <http://journals.apa.org/prevention/volume4/pre0040001a.html>

IV. Treatment for Problems

A. The American Psychological Association, Division of Child Clinical Psychology, Ad Hoc Committee on Evidence-Based Assessment and Treatment of Childhood Disorders, published it's initial work as a special section of the *Journal of Clinical Child Psychology* in 1998.

1. *How it was developed:* Reviewed outcomes studies in each of the above areas and examined how well a study conforms to the guidelines of the Task Force on Promotion and Dissemination of Psychological Procedures (1996).
2. *What it contains:* reviews of anxiety, depression, conduct disorders, ADHD, broad spectrum Autism interventions, as well as more global review of the field. For example:
 - > *Depression:* results of this analysis indicate only 2 series of studies meet criteria for probably efficacious interventions and no studies meet criteria for well-established treatment.
 - > *Conduct disorder:* Two interventions meet criteria for well established treatments: videotape modeling parent training programs (Webster-Stratton) and parent training program based on Living with Children (Patterson and Guillion). Twenty additional studies identified as probably efficacious.
 - > *Attention Deficit Hyperactivity Disorder:* behavioral parent training and behavioral interventions in the classroom meet criteria for well established treatments. Cognitive interventions do not meet criteria for well-established or probably efficacious treatments.
 - > *Phobia and Anxiety:* for phobias participant modeling and reinforced practice are well established; filmed modeling, live modeling, and cognitive behavioral interventions that use self instruction training are probably efficacious. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management were found to be probably efficacious.

Caution: Reviewers stress the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child; need for research that is informed by clinical practice.

3. *How it can be accessed:* APA *Journal of Clinical Child Psychology* (1998) v.27, pp. 156-205.

V. Review/Consensus Statements/ Compendia of Evidence Based Treatments

A. School-Based Prevention Programs for

Children & Adolescents (1995). J.A. Durlak. Sage: Thousand Oaks, CA. Reports results from 130 controlled outcome studies that support "a secondary prevention model emphasizing timely intervention for subclinical problems detected early.... In general, best results are obtained for cognitive-behavioral and behavioral treatments & interventions targeting externalizing problems."

B. Mental Health and Mass Violence:

Evidence-based early psychological intervention for victims/ survivors of mass violence. A workshop to reach consensus on best practices (U.S. Departments of HHS, Defense, Veterans Affairs, Justice, and American Red Cross). Available at: (<http://www.nimh.nih.gov/publicat/massviolence.pdf>)

C. *Society of Pediatric Psychology*, Division 54, American Psychological Association, *Journal of Pediatric Psychology*. Articles on empirically supported treatments in pediatric psychology related to obesity, feeding problems, headaches, pain, bedtime refusal, enuresis, encopresis, and symptoms of asthma, diabetes, and cancer.

D. *Preventing Crime: What works, what doesn't, what's promising. A Report to the United States Congress* (1997) by L.W. Sherman, Denise Gottfredson, et al. Washington, DC: U.S. Dept. of Justice. Reviews programs funded by the OJP for crime, delinquency and substance use. (<http://www.ncjrs.org/pdffiles/171676.pdf>). Also see Denise Gottfredson's book: *Schools and delinquency* (2001). New York: Cambridge Press.

E. *School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions* (1999). Center for Mental Health Services SAMHSA. Provides a synthesis of several lists cited above to highlight examples of programs which meet some criteria for a designation of evidence based for violence prevention and substance abuse prevention. (i.e., Synthesizes lists from the Center for the Study and Prevention of Violence, Center for Substance Abuse Prevention, Communities that Care, Dept. of Education, Department of Justice, Health Resources and Services Administration, National Assoc. of School Psychologists) (<http://nrepp.samhsa.gov/>)

BUT THE NEEDS OF SCHOOLS ARE MORE COMPLEX!

Currently, there are about 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of behavior, emotional, and learning, problems in mind. School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity.

There is a large body of research supporting the promise of specific facets of this activity. However, no one has yet designed a study to evaluate the impact of the type of comprehensive, multifaceted approach needed to deal with the complex range of problems confronting schools.

It is either naive or irresponsible to ignore the connection between children's performance in school and their experiences with malnutrition, homelessness, lack of medical care, inadequate housing, racial and cultural discrimination, and other burdens

Harold Howe II

. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

What the best and wisest parent wants for (her)/his own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.

John Dewey
