Local Adaptations of Crime Prevention Programs: Finding the Optimal Balance Between Fidelity and Fit

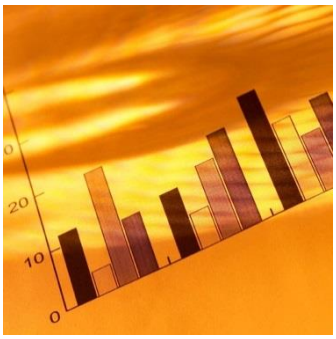
Key Effective Elements of Crime Prevention Programming

by Melanie Bania, PhD, Vanessa Chase, MCA, Ben Roebuck, PhD, and Beth O'Halloran

RESEARCH REPORT: 2017–R019-A

RESEARCH DIVISION

www.publicsafety.gc.ca



BUILDING A **SAFE** AND **RESILIENT CANADA**

Public Safety Canada | Sécurité publique Canada

Canada

Abstract

Evidence-based programs have been tested using the most rigorous of scientific evaluation designs and methodologies. These programs are effective and have been studied in-depth to reveal the key elements that contribute directly to positive outcomes for their target population. These programs have a very specific set of standards and practices that their developers insist must be adhered to for the program to be effective. The objective of this document is to highlight the key effective elements of a series of well-researched crime prevention programs. A review of a total of thirty-one individual programs were included in the present study

Author's Note

The views expressed are those of the authors and do not necessarily reflect those of Public Safety Canada. Correspondence concerning this report should be addressed to:

Research Division
Public Safety Canada
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P8
Email: PS.CSCCBResearch-RechercheSSCRC.SP@canada.ca

Product Information:

Cat. No.: PS113-1/2017-19-1E
ISBN Number: 978-0-660-26550-6

Table of Contents

1. Introduction

Programs that are considered "evidence-based" have been tested using the most rigorous of scientific evaluation designs and methodologies. Not only have they been proven effective, but they have also been studied in-depth to reveal the key elements that contribute directly to positive outcomes for their target population. In this way, they are neatly 'packaged' programs with a very specific set of standards and practices that their developers insist must be adhered to for the program to be effective. This is also referred to as "fidelity" in program implementation (see Bania, Roebuck, & Chase, 2016).

The objective of this document is to highlight the key effective elements of a series of well-researched crime prevention programs. This includes a review of a total of thirty-one (31) individual programs, including:

- Programs in Indigenous Communities (N=3)
- Programs for Children Ages 6 to 11 (N=13)
- Programs for Youth Ages 12 to 17 (N=12)
- Programs for Addressing Youth Gang Involvement (N=3)
- Programs for Offenders (N=1)

The programs are presented in a series of tables which highlight the key elements of each program such as its: main objectives; target population; setting; key components; specifics of delivery; dosage (amount of intervention); and duration (length of intervention). The tables also highlight the evaluation methodologies used to test the interventions, and the results obtained. Following these tables, we highlight some of the more universal effective elements of crime prevention programming that can be considered key drivers of quality. We finish by exploring recent trends in the literature on effective supports for diverse individuals and communities who face barriers to success, including the key strategies of providing strength-based supports, ensuring cultural safety, and providing trauma-informed supports.

2. Methodology

The focus of this review was on a list of thirty-one (31) evidence-based crime prevention programs identified by the Research Division of Public Safety Canada. The objective was to research and document information relating to the key effective elements of these programs, along fourteen (14) variables described in the coding framework below. The first thirteen variables were identified at the beginning of this project. Research revealed that many of these evidence-based programs have already been adapted to different populations or settings. As such, a brief mention of existing program adaptations is included (variable 14) as this may also be of interest to the reader.

These fourteen categories formed the basis for the overarching framework of the tables presented in this report. Note that the principles, terms and language used in the tables represent those used in the literature by program developers and evaluators. They do not necessarily represent the views or language preferences of the authors.

2.1 Coding Framework

	Variable	Description / Examples
1	**Main objectives of the intervention**	Describe the key aim and purpose of the program, including the crime issues targeted (ex: aggression, dating violence, bullying, substance abuse, youth gang involvement, recidivism, etc.)
2	**Target risk and protective factors**	List the risk/protective factors the program addresses; Use the authors' language, and add/describe other important ones as you see fit. (ex: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2013-mjr-risk-fctrstfrgf-ntscl/index-en.aspx)
3	**Definition & description**	Provide an overarching summary of the program, including its central theory and assumptions.
4	**Universal vs. targeted program**	Identify whether the program is offered to the general population (= universal) or to specific participants (= targeted)
5	**Target population**	Describe who the intervention is designed for (age, gender, socio-demographics, etc.)
6	**Setting**	Describe where the intervention takes place (physical location) (ex: in the community; juvenile justice setting; mental health facility; residential setting; school; social services location; other)
7	**Level of intervention**	Describe where the focus of the intervention lies (i.e.: Individual and/or group and/or family and/or community)
8	**Components**	The program's main strategies and practices, and their orientation (these are parts of the larger program but could also stand alone); List the key components and provide a brief description of each (ex: academic support; after school support; alternative to detention; cognitive behavioral therapy; community supervision and aftercare; conflict resolution; individual counselling; family therapy; employment training; job placement; leadership training and opportunities; mentoring; tutoring; parent training; peer counseling and mediation; skills training; social emotional learning; substance abuse prevention/treatment; truancy prevention; etc.)
9	**Specifics of delivery**	Describe other particular practices or principles to adhere to (ex: staffing requirements (staff vs volunteers), training requirements, staff to client ratio, group number, partnership requirements, tools to use, curriculum

		to follow, etc.)
10	**Dosage**	Identify amount (quantity) and frequency of intervention
11	**Duration**	Identify the required period of time (length) of program
12	**Evaluation methods and findings**[1]	Provide type of evaluation (performance monitoring, process, impact), brief summary of methodology (quasi-experimental, mixed methods, etc.) and methods (pre/post testing, interviews, focus groups). Describe the populations this program has been evaluated with (samples). Describe the key overall findings on program impacts / outcomes / effectiveness.
13	**References**	Provide list of all sources consulted for the program review
14	**Existing adaptations**	Provide a summary of for whom, in what ways, and how the program was adapted – with references/sources – as applicable N/A designates that no adaptations were found in the literature consulted

2.2 Programs Reviewed

The list of programs to review was determined in consultation with representatives from the Research Division of Public Safety Canada. The list below presents the thirty-one (31) programs included in this report.

Programs in Indigenous Communities

1. Aboriginal Empathic Program
2. Project Venture

Programs for Children At-Risk Ages 6 to 11

3. Coping Power Program
4. Good Behavior Game
5. Incredible Years
6. Steps to Respect
7. Strengthening Families Program
8. The “l'Allié” Program
9. The Fluppy Program
10. Fast Track
11. Olweus Bullying Prevention Program (BPP)
12. Positive Action (also for youth 12-14)

[1] Information provided to describe the methods, samples, and findings of the program can vary in quantity and quality from one program to another based on original information provided by the author(s) reviewed.

13. Promoting Alternative Thinking Strategies (PATHS)
14. SNAP™ (Stop Now and Plan)
15. Triple P – Positive Parenting Program

Programs for Youth At-Risk Ages 12 to 17

16. Aggression Replacement Training
17. Alternative Suspension
18. Pathways to Education Program
19. The Fourth R
20. Functional Family Therapy (FFT)
21. Leadership and Resiliency Program (LRP) (also for youth 18 to 24)
22. Life Skills Training (LST)
23. Multisystemic Therapy (MST)
24. Multisystemic Therapy (MST) – Problem Sexual Behaviour
25. Project Towards No Drug Abuse (Project TND)
26. Wraparound (also for youth 18 to 24)
27. Youth Inclusion Program (YIP) (also for youth 18 to 24)

Programs for Addressing Youth Gang Involvement

28. Cure Violence (formerly Chicago Ceasefire)
29. OJJDP Comprehensive Gang (or "Spergel") Model – specifically the Gang Reduction Program
30. Philadelphia Youth Violence Reduction Partnership

Programs for Offenders

31. Circles of Support and Accountability (COSA)

2.3 Criteria for selecting and reviewing references

With 31 programs to review in depth, the number of references found in the literature was very high. Some sources provided good quality and detailed information, while others provided less complete information or were repetitive of earlier publications. As a result, the three key references that provided the most information, covered the essential program elements, and reported on original evaluations of the program were read and reviewed in much detail. Other references were scanned for new information, different information, or details of existing adaptations, and included in this report as appropriate.

2.3.1 Challenges & Limitations

With many sources to review and incorporate, the following challenges emerged:

- Some programs had many studies over the span of decades, and the same or similar studies were published in different formats or through different avenues. This resulted in a large amount of data to review to determine what to include.
- Some reports highlighted different program evaluation outcomes / results, but did not always document their sources clearly.
- It was sometimes difficult to tease out what was the 'original' program versus later tweaks and adaptations of a program. Program developers and evaluators did not necessarily discuss their work through this lens (original versus adapted).
- Many programs evolved over time: what was considered the 'original' program at one point was no longer considered the 'original' program later on as improvements were made, including within the same program population and setting (e.g., The Incredible Years). This sometimes made it difficult to determine what to include in our review.
- We did not set out to find every adaptation of each program. Rather, we documented adaptations when we came across them in the literature. This is therefore not a comprehensive review of all the existing adaptations of these programs.

Given this vast amount of data, we included what appeared to be the most essential and pertinent information for those interested in the key elements of the evidence-based crime prevention programs listed above, and any existing adaptations of each program that we came across.

3. Findings

3.1 Programs for Indigenous Communities

3.1.1 Aboriginal Empathic Program

Aboriginal Empathic Program	
Variable	**Description**
Main objectives of the intervention	Help youth develop emotional awareness and impulse control and ideally reduce the likelihood of violence and criminality.
Target risk and protective factors	Risk Factors • Low impulse control • Anti-social behaviours • Bullying • Weak attachment to school • Incidents of violence Protective Factors • Emotional maturity • Problem-solving and awareness • Impulse control • Addressing emotional, physical, mental, and spiritual aspects • Connection to school • Connection with parents, school, and children
Definition & description	This program was modified from the PATHS (Promoting Alternative Thinking Strategies) program to reflect Aboriginal cultural values and teachings. The program focuses on teaching children to understand and manage their emotions and how to solve problems in a positive way.
Universal vs. targeted program	Designed to target Indigenous children, but program delivered in classroom universally (original testing done in a school for Indigenous children)
Target population	Aboriginal children in grades 1-5
Setting	Classroom, community
Level of intervention	Individual, group, and family

Components	In Class Lessons • Different methods are used to implement lessons, including role playing, journal writing, picture-based scenarios, and storytelling Home Visits • Program staff conduct home visits each week for select children to reiterate positive development and integrate teachings into the family and community
Specifics of delivery	• Focus on using elements of Mi'kmaw culture, including the Medicine Wheel, Talking Circles, Mi'kmaw language • Lessons are reinforced by teachers and school administrators
Dosage	• 40 weekly lessons (1-2 hours each) per grade level • Weekly home visits for select children and families
Duration	5 years of weekly in-school lessons
Compatible / not compatible with	Designed for Aboriginal, specifically Mi'kmaw, population
Evaluation methods & findings	The study of the Aboriginal Empathic Program was completed using a quasi-experimental design with pre- and post-survey data. Results show: • School staff and parents supported the implementation of the program. • Program was effectively designed and was a successful adaption of the PATHS program for the Aboriginal community. • More awareness about the program in the community was needed. • Students reported the program helped them manage emotions better. • Teachers reported students using language from the program and increased likelihood of walking away from a conflict. • Teachers reported students showing more concern for one another and giving each other more compliments. • Some teachers reported less aggressive behaviour in class and less time required addressing behaviour in class. • Some parents reported their children had increased self-esteem.
References	Educational Program Innovations Charity, 2016 Public Safety Canada, 2009
Existing adaptations	N/A

3.1.2 Project Venture

Project Venture	
Variable	**Description**
Main objectives of the intervention	Help youth develop strengths to build general resilience, which can be used to resist alcohol and drug use.
Target risk and protective factors	Risk Factors • Early substance use Protective Factors • Habilitation (use of strength-based approaches) • Developing a positive self-concept • Effective social and communication skills • Community service ethic • Self-efficacy • Increased decision-making and problem-solving skills
Definition & description	Project Venture is an outdoor experiential program that emphasizes positive youth development and building resilience. The program was developed specifically for American Indian youth, as most interventions for Indigenous participants are adaptations of programs for other populations.
Universal vs. targeted program	Targeted to Indigenous youth, universally delivered in school and to all who self-select for out of school programs
Target population	At-risk American Indian youth in grades 5-8
Setting	Classroom, outdoor, community
Level of intervention	Individual, group, and community
Components	• Weekly problem solving games and activities in school • Weekly experiential activities (after-school, on weekends and during the summer) • Monthly outdoor challenge activities, including hiking, recreation and camping • Service leadership projects in the community throughout the year • After a year of participation, youth can become service staff / peer leaders in subsequent years

Specifics of delivery	• Activities are led by trained experiential educators • One staff member works with 7-15 youth per group • Staff debrief activities with youth to help them gain life lessons • Programming is guided by American Indian traditional values, such as family, learning from the natural world, spiritual awareness, service to others and respect
Dosage	• Classroom activities take place weekly with a minimum of 20 one-hour sessions per year • After-school and weekend activities take place weekly throughout the school year • Outdoor challenges take place monthly • Community service projects are delivered four times per year • Wilderness camp and treks each take place once per year • Youth self-select for community and wilderness-based activities, so dosage varies
Duration	Classroom activities delivered throughout the school year
Compatible / not compatible with	Designed specifically for Indigenous youth and has been used in various American Indian communities in the United States
Evaluation methods & findings	Schools were randomly assigned to treatment and control groups: • Treatment participants demonstrated less growth in substance use than members in the control group. • There was a significant effect for less growth in alcohol use for the treatment participants.
References	Carter, Straits, & Hall, 2007; U.S. Department of Health and Human Services, 2010;
Existing adaptations	N/A

3.2 Programs for Children Ages 6 to 11

3.2.1 Coping Power Program

Coping Power Program	
Variable	**Description**
Main objectives of the intervention	The program targets school-aged children and addresses the four predictive factors of adolescent and adult substance abuse, which is seen as correlated with antisocial behaviour. The predictive factors addressed in the program are: • Lack of social competence and inability to get along with other children; • Poor self-regulation, self-control, and impulse control; • Weak social bond with the school and resulting academic failure; and • Poor caregiver investment in the child (Lochman & Wells, 2002b)
Target risk and protective factors	Risk Factors • Lack of social competence and inability to get along with peers • Poor self-regulation and impulse control • Weak social bond with the school and academic failure • Poor caregiver relationship with the child (lack of a warm, protective environment, and consistent discipline) • Poor caregiver engagement in parenting interventions Protective Factors • Social bonding between home and school, child and school, and parent and child • Social competence • Self-regulation • School bonding • Parent involvement (Lochman & Wells, 2002b)
Definition & description	Modeled after the Anger Coping Program, the Coping Power Program is designed to disrupt the development of behaviours (e.g., increased substance use and aggression) that are associated with a student's transition from elementary to middle school. The program was designed for students during their time in grades 5 and 6. The youth component of the program is based on the contextual social-cognitive model, which assumes children who act 'delinquently': • Have problems understanding and processing social cues

	• Have difficulty problem solving • Have parents who may provide inconsistent discipline and/or are less involved in the child's life The adult content of the program was derived from evaluated parent programs based on social learning theory. (Lochman & Wells, 2002a, 2002b, 2003)
Universal vs. targeted program	Targeted to children in grades 5-6 displaying aggression
Target population	Children in grades 5 and 6 identified as aggressive by teachers
Setting	School, community agencies
Level of intervention	Individual, group, family
Components	Child Component – Group Sessions • Establish and reinforce group rules • Help youth develop and utilize alternative solutions to social problems • Watch videos with children modeling healthy problem solving • Create videos using health problem solving for experiences in their own life • Address anxiety and anger • Deal with peer pressure • Develop social skills and making new friends • Learn new study and organizational skills Child Component – Individual Sessions • Used to monitor and reinforce behaviours learned in group sessions • Opportunity for children to discuss problem solving issues in their personal life Parent Component • Identify prosocial and disruptive behaviours in their children in a prescribed way • Learn to reward child for appropriate behaviours • Instruct their children and establish age-appropriate rules in the home • Use effective consequences for negative behaviours • Manage their child's behaviours outside the home • Learn strategies to communicate effectively with the family • Deal with stress (Lochman & Wells, 2002b)

Specifics of delivery	Child Component – Group Sessions • Take place at schools during non-academic times (before/after school and during free homeroom period) • Sessions are 40-50 minutes in length • 5-8 children attend each session • Sessions are co-facilitated by program staff and school guidance counselor Child Component – Individual Sessions • Children receive individual support at school • Sessions are 30 minutes in length Parent Component • Groups of at least 12 parents or parent pairs • Facilitated by two leaders (Lochman & Wells, 2002b)
Dosage	• Group program for Grade 5 students – 22 sessions during the year, 40-50 minutes each session • Group program for Grade 6 students – 12 sessions during the year, 40-50 minutes each session • Individual sessions occurred approximately once every 2 months, 30 minutes each session • 11 parent sessions during the child's grade 5 year • 5 parent sessions during the child's grade 6 year (Lochman & Wells, 2002b)
Duration	16 months (two school years)
Evaluation methods & findings	The program was tested using a randomized trial with random assignment to intervention and control conditions. Results show: • CPP was found to positively affect behaviour (aggression, delinquency), social competence, substance abuse, school behaviour, and parental supportiveness outcomes immediately after the program was completed. • After one year, no intervention effects were found from self-reported data on substance use, but parent outcomes were found to have intervention effects on substance use. • Those who received both the classroom and individual programs had better problem solving and social skills than other conditions. • One study found no effects on school bonding for those who received

	interventions. • Staff who received more intense training were more conscientious and less cynical about organizational change, and found to better engage children and parents through the program. • Staff agreeableness was positively associated with completion of the session objectives, the number of sessions scheduled, and engagement with parents. (Lochman, Boxmeyer, et al., 2009; Lochman, Powell, et al., 2009; Lochman & Wells, 2002a, 2002b, 2003, 2004)
References	Lochman & Wells, 2002a, 2002b, 2003, 2004; Lochman, Boxmeyer, et al., 2009; Lochman, Powell, et al., 2009;
Existing adaptations	**Utrecht Coping Power Program** Adaptation of CPP for children with Disruptive Behaviour Disorders in outpatient programs. Sessions were adapted to suit children with shorter attention spans (i.e., more variation in the training, fewer discussions, more activities) (Lochman et al., 2012; Van De Wiel et al., 2007; Van De Wiel, Matthys, Cohen-Kettenis, & Van Engeland, 2003; Zonnevylle-Bender, Matthys, van de Wiel, & Lochman, 2007). **Abbreviated Coping Power Program** Due to school staff concerns that the program was too long, it was altered to be completed in one year, instead of 16 months – there were 24 child sessions instead of 48 and 10 parent sessions instead of 16 (Jurecska, Hamilton, & Peterson, 2011; Lochman et al., 2012; Lochman, Boxmeyer, Powell, Roth, & Windle, 2006; Peterson, Hamilton, & Russell, 2009). **Abbreviated Coping Power Program with Booster** Use of the Abbreviated CPP with a booster, which included monthly individual sessions with clinicians to support what they learned in the group program (Lochman et al., 2014). **Intensive After-School Program** Designed for use with intensive mental health context – it includes more activity-based learning and there are 27 sessions with the children's group delivered twice weekly and the parent group held weekly (Lochman et al., 2012). **Coping Power for Deaf Students** Program adapted to work specifically with aggressive deaf students by involving more visual and spatial learning (Lochman et al., 2012). **Poder Resolver** The program was adapted for Mexican-American children by translating the program brochures into Spanish, providing parents with a Spanish speaking

	contact, using Mexican / Mexican-American cultural examples, and having a facilitator who is fluent in Spanish (O'Donnell, Jurecska, & Dyer, 2012). **Universal Classroom-Based Coping Power Program** The CPP child sessions were adapted to be used for all students in a classroom – the program content was slightly altered to be more appropriate for larger groups (Muratori et al., 2015). **Individual Coping Power Program** CPP was adapted to be used for individuals only (Lochman et al., 2012). **Coping Power Program for Adolescents** CPP for children through middle school that focuses more on adolescent issues (Lochman et al., 2012). **Coping Power Program with Adaptive Parent Component** This adaptation included enhancing parent engagement in the program through use of Family Check-Ups, which assess the family to help them target specific areas of concern (Lochman et al., 2012). **Hybrid Coping Power Program** Use of in-person sessions and web-based learning to increase and enhance engagement, including 12 bi-weekly child sessions and 7 parent sessions interspersed with web-based content (Lochman et al., 2012).

3.2.2 FAST (Family and School Together) TRACK

FAST (Family and School Together) TRACK	
Variable	**Description**
Main objectives of the intervention	The program is a developmental and clinic model that integrates five program components to support children showing early signs of aggression. It provides support for children, their family and school to help prevent behavioural problems, increase social relationships and address academic challenges. It is designed to affect change in six domains: 1. Reducing disruptive behaviour at home 2. Reducing disruptive behaviour at school 3. Increasing social-cognitive skills 4. Improving peer relationships 5. Gaining academic skills 6. Improving the school-family relationship (The Conduct Problems Prevention Research Group, 1992)
Target risk and protective factors	Risk Factors • Early signs of irritability, discipline problems, inattentiveness, and impulsivity • Families experiencing high stress and instability • Parental psychopathology and use of punitive discipline • Low parent support in developing emotional control, social skills, and academic readiness • Lacking social-cognitive skills (e.g., not being able to recognize social cues, not understanding peers' intentions) • Low levels of academic readiness when entering school • High density of children with behavioural problems may lead to a poor learning atmosphere • Rejection by peers and teachers • Poor performance at school • Developing negative self-concepts • Involvement with deviant peer groups in middle childhood

	Protective Factors • Children use positive social-cognitive skills (responding to aggression effectively) • Children know how to recognize negative feelings and respond in a socially appropriate way • Healthy bonds between the child and parents, the child and school, parents and school • Parents use consistent, positive, and less punitive discipline strategies • Parent support their children's cognitive growth • A more stable and supportive home atmosphere • Teachers support children with behavioural problems (The Conduct Problems Prevention Research Group, 1992)
Definition & description	The FAST Track program is based on the social information processing model, which identifies that deficits in social and cognitive skills and challenges in early family life may lead to later conduct disorders (CD). The program was designed as a comprehensive model to address conduct disorders as previous programs for children with CD were found to have few long-term results. The program thus is modeled on various previously developed strategies and programs to create a coordinated approach to bring together children, their families and schools. (The Conduct Problems Prevention Research Group, 1992)
Universal vs. targeted program	Universal classroom component and targeted individual program elements for "aggressive" children
Target population	For children showing aggressive behaviours in grade one
Setting	School, community, home
Level of intervention	Individual, group, family
Components	Child Social Skills Training • Combines features of previous social skills training programs and anger/problem-solving programs • Emphasizes the importance of building friendships • Includes peer pairing program - treatment children paired with classmates to complete activities, pairs rotate throughout the year • Mentoring component added for grades 4-5 Child Academic tutoring • Uses the Wallach's program (1976) and is delivered by tutors • Tutors work with children individually and focus on reading

	Classroom intervention • Taught be teachers who receiving training in the PATHS program • Delivered to all children in specific classes • Focus on self-control, problem-solving, emotional awareness, positive peer climate Parent Training • Based on social learning and behavioural family therapy • Focus on developing skills, building positive family-child relationships and family-school relations Home Visits by staff • Help with problem solving, promote empowerment and increase family organization Adolescent Program • Intensive individual support provided as needed • Family sessions on adolescent developmental issues (e.g., adapting to middle school) • *Years 7-8* – Youth forums (workshops) were delivered for small groups of youth based on the Future Selves Program (Slough, McMahon, & The Conduct Problems Prevention Research Group, 2008; The Conduct Problems Prevention Research Group, 1992, 2000)
Specifics of delivery	• Parents treated as partners in supporting their children and provided a financial incentive to be involved
Dosage	Parent Training • Year 1 – 1.5 hours weekly (1 hour parent group, 30 minutes parent-child activity time) for 22 weeks (22 sessions/year) • Year 2 – 1.5 hours biweekly enrichment sessions for parents and children together, for 22 weeks (14 sessions/year) • Years 3-5 – 1.5 hours monthly enrichment sessions for parents and children together, 9 sessions/year Home Visits • Year 1 – weekly phone calls and biweekly visits during school year, weekly phone contact and monthly visits during summer (11 visits/ year) • Years 2-5 – Delivery level depends on family needs (8, 16, or 32 visits/ year) Social Skills Training • Year 1 – 1.5 hours weekly (one hour group enrichment program, 30 minutes peer pairing), (22 sessions/year) • Year 2 – 1.5 hours biweekly (14 sessions/ year), peer pairing as needed

	• Year 3-5 – 1.5 hours monthly (9 sessions/ year) • Year 4-5 – Additional mentoring component, 1-2 times/month, duration not specified Tutoring • Year 1 – 30 minutes three times per week for 22 weeks (60 sessions/ year); one weekly session occurs outside of school time where parent is present, and the other two occur during school hours • Year 2-5 – as needed for children struggling academically (up to 60 sessions/year) Classroom Intervention • Years 1-5 –approximately three times per week for school year Adolescent Program • Years 5-6 – 2-hour family sessions, frequency not specified • Years 7-8 – four sessions offered each year, duration not specified (Bierman & The Conduct Problems Prevention Research Group, 1996, 1997; Slough et al., 2008; The Conduct Problems Prevention Research Group, 1992, 2000)
Duration	Up to 10 years (grades 1-10) for children displaying aggression in grade 1
Evaluation methods & findings	The studies of FAST TRACK employed quasi-experimental designs with pair matching for treatment and control conditions; pre-/post-testing measures show: • FAST TRACK improved social and emotional skills, including reduced aggression and better peer relations. • The intervention had a statistically significant effect on preventing externalizing psychiatric disorders, conduct disorders, ADHD, and other antisocial behaviours. • Teachers reported that students had better social and academic performance, and were less likely to be involved with special education following the intervention. • Reductions in criminal justice involvement and arrest rates was found for youth who participated in FAST TRACK. • Parents who participated in the intervention had more warmth, displayed more consistent discipline, were more involved with school and provided less harsh discipline than parents in the control condition. • Better results were found for children with less severe challenges, whose caregivers were less depressed, who lived in two-parent families, whose families had a higher socio-economic status and were White.

	• The Fast Track intervention was found to have cumulative effects on externalizing disorders - intervention participants were found to be less likely to have these disorders the more time they spent in the program. • Effect sizes were often found to be modest for changes in child behaviours. • One study found there were limited results for children in grades 6-8. • There were conflicting results about whether the positive outcomes were maintained after long-term follow-ups. (Bierman et al., 2002a, 2002b, 2004, The Conduct Problems Prevention Research Group, 1999a, 1999b, 2002, 2007, 2010, 2011)
References	Bierman et al., 2002a, 2002b, 2004; Bierman & The Conduct Problems Prevention Research Group, 1996, 1997; The Conduct Problems Prevention Research Group, 1992, 1999a, 1999b, 2000, 2002, 2007, 2010, 2011; Slough, McMahon, & The Conduct Problems Prevention Research Group, 2008;
Existing adaptations	**Rural Adaptations** The FAST TRACK program was adapted for children in rural communities by using staff from the community, employing strengths vs. deficits language, having more leader-directed activities for parents, connecting families to available community programs, and beginning programs when there were gaps in services (Bierman & The Conduct Problems Prevention Research Group, 1997)

3.2.3 Good Behavior Game

Good Behavior Game	
Variable	**Description**
Main objectives of the intervention	The Good Behavior Game was designed in 1969 to reduce disruptive classroom behaviour and increase positive behaviour in classrooms. (Barrish, Saunders, & Wolf, 1969)
Target risk and protective factors	Risk Factors • Disruptive classroom behaviours (e.g., talking without permission, getting out of one's chair without permission) Protective Factors • Group consequences for behaviours (including rewards for positive group behaviour) (Barrish et al., 1969; Harris & Sherman, 1973)
Definition & description	The Good Behavior Game is a token reinforcement strategy for teachers to use to encourage students to behave in the classroom by having an individual's behaviour impact the potential privileges their group can receive. (Barrish et al., 1969)
Universal vs. targeted program	Universal program offered to all students in a classroom regardless of their engagement in disruptive behaviours.
Target population	Children in a classroom with disruptive behaviour.
Setting	School
Level of intervention	Individual, peer group
Components	The Good Behavior Game is for use in a classroom. The Game is delivered by the teacher, who introduces the details: 1. When the game will be played 2. The class will be divided into teams 3. There are specific rules that must be followed by everyone during the game: • Students cannot leave their seats without permission • Students cannot sit on top of the desks • Students cannot move their desks • Students cannot get out of their desks to speak with others or whisper to others • Students can approach the teacher's desk during independent study time

	• Students cannot speak without permission 4. If the teacher observes anyone breaking the rules, the teacher will give the team with the person who broke the rule a point. 5. At the end of the game period, teams that have less than 5 points or have less than the other teams win the following privileges: wearing victory tags, putting a star beside their name on a chart, lining up first for lunch, participating in a special project for 30 minutes at the end of the day (Barrish et al., 1969)
Specifics of delivery	N/A
Dosage	No recommended dosage provided
Duration	No recommended duration provided
Evaluation methods & findings	The studies of the Good Behavior Game used random assignment to treatment and control conditions, observational data, interviews, pre- and post-testing. Results show: • Reduced targeted behaviours, including talking-out, out-of-seat behaviours, aggression, shyness, and peer rejection. • One study found no significant outcomes on academic performance. • Boys who participated in the Game were less likely to initiate smoking, use behavioural/mental health services and drug/alcohol treatment. • When privileges were removed for acting positively, the effectiveness of the Game was greatly reduced. • One study also found that treatment effects disappeared when the intervention ended, conversely long-term reductions in behavioural problems were found for boys at ages 19-21. • Multiple studies found few positive effects for girls who participated in the intervention. (Barrish et al., 1969; Dolan et al., 1993; Donaldson, Vollmer, Krous, Downs, & Berard, 2011; Harris & Sherman, 1973; Johnson, Turner, & Konarski, 1978; Kellam et al., 2011; Kellam, Rebok, Ialongo, & Mayer, 1994; Kellam & Anthony, 1998; Leflot, van Lier, Onghena, & Colpin, 2013; Medland & Stachnik, 1972; Poduska et al., 2008; Saigh & Umar, 1983; Tingstrom, 1994)
References	Barrish, Saunders, & Wolf, 1969; Dolan et al., 1993; Donaldson, Vollmer, Krous, Downs, & Berard, 2011; Harris & Sherman, 1973; Johnson, Turner, & Konarski, 1978; Kellam & Anthony, 1998; Kellam et al., 2011; Kellam, Rebok, Ialongo, & Mayer, 1994; Leflot, van Lier, Onghena, & Colpin, 2013; Medland & Stachnik, 1972; Poduska et al., 2008; Saigh & Umar, 1983; Tingstrom, 1994);[2]

[2] Additional replication studies with similar methodologies and findings have been conducted (Bostow & Geiger, 1976; Darch & Thorpe, 1977; Darveaux 1984; Davies & Witte, 2000; Hegerle, Kesecker, & Couch, 1979; Huber, 1979;

Existing adaptations	**Good Behavior Game for the Library** The game was altered for addressing behavioural issues during school library periods (Fishbein & Wasik, 1981) **The Astronaut Game** The Good Behavior Game was implemented using astronauts as a theme- for example, rewards were astronaut-related (Maloney and Hopkins, 1973). **The Good Productivity Game** Using the game to encourage productivity of adults in the workplace (Lutzker & White-Blackburn, 1979). **The Good Toothbrushing Game** Children are divided into teams and each day their oral hygiene is assessed and the winning team gets a prize (Swain, Allard, & Holborn, 1982). **Individualized Good Behavior Game** This intervention involves putting children into groups that have different target behaviours to focus on during the Good Behavior Game based on their specific challenges (Salend, Reynolds, & Coyle, 1989). **Good Behavior Game for Behavior and Volleyball Skills** Using the Good Behavior Game to address behavioural issues (swearing, negative comments) during volleyball and other physical education classes (Patrick, Ward, & Crouch, 1998). **The Good Behavior Game with the Say-Do-Report Correspondence Training** A combination of the Good Behavior Game and the Say-Do-Report Correspondence Training which reinforces the correspondence between what people say they are going to do and what they actually do (Ruiz-Olivares, Pino, & Herruzo, 2010). **Caught Being Good Game** A positive version of the Good Behavior Game whereby points are given for following the rules (Wahl, Hawkins, Haydon, Marsicano, & Morrison, 2016; Wright & McCurdy, 2011). **Attention, je lis!** An French language adapted version of Good Behavior Game that focuses on helping children maintain attention (Dion et al., 2011) **Good Behavior Game for students with Emotional or Behavioral Disorders (EBD)** Adapted version of the Good Behavior Game specifically designed to integrate children with emotional and behavioral disorders into the regular classroom (Lastrapes, 2014). **PAX Good Behavior Game** Updated version of the original Good Behavior Game (Becker, Bradshaw, Domitrovich, & Ialongo, 2013; Domitrovich et al., 2015).

Keenan, Moore, & Dillenburger, 2000; Kleinman & Saigh, 2011; Kosiec, Czernicki, & McLaughlin, 1986; Phillips & Christie, 1986; Robertshaw & Hiebert, 1973; Swiezy, Matson, & Box, 1992; Tanol, Johnson, McComas, & Cote, 2010; Warner, Miller, & Cohen, 1977). A review of all studies from 1969-2002 can be found in (Tingstrom, 2006).

3.2.4 Incredible Years

Incredible Years	
Variable	**Description**
Main objectives of the intervention	The goals of the Incredible Years program are to: • Treat aggressive behaviours and ADHD early in life • Promote child social competence, emotional regulation, positive attributions, academic readiness, and problem solving • Reduce family risk factors that can lead to the development of social-emotional and behavioural problems in children • Help parents build positive relationships with their children using proactive discipline, child-directed play, positive attention, coaching, praise, and increasing support networks for parents • Improve teacher classroom management skills, teacher-child relationships, and teacher-parent partnerships • Prevent conduct problems, delinquency, violence, and drug abuse later in life (The Incredible Years, n.d.; Webster-Stratton & McCoy, 2015)
Target risk and protective factors	Risk Factors: • Ineffective parenting (harsh discipline, poor parent attachment, chronic neglect, poor monitoring, isolation, lack of support for parents) • Family mental health and criminal risk factors • Child biological and developmental risk factors (e.g., ADHD, learning disabilities) • School risk factors • Peer and community risk factors (e.g., poverty, violence, gang involvement) Protective Factors: • Improved parent-child relationships • Proactive parent discipline • Improved parent-teacher relationships • Parent support of children • Social/emotional competence • Emotional regulation • School readiness (Webster-Stratton & McCoy, 2015; Webster-Stratton & Reid, 2010b)

Definition & description	This is a multi-modal, early prevention program for children 12 years and under founded on the belief that the earlier intervention and support is provided to at-risk families, the better the likelihood of preventing problems later in life. The program was founded on the following theoretical approaches: • Cognitive social learning, particularly Patterson's coercion hypothesis of negative reinforcement developing and maintaining deviant behaviour • Bandura's modeling and self-efficacy • Piaget's cognitive developmental and interactive learning • Attachment theory It is a multi-modal program with many different components for parents, children, and teachers. (The Incredible Years, n.d.; Webster-Stratton & Hammond, 1997; Webster-Stratton & McCoy, 2015; Webster-Stratton & Reid, 2010b)
Universal vs. targeted program	The parent training and one child program are targeted to families with children who are experiencing early behavioural problems. The classroom and teacher interventions are designed for universal use.
Target population	Children under 12 years and their parents, teachers
Setting	Individual, family, school, community
Level of intervention	Individual, group (family, classroom)
Components	Parenting Programs • For parents of children 0-12 years old • BASIC Parent Training has four curriculae: 1. Baby Program (8-9 sessions) 2. Toddler Program (12 sessions) 3. Preschool / Early Childhood Program (18-20 sessions) 4. Early School-Age / Preadolescent Program (12-16 sessions) • Focuses on understanding children and their abilities, modeling appropriate behaviour, setting developmentally appropriate expectations, and using positive parenting strategies[3] • ADVANCE Parent Program focuses more on the parents' interpersonal and problem solving skills (10-12 sessions) Child Programs • For children 3-8 years old

[3] The parent program has been tested for use in different countries, including Sweden, Denmark, Portugal, New Zealand (Axberg & Broberg, 2012; Azevedo, Seabra-Santos, Gaspar, & Homem, 2014; Sturrock, Gray, Fergusson, Horwood, & Smits, 2014; Trillingsgaard, Trillingsgaard, & Webster-Stratton, 2014). A meta-analysis of the outcomes from applying the Incredible Years program to different locations (Gardner, Montgomery, & Knerr, 2015).

	• Two programs for children using the dinosaur School Social, Emotional Skills and Problem Solving curriculum: 1. Small Group Dinosaur Child Treatment 2. Classroom Dinosaur Prevention Program • Both programs address inattentiveness, impulsivity, hyperactivity Teacher Program • For teachers of children aged 3-8 years • Training includes strategies for preventing behavioural problems in classes, building positive relationships with students and their families, and teaching social skills to the students (problem solving, emotional literacy)[4] (The Incredible Years, n.d.; Webster-Stratton & Reid, 2010b)
Specifics of delivery	All Programs: • assume a self-learning model whereby participants engage in goal setting and self-monitoring • are delivered using various methods, including group discussions, problem solving, DVD vignettes, role playing, homework assignments, and leader phone calls • Have age and content appropriate materials for use during the sessions, including the Incredible Years book/CD, DVDs, and handouts • Facilitators are designated trainers and mentors who have participated in a training program and have completed an accreditation process Parenting Programs: • delivered by two facilitators • use a problem-solving format • 10-14 participants per group • Food, child care, and transportation are usually provided to remove barriers to participation Child Programs: • use a series of DVDs to show vignettes and help children learn from modeling in the videos Teacher Program • Teachers work with facilitators to create plans to support children with conduct problems (The Incredible Years, n.d.; Webster-Stratton & Reid, 2010b)

[4] Study assessing the cultural adaptability of the IY Teacher Program to Jamaican pre-schools (Baker-Henningham, 2011).

Dosage	Parenting Programs • 2-2.5 hours per week, number of weeks depends on component Child Programs • 2 hours per week for 22 weeks Teacher Program • 6 full-day workshops every 3-4 weeks (42 hours total)
Duration	Duration varies for each program component (see above)
Evaluation methods & findings	All studies mentioned below used randomized controlled trials to assess the outcomes of the program. Many of the studies were completed by the program developer and many others were replicated by other researchers. Parent Program Findings: Improved parental attitudes and parent-child interactions: o More child-directed play, coaching, praise o Reduced use of criticism and negative commands o Effective limit-setting and replacing hitting / harsh discipline with better monitoring and proactive discipline o Better communication and problem solving Reduce child conduct problems: o Better responses to parents, positive affect, compliance to parental commands o Children appeared more positive and friendly • Many studies found that positive results for parents and children were maintained at long-term follow-up (up to 10 years later) • Treatment component analysis found that combining group discussion, a trained therapist, and video modeling was more effective than just using one approach • Adding the ADVANCE intervention to the BASIC program was found to show significantly greater increases in parents' problem solving skills • Helping parents manage personal distress and interpersonal marital issues enhanced the treatment outcomes of the BASIC program • An 8-12 year follow-up of parents and children whose parents participated in the BASIC + ADVANCE programs found most (75%) of the teenagers were well-adjusted and had few behavioural or emotional problems • Interventions that included parent training seemed to be more effective • Combining the parent and child interventions was found to have positive outcomes for children with Oppositional Defiant Disorder (ODD) and Attention Deficit and Hyperactivity Disorder (ADHD) • With multiethnic, socially-disadvantaged families and families referred by

	social welfare due to issues with abuse and neglect, the parenting programs were found to promote positive parenting, prevent child conduct problems, and strengthen social competence of children • The program had positive results for parents who had a history of child maltreatment • In a trial of the program with mothers who had been incarcerated, parenting and child behaviour was significantly affected in positive ways • Application of the program with parents of children with Autism Spectrum Disorder (ASD) was found to decrease parent stress following the intervention (Azevedo, Seabra-Santos, Gaspar, & Homem, 2014; Dababnah & Parish, 2014; Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, 2013; Leijten, Raaijmakers, Orobio de Castro, van den Ban, & Matthys, 2015; McGilloway et al., 2012; A. T. A. Menting, De Castro, Wijngaards-De Meij, & Matthys, 2014; Ankie T A Menting, Orobio de Castro, & Matthys, 2013; Scott, Briskman, & O'Connor, 2014; Sturrock, Gray, Fergusson, Horwood, & Smits, 2014; Trillingsgaard, Trillingsgaard, & Webster-Stratton, 2014; Webster-Stratton, 1982a, 1982b, 1990, 1992, 1994; Webster-Stratton & Hammond, 1997; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton, Reid, & Beauchaine, 2013; Webster-Stratton, Rinaldi, & Reid, 2011) Child Program Findings: • Children who participated had increased problem solving and conflict management skills compared to those who only had their parents participate in the parent training program • After one year, the most positive results were found for children who participated in the child program and whose parents participated in the parenting program when compared to families who only participated in one intervention (parent or child) • In another study, when multiple training conditions were tested, the greatest effects on children's social skills were found for children who participated in the child program • The child training program enhances positive outcomes for children with pervasive conduct problems when combined with parent training • Combining the parent and child interventions was found to have positive outcomes for children with ODD and ADHD (Reid, Webster-Stratton, & Hammond, 2007; Webster-Stratton & Reid, 2003; Webster-Stratton et al., 2013; Webster-Stratton, Reid, & Hammond, 2001) Teacher Program Findings: • Parent-teacher bonding was higher when the teacher program was delivered compared to those in the control condition • Trained teachers showed significant increases in use of positive behaviour

	management strategies in the classroom and children in their classes had fewer behavioural problems (e.g., less off-task behaviour) at school compared to those in the control condition • Children who received the child program and had teachers who participated in the teacher program showed greater improvements in behavioural issues, self-regulation and social competence than the control group • When the program was delivered with greater fidelity, teachers were more likely to utilize the skills or praise that they learned in the sessions (Fergusson, Horwood, & Stanley, 2013; Hutchings, Martin-Forbes, Daley, & Williams, 2013; Reinke, Herman, Stormont, Newcomer, & David, 2013; Webster-Stratton, Reid, & Stoolmiller, 2008)
References	Azevedo, Seabra-Santos, Gaspar, & Homem, 2014; Dababnah & Parish, 2014; Fergusson, Horwood, & Stanley, 2013; Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, 2013; Hutchings, Martin-Forbes, Daley, & Williams, 2013; Leijten, Raaijmakers, Orobio de Castro, van den Ban, & Matthys, 2015; McGilloway et al., 2012; Menting, De Castro, Wijngaards-De Meij, & Matthys, 2014; Menting, Orobio de Castro, & Matthys, 2013; Pidano & Allen, 2014; Reid, Webster-Stratton, & Hammond, 2007; Reinke, Herman, Stormont, Newcomer, & David, 2013; Scott, Briskman, & O'Connor, 2014; Sturrock, Gray, Fergusson, Horwood, & Smits, 2014; The Incredible Years, 2013; The Incredible Years, n.d.; Trillingsgaard, Trillingsgaard, & Webster-Stratton, 2014; Webster-Stratton, 1982a, 1982b, 1990, 1992, 1994; Webster-Stratton & Hammond, 1997; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton & McCoy, 2015; Webster-Stratton & Reid, 2003; Webster-Stratton & Reid, 2010b; Webster-Stratton, Reid, & Beauchaine, 2013; Webster-Stratton, Reid, & Hammond, 2001; Webster-Stratton, Reid, & Stoolmiller, 2008; Webster-Stratton, Rinaldi, & Reid, 2011;
Existing adaptations	**Incredible Years for Families Involved with the Child Welfare System** Updated program to support families that have been referred to child welfare due to maltreatment and neglect (Webster-Stratton & Reid, 2010a). **Incredible Years BASIC Programme for Bereaved Families** Designed to support grieving families due to the fact that bereaved children may experience more behavioural issues (Braiden, McDaniel, Duffy, & McCann, 2011). **Incredible Years for Children with ADHD** Tailored for children with ADHD (Webster-Stratton & Reid, 2014).

3.2.5 Olweus Bullying Prevention Program

Olweus Bullying Prevention Program	
Variable	**Description**
Main objectives of the intervention	The goal of the program is to reduce bullying and prevent new incidences of bullying by creating a school environment characterized by: 1. Warmth, positive interest, and involvement from adults 2. Firm limits regarding unacceptable behaviour 3. Consistent application of (non-aggressive/ non-physical) sanctions in response to unacceptable behaviour 4. Adults at school and home acting as authorities and positive role models (Olweus, 1997)
Target risk and protective factors	Risk Factors • Presence of opportunities and rewards for bullying Protective Factors • Positive adult involvement • Adult authority and role modelling • Limits for unacceptable behaviour • Consistent non-aggressive responses to unacceptable behavior (Olweus, 1997)
Definition & description	Olweus (1997) developed the Bullying Prevention Program in Norway based on the following four principles, which are rooted in findings from bullying research: 1. Using a whole school approach 2. Restructuring the social environment 3. Having teachers and school facilitate the intervention 4. Creating a set of routines, rules, and strategies of communication and action for dealing with existing and future bullying problems in the school (Olweus, 1997)
Universal vs. targeted program	Universal program delivered as a school-wide approach
Target population	Children in grades 1-9
Setting	School
Level of intervention	Individual, classroom, school

Components	School level components: • Establish a staff committee to support the changing school climate • Train all school staff • Administer the Bully/Victim Questionnaire to students • Hold staff discussion meetings • Create and post school rules against bullying • Increase staff supervision during recess • Hold a launch event for the entire school • Host parent circles (study and discussion groups) Classroom level components: • Implement class rules that address bullying- using clarification, praise, and sanctions • Hold regular class meetings • Hold class meetings for parents • Teach the students about bullying and how to respond, including use of cooperative learning, role playing, stories, and other shared positive activities Individual level: • Teacher has serious talks with children who are involved with bullying and their parents • Use of creativity by teachers to prevent and solve problems, including using "neutral students" in solving problems in the class • Provide parents with a brochure about how to address any bullying concerns • Consider change of class or school for persistent issues (Limber, 2011; Olweus, 1991)
Specifics of delivery	Program Materials designed for the original implementation of the OBPP are as follows: 1. Booklet for School Personnel • 32-page booklet distributed for free to all schools in Norway • designed to inform people about bullying (based on findings from research) • included suggestions about what can be done by the school and the teachers to address and prevent bullying • dispelled common myths about bullying

	2. Parent Folder • 4-page folder distributed to all families with school-age children in Norway 3. Video • 25-minute video showing the experiences of children who have been bullied 4. Bully/Victim Questionnaire • Short survey to help schools understand the current nature of bullying in their schools (e.g., the frequency and readiness of teachers to respond to bullying) • Completed anonymously by children • Goal is to encourage schools and parents to recognize bullying as an issue and take action to remedy it and prevent further issues 5. Teacher Meeting • 2-hour meeting with staff about the specifics of bullying at that school based on results from the Questionnaire and how to respond to those issues • Facilitated 15 months after original intervention components were distributed (Limber, 2011; Olweus, 1991)
Dosage	No specific dosage required as the Program encourages schools and parents to take action on bullying issues, but provides guidelines about how to do this, not a prescribed method for responding
Duration	No specific duration required as the Program encourages schools and parents to take action on bullying issues, but provides guidelines about how to do this, not a prescribed method for responding
Evaluation methods & findings	Methods employed to test the effectiveness of the OBPP were randomized controlled trial, quasi-experimental design, extended selection cohorts design, and observations. Results show: • Reductions in bully/victim problems were found following the intervention, including participating in bullying, passive observations of bullying, joining others in bullying, and reports of victimization. • One study found those who reported being directly involved with bullying (bullying or being bullied) decreased by 50%. • Overall, following the intervention, students were more likely to report bullying to a teacher, believe that school staff would respond adequately, and report enjoying school more.

	• Certain factors increased the teacher's level of involvement in the intervention:
	  • Perception of bullying at school
	  • Belief of the importance of the intervention
	  • Having read the program materials
	  • Affective involvement (emotionally connecting to bullying as an issue)
	  • Personal experience being bullied as a child
	  • Better understanding of what happens during school break times
	(Bauer, Lozano, & Rivara, 2007; Black & Jackson, 2007; Cecil & Molnar-Main, 2015; Kallestad & Olweus, 2003; Limber, 2008, 2011; Olweus, 1991; Olweus & Limber, 2010; Schroeder et al., 2012)

References	Bauer, Lozano, & Rivara, 2007; Black & Jackson, 2007; Cecil & Molnar-Main, 2015; Kallestad & Olweus, 2003; Limber, 2008, 2011; Olweus, 1991, 1997, 2001; Olweus & Limber, 2010; Schroeder et al., 2012;
Existing adaptations	**Flemish Anti-Bullying Programme** Adapted specifically for the Flemish context (Stevens, De Bourdeaudhuij, & Van Oost, 2000). **Toronto Anti-Bullying Intervention** Adapted specifically for the Canadian context in Toronto (Pepler, Craig, Ziegler, & Charach, 1994). **Finnish Anti-Bullying Programme** Adapted specifically for the Finnish context (Salmivalli, Kaukiainen, & Voeten, 2005).

3.2.6 Positive Action

Positive Action	
Variable	**Description**
Main objectives of the intervention	The Positive Action program is a comprehensive, integrated, and holistic school model for character development, prevention of problem behaviours, and increased academic achievement. The objectives of the intervention have been broken down into four domains: Individual • Allowing all individuals the opportunity to learn and practice positive actions in physical, intellectual, and emotional areas • Understanding that success means feeling good about yourself and your actions • Developing good character, morals, and ethics Family • Enabling a positive learning environment at home • Supporting adults in improving literacy and life skills • Creating an environment that supports children to be effective learners before going to school School • Reforming the school environment • Developing leadership and other lifelong skills that contribute to experiencing success and happiness in and out of school • Creating a safe, positive, and drug-free school and learning environment • Promoting personal and professional development of all school staff • Combing the efforts of school, home, and community to promote social, academic, and emotional development of children Community • Involving the whole community in learning and practicing the use of positive actions • Supporting a positive community environment (Flay, Allred, & Ordway, 2001)
Target risk and protective factors	Risk Factors: • Disruptive behaviours • Disciplinary problems • Substance use • Violence

	• School suspensions Protective Factors: • Improved family bonding • Improved peer selection and relationships • Appreciation of school • Increased school performance (decreased absenteeism, improved academic achievement)
Definition & description	The Positive Action intervention is based on theories of self-concept, learning, behaviour and school ecology. Specifically, the theory of self-concept posits that people determine their self-concepts by what they do, thus when people make positive choices they feel more self-worth. PA emphasizes building this positive self-concept by encouraging and supporting children, school staff, and community members in making positive choices. Additionally, social learning theory dictates that people learn from social interactions and thus PA trains school staff and parents to identify and reinforce children's positive actions, thoughts, and feelings. Research suggests an intervention with a curriculum, teacher training, school wide climate change, and involvement of parents and the community may be more successful in improving behaviours and academic performance. (Flay & Allred, 2003; Flay et al., 2001)
Universal vs. targeted program	Universal
Target population	Children in grades K-8
Setting	School
Level of intervention	Group
Components	All information is delivered through the lens of six units: 1. Self-concept 2. Positive actions for body and mind 3. Social/emotional positive actions for managing yourself responsibly 4. Social/emotional positive actions for getting along with others 5. Social/emotional positive actions for being honest with yourself and others 6. Social/emotional positive actions for improving yourself continually 7. Review of all units School Curriculum • Over 140 lessons (15-20 minutes each) per grade for grades K-6 • 82 lessons (15-20 minutes each) per grade for grades 7-8 School Climate

	• Activities are delivered to the entire school to reinforce the curriculum • Activities are inclusive, varied, and comprehensive • Schools are encouraged to adopt and adapt the activities to suit their school population Family • Families receive a Family Kit with over 42 lessons that are coordinated with school activities based on the 6 units Community • Offers tools to plan and cultivate positive actions in the community to produce an environment that is complementary to the school and family components (Flay & Allred, 2003; Flay et al., 2001)
Specifics of delivery	School Curriculum • Teacher present the lesson using information from the Teacher's Kit, which includes scripted lessons that employ various methodologies and can address different learning styles • PA trainers support the school in planning to implement the intervention and by delivering workshops for teachers in the PA program delivery School Climate • Principal's Kit providers administrators with directions about how to promote and reinforce positive actions in the school community Family • The Family Kit is a manual with all of the required materials for parents to deliver activities at home Community • Community kit provided to community leaders that includes a guide, the Positive Actions for Living test, CDs, books, family kits, and other materials to help community members support the Positive Action intervention (Flay & Allred, 2003; Flay et al., 2001)
Dosage	The school curriculum is delivered almost daily during the school year and family lessons are designed to be delivered once a week
Duration	PA is delivered as a whole school intervention and thus duration is often during a student's entire school career from grades K-8
Evaluation methods & findings	Evaluations of the Positive Action program primarily employed pair matched, cluster randomized designs. Other methodologies included randomized controlled trials, quasi-experimental designs, and long-term outcome assessments. • PA program was found to be effective at increasing self-concept, reducing

	disciplinary referrals (including suspensions), and improving academic achievement • Substance use, violence, bullying behaviours, and sexual activity were lower for children who attended PA schools • Normative beliefs supporting aggressive behaviours were reduced through the PA intervention • Students in PA school had increased positive affect and life satisfaction, and significantly lower depression and anxiety • Schools that participated in PA had better reading and math scores • PA positively impacted student academic motivation and limited disaffection with learning • PA was found to impact teacher, parent, and student perceptions of school quality and safety • Effects on substance use, violence, and sexual activity were mediated by positive academic achievement • Longitudinal analyses found that PA had favourable effects on personal hygiene, healthy eating, exercising, unhealthy eating, and BMI scores • Wahsburn and colleagues (2011) found that both control and PA schools experienced a decline in positive behaviours over the 3-4 years of data collected (Bavarian et al., 2013, 2016; Beets et al., 2009; Flay & Allred, 2003; Flay et al., 2001; Lewis et al., 2013; Li et al., 2011; Snyder et al., 2010, 2013; Snyder, Vuchinich, & Acock, 2012; Washburn et al., 2011)
References	Flay & Allred, 2003; Flay et al., 2001; Flay, Allred, & Ordway, 2001; Bavarian et al., 2013, 2016; Beets et al., 2009; Lewis et al., 2013; Li et al., 2011; Snyder et al., 2010, 2013; Snyder, Vuchinich, & Acock, 2012; Washburn et al., 2011;
Existing adaptations	**Positive Action Prekindergarten Lessons** 60 lessons (15 minutes each) were designed to be used with prekindergarten children utilizing age-appropriate methods, such as puppets, games, and songs (Schmitt, Flay, & Lewis, 2014)

3.2.7 Promoting Alternative Thinking Strategies (PATHS)

Promoting Alternative Thinking Strategies (PATHS)	
Variable	**Description**
Main objectives of the intervention	PATHS is a preventive intervention designed to improve self-control, emotional understanding, and problem solving skills for children The program has four main objectives: 1. Help children "stop and think" to regulate their actions 2. Help children communicate with others so they can better understand themselves and others 3. Help children integrate emotions, thoughts, and communication skills to solve problems 4. Help children learn to use self-control, emotional awareness, problem solving in various contexts (Greenberg & Kusché, 1998; Greenberg, Kusché, Cook, & Quamma, 1995)
Target risk and protective factors	Risk Factors Individual • Deficits in social understanding • Lack of understanding the causes and effects of one's own and other's behaviors • Limited ability for reflective thinking and planning • Limited understanding of oneself • Poor communication skills (difficulty in expressing feelings and attitudes) • Antisocial/aggressive behaviour • Early initiation of antisocial behaviour • Favourable attitudes toward antisocial behaviour • Hyperactivity School • Low school commitment and attachment • Grade repetition Protective Factors Individual • Clear standards for behaviour • Problem solving skills

	• Prosocial behaviour • Skills for interaction Peer • Interaction with prosocial peers School • Opportunities for prosocial involvement in education • Rewards for prosocial involvement in school (Blueprints for Healthy Youth Development, n.d.; Greenberg & Kusché, 1998)
Definition & description	• PATHS was developed due to the lack of efficacy of behavioral interventions for children • Research showed that seven factors may contribute to better outcomes in behavioural interventions: 1. Having intervention be longer in duration 2. Synthesizing numerous successful approaches 3. Using a developmental model 4. Focusing more on emotional development 5. Increasing opportunities for generalizing skills learned 6. Ongoing training and support for implementation 7. Assessing effectiveness with multiple measures • PATHS is based on the ABCD (affective-behavioral-cognitive-dynamic) model of development that identifies emotional development as typically preceding cognitive understandings / bheaviours and thus interventions should target affect/ emotional maturity before thoughts and behaviours • Children develop emotional competencies prior to preschool, but between 5-7 years old children have significant increases in cognitive processing, brain size and functions, so the intervention was designed to address neurocognitive models of development, namely, vertical control and horizontal communication • PATHS also operates on 4 assumptions: 1. Emotional awareness is related to one's behaviour 2. Development and socialization practices impact one's emotional awareness 3. Understanding emotions is an important element of problem solving 4. School can be a locus of change as it is a fundamental ecology for children

	(Greenberg et al., 1995; Kam, Greenberg, & Kusché, 2004)
Universal vs. targeted program	Universal
Target population	Children grades K-6
Setting	School
Level of intervention	Group, community
Components	Classroom • Structured activities that help students recognize emotions in themselves and others, manage emotions, learn strategies to minimize interpersonal conflict • Each grade has a set of developmentally appropriate lessons that utilize many methods, including visual, verbal, and kinesthetic modalities • Lessons focus on helping children to use cognitive affective skills in real-life situations • Each unit focuses on one or more skill domains (e.g., emotional recognition, friendship, self-control, problem solving) and builds upon the learning from the previous lessons • Use of the Control Signals Poster – modeled after a stoplight with red, yellow, and green lights o The red light prompts children to "stop- calm down" by taking a deep breath and indicating how they feel o The yellow light prompts children to "slow down- think" by considering options and making a plan o The green light prompts children to "go- try my plan" by taking planned actions • Use of Feeling Face Cards – cards show images of emotions and display the written word for the emotion, cards are also colour coded as uncomfortable (blue) or comfortable (yellow) • Unit lessons are augmented with standard daily activities (e.g., PATHS kid of the day) School • School-wide activities that include all staff (including lunchroom staff and bus drivers) in supporting emotional development of children (Blueprints for Healthy Youth Development, n.d.; Riggs, Greenberg, Kusché, & Pentz, 2006; Seifer, Gouley, Miller, & Zakriski, 2004)

Specifics of delivery	• The intervention is usually implemented as whole school approach • Each site of the program has a PATHS coordinator that supports implementation, including motivation to teachers and efforts to enhance program integrity • Classroom lessons are delivered by teachers with scripted lessons that can be adapted to the particular needs of the students and classroom • Materials are provided that guide structured class lessons, include information on behavioural strategies, and offer personalized tools • Parent involvement (Blueprints for Healthy Youth Development, n.d.; Seifer et al., 2004)
Dosage	Classroom • Lessons are 20-30 minutes each and designed to be delivered at least 2-3 times per week • Daily generalization activities are also available to reinforce the lessons (Blueprints for Healthy Youth Development, n.d.)
Duration	Designed to be a multi-year intervention (Blueprints for Healthy Youth Development, n.d.)
Evaluation methods & findings	PATHS has been evaluated using randomized design, quasi-experimental wait-list control design, post-test only design, and cluster-randomized trial. Results show: • PATHS was found to improve vocabulary, emotional competency, self-control, communication skills, social competence, and problem solving • Reduced aggression, conduct problems, delinquency, acting out problems • PATHS reduced the rate of growth of behavioural problems • Had a sustained reduction depressive symptoms reported by children • During one study, the control group was found to have increased aggressive behaviours while the intervention group was found to be relatively stable • Follow up data showed maintenance of the changes elicited by PATHS after 1 and 2 years • In one study, positive effects of the intervention were only found for some of the participating treatment schools

	• Two factors appeared to contribute most to successful implementation of PATHS: significant support from school principals, and high classroom program implementation by teachers (Crean & Johnson, 2013; Greenberg & Kusché, 1998; Greenberg et al., 1995; Humphrey et al., 2015; Kam et al., 2004; Kam, Greenberg, & Walls, 2003; Riggs et al., 2006; Seifer et al., 2004)
References	Greenberg & Kusché, 1998; Greenberg, Kusché, Cook, & Quamma, 1995; Blueprints for Healthy Youth Development, n.d.; Crean & Johnson, 2013; Humphrey et al., 2015; Kam et al., 2004; Kam, Greenberg, & Walls, 2003; Riggs et al., 2006; Seifer, Gouley, Miller, & Zakriski, 2004; Riggs, Greenberg, Kusché, & Pentz, 2006;
Existing adaptations	**Head Start REDI** This version of PATHS was adapted for preschool children and includes 30 lessons delivered during circle time at school in order to help foster an environment of social-emotional skills (Bierman et al., 2014; Domitrovich, Cortes, & Greenberg, 2007; Domitrovich, Gest, Jones, Gill, & DeRousie, 2010; Hamre, Pianta, Mashburn, & Downer, 2012; Kelly, Edgerton, Graham, Robertson, & Syme, 2015; Nix, Bierman, Domitrovich, & Gill, 2013; Sanford DeRousie & Bierman, 2012) **Cultural Adaptation of Head Start REDI for Children in Pakistan** Using the heuristic framework of adaptation, the intervention was adapted for Pakistani children by making changes to the language, presentation of materials, concepts used, training needs, and program delivery (Inam, Tariq, & Zaman, 2015)

3.2.8 Stop Now and Play (SNAP)

Stop Now and Play (SNAP)	
Variable	**Description**
Main objectives of the intervention	SNAP aims to support children and parents to learn skills to reduce a child's behavioural problems that can lead to later criminal involvement. Research has shown that children with more disruptive behaviours are two to three time more likely to become serious, violent, or chronic offenders when older. (Augimeri, Farrington, Koegl, & Day, 2007)
Target risk and protective factors	Risk Factors • Involvement in delinquency and crime • Conduct disorders • Psychiatric problems Protective Factors • Self-control • Problem solving- considering consequences and coming up with an appropriate plan • Social skills • Positive parenting (Augimeri, Walsh, & Slater, 2011)
Definition & description	SNAP was developed to reflect the change in youth justice legislation in Canada as the new legislation decriminalized behaviour of children under 12 years of age. Additionally, during the 1980's few programs in North America existed to support children under 12 who engage in behaviours that may lead to police contact. Research was showing, at the time, that helping families and children develop cognitive-behavioural skills can prevent future antisocial behaviour. SNAP uses the image of a stoplight to help children: • Red Light – STOP – Calm down • Yellow Light – NOW AND – Use coping statements • Green Light – PLAN – Generate effective solutions • (Augimeri et al., 2007, 2011)

Universal vs. targeted program	Targeted to children who have had police contact or have high rates of delinquency
Target population	Children under 12 who display behaviours that are predictive of future involvement in the criminal justice system
Setting	Community and school
Level of intervention	Individual, group, and family
Components	SNAP was updated in 2006 to reflect the findings from research of the original program, which involved two core components (SNAP Children's Club and SNAP Parenting Group). SNAP now uses a Structured Professional Judgment (SPJ) approach to risk assessment and management, offers continued care and is not time-limited, and there is a gender-specific component (SNAP Boys and SNAP Girls). SNAP Under 12 Outreach Project components: • SNAP Boys Group (Transformer Club)* • SNAP Parent Group* • Individual Counselling / Mentoring & Community Connections • School Advocacy / Teacher Consultations • Leaders in Training (LIT) • Stop Now and Plan Parenting (SNAPP): Individualized Family Counselling • Homework Club / Academic Tutoring • Victim Restitution • TAPP-C (The Arson Prevention Program-Children) • Parent Problem Solving Continued Care Group • Crisis Intervention SNAP Girls Connection components: • SNAP Girls Club* • SNAP Parent Group* • Girls Growing Up Healthy (GGUH)* • School Advocacy / Teacher Consultations • Leaders in Training (LIT) • Stop Now and Plan Parenting (SNAPP): Individualized Family Counselling

	• Homework Club / Academic Tutoring • Victim Restitution • TAPP-C (The Arson Prevention Program-Children) • Parent Problem Solving Continued Care Group • Crisis Intervention * Indicates core components of the programs (Augimeri et al., 2007, 2011)
Specifics of delivery	• The SNAP Children's Club and SNAP Parenting Group are the two core programs provided to families participating in the intervention • SNAP has a standardized curriculum
Dosage	SNAP group programs operate weekly
Duration	SNAP group programs (Boys and Girls Clubs) run for 13 weeks and if the child or family requires additional services they can participate in other SNAP program components
Evaluation methods & findings	Randomized controlled trials were primarily used to assess the SNAP program, including trials using neurological testing; some studies also used qualitative analysis and interviews. • Children who received SNAP had significantly fewer delinquent, conduct, behavioural, and aggressive behaviours following the intervention • Studies of SNAP also found children overall had greater social competencies • Children who improved after the intervention showed an overall reduction in ventral prefrontal activation, which made them equivalent to nonclinical children • High dorsal activation was still observed for children who improved and did not improve when compared to non-clinical children • Woltering, Granic, Lamm, and Lewis (2011) also assessed neurological self-regulation change and found that there were positive changes in the neural correlates of self-regulation for children who participated in the intervention (Augimeri, 2014) • Parents reported improved parenting skills, lower stress, and increased likelihood to use positive parenting • SNAP was also found to be more effective for children who entered the program with greater severity of behavioural problems (Augimeri, 2014; Augimeri et al., 2007; Burke & Loeber, 2014, 2016; Koegl, Farrington, Augimeri, & Day, 2008; Lipman et al., 2008; Lipman, Kenny,

	Brennan, O'Grady, & Augimeri, 2011) [5, 6]
References	Augimeri, Farrington, Koegl, & Day, 2007; Augimeri, Walsh, & Slater, 2011; Augimeri, 2014; Augimeri et al., 2007; Burke & Loeber, 2014, 2016; Koegl, Farrington, Augimeri, & Day, 2008; Lipman et al., 2008; Lipman, Kenny, Brennan, O'Grady, & Augimeri, 2011;
Existing adaptations	The National Crime Prevention Centre published two reports about implementation and evaluation of SNAP in diverse communities across Canada (see National Crime Prevention Centre, 2013c; Public Safety Canada, 2013)

[5] Additional studies of the SNAP Program have been completed finding largely positive behavioural changes for children who have received the intervention (Augimeri, 2014)

[6] Woltering, Granic, Lamm, and Lewis (2011) also assessed neurological self-regulation change and found that there were positive changes in the neural correlates of self-regulation for children who participated in the intervention (Augimeri, 2014)

3.2.9 Steps to Respect

Steps to Respect	
Variable	**Description**
Main objectives of the intervention	Steps to Respect is a school-wide program that was designed to reduce bullying at school by: 1. Increasing staff awareness, monitoring, and responsiveness 2. Supporting children in being socially responsible 3. Teaching social-emotional skills to help children build healthy relationships and respond to bullying in an appropriate way (Frey et al., 2005; Hirschstein, Edstrom, Frey, Snell, & MacKenzie, 2007)
Target risk and protective factors	Risk Factors: • Lack of adult awareness and systemic supports to prevent bullying • Destructive bystander behaviour • Student beliefs that support bullying • Student social-emotional skills deficits Protective Factors: • Prosocial beliefs about bullying (less acceptance of bullying, less interest in watching bullying, and more perceived responsibility to intervene when witnessing bullying) • Social emotional skills (Frey et al., 2005)
Definition & description	Steps to Respect is primarily informed by social-ecological theory, which emphasizes that a person's context plays a key role in their behaviours. Social-ecological theory implies that peer attitudes, norms, and behaviours play a key role in the rates of bullying. This program was also developed to address relational/social aggression (e.g., gossip, social exclusion) because most other anti-bullying programs have focused on physical and verbal aggression. (Brown, Low, Smith, & Haggerty, 2011; Low, Frey, & Brockman, 2010)
Universal vs. targeted program	Universal program for all students
Target population	Students in grades 3-6
Setting	School-based
Level of intervention	Group and individual

Components	Staff Training 1. All school staff are provided with an introductory session, which provides them with key information about bullying and a model to respond to bullying 2. Grade 3-6 teachers are provided with an orientation to the class curriculum 3. Teachers, counselors, and administrators are provided with two in-depth training sessions- these sessions include information about the following individual intervention strategies: Take bullying reports – us "Four A Response" • Affirm behaviour • Ask questions • Assess immediate safety • Act Coach students involved in bullying • Determine history • Provide support and/or consequences • Generate a plan for the future Follow up with involved students • Assess plan's success • Assess long-term safety of children • Refer/contact parents as needed Classroom Curriculum 4. Teachers deliver weekly sessions to help them build social skills and strategies to respond to bullying 5. Following completion of the classroom curriculum teachers implement a literature unit that relates to anti-bullying themes 6. There are different levels for each grade (level 1 – gr. 3/4, level 2 – gr. 4/5, level 3 – gr. 5/6) Parent Engagement 7. All parents are provided with scripted information about bullying 8. School administrators clarify anti-bullying policies for parents 9. Parents receive info throughout the curriculum delivery period about the lessons the children are learning in class (Frey et al., 2005; Hirschstein et al., 2007)

Specifics of delivery	• Teacher training is delivered by certified Steps to Respect trainers • Teachers deliver the Steps to Respect classroom curriculum • Teachers and school staff are responsible for addressing bullying incidents and coaching children involved with bullying
Dosage	Classroom curriculum is delivered for 45 minutes weekly with a 15-minute booster session
Duration	• School staff training is provided for 6 hours • Classroom component runs for 12-14 weeks
Evaluation methods & findings	This program has been evaluated using randomized cohort-sequential designs and multilevel analysis. • Modest positive program effects were found for teacher observations of bullying and social interactions, and attitudes related to bullying • 50% reductions in bullying at schools were found following the intervention • There were significant reductions in gossip and being targeted for gossiping, although the finding was only significant for students in the intervention group who had more supportive friends • High levels of student engagement in classroom curriculum was found to predict higher levels of engagement on a range of outcomes, including student attitudes towards bullying intervention, school climate, and lower levels of bullying • Teacher adherence to the program resulted in better teacher reports of peer interaction skills • Teacher skills in coaching and prompting students resulted in reduced antisocial behaviours observed on the playground • Findings were consistent with the social-ecological approach which stipulates that outcome effects are strongest when the intervention occurs at multiple levels Cohort-sequential design with control group data, random assignment, and multilevel analysis were employed to evaluate the Steps to Respect program. (Brown et al., 2011; Frey et al., 2005; Hirschstein et al., 2007; Low et al., 2010; Low, Van Ryzin, Brown, Smith, & Haggerty, 2014)
References	Frey et al., 2005; Hirschstein, Edstrom, Frey, Snell, & MacKenzie, 2007; Brown, Low, Smith, & Haggerty, 2011; Low, Frey, & Brockman, 2010; Low, Van Ryzin, Brown, Smith, & Haggerty, 2014;
Existing adaptations	N/A

3.2.10 Strengthening Families Program (SFP)

Strengthening Families Program (SFP)	
Variable	**Description**
Main objectives of the intervention	Strengthening families program is a strength-based program that builds on existing skills of the family. The goals of SFP are to: • Improve parenting skills and empathy • Help youth build decision making and other life skills (stress management, conflict resolution, peer resistance, empathy) • Strengthen family relationships and promote positive communication and joint problem-solving (EPISCenter, 2016)
Target risk and protective factors	Risk Factors • Child and family management practices, including harsh, inappropriate, or inconsistent discipline, indulgence, poor parental monitoring, demanding/rejecting behavior, and poor communication of rules • Youth aggressive or withdrawn behavior • Favorable attitudes toward problem behaviors and substance use • Friends who engage in problem behaviors – Negative peer influences • Poor social and stress management skills • Family conflict • Early initiation of problem behaviors • Early and persistent antisocial behavior • Poor school performance Protective Factors • Youth and family management practices, including monitoring, age-appropriate parental expectations, and consistent discipline • Effective and empathetic parent-child communication • Promotion of healthy beliefs and clear standards • Family bonding and supportive family involvement • Goal setting and positive future orientation

	• Positive parent-child affect • Emotional management • Pro-social family values • Peer pressure refusal skills (EPISCenter, 2016)
Definition & description	• Theories that informed development of the intervention include the social learning, family systems theory, biophysical vulnerability model, resiliency model, and a family process model linking family economic stress and adolescent adjustment • A major revision of Strengthening Families Program that was originally developed for methadone-maintenance and substance-abusing outpatient parents and their children 6-12 years of age took place in 1993 (EPISCenter, 2014)
Universal vs. targeted program	Universal
Target population	Youth 6-11 years of age and their primary caregivers
Setting	Community
Level of intervention	Group
Components	• SFP involves 14 interactive sessions broken down into three parts: a meal for families and facilitators, separate caregiver and youth sessions, and a session for caregivers and youth together • The program is ideally delivered to 8-13 families at a time • Facilitators can provide four booster sessions for families 3-12 months after the original intervention 1st Hour of Programming • Caregivers and youth meet separately and learn complementary content • Caregiver sessions focus on topics, such as setting limits, using consequences effectively, preventing substance abuse, and showing love • Caregiver sessions are video-based to show effective caregiver-child interactions • Youth sessions focus on setting goals for the future, showing appreciation to parents, managing stress, following rules, and resisting peer pressure • Youth sessions include various teaching methods, such as discussions, role-playing, skills practicing, and game-like activities 2nd Hour of Programming • Caregivers and their children come together to practice skills, play games,

	and participate in family projects • Together they explore family strengths and values, practice handling difficult situations, and effective communication (EPISCenter, 2014, 2016; National Crime Prevention Centre, 2011)
Specifics of delivery	• PATHS trainers provide three days of consecutive training for local staff to implement he intervention • SFP is generally more effective when a mix of families participate (not just high risk families) and thus referrals should be done through multiple community channels • The lessons are delivered by three trained facilitators (one for parent session and two for the youth session) • The program can be delivered evenings or weekends at any suitable community location • SFP has a series of curriculum manuals and lesson videos which are used to help standardize the curriculum (EPISCenter, 2016)
Dosage	One session per week (meal time plus two hours of training)
Duration	14 weeks
Evaluation methods & findings	Most studies of the SFP used randomized designs to test the program's effectiveness. Methods employed were: • Randomized controlled design with a multi-method study • Randomized experimental design • Randomized block design • Longitudinal prevention trial • Mixed method case study • Survival analysis • Quasi experimental pre-/post-test design Results show: • Improved family functioning, family cohesion, mental health of parents (e.g., reduced depression), and positive parenting • Improved scores on the Child Behavior Checklist • Parenting outcomes were maintained after a one-year follow up study • Participation in SFP was found to delay initiation of use of alcohol, cigarettes, and marijuana compared to control groups • When the intervention was delivered in grade 6 it reduced exposure to substance use, which was associated with reduced substance abuse in

	grade 12 • Children of parents with substance use issues who were placed in foster care and received Strengthening Families were significantly more likely to be reunited with their families • When compared to another drug abuse prevention program (Preparing for the Drug Free Years) for youth, SFP was found to be more effective • Some studies found that positive effects were only moderate in size • Following a review of the key principles in resiliency theory, SFP was identified as a good example of an intervention that can help children and families build resiliency to help combat the challenges the result from substance use and abuse in the family • One study assessed the difference in outcomes where families were assigned or had a choice to participate in one of two substance use prevention interventions (one of which was SFP) and the authors found that choice increases family engagement in the programs • One study used feedback from program staff to assess challenges with implementing the SFP program in larger multi-organization initiatives; concerns were found relating to cultural relevance, working and coordinating with partners, and organizing the intervention. The authors suggest good communication amongst partners, use of community outreach, and securing additional resources to help mitigate these issues • SFP was found to have a benefit-cost ratio of $9.60 per $1 invested for the prevention of substance use issues • In terms of cost for children in child welfare care and the impact of SFP in reunifying families, for every $1 invested in the intervention there is an average savings of $9.83 • When combined with the classroom Life Skills Training program, SFP showed significant reductions in marijuana initiation and 30% reductions in alcohol initiation at one year follow-up testing • When combined with the I Can Problem Solve (ICPS) program, SFP had positive effects on school bonding, parenting skills, family relationships, social competency, and behavioural self-regulation (Aalborg et al., 2012; Brook, McDonald, & Yan, 2012; Fox, Gottfredson, Kumpfer, & Beatty, 2004; Harrison, Boyle, & Farley, 1999; Johnson-Motoyama, Brook, Yan, & McDonald, 2013; Kumpfer, Alvarado, Tait, & Turner, 2002; Kumpfer & Bluth, 2004; Miller et al., 2013; Redmond, Spoth, Shin, & Lepper, 1999; Riesch et al., 2012; Spoth, Guyll, & Day, 2002; Spoth, Guyll, & Shin, 2009; Spoth, Redmond, & Shin, 1998; Spoth, Redmond, Shin, & Azevedo, 2004; Spoth, Redmond, Trudeau, & Shin, 2002; Spoth, Trudeau, Guyll, Shin, & Redmond, 2009)

References	EPISCenter, 2014, 2016; National Crime Prevention Centre, 2011; Aalborg et al., 2012; Brook, McDonald, & Yan, 2012; Fox, Gottfredson, Kumpfer, & Beatty, 2004; Harrison, Boyle, & Farley, 1999; Johnson-Motoyama, Brook, Yan, & McDonald, 2013; Kumpfer, Alvarado, Tait, & Turner, 2002; Kumpfer & Bluth, 2004; Miller et al., 2013; Redmond, Spoth, Shin, & Lepper, 1999; Riesch et al., 2012; Spoth, Guyll, & Day, 2002; Spoth, Guyll, & Shin, 2009; Spoth, Redmond, & Shin, 1998; Spoth, Redmond, Shin, & Azevedo, 2004; Spoth, Redmond, Trudeau, & Shin, 2002; Spoth, Trudeau, Guyll, Shin, & Redmond, 2009;
Existing adaptations	SFP can be adapted to various cultural settings and has been modified for use in over 17 countries. Kumpfer and colleagues offer a framework to guide cultural adaptation (Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008) **Strengthening Families Program for 3-5, 6-11,10-14, 12-16 years** Multiple adaptations were made to the program to suit various age ranges (Kumpfer, Whiteside, Greene, & Allen, 2010) **Strengthening Washington D.C. Families Project** This local adaption of the SFP program was approved by the program developer and included 35 classes delivered bi-weekly as opposed to the standard 14 sessions delivered weekly (Gottfredson et al., 2006) **Strengthening Families Program for Swedish Context** The intervention was adapted to be used for families in Sweden. Modifications included having the youth sessions take place during regular the school day and caregiver sessions. There were only two family sessions delivered in total. This adaptation also allowed for the participation of 25-30 youth and any of their interested caregivers. Booster sessions were delivered as part two of the intervention and there was a greater focus on preventing substance use issues (Skärstrand, Larsson, & Andréasson, 2008) **Strengthening Families Program for Irish Context** Due to the fact that social exclusion of youth and families is a multi-faceted issues in Irish society, there was a need for cross-cutting strategies and as such an interagency approach was chosen for delivery of the program (Kumpfer, Xie, & O'Driscoll, 2012) **Strengthening Families Program for Portuguese Context** Updates were made to the language, terminology, names, and activities to make them more appropriate for the Portuguese setting (Magalhães & Kumpfer, 2015)

3.2.11 L'allié

L'allié	
Variable	**Description**
Main objectives of the intervention	To prevent the further development and entrenchment of problem behaviours (behavioural disorders) among school-aged children and violence in schools by creating a network (alliance) of support around children in need of intervention. • Developing the social competencies of school-aged children displaying problem behaviours. • Harnessing the potential of children displaying problem behaviours to increase their school engagement and success. • Augmenting the potential of parents. • Augmenting communication and coordination between school representatives. (Duguay, 2011)
Target risk and protective factors	Risk factors: • Antisocial / problem behaviours at school • Peer rejection • Deviant peers • Ineffective parenting • Lack of connection between school and family Protective factors: • Social, behavioural, and cognitive skills • Conflict resolution skills • Parenting skills • Positive peer relationships • Support system at school (Duguay, 2011)
Definition & description	The program uses an interactive teaching approach and multi-modal intervention strategies to foster the adoption, maintenance, and generalization of social competence in children with behavioural disorders. Founded on principles of social learning theory, socio-cognitive functioning, attachment theory, and collaborative approaches, it places a heavy focus on positive relationships and positive reinforcement with children to encourage prosocial behaviours. (Duguay, 2011; Desbiens et al., 2009; Gaudet & Breton, 2009)

Universal vs. targeted program	Targeted to students displaying problem bahaviours
Target population	Children aged 8 to 12 years who display problem behaviours, and their parents
Setting	Classroom / school Designed and delivered by the University de Montreal in Québec. Pilot implementation occurred in 2004-2006 in 6 elementary schools. Since 2008, the program has been implemented in 20 elementary schools in Québec. (Duguay, 2011 ; Desbiens et al., 2009; Gaudet & Breton, 2009)
Level of intervention	Individual; peers; families; schools
Components	Student component – Developing social competencies in the areas of: • Emotional self-regulation • Conflict resolution • Communication skills • Self-control • Empathy Targeted students are accompanied by their friends ('peer helpers') in the sessions to help develop social skills and interpersonal problem solving (around 10 youth per group). Parent component – Developing parenting skills in: • Behavior management • Conflict resolution including negotiation • Self-control • School engagement (Duguay, 2011; Desbiens et al., 2009; Gaudet & Breton, 2009)
Specifics of delivery	Ideally, the program is implemented in a school already adopting a whole school approach to conflict resolution (e.g., *Vers le pacifique*). Two school representatives must be assigned to facilitate the program. A coordinating committee within the school has been deemed an essential asset. A 6-hour training and ongoing support is offered to school program facilitators. Additional support for child care is ideal to facilitate parent participation in program activities. A program package includes: Program Implementation Guide, a CD containing all program material, Facilitator Guides for all sessions, an Activity Guide for students and parents, an illustrated short story and DVD with instructional videos for use during parent sessions. (Duguay, 2011 ; Desbiens et al., 2009; Gaudet & Breton, 2009)

Dosage	**For students**: 15 sessions for students displaying problem behaviours over the course of one school year. Student alumni who were the target or intervention the year before are invited to 9 booster sessions the following school year. **For parents:** 15 sessions of 1 hour each on parenting skills (Duguay, 2011)
Duration	One school year (with optional booster sessions in following year)
Evaluation methods and findings	This program was evaluated with students in the program (N=188) across 8 schools in Montreal using a quasi-experimental design with a comparison group from 4 other schools in the same region (Desbiens et al. 2009). After 2 years of implementation, statistically significant impacts on students included: • Increased knowledge of positive conflict resolution strategies • Increased conflict resolution skills • Increased prosocial behaviours • Reduced negative internalizing and externalizing behaviours; • Reduced victimization; • Improved school climate; • More effective with girls displaying externalizing problem behaviours than with boys displaying externalizing problem behaviours; • Greater impacts on girls regarding emotional regulation and self-control; • Greater reduction in victimization among girls and increased feelings of safety; • Students experiencing difficulties report feeling more supported; • More effective for students who's parents participated in the parenting components of the program. The complexity of the program implementation is an ongoing concern, both for the program designers and for the schools that are implementing the program. A graduated implementation model that respects the particular needs of the school environment where it is being applied is suggested (Duguay, 2011; Desbiens et al., 2009; Gaudet & Breton, 2009).
References	Desbiens et al., 2009; Duguay, 2011; Gaudet & Breton, 2009;
Existing adaptations	N/A

3.2.12 Triple P (Positive Parenting Program)

Triple P (Positive Parenting Program)	
Variable	**Description**
Main objectives of the intervention	Triple P is a multilevel system of interventions with 5 levels that are tailored to specific needs and challenges. The program includes a universal intervention component for all families to learn effective parenting skills and parents with children experiencing behavioural issues and the subsequent levels are designed for parents and caregivers to learn skills to address the specific issues that their child is facing (Sanders, 1999)
Target risk and protective factors	Risk Factors • Severe behavioural problems and emotional issues • Coercive parenting practices Protective Factors • Parent knowledge, skills, confidence, self-sufficiency, and resourcefulness • Safe, engaging, nonviolent, and low-conflict environments for children • Positive parenting that promotes social, emotional, language, intellectual, and behavioural competencies of children (Sanders, 1999)

Definition & description	• Based on social learning theory, applied behaviour analysis
	• Based on the principles of positive parenting:
	  ○ Creating a safe and engaging environment
	  ○ Creating a positive learning environment
	  ○ Using assertive discipline
	  ○ Having realistic expectations of children based on their developmental stage
	  ○ Parental self-care
	• Construct of parent self-regulation guides is central to the intervention
	• Many social, economic, and mental problems are linked to the breakdown of family relationships
	• Designed as a tiered approach to maximize efficiency / costs, avoid observing, and ensure the program has wide reach

	• Built-in flexibility to enable practitioners to determine the level of intervention based on service priorities and funding
	• Distinguishing features of Triple P
	  ○ Principle of program sufficiency – offering the minimally sufficient level of intervention based on support required
	  ○ Flexible tailoring to identified risk and protective factors – different programs of varying intensity were developed to support youth with additional family risk factors
	  ○ Varied delivery modalities – the program can be delivered in a variety of formats, which allows families to have flexibility to engage in ways that suit their circumstances (e.g., living in a rural community)
	  ○ Wide potential reach – designed to be implemented at a system level to impact an entire population
	  ○ Multidisciplinary approach – able to be delivered by a range of helping professionals
	(Sanders, 1999)

Universal vs. targeted program	Level 1 – universal Levels 2-5 – targeted
Target population	Parents of children 0-12 years of age
Setting	Community
Level of intervention	Individual, group, family, community
Components	All program components are matched to the level of challenges that a family is facing (i.e., Level 5 is reserved for families with children experiencing multiple issues and have not found success in other interventions) Level 1: Media and Information Campaign • Universal media campaign for all parents • Aim to increase community awareness Level 2: Selective Triple P • Brief early intervention for parents of children with mild behavioural issues • This primary health care intervention offers parents guidance to supporting their children with their challenges • One to two sessions

	Level 3: Primary Care Triple P • Information and active skills training for parents of children with mild to moderate behavioural issues • Supports parents in learning how to apply their knowledge and skills to non-targeted behaviours and siblings • Involves staff supporting parents in identifying and defining the problems with their child and then creating a plan to address it • Four session intervention Level 4: Standard Triple P • Intensive program for children with more severe behavioural issues • Offered in several different formats, including a individual, group, and self-directed • 8-10 sessions Level 5: Enhanced Triple P (Pathways) • Enhanced family intervention that supports parents whose children are having behavioural issues which are complicated by other sources of family distress (e.g., marital conflict, high levels of stress) • Parents participate in active skills training, complete homework on the lessons, and receive constructive feedback provided by program staff • Three enhanced therapy modules: home visits, coping skills, and partner support • Ideally delivered in nine sessions (Sanders, 1999)
Specifics of delivery	Flexible delivery modalities are available to tailor the intervention to the level of need of the families (using individual, group, phone-based, self-directed) Level 1 • Media resource kit available to support implementation of a media campaign, includes TV and radio commercials, audio sound bites, newspaper columns, printed advertising materials, and information resources for parents (e.g., tip sheets, videos) • Delivered by Triple P coordinator Level 2 • Primary providers are given a training session to support parents requiring assistance Level 3 • This level of the intervention is appropriate for managing individual issues that are not complicated by other individual or family issues

	Level 4 • The level of the intervention is appropriate for families of youth who have "high-risk" behavioural issues that are not defined as behavioural disorders Level 5 • Intended to support families with multiple risk factors that have not been modified through other less-intensive interventions • Families are referred if they complete Level 4 of the intervention and appear to need more support or request additional support (Sanders, 1999)
Dosage	Level 2 – one 20-minute session Level 3 – 20 minutes per session Level 4 1. Standard Triple P – 90 minutes for training sessions, 40-60 minutes for home visits 2. Group Triple P – two-hour group session, 15-30 minute phone calls 3. Self-Directed Triple P – parent participates independently, so dosage varies Level 5 1. Home visit module – three 40-60 minute sessions 2. Coping skills module – three 90 minute sessions 3. Partner support module – three 90 minute sessions
Duration	Level 2 – one session Level 3 – four sessions Level 4 1. Standard Triple P – 10 sessions 2. Group Triple P – four group sessions, four follow-up phone calls 3. Self-Directed Triple P – 10 sessions Level 5 – nine sessions
Evaluation methods & findings	Findings from Meta-Analyses A meta-analysis of Triple P Level 4 found: • Dysfunctional parenting styles decreased significantly after intervention and were maintained for 3-12 months • Parents were more satisfied with their parenting role and feelings of efficacy after intervention and were maintained for 3-12 months • Therapist-assisted and self-directed versions of the intervention were equally effective

	• Effectiveness was equal for parents of children with clinically defined behavioural issues and nonclinical behavioural issues • Studies that had more boy participants had better outcomes on parental competencies A meta-analysis of all levels of Triple P found: • Positive change in parenting skills, child problem behaviours, and parental well-being • More intensive intervention delivery resulted in better program outcomes • Families who began the program with greater levels of distress experienced better outcomes (Graaf, Speetjens, Smit, Wolff, & Tavecchio, 2008; Nowak & Heinrichs, 2008; Sanders, Kirby,, Tellegen, & Day, 2014) Other Findings • Parents who participated in Triple P had reductions in depression, stress, and coercive parenting • One study found that the following parent characteristics were associated with better program outcomes: high stress levels prior to intervention, lower family income, and immigration • Communities that received the Triple P intervention had fewer children with clinically defined behavioural disorders compared to control communities • One study found large effect sizes for child maltreatment, child maltreatment injuries, and out-of-home placements for children • One study found no significant differences for secondary outcomes (e.g., parenting stress, family functioning) between Triple P and service-as-usual • When Level 5 Triple P was implemented with parents referred to the child welfare system there were improvements in parenting skills, use of non-physical discipline, and consequently improved home life • The cost of the universal Triple P program was less than $1 per child in the population and the cost to train providers in other Triple P levels were determined to be $11.74 per child • An estimate was made that the costs for delivering the program could be recovered in a year with a 10% reduction in the rate of abuse and neglect (Bodenmann, Cina, Ledermann, & Sanders, 2008; Crisante & Ng, 2003; Foster, Prinz, Sanders, & Shapiro, 2008; Houlding, Schmidt, Stern, Jamieson, & Borg, 2012; Leung, Sanders, Ip, & Lau, 2006; Leung, Sanders, Leung, Mak, & Lau, 2003; Matsumoto, Sofronoff, & Sanders, 2010; McConnell, Breitkreuz, & Savage, 2012; Petra & Kohl, 2010; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Roux, Sofronoff, & Sanders, 2013; Sanders et al., 2008; Sanders, Markie-Dadds, Tully, & Bor, 2000)

References	Bodenmann, Cina, Ledermann, & Sanders, 2008; Crisante & Ng, 2003; Foster, Prinz, Sanders, & Shapiro, 2008; Graaf, Speetjens, Smit, Wolff, & Tavecchio, 2008; Houlding, Schmidt, Stern, Jamieson, & Borg, 2012; Leung, Sanders, Ip, & Lau, 2006; Leung, Sanders, Leung, Mak, & Lau, 2003; Matsumoto, Sofronoff, & Sanders, 2010; McConnell, Breitkreuz, & Savage, 2012; Nowak & Heinrichs, 2008; Petra & Kohl, 2010; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Roux, Sofronoff, & Sanders, 2013; Sanders et al., 2008; Sanders, 1999; Sanders, Kirby, Tellegen, & Day, 2014; Sanders, Markie-Dadds, Tully, & Bor, 2000;
Existing adaptations	Triple P has been modified for use with various cultural groups, including Chinese families living in Australia and Hong Kong, Australian and Canadian Indigenous families, Swedish Families, and Japanese families (Bodenmann et al., 2008; Crisante & Ng, 2003; Houlding et al., 2012; Leung et al., 2006, 2003; Matsumoto et al., 2010; Turner et al., 2007). A few examples are provided below. **Group Triple P for Indigenous Families** An extensive community consultation took place to support the modification of the Group Triple P program with Indigenous families in Australia. Updates to the intervention were made regarding language, images used, and allowing for more time in group sessions for discussions and storytelling (Turner, Richards, & Sanders, 2007). Triple P with Indigenous families in Northwest Ontario (Canada) found perceived improvements in parenting skills, child behaviour and competency, and parent/child relationships. **Stepping Stones Triple P** Designed for use with families with children who have disabilities; combines Triple P strategies with findings from disabilities literature. It has been found to be effective for parents of children with disabilities, including Autism Spectrum Disorder (Roux et al., 2013; Whittingham, Sofronoff, Sheffield, & Sanders, 2009). **Primary Care Triple P** This adaptation of Triple P was developed as a level 3 intervention for use in primary care settings, such as healthcare agencies. The goal of this intervention is to help detect parent-child difficulties early (Boyle et al., 2010).

3.3 Programs for Youth Ages 12 to 17

3.3.1 Aggression Replacement Training (ART)

Aggression Replacement Training (ART)	
Variable	**Description**
Main objectives of the intervention	ART is a multi-modal asset-based social learning approach that helps youth build core social and relationship skills with a focus on three domains: behavioural (Structure Learning Therapy), affective/emotional (Anger Control Training), and cognitive (Moral Education) (Goldstein et al., 1986; Nugent, Bruley, & Allen, 1999; Roth & Striepling-Goldstein, 2003)
Target risk and protective factors	Risk Factors: • Antisocial behaviour • Family violence Protective Factors: • Social and relationship skills • Resilient temperament • Community involvement (National Crime Prevention Centre, 2011; Nugent et al., 1999)
Definition & description	Aggression Replacement Training was developed due to the fact that few interventions had found significant reductions in antisocial or aggressive behaviours (Nugent et al., 1999). Research about youth who are aggressive found that these youth often lack prosocial skills. Thus, the focus of the ART intervention activities is on replacing these antisocial skills with prosocial skills utilizing social learning and cognitive behavioural theories (Amendola & Oliver, 2010; Goldstein et al., 1986). The program uses modeling, role playing, providing reinforcement and feedback, and encouraging youth to practice their skills (Amendola & Oliver, 2010). ART was designed for use in youth facilities (e.g., custody facilities, shelters) (Roth & Striepling-Goldstein, 2003)
Universal vs. targeted program	Targeted
Target population	Youth (11-17) who have experiences of serious aggression, violence, and antisocial behaviour
Setting	Community
Level of intervention	Group

Components	Structured Learning Training • Psychoeducational intervention for small groups of 8-12 adolescents for youth with chronic aggression issues • SLT is delivered using modeling, role playing, performance feedback, and transfer training (helping youth learn to apply their new skills in the 'real world') • 50 skill curriculum based on five themes: 1. Beginning social skills (e.g., starting a conversation) 2. Advanced social skills (e.g., asking for help, apologizing) 3. Skills for dealing with feelings (e.g., coping with and expressing emotions) 4. Alternatives to aggression (e.g., responding to bullying) 5. Skills for dealing with stress (e.g., dealing with being left out) 6. Planning skills (e.g., goal setting, problem solving) Anger Control Training • Goal to help youth inhibit their anger • At each session, youth bring an example of a recent anger-inducing experience (a hassle) and are trained to respond to each hassle by: 1. Identifying triggers that led to the anger response 2. Identifying physical cues that alert one to the anger response 3. Using reminders (internal cues or self-statements) to help calm down and understand others' behaviours 4. Using reducers or techniques to lower one's anger (e.g., deep breathing, counting backward) 5. Using self-evaluation to assess how well one handles a difficult situation Moral Education • Using group discussions to have youth reflect on moral dilemmas • Goal to help youth learn to view the world from another's perspective and thus enhance their ability to act with fairness, justice, and concern for the needs and interests of others (Glick & Goldstein, 1987; National Crime Prevention Centre, 2011)
Specifics of delivery	Facilitators are trained to implement the ART intervention
Dosage	Intervention sessions provided for one hour three times per week

Duration	10 weeks (30 hours)
Evaluation methods & findings	The studies referenced in this summary used various methods, including randomized control trials, quasi random designs, and interrupted time series designs. Results show: • Youth who received ART were more likely than those in the control condition to have reductions in impulsiveness, complaining, fighting, accusing, aggression and improved social functioning (offering/accepting criticism, using self-control) • ART reduced recidivism rates for youth with criminal involvement • Combining ART with motivational interviewing was found to have significant reductions in antisocial behaviours • A condensed version of ART found a 20% decrease in the rate of antisocial behavior and a 17% decrease in the daily number of antisocial behavior incidents • Youth in the court system who received ART had a 24% reduction in recidivism rates compared to the control group • When ART was delivered adequately, it was found to generate $11.66 in benefits (reduced crime costs) for each dollar spent on ART • One study found no significant differences between control and ART treatment groups • A systematic review found there is not enough evidence to show that ART has a positive impact on recidivism, self-control, social skills, and moral development (Amendola & Oliver, 2010; Barnoski, 2004; Brännström, Kaunitz, Andershed, South, & Smedslund, 2016; Coleman, Pfeiffer, & Oakland, 1992; Glick & Goldstein, 1987; Gundersen & Svartdal, 2006; Koposov, Gundersen, & Svartdal, 2014; National Crime Prevention Centre, 2011; Nugent et al., 1999)
References	Amendola & Oliver, 2010; Barnoski, 2004; Brännström, Kaunitz, Andershed, South, & Smedslund, 2016; Coleman, Pfeiffer, & Oakland, 1992; Glick & Goldstein, 1987; Goldstein et al., 1986; Gundersen & Svartdal, 2006; Koposov, Gundersen, & Svartdal, 2014; National Crime Prevention Centre, 2011; Nugent et al., 1999; Roth & Striepling-Goldstein, 2003;
Existing adaptations	**Condensed Aggression Replacement Training** The original ART program was condensed to be completed in 15 days over 3 weeks and moral reasoning was removed from the intervention (Nugent et al., 1999) **School-Based Aggression Replacement Training** Adapted for use as a generalized intervention for students and as a response to incidents at school (Roth & Striepling-Goldstein, 2003)

3.3.2 Alternative Suspension

Alternative Suspension	
Variable	**Description**
Main objectives of the intervention	The goal of Alternative Suspension is to support youth who have been suspended or are at risk of being suspended from school in overcoming challenging behaviours and continuing to work toward success in academics. This program was developed by the YMCA of Québec and is now implemented in various communities across Canada. (National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.)
Target risk and protective factors	Risk Factors • School suspensions • Academic difficulties • Poor relationships with adults Protective Factors • Improved social skills • Improved self-worth • Staying up to date with school work/ continuity in the educational process • Supervision of students during suspensions (National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.)
Definition & description	Alternative Suspension is an out of school program that is designed to improve attitudes toward school and build social relationships. Many youth who are suspended have difficulties not only in school and with staff at school, but also with parents. The ultimate goal of this non-judgemental approach is to turn suspensions into positive opportunities for students to access support. (National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.)
Universal vs. targeted program	Targeted
Target population	Students 12-17 years old who are experiencing social and academic challenges and are at risk of being suspended
Setting	Neutral community location
Level intervention	Individual and group

Components	Group Workshops Addressing topics associated with risk behaviours, such as: • Stress and anger management • Responsibility • Conflict resolution • Relating to authority figures • Organization skills • Self-esteem • Violence and bullying • Gangs • Substance abuse Individual Sessions • Focus on particular needs of youth (National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.)
Specifics of delivery	During morning sessions, students complete their schoolwork and during afternoon sessions workshops and individual interventions take place. Staff ideally work at six-to-one ratio with students. They are responsible for building relationships of trust with the students and communicating regularly with the school and parents about the students' progress. (National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.)
Dosage	Not specified
Duration	Varies depending on the length of the suspension
Evaluation methods & findings	One study was found; it used a pre-post non-equivalent group design with follow-up surveys after 6 and 12 months. This study used a mixed methods approach collecting both quantitative and qualitative data. • Participants felt they made improvements at first post-intervention follow-up • School administrators noted there were fewer problem behaviour referrals to the office and consequently fewer disciplinary actions required • School administrators also noted fewer negative interactions with participants • Student academic performance improved 39.4% of the time (National Crime Prevention Centre, 2013a)
References	National Crime Prevention Centre, 2013a; YMCA Alternative Suspension, n.d.;
Existing adaptations	N/A

3.3.3 Functional Family Therapy

Functional Family Therapy	
Variable	**Description**
Main objectives of the intervention	Functional Family Therapy (FFT) is a strength-based therapeutic support for families with children who have behavioural problems. It is an integrative and multisystem therapy designed as a primary and secondary prevention of delinquency. The goals of FFT are to: • Improve communication and interactions between youth and their family members • Enhance the caregiver's parenting skills • Promote positive relationships with teachers and peers (Barton, Alexander, Waldron, Turner, & Warburton, 1985; Bowen, 2003; DeVore, 2011)
Target risk and protective factors	Risk Factors: Individual • Antisocial/aggressive behaviour • Early initiation of antisocial behaviour • Early initiation of drug use • Favourable attitudes towards antisocial behaviour • Favourable attitudes towards drug use • Hyperactivity • Rebelliousness • Substance use Peer • Interaction with antisocial peers • Peer substance use Family • Family conflict/violence • Family history of problem behaviour • Neglectful parenting • Parental attitudes favourable to antisocial behaviour

	• Parental attitudes favourable to drug use • Poor family management • Violent discipline Protective Factors: Individual • Clear standards for behaviour • Problem solving skills • Prosocial behaviour • 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 peers (Blueprints for Healthy Youth Development, 2016)
Definition & description	• FFT is based on a decade of research on family communication styles • The intervention was originally developed to integrate both systems theory and transactional behaviorism, which indicate that behaviours occur in the context of relationships and are often circular and reciprocal FFT uses the following techniques: • Strategic method (e.g., tasks, directions, and problem solving) • Positive relabeling and reattribution of family functions • Improving family communication • Creating a safe atmosphere • Helping clients learn to see themselves as others see them (self-awareness and self-esteem building) (Barton et al., 1985; DeVore, 2011; Friedman, 1989; Wetchler, 1985)

Universal vs. targeted program	Targeted
Target population	Youth 10-18 years of age who experience behavioural issues, violence, or substance use issues and their families
Setting	Community
Level of intervention	Group (family)
Components	There are 3 phases of Functional Family Therapy: 1. Motivate the family toward change 2. Teach the family how to address a critical problem identified in phase 1 3. Help the family learn to generalize their problem-solving skills, including creating plans for addressing issues in the future and referring families to other agencies that can provide additional supports to the family (Barnoski, 2004; DeVore, 2011; Wetchler, 1985)
Specifics of delivery	• During assessment a cross-sectional view of the family is taken • Carter and McGoldrick's framework of family life cycle is used during therapy sessions; life cycle stages are assessed to determine if family members are meeting the global functions that align with developmental stages • The focus of the intervention is the understanding that behaviour is not static and can be changed • Use of positive communication training, assigned tasks, and conflict resolution skills to alter persistent patterns of negative behaviours within families are emphasized • Therapists work with the family to assess family factors that contribute to the young person's challenges and then support them in making changes with a focus on relationships • FFT trains therapists, provides them with a training manual to help standardize treatment, and supervise them throughout the intervention • Therapists typically have 10-12 families on their caseload (Barnoski, 2004; DeVore, 2011; Friedman, 1989)
Dosage	8 to 12 one-hour sessions (8 to 12 hours total)
Duration	Sessions are typically delivered over three months

Evaluation methods & findings	FFT has been evaluated using randomized clinical trials, random assignment with convenience sample, propensity score matching, qualitative and semi-structured interviews. Results show: • Improvements in family functioning (communication, expressing emotions, involvement) • Improvements in intrapersonal issues, including distress, sleep issues, social problems, and behaviour dysfunctions • Youth who participated in FFT were less likely to be rearrested than those who did not complete the program; one study found FFT reduced felony recidivism by 38% • FFT was found to reduce recidivism when therapists adhered to the treatment model (i.e., implemented the model with fidelity); otherwise, FFT had significantly greater recidivism rates than standard probation services • For youth with alcohol use problems who are in shelters, the FFT intervention was found to reduce number of days of alcohol use and the number of drinks consumed on drinking days after 15 months • Both youth and caregivers reported satisfaction with FFT, although caregivers had higher rates of satisfaction overall • Individuals who had stronger alliances to their therapist did not necessarily have stronger retention rates in the program; unbalanced alliances in families were predictive of program drop-out rates • In terms of savings, FFT saves $2.77 in avoided crime costs for every dollar spent on the program, regardless of therapist competence; for competent therapists, FFT saves $10.69 for every dollar spent • FFT was less effective at engaging and retaining youth and their caregivers and had less dramatic results on substance use problems than a home-based therapy program for substance misusers • When compared to Multisystemic Therapy, FFT had similar results in terms of peer associations, substance use, and lack of adherence to parental rules • When compared to Multisystemic Therapy, FFT was more effective at reducing recidivism for female youth and low-risk youth • The combination of FFT and the Adolescent Coping with Depression course (CWD) found reductions in symptoms of depression • FFT is more likely to be implemented in organizations where their mission aligns with the intervention and there is a strong interest in evidence-based treatments • Four factors were found to help facilitate effective implementation of FFT: ○ Collaboration

	○ Training ○ Agencies' readiness ○ Funding source expectations • Implementing FFT may be more difficult with different populations that have varying cultural contexts and needs (Baglivio, Jackowski, Greenwald, & Wolff, 2014; Barnoski, 2004; Bowen, 2003; Celinska, Cheng, & Virgil, 2015; Duncan, Davey, & Davey, 2011; Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Friedman, 1989; Robbins, Turner, Alexander, & Perez, 2003; Rohde, Waldron, Turner, Brody, & Jorgensen, 2014; Sexton & Turner, 2011; Slesnick & Prestopnik, 2009; Waldron, Slesnick, Brody, & Turner, 2001; Zazzali et al., 2008)
References	Baglivio, Jackowski, Greenwald, & Wolff, 2014; Barnoski, 2004; Barton, Alexander, Waldron, Turner, & Warburton, 1985; Blueprints for Healthy Youth Development, 2016; Bowen, 2003; Celinska, Cheng, & Virgil, 2015; DeVore, 2011; Duncan, Davey, & Davey, 2011; Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Friedman, 1989; Robbins, Turner, Alexander, & Perez, 2003; Rohde, Waldron, Turner, Brody, & Jorgensen, 2014; Sexton & Turner, 2011; Slesnick & Prestopnik, 2009; Waldron, Slesnick, Brody, & Turner, 2001; Wetchler, 1985; Zazzali et al., 2008;
Existing adaptations	Applications of Functional Family Therapy in different cultural settings have taken place in various locations, including the Netherlands and Ireland (see Breuk et al., 2006; Graham, Carr, Rooney, Sexton, & Wilson Satterfield, 2014)

3.3.4 Leadership and Resiliency Program

Leadership and Resiliency Program	
Variable	**Description**
Main objectives of the intervention	The Leadership and Resiliency Program is a school- and community-based prevention program. This holistic program includes three program components that address extreme risk factors (including cognitive dissonance) to support attitude formation. The program is designed to identify and enhance strengths that have been identified in resiliency research as predictive of future success and adaptation, while preventing substance abuse and violence. Long Range Goals • Reducing substance misuse • Increasing high school graduation • Reducing illegal activity • Increasing post- high school employment or post-secondary education • Increasing resiliency in at least two life domains and attitudes that view substance abuse as undesirable and unhealthy Intermediate Goals • Reducing behavioural problems at school • Better attendance Better academic achievement • Increasing school and community bonding (Daryanani et al., 2009; Public Safety Canada, 2016)
Target risk and protective factors	Risk Factors • Mental health disorders/ substance abuse • Youth living in care • Academic difficulties • Behavioural problems at school • Low community/ school bonding • High impulsivity in youth or family • Mental health disorders/ substance abuse in an immediate family member • Immediate family involved with the criminal justice system • Serious conflict in the parents' relationship • Overcrowding in the home • Violence at home

	• Poverty Protective Factors • Desire and ability to use empathy toward others • Desire to help others • Positive relationships with adults • Ability to delay gratification • Being focused on the future • A sense of self-control • Genuine acceptance of one's circumstances • A sense of self-efficacy • A sense of humour • Ability to take measured and appropriate risks • Optimism (Daryanani et al., 2009)
Definition & description	The LRP is rooted in resiliency theory and designed to support youth in developing positive identities. Additionally, it is rooted in the whole person and strengths-based approaches with the underlying idea that youth who learn to be successful will have the skills to be successful later in life. (Daryanani et al., 2009; Public Safety Canada, 2016)
Universal vs. targeted program	Targeted
Target population	Youth at-risk of involvement with substance abuse and/or violence who are enrolled in mainstream or alternative high school
Setting	School and community
Level of intervention	Group, individual
Components	In-School Groups • Delivered with groups of 10-15 youth • Take place during the school day • Initially, a structured format is used and then it becomes more process-oriented • There is no standardized programming, instead the focus is on creating a healthy, healing community in the school • Goal to have the group take on more autonomy and become more participant-directed • Smaller group or individual meetings can be provided for youth needing additional support

	Community Volunteer Experiences • Original volunteer opportunities were provided at an animal shelter and with a puppet project • Includes debriefing by staff that encourages youth to heal and develop altruism Alternative or Adventure Activities • Outdoor adventure or camping trips • Includes debriefing that helps to build resiliency skills (Daryanani et al., 2009)
Specifics of delivery	• All activities include discussions and debriefs focused on developing and strengthening resiliency through providing care for others, self-efficacy, goal orientation, optimism, and genuine sense of responsibility • Activity examples and debrief questions can be found in the LRP Guide • Youth are referred to the program when struggling with academics or experiencing behavioural issues at school and/or have severe life stressors (abuse, emotional difficulties) • Youth who are referred choose whether to join the program • Teen participants act as mentors to younger students informing them of the risks of substance abuse (peer helping model) • School partnerships are a key component of building the program • Staff should have strong clinical skills, experience working with youth facing barriers, the ability to impose professional boundaries, information to refer youth to other services (Daryanani et al., 2009; Public Safety Canada, 2016)
Dosage	The school program takes place once per week for 1.5 hours, the volunteer activities are offered monthly, and outdoor activities are offered monthly as well
Duration	Students usually enter LRP in grade 10 and stay for the duration of their high school career
Evaluation methods & findings	We found one study of LRP. Data for this study were collected from LRP staff reports, youth participants, and school data. • 65% reduction in school absences, 60% reduction in school disciplinary reports, increase in academic achievement (GPA) (Daryanani et al., 2009)
References	Daryanani et al., 2009; Public Safety Canada, 2016;
Existing adaptations	N/A

3.3.5 Life Skills Training ™

Life Skills Training ™	
Variable	**Description**
Main objectives of the intervention	Life Skills Training is a substance abuse prevention initiative designed to promote anti-drug norms, teach refusal skills, and foster general social skills. The program promotes healthy alternatives to risky behaviours through: • Teaching skills to resist social pressure to use substances • Developing self-esteem and confidence • Helping students cope with anxiety • Increasing knowledge about consequences of substance use • Enhancing skills to prevent other health risks (EPISCenter, 2013)
Target risk and protective factors	Risk Factors • Low perceived risks of drug use • Early initiation of drug use • Sensation seeking • Rebelliousness • Friends' delinquent behaviour • Friends' use of drugs • Peer rewards for antisocial behaviour • Favourable attitudes toward antisocial behaviour • Favourable attitudes toward alcohol, tobacco, and other drug use Protective Factors • Social skills • Interaction with prosocial peers (EPISCenter, 2013)

Definition & description	LST is developmentally appropriate and employs collaborative methods LST was based on the three domains found to promote drug abuse: 1. Drug Resistance Skills • Students learn common misconceptions about drug use • Students also learn and practice skills to resist pressure to use substances from their peers and the media 2. Personal Self-Management • Students learn what factors influence the decisions they make • Students learn how to analyze problems and develop alternative solutions • Students set personal goals and track their progress • Students learn how to reduce stress/anxiety and to view problems in a more positive light 3. General Social Skills • Students learn social skills to communicate effectively with others and learn to solve problems positively (EPISCenter, 2013)
Universal vs. targeted program	Universal
Target population	Students in grades 6 to 9
Setting	School/community
Level of intervention	Group
Components	Level 1 • For grades 6 or 7 • 15 sessions plus 3 optional violence prevention sessions Level 2 • For grades 7 or 8 • 10 sessions plus 2 optional violence prevention sessions Level 3 • For grades 8 or 9 • 5 sessions plus 4 optional violence prevention sessions (EPISCenter, 2013)

Specifics of delivery	• The program is delivered using various methods, including lecture, discussion, coaching, and practice • LST can be delivered by school staff or other staff in community agencies using the LST teaching manual • For new facilitators of LST it is recommended that they attend the LST Two-Day Core Training Workshops (Botvin, Renick, & Baker, 1983; EPISCenter, 2013)
Dosage	2-3 sessions per week or once per week (each session is 30-45 minutes)
Duration	30 sessions delivered over three years
Evaluation methods & findings	Evaluations of LST were conducted with various methodologies, including randomized controlled trial, randomized block design, repeated panel design, pre- post-test experimental design, and pre-post-test without control. Studies found: • LST reduced risk-taking and problem behaviours in school, and increased students' competency at refusing drugs • Reduced pro-drinking attitudes, and peer drinking norms • Reduced cigarette, marijuana, inhalant, and heavy alcohol use • Intervention participants were 66% less likely to use marijuana, alcohol, and cigarettes compared to the control group • One study found reduced cigarette smoking at the following rates: o 50% reduction in new cigarette smoking after year 1 o 32% reduction in new smoking after year 2 o 49% reduction in more regular smoking • Booster sessions significantly reduced smoking behaviour further • Another study found no impact on getting students who smoke to quit nor on the number of students who worry about the effects of smoking on their friends following the intervention • One study only found significant findings for reduced substance use effects on young women, not young men; girls who participated in LST increased understanding of substance use, skills for coping with anxiety, communicating, decision-making, and assertiveness • Another study found reduced binge drinking by 50% for youth who participated in the intervention • Youth who participated in LST had improvements in terms of self-efficacy, attitudes, and knowledge about substance use • LST was found to have positive impacts on driving violations and demerit points for intervention participants

	• LST also resulted in significant reductions in violence and delinquency • Participation in LST during middle and high school had a protective effect on HIV risk behaviours for young adults • One study found that LST had treatment effects at first and second follow-up, but those effects were not maintained over time (after grade 9) • Intensive LST (offered multiple times per week) was found to be more successful at reducing smoking • Students who received at least half of the LST sessions were more likely to have positive results • When combined with the Strengthening Families Program, LST had significant effects on prescription drug misuse (Botvin, Baker, Dusenbury, Tortu, & Botvin, 1990; Botvin, Griffin, Diaz, & Ifill-Williams, 2001a, 2001b; Botvin, Griffin, & Nichols, 2006; Botvin et al., 1983; Botvin, Schinke, Epstein, Diaz, & Botvin, 1995; EPISCenter, 2013; Griffin, Botvin, & Nichols, 2004, 2006; MacKillop, Ryabchenko, & Lisman, 2006; Savoji & Ganji, 2013; Smith et al., 2004; Spoth, Randall, Trudeau, Shin, & Redmond, 2008; Spoth, Trudeau, Shin, & Redmond, 2008; Trudeau, Spoth, Lillehoj, Redmond, & Wickrama, 2003; Vicary et al., 2006; Zollinger et al., 2003)
References	Botvin, Renick, & Baker, 1983; Botvin, Baker, Dusenbury, Tortu, & Botvin, 1990; Botvin, Griffin, Diaz, & Ifill-Williams, 2001a, 2001b; Botvin, Griffin, & Nichols, 2006; Botvin, Schinke, Epstein, Diaz, & Botvin, 1995; EPISCenter, 2013; Griffin, Botvin, & Nichols, 2004, 2006; MacKillop, Ryabchenko, & Lisman, 2006; Savoji & Ganji, 2013; Smith et al., 2004; Spoth, Randall, Trudeau, Shin, & Redmond, 2008; Spoth, Trudeau, Shin, & Redmond, 2008; Trudeau, Spoth, Lillehoj, Redmond, & Wickrama, 2003; Vicary et al., 2006; Zollinger et al., 2003;
Existing adaptations	**Stay SMART** Developed as a component of SMART Moves, this adaptation of LST was completed by the Boys and Girls Clubs of America. Includes a condensed version of the LST intervention with three additional sessions designed to prevent early sexual activity. This program also includes two booster sessions, SMART Leaders I and II (St. Pierre, Kaltreider, Mark, & Aikin, 1992). **Nimi Ichinohabi** This adaptation of LST was designed for the Alexis Nakota Dioux First Nation in Alberta, Canada (Baydala et al., 2012)

3.3.6 Multisystemic Therapy (MST)

Multisystemic Therapy (MST)	
Variable	**Description**
Main objectives of the intervention	Multisystemic Therapy (MST) is an intensive family treatment for youth displaying serious clinical problems that uses individualized and comprehensive treatment to address individual risks and build protective factors. The primary goals of MST are: • Decreased rates of antisocial behaviour / other clinical problems • Improved family relationships, including enhanced caregiver disciplinary practices • Improved school/vocational performance • Reduced out-of-home placements (due to detention, custody, hospitalization) • Increased prosocial recreational involvement • Family empowerment to achieve and maintain changes (Henggeler, 2001; Multisystemic Therapy Services, 2007)
Target risk and protective factors	Risk Factors Individual • Low verbal skills • Favourable attitudes toward antisocial behavior • Psychiatric symptomatology • Cognitive bias to attribute hostile intentions to others Family • Lack of monitoring • Ineffective discipline • Harsh and inconsistent discipline • Low warmth • High conflict • Parental difficulties Peer • Association with deviant peers • Poor relationship skills • Low association with prosocial peers

	School • Low achievement • Dropout • Low commitment to education • Aspects of the school, such as weak structure and chaotic environment Neighbourhood & Community • High mobility • Low community support (neighbors, church, etc.) • High disorganization • Criminal subculture Protective Factors Individual • Intelligence • Easy temperament • Conventional attitudes • Problem solving skills Family • Attachment to parents • Supportive family environment • Marital harmony Peer • Bonding with prosocial peers School • Commitment to schooling Neighbourhood & Community • Ongoing involvement in faith-based activities • Strong indigenous support network (Multisystemic Therapy Services, 2007)

Definition & description	• MST is based on Brofenbrenner's Theory of Social Ecology which posits that systems (family, peers, school, community) and the ways they interact affect how youth behave and Haley and Minuchen's Family Systems Theory • MST is family-driven to impact the entire ecology of the young person • Developed to address limitations of services for youth with serious mental health issues and involved with the criminal justice system, such as limited effectiveness, high cost, and low service provider accountability • The key treatment ingredients of MST are: o Comprehensive services – evaluating risk factors and addressing all of them to affect the young person o Ecological validity – providing services in multiple contexts (home, school, community) o Quality assurance – intensive quality assurance protocols o Evidence-based interventions – use of evidence based therapeutic approaches o Empowering caregivers – incorporating parents and caregivers into the treatment and supporting them to build new skills to support change for the young person o Accountability – staff are accountable for engaging families in effective programming MST is similar to family therapy, but has some key differences: • Attention to factors in the adolescent and family's social networks that are linked with antisocial behavior • Commitment to removing barriers to accessing community services • Tends to be more intensive • There are more documented long-term outcomes with youth and families (Henggeler, 2001; Multisystemic Therapy Services, 2007)
Universal vs. targeted program	Targeted
Target population	Youth with serious clinical problems (e.g., violence, drug abuse) and at risk of being removed from the home
Setting	Sessions occur in natural settings (school, community, home)
Level of intervention	Individual, family
Components	MST is operationalized through nine principles, with flexibility in the design and delivery of the interventions: 1. Finding the Fit – assessing the fit between a young person's problems and

	their social ecology 2. Positive and Strength Focused – all therapeutic contacts focus on the strengths of the family 3. Increasing Responsibility – encouraging family members to take responsibility for their actions and desired change instead of using a pathological or deficit focus 4. Present-Focused, Action-Oriented, and Well-Defined – family-members are encouraged to define and work toward clear and manageable goals in the present 5. Targeting Sequences – intervention focuses on behaviours and how they interact between multiple systems with the result of changing family interactions 6. Developmentally Appropriate – interventions are designed to fit the needs of the youth and support them in building key skills 7. Continuous Effort – family commitment is emphasized to help encourage rapid change and empower families to make changes 8. Evaluation and Accountability – evaluation takes place continuously and staff assume accountability for helping the family overcome barriers to achieving success 9. Generalization – interventions are designed to support family members in learning skills that can be generalized to other contexts and thus used in the future for other challenges (Multisystemic Therapy Services, 2007)
Specifics of delivery	• MST is typically delivered within the context of mental health agencies • Interventions are delivered by master's level therapists with on-site supervision by a doctoral level therapist • Therapists are provided with a five-day training and receive booster sessions quarterly • The typical caseload for each therapist is 4-6 families (Henggeler, 2001; Multisystemic Therapy Services, n.d.-a)
Dosage	Daily or weekly sessions depending on the needs of the young person and their family
Duration	Average duration of treatment is four months
Evaluation methods & findings	Studies of MST were conducted in various ways, such as randomized controlled trials, quasi-experimental designs, and qualitative studies. • Youth and families who participated in MST had significantly improved emotional, behavioural, social, and mental health outcomes • Youth had better school attendance

	• Youth had 54% fewer arrests and 57% fewer days of confinement in adult detention facilities • Youth had reduced recidivism rates • Participation in MST led to 47-64% decreases in long-term rates of time spent in care (out-of-home facilities) • Increased parental confidence and skills, improved family relationships, a return to education, and greater reflection and aspiration on the part of the young person were found for families that participated in MST • In general, larger effects were found for outcomes related to family relationships compared to individual or peer effects • Found to be most effective for youth under age 15 who have severe challenges prior to beginning MST • When compared to individual treatment / standard social welfare treatment, MST had significantly better outcomes • Long-term studies found treatment effects to be sustained up to approximately 14 years following treatment • Cost benefit of $5.27 for every $1 spent on MST implementation MST has been replicated in other locations, including Ontario (Leschied & Cunningham, 2002) and Norway (Ogden & Halliday-Boykins, 2004) (Borduin, Henggeler, Blaske, & Stein, 1990; Brunk, Henggeler, & Whelan, 1987; Henggeler, 2001; Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; McIntosh, 2015; Multisystemic Therapy Services, n.d.-b, 2007; Ogden & Halliday-Boykins, 2004; Schaeffer & Borduin, 2005; Schoenwald, Ward, Henggeler, & Rowland, 2000; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012; van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014; Weiss et al., 2013)
References	Borduin, Henggeler, Blaske, & Stein, 1990; Brunk, Henggeler, & Whelan, 1987; Henggeler, 2001; Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; McIntosh, 2015; Multisystemic Therapy Services, n.d.-b, 2007; Ogden & Halliday-Boykins, 2004; Schaeffer & Borduin, 2005; Schoenwald, Ward, Henggeler, & Rowland, 2000; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012; van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014; Weiss et al., 2013;
Existing adaptations	MST for Problem Sexual Behavior (see table below) MST for Substance Abusing Youth (MST-SA – see www.mstservices.com) MST for Child Abuse and Neglect (MST-CAN – see mstservices.com)

3.3.7 Multisystemic Therapy (Problem Sexual Behavior)

Multisystemic Therapy (Problem Sexual Behavior)	
Variable	**Description**
Main objectives of the intervention	Multisystemic Therapy for Problem Sexual Behavior (MST-PSB) aims to address individual youth and family characteristics that have been linked with sexual offending behavior. This is done by addressing deficits in youth cognitive processes (denial, empathy, distortions), family relations (cohesion, parental supervision), and peer relations (deviant peer associations), and academic success (school failure). The goals of the intervention are to: • Reduce family denial and minimization of young person's actions • Help family develop plans and gain skills to help the young person avoid relapse • Address family experiences of victimization issues and determine it further specific treatment is required • Target negative peer associations and help youth develop positive peer associations (Borduin, n.d.; Borduin et al., 1990)
Target risk and protective factors	Risk Factors • Individual factors (e.g., internalizing problems, hyper-sexuality) • Family factors (e.g., low warmth, high conflict, low monitoring, history of abuse) • Parental problems (e.g., spousal violence, substance abuse) • Peer relations (e.g., social isolation, immaturity) • School performance (e.g., low achievement, behavior problems, school suspension, learning disabilities) (Borduin, n.d.)
Definition & description	Multisystemic Therapy (MST – see previous table) was modified for youth who engage in sexual offending. It was developed because traditional treatment for sex offenders that was focused on individuals was not found to significantly reduce recidivism and was not designed to enhance skills in "real world" settings. (Borduin, n.d.)
Universal vs. targeted program	Targeted
Target population	Youth with sexual offending behaviour
Setting	Sessions occur in natural settings (school, community, home)
Level of intervention	Individual, family

Components	*Same as standard MST approach (see table above) For youth involved with sexual offending and their parents, the following strategies are more commonly used within the MST framework: Family Level • Remove barriers to effective parenting, enhance parenting knowledge, support increased affection and communication Peer Level • Supporting parents to intervene when they witness their child associating with peers involved with delinquent behaviours and to encourage their child to make prosocial friendships (i.e., through community clubs, sports) School Performance/ Job Functioning • Establishing positive communication between parents and teachers Individual Interventions • Where necessary, helping youth and parents modify their attitudes or values that contribute to the sexual offending behaviour and cycle of sexual abuse (Borduin & Schaeffer, 2001)
Specifics of delivery	*Same as standard MST approach (see table above)
Dosage	*Same as standard MST approach (see table above)
Duration	*Same as standard MST approach (see table above)
Evaluation methods & findings	Studies assessing MST-PSB used various randomized control trial and quasi-experimental designs. Many of these studies had small sample sizes and thus the findings should be interpreted with caution. • Youth who participated in MST-PSB had reduced recidivism of 12.5% for sexual offenses and 25% for nonsexual offences, compared to 75% and 50% for youth who participated in regular individual therapy • MST-PSB had positive effects on socio-ecological factors that impact sexual offending • Youth who participated in MST-PSB had lower sexual offending recidivism rates than non-treated peers at long term follow-up (8-9 years) • One study with 2-year follow-up assessments found similar improvements in behaviours, but did not have significantly fewer rearrests • For every $1 put into MST-PSB for youth sexual offending, the savings were $48.81 (Borduin et al., 1990; Borduin, Schaeffer, & Heiblum, 2009; Borduin & Schaeffer, 2001; Letourneau et al., 2013)
References	Borduin et al., 1990; Borduin, Schaeffer, & Heiblum, 2009; Borduin & Schaeffer, 2001; Letourneau et al., 2013;
Existing adaptations	N/A

3.3.8 Pathways to Education

Pathways to Education	
Variable	**Description**
Main objectives of the intervention	Designed to reduce poverty and its effects by increasing high school completion and post-secondary participation for economically marginalized youth. (National Crime Prevention Centre, 2011)
Target risk and protective factors	Risk Factors • Low school attendance • Behavioural issues • Class failure • Class disengagement • Low socioeconomic status • Minority group status • Household stress • Poor family relations • Limited social support for engagement in school • Social isolation • Discrimination / identity conflict • Experiences of learning/behavioral/physical disabilities or mental illness • Other Adverse Childhood Experiences (ACE), such as single parent household, abuse at home Protective Factors • Programs with more than one support strategy • Case management and mentoring • Strong relationships and supportive environments • Development of life skills • Parent engagement (Glogowski, 2015)

Definition & description	• The focus of Pathways to Education is on breaking the cycle of poverty through a youth-centred approach • Research has shown that dropping out of school is part of a trajectory of disengagement from school based on complex interactions between a student, their family, school, and community • Research has also found that dropout prevention is most effective when it is personalized and multifaceted and thus, Pathways was designed to be flexible and tailored to the individual needs of students • Pathways was developed using an action research framework and as such, employs a bottom-up approach engaging community and local agencies first prior to implementing the intervention; these initial steps help local sites of Pathways address the unique needs of each community with best practices from related interventions • Key components of the program design are to promote a sense of belonging through community-based interventions which can also refer students to other support services (Glogowski, 2015)
Universal vs. targeted program	Targeted to socioeconomically vulnerable youth living in marginalized neighbourhoods
Target population	High school youth living in low income / marginalized neighbourhoods
Setting	School, community
Level of intervention	Individual, group
Components	Academic • Tutoring in five core subjects offered four days per week Social • Group mentoring for grade 9 and 10 students – involves activities, such as problem solving, teambuilding, communication, and conflict resolution • Career mentoring for grade 11 and 12 students – helping students plan and prepare for life after high school, including exploring career and post-secondary education opportunities Financial • Immediate financial support to assist with engagement in school and the program (e.g., bus tickets, lunches) • Bursaries for post-secondary education based on student adherence to program requirements and regular class attendance (up to $2,000) Individual Counselling • Student Parent Support Workers (SPSW) monitor school attendance and academic achievement

	• Help students build positive peer, teacher, and family relationships • Engage parents meaningfully • Work with teachers to address academic issues • Advocate for the youth when parents are unable to do so (Glogowski & Ferreira, 2015; National Crime Prevention Centre, 2011)
Specifics of delivery	• Community engagement is a key component of the intervention, so there must be community "buy-in" and strong local partnerships (National Crime Prevention Centre, 2011)
Dosage	Students are required to attend tutoring twice per week
Duration	Program offered during the school year, and over multiple school years as necessary
Evaluation methods & findings	(eval methods) • The program was found to reduce the drop-out rates, absenteeism, and number of students seen as at academic risk • The program increased school attendance, academic achievement, and high school graduation • One study found Pathways participation also increased post-secondary enrolment from 20% to 80% • When parents are meaningfully engaged in the program, the results of the intervention can be more effective • Return on investment was $25 every dollar invested in the program (Glogowski & Ferreira, 2015; National Crime Prevention Centre, 2011; Pathways to Education, 2011, 2012, 2014a, 2014b)
References	Glogowski & Ferreira, 2015; National Crime Prevention Centre, 2011; Pathways to Education, 2011, 2012, 2014a, 2014b;
Existing adaptations	N/A

3.3.9 Project Towards No Drug Abuse

Project Towards No Drug Abuse	
Variable	**Description**
Main objectives of the intervention	Project Towards No Drug Abuse is a classroom-based program for alternative schools that is based on fostering health motivation, social skills, and decision-making as substance abuse prevention. The main goal is to support youth at highest risk of developing substance use issues. (Sussman, Dent, Stacy, & Craig, 1998)
Target risk and protective factors	Risk Factors • Norms Favorable to Drug Use • Poor Social Skills • Favorable Attitudes towards ATOD use 1 • Favorable Attitudes towards Anti-social behavior • Low Perceived Risks of Drug Use • Low School Commitment • Peer Rewards for Anti-Social Behavior Protective Factors • Exposure to community/cultural norms that do not favor antisocial behaviors and substance use • Recognition of the value of pro-social activities • Promotion of healthy beliefs and clear standards • Goal setting/Positive future orientation • Increased knowledge of the negative consequences of Drug Use • Improved relations with pro-social peers • Positive orientation to school • Communication/interpersonal skills • Decision-making and critical thinking skills • Adaptive coping/self-management skills Risk (EPISCenter, 2006)
Definition & description	• Project TND targets youth attending alternative schools; drug use and favourable attitudes towards drug use are typically more normalized in these schools • The program was developed based on assumptions that students need to be motivated to want to resist drugs, taught skills that address factors that can lead to drug use, and develop decision-making skills that help motivate

	students to avoid drug use • The program was also rooted in theories by i) Eggert and colleagues about the importance of developing social skills and decision making to help reduce negative behaviours, and ii) Leventhal's ideas about the importance of motivation • The emphasis on developing schools as communities for this intervention was based on several theories that stress that healthy community relationships can have a preventive effect on harmful behaviours (Sussman et al., 1998)
Universal vs. targeted program	Targeted to youth attending alternative schools
Target population	High school students 14-19 years of age in alternative school settings; Project TND developer, Steve Sussman, suggests that the program <u>not</u> be used for children younger than 14
Setting	School
Level of intervention	Group, school
Components	12 sessions based on the following topics and activities: 1. Listening 2. Stereotyping 3. Drug use myths and denial 4. Stages of chemical dependency 5. Talk show on consequences of drug abuse 6. Stress-coping sessions 7. Self-control skills 8. Taking a moderate perspective 9. Decision-making and commitment 10. Marijuana panel 11. Positive and negative thought loops and subsequent behaviour 12. Smoking cessation School-as-community component: • Associated Student Body Core Group (ASB) meetings held weekly for six months • Planning and implementing six or more events (e.g., sports events, drug awareness week, job training) • Distributing a community newsletter

	(Sussman et al., 1998)
Specifics of delivery	• Project TND is delivered by teachers or health educators who receive a two-day training workshop with a certified Project TND trainer • Trained teachers or health educators typically deliver the Project TND curriculum • Developers recommend the program be facilitated by one person (no co-facilitators) • Curriculum content is adaptable to community settings • Lessons must be delivered in the prescribed order • The lessons should be delivered with groups of 5-35 youth (EPISCenter, 2006)
Dosage	Two to three sessions (40-50 minutes each) per week
Duration	12 sessions delivered over four to six weeks
Evaluation methods & findings	Studies of Project TND used various approaches, including random assignment experimental design / randomized control trials, and randomized block design. Results show: • Overall increase in program-related knowledge and motivation, and decreased in drug use intentions • Multiple studies found reductions in alcohol and hard drug use • One study found a reduction in alcohol use, hard drug use, and cigarette smoking • Multiple studies found no significant reductions in marijuana and tobacco use • One study found a 42% reduction in hard drug use at one-year follow-up • After five years, Project TND was found to have long-term reductions in hard drug use at the rate of 46% • Project TND was not found to have any significant effects on risky sexual behaviour • When the intervention was delivered with implementation support from Project TND (web-based support, on-site coaching, and technical assistance) there were stronger effects on implementation fidelity (Dent, Sussman, & Stacy, 2001; Hopson, Wodarski, & Tang, 2015; Lisha et al., 2012; Rohrbach, Gunning, Sun, & Sussman, 2010; Rohrbach, Sun, & Sussman, 2010; Skara, Rohrbach, Sun, & Sussman, 2005; P. Sun, Sussman, Dent, & Rohrbach, 2008; W. Sun, Skara, Sun, Dent, & Sussman, 2006; Sussman, Sun, Rohrbach, & Spruijt-Metz, 2012; Sussman, Dent, Craig, & Ritt-Olson, 2002; Sussman et al., 1998; Sussman, Sun, McCuller, &

	Dent, 2003; Valente et al., 2007)
References	Dent, Sussman, & Stacy, 2001; EPISCenter, 2006; Hopson, Wodarski, & Tang, 2015; Lisha et al., 2012; Rohrbach, Gunning, Sun, & Sussman, 2010; Rohrbach, Sun, & Sussman, 2010; Skara, Rohrbach, Sun, & Sussman, 2005; P. Sun, Sussman, Dent, & Rohrbach, 2008; W. Sun, Skara, Sun, Dent, & Sussman, 2006; Sussman, Sun, Rohrbach, & Spruijt-Metz, 2012; Sussman, Dent, Craig, & Ritt-Olson, 2002; Sussman et al., 1998; Sussman, Sun, McCuller, & Dent, 2003; Valente et al., 2007;
Existing adaptations	**Self-Instructed Project Towards No Drug Abuse** The program was modified from a health educator delivery model to a self-instructed model. This adaptation was made to work more effectively with students attending alternative schools (Sussman et al., 2002). The self-instructed model of Project TND was easier to implement and resulted in equivalent outcomes as the health educator facilitation model after one year, but no effects at the two-year follow-up. The health educator facilitated model was somewhat better received and perceived as of higher quality than the self-instructed pilot model. **TND Network** TND Network is a modification of Project TND to have more group interaction. Peer leaders were identified and then trained to deliver the activities with peer groups (Valente et al., 2007). This peer-led version of Project TND (TND Network) was only found to be effective at preventing substance abuse if the youth's peer group supported non-use; for those with peers who support substance use, the program may have deleterious effects.

3.3.10 The Fourth R

The Fourth R	
Variable	**Description**
Main objectives of the intervention	The Fourth R is a range of school-based programs that integrate students, the school community, and parents into comprehensive violence prevention. The program is youth-focused, harm-reduction strategy that encompasses gaining knowledge, building positive relationship skills, and learning effective decision-making. The goal of the Fourth R is to help youth build resiliency by developing social and emotional competencies to make safe choices and avoid risk behaviours (violence, unsafe sexual behaviours, and substance abuse). (Colorado School Safety Resource Center, 2016; Crooks, Zwarych, Hughes, & Burns, 2015; Crooks, Wolfe, Hughes, Jaffe, & Chiodo, 2008; National Crime Prevention Centre, 2011)
Target risk and protective factors	Risk Factors: • Violence (bullying, peer and dating violence) • Substance abuse • Unsafe sex (Crooks et al., 2008)
Definition & description	• The Fourth R is based on the Youth Relationships Project (YRP) designed to be generalized to all youth instead of targeted to youth with certain risk factors • Developers believe relationships skills should be taught like the "three R's" of academics (reading, writing and arithmetic) and are fundamental part of healthy youth development • Based on the Information Motivation Behavior Skills (IMB) model, which indicates that youth will be more likely to use newly acquired skills if they have received accurate information, how to respond in difficult situations, and motivation to use these skills • The guiding principles of the intervention are: o Universal focus – all students should have opportunities to learn skills for building healthy relationships to develop resiliency o Positive youth development – focus not on avoiding negative outcomes, but on building positive skills for the future o Skills based – using the notion that relationship skills can be taught the same as other academic skills through teaching clear steps and providing practice opportunities (e.g., role plays) o Relationships are the core foundation – healthy relationships are key for understanding the context of behaviours and increasing protective factors (Crooks, Zwarych, et al., 2015; Crooks et al., 2008)

Universal vs. targeted program	Universal
Target population	Youth in grades 8-12
Setting	School
Level of intervention	Group
Components	Classroom Curriculum • The Fourth R programs align with the Ontario Ministry of Education Health Education curriculum for grades 8-9 and English curriculum for grades 9-12 • Health Education Curriculum involves 21 lessons delivered in three units (75 minutes each): 1. Violence/Bullying (7 lessons) • Students learn conflict resolution skills • Students learn about the barriers to building healthy relationships • Students explore the factors that contribute to violence • Students present examples of violence in the media 2. At-Risk Sexual Behaviour (7 lessons) • Students learn about sexuality in the media, preventing pregnancy and STDs, responsible sexuality, and sexual decision-making • Students explore community resources they can go for assistance • Students learn assertiveness skills to deal with relationship pressures 3. Substance Use (7 lessons) • Students learn about myths, facts, and effects of substance use • Students learn how to make informed choices about substance use and how to deal with peer pressure • Students engage in discussions and practice their skills The English curriculum addresses violence/bullying, at-risk sexual 97behaviour, gangs, substance use and abuse, and impacts of media violence: 1. Grade 9 / Grade 12 • Seven lessons • Book club format • Include character development, critical literacy skills, and critical thinking skills 2. Grade 10 • 30 lessons • Short story unit

	3. Grade 11 • 24 lessons • Non-fiction literature unit School Component • Educates school staff about the signs and risk factors of drug use and unsafe sexual behaviour • Staff learn about the Fourth R program and its components • A Youth Safe Schools Committee manual can be purchased to assist staff with implementing whole school initiatives Parent Component • Parents of children attending the intervention schools receive information about adolescent development and positive parenting strategies Community Component • Guest speakers and field trips are arranged throughout the program to connect students to the community (National Crime Prevention Centre, 2011)
Specifics of delivery	For some program components, it is advocated that older students support younger students in their learning
Dosage	No specified dosage for the program components was specified
Duration	No specified duration for the program components was specified
Evaluation methods & findings	The results below emerged from studies using cluster randomized controlled trials and one used observational data. • Fourth R significantly increased knowledge and attitudes about violence, substance use, and sexual health • The intervention also helped students gain negotiation skills and learn to resist negative pressure • Students in Fourth R schools were less likely to engage in violent delinquency than students attending control schools • 2.5 years after Fourth R was implemented, positive outcomes remained for reductions in physical dating violence and increased condom use • Students who received the intervention in Physical Education class were found to enjoy the classes more • For students with experiences of maltreatment, the school-level components of the Fourth R had a buffering impact allowing them to engage in the program without stigma • Teachers reported high satisfaction with the program and continued to implement it several years after training • Implementation fidelity was predicted by teacher perceptions of i) readiness to deliver the program following training, ii) support and

	accountability, and c) the benefits of the program • Fourth R for younger students (grades 7-8) found significant improvements in knowledge about violence, critical thinking around the impact of violence, and identifying more successful coping strategies (Crooks, Chiodo, Zwarych, Hughes, & Wolfe, 2013; Crooks, Scott, Ellis, & Wolfe, 2011; Crooks et al., 2008; Wolfe, Crooks, Chiodo, Hughes, & Ellis, 2012; Wolfe, Crooks, Jaffe, & Chiodo, 2009)
References	Colorado School Safety Resource Center, 2016; Crooks, Chiodo, Zwarych, Hughes, & Wolfe, 2013; Crooks, Scott, Ellis, & Wolfe, 2011; Crooks et al., 2008; Crooks, Zwarych, et al., 2015; National Crime Prevention Centre, 2011; Wolfe, Crooks, Chiodo, Hughes, & Ellis, 2012; Wolfe, Crooks, Jaffe, & Chiodo, 2009;
Existing adaptations	**The Fourth R: Uniting Our Nations** Developers worked with a school board and community partners to develop culturally appropriate programming for First Nations students that focuses on healthy relationship development, mentoring, and cultural connectedness. Numerous initiatives were developed, including (Crooks, Burleigh, et al., 2015): 1. Elementary Mentoring Program 2. Grade 8 Transition Conferences 3. Peer Mentoring for Secondary Students 4. Cultural Leadership Course 5. Cultural Leadership Camp 6. First Nation, Métis, Inuit Student Advisory Committee **The Fourth R for Catholic School Settings** Major changes to this curriculum include removing content about healthy sexuality, including a focus on Catholic values and Catholic faith, and linking the curriculum to Catholic Graduate Expectations (Crooks, Zwarych, et al., 2015) **The Fourth R Alternative Education Programming** Adapted for the alternative school setting to meet cross-curricular needs, adding lessons (increase lessons on drug use/abuse), adding more role playing, adding booster lessons to support transient nature of the student population, and ensuring flexibility for use in non-traditional class settings (Crooks, Zwarych, et al., 2015) **The Healthy Relationships Plus Program** This program was designed to focus on mental well-being and mental health issues by increasing awareness and reducing stigma. The program includes teaching youth how to support a friend facing mental health challenges and when to get assistance. The program can also accommodate a wider range of youth and is more interactive (Crooks, Zwarych, et al., 2015)

3.3.11 Wraparound

Wraparound	
Variable	**Description**
Main objectives of the intervention	The Wraparound intervention combines home-based services and psychological support in a community environment to assist families, address mental health concerns, and support a young person's education. The process was designed to offer more coordinated services to youth with emotional and behavioural problems and their families. The wraparound service model is based on three premises: 1. Children and youth should be educated with their peers and in a community setting 2. Community-based services should be provided instead of more restrictive service options 3. Providing multiple community services individualized to the young person's needs allows for more integrated and less restrictive support (Clarke, Schaefer, Burchard, & Welkowitz, 1992)
Target risk and protective factors	Risk Factors • Anti-social behaviour • Aggression • Mental health problems • Child victimization • Parental criminalization • Family violence • Inadequate school climate • Economic deprivation • Low attachment to community • Association with delinquent peers • Gang involvement • Peer rejection (National Crime Prevention Centre, 2008)
Definition & description	• The Wraparound process was developed due to a gap in mental health services for children and youth; many families were not able to access services in their communities and thus individuals were either underserved or had to rely on more intensive inpatient treatment programs

	• Based on ecological systems theory and strengths and systems theory • Wraparound aims to create an "enabling niche" based on the idea presented by James Taylor which indicates that one's social niche can support them in their development by recognizing their strengths and offering rewards for growth and improvements • Researchers found that treatment that occurs outside one's community is more costly and may not allow one to develop skills that can be generalized to their home community setting • Wraparound services address the fact that families and youth may have multiple, overlapping challenges that may be addressed by breaking down silos and encouraging greater inter-agency collaboration • In Wraparound, families participate in decision-making to enhance the ecology of the young person and build on their strengths • There are 10 Principles of Wraparound: 1. Family Voice and Choice – intentionally eliciting and prioritizing the family members' perspectives 2. Team Based – creating a team of supports (formal and informal) that are committed to the family 3. Natural Supports – using sources of support based on the family's "natural" connections in their community 4. Collaboration – team members share responsibility for managing and implementing a plan for the family 5. Community Based – the support plan is implemented in the family's community 6. Culturally Competent – the family's culture is respected and included as a key aspect of support plans 7. Individualized – all plans are customized to the individual family 8. Strengths Based – plans recognize and build on the family's strengths 9. Persistent/Unconditional – the team does not give up on the family until a support plan is no longer required 10. Outcome Based – plans are developed with specific measurable indicators of success (Bruns et al., 2004; Bruns & Walker, 2010; Clarke et al., 1992; Cox, 2008; Malysiak, 1997; Wyles, 2007)
Universal vs. targeted program	Targeted
Target population	Youth with needs in multiple life domains, including mental health

Setting	Community
Level of intervention	Family
Components	A wraparound team creates a plan to address unique family challenges in a holistic way with regular meetings to help create, implement, and monitor plans Phase 1: Engagement and Team Preparation • Meeting with family and stakeholders • Assessment of family safety, strengths, needs • Any safety concerns addressed immediately • Wraparound process explained to family • Identification of Child and Family Team Members • Initial planning meeting with Child and Family Team Members Phase 2: Initial Plan Development Initial Plan of Care meeting • Team members are introduced • Strengths summary prepared and distributed • Team creates a mission • Needs statements presented • Team brainstorms methods to meet needs • Team members take on specific roles to support the plan • Plan documented and distributed to all team members Phase 3: Implementation Regular team meetings held • Feedback is gathered and the plan is assessed • Adjustments are made to the plan as needed • Updated plan and actions are documented and distributed Phase 4: Transition • Plan continues to be assessed • Team members discuss opportunities and potential challenges post-Wraparound and how to address them • Individuals that can offer support post-Wraparound are identified • Potential follow-up strategies are created and shared with the team • Team participates in a commencement ritual (Bruns & Walker, 2010)

Specifics of delivery	• Wraparound Facilitators are the individuals who support families • Community Mobilization Teams (CMT) are made up of community connectors that support the work of Wraparound Facilitators (akin to an advisory committee) • Plans are driven and "owned" by families and youth • Plans have built-in flexibility as the order of activities is not fixed and can be tailored to each family (Debicki, 2002)
Dosage	Dosage not specified – tailored to each family's needs
Duration	Duration not specified – tailored to each family's needs
Evaluation methods & findings	Findings from Meta-Analyses and Literature Reviews Meta-Analysis of seven studies about Wraparound used for youth with emotional and behavioural disorders • When compared to conventional services, wraparound resulted in better outcomes in terms of mental health and overall functioning in school and criminal justice settings • Effect sizes were found to be small to medium, although this may be due to all control groups receiving some kind of treatment Findings of a literature review about Wraparound • Many reviews of wraparound programs lacked information about how specific wraparound programs were delivered and key details about staff training and supervision (Bertram, Suter, Bruns, & O'Rourke, 2011; Suter & Bruns, 2009) The methods that have been used to evaluate Wraparound are pre-/ post-test with no comparison group, pre-/post- test with control group, experimental design with repeated measures, cox regression survival analysis, quasi-experimental design with three non-comparison groups, and case study. Results show: • Wraparound services resulted in significant child behaviour and emotional improvements, enhanced parent/child relationships and quality of emotional support provided to the child, and increases in family functioning • Participation in Wraparound was found to lead to less reliance on residential treatment (e.g., custody facilities, inpatient mental health treatment); most youth who received wraparound support remained in the community • For youth with clinical mental health challenges, Wraparound reduced problem severity and enhanced function and goal attainment • Improved school attendance, engagement, and academic achievement • Multiple studies found no significant differences for youth who received Wraparound services when compared to those who received 'service as

	usual' • Conflicting results: One study found behaviour improved at school AND another study found no improvement in child behaviour at school • Wraparound for youth in the criminal justice system found a reduced rate of recidivism • No differences were found in outcomes for youth who received Wraparound with ongoing feedback and better adherence to core principles when compared to youth who received wraparound without these added features (Bruns, Burchard, & Yoe, 1995; Carney & Buttrell, 2003; Clarke et al., 1992; Copp, Bordnick, Traylor, & Thyer, 2007; Della Toffalo, 2000; Hyde, Burchard, & Woodworth, 1996; Lechtenberger, Barnard-Brak, Sokolosky, & McCrary, 2012; Mears, Yaffe, & Harris, 2009; Ogles et al., 2006; Quick, Coldiron, & Bruns, 2014; Wyles, 2007)
References	Bertram, Suter, Bruns, & O'Rourke, 2011; Bruns et al., 2004; Bruns & Walker, 2010; Bruns, Burchard, & Yoe, 1995; Carney & Buttrell, 2003; Clarke, Schaefer, Burchard, & Welkowitz, 1992 Copp, Bordnick, Traylor, & Thyer, 2007; Cox, 2008; Debicki, 2002; Della Toffalo, 2000; Hyde, Burchard, & Woodworth, 1996; Lechtenberger, Barnard-Brak, Sokolosky, & McCrary, 2012; Malysiak, 1997; Mears, Yaffe, & Harris, 2009; National Crime Prevention Centre, 2008; Ogles et al., 2006; Suter & Bruns, 2009; Quick, Coldiron, & Bruns, 2014; Wyles, 2007;
Existing adaptations	**Connections** Using the wraparound approach, an intervention was developed to address the needs of youth in conflict with the law who are experiencing emotional and behavioural disorders (Pullmann, 2006). **Turnaround** An Australian adaptation uses a Good Practice Framework with 10 key practices to implement the wraparound intervention (Wyles, 2007). **Achieve My Plan** Designed as an enhancement to Wraparound to assist young people with serious mental health challenges to learn skills, set goals, and help them become more involved in their treatment (Holman, Powers, Boyer, Janssen, & Sweeney, 2016)

3.3.12 Youth Inclusion Program (YIP)

Youth Inclusion Program (YIP)	
Variable	**Description**
Main objectives of the intervention	The Youth Inclusion Program (YIP) is an intervention that is applied to neighbourhoods with high rates of crime and social problem by engaging young people, maintaining their interest, and addressing their identified risk factors. The goals of YIP are to: • Reduce arrest rates by 60% • Reduce youth truancy and exclusion at school by one-third • Reduce recorded crime in an area by 30% (Burrows, 2003, 2008)
Target risk and protective factors	Risk Factors Family • Living with a single parent • Living with step family • Low parental supervision • Poor relationship wit parents • Low degree of attachment to family • Young offender with siblings in trouble with police Peer • Young offender with friends in trouble with police • School • Dislike of school • Rated performance below average • Regular truancy from school • Excluded from school Protective Factors Family • Young person leaving home • Getting married / forming stable relationship • Staying in to look after children • Formation of new family unit • Continuing to live at home

	Peer • Avoiding associating with offenders • Avoiding drug use / heavy drinking School • Completing full time education Employment • Taking up stable employment (Burrows, 2003)
Definition & description	• YIP was modeled after the Youth Works initiative in the UK, which was a crime reduction model; YIP was developed to help support youth and prevent crime • YIP differs from a generic youth club in many ways: o YIP is targeted to youth facing barriers and referred to the program o YIP focuses on helping youth prevent/reduce negative behaviours instead of just participating in recreational activities o YIP includes individual action planning o YIP works with parents and families more often o YIP works to continually keep youth engaged and does not typically ask individuauls to leave for poor behaviour o YIP is more planned with measurable targets and goals o YIP takes place where youth are; outreach is a larger part of this type of intervention o Partnerships are key for making YIP a success o YIP has a strong emphasis on monitoring and evaluation unlike many other community programs (Burrows, 2003)
Universal vs. targeted program	Targeted and Universal (some youth assessed and referred to the program, others self-refer to the program)
Target population	Youth 13 to 16 years of age who are most at risk of offending, truancy, and social exclusion and their siblings and peers
Setting	Community
Level of intervention	Group
Components	Effectiveness of YIPs need to meet three criteria: 1. Meet appropriate pre-conditions – programs should be delivered in relatively compact, high crime areas to have the most impact • YOTs complete a neighbourhood audit to assess and define the problems in that area

	2. Apply a targeted approach – identifying youth participants with the highest needs and keeping them engaged • Referrals from local police and school staff were used to identify the '50' youth to participate in the intervention 3. Run tailored and intensive interventions- address the specific needs of individual youth in the program • YOTs plan activities in various areas to support the youth participants, which may include education/training, sports, group training, mentoring, etc.(Burrows, 2003)
Specifics of delivery	• Individual locations deliver different programs, which increase positive community connections and may prevent involvement in criminal activities, including mentoring, motor projects, sport, environment, family projects, etc. • Utilizes cooperation amongst local agencies and community groups • Local Youth Offending Teams (YOTs) manage and deliver the YIPs • YOTs and other community agencies identify the top 50 youth in the neighbourhood most at risk / hardest to reach (Burrows, 2003)
Dosage	Ideal dosage is an average of 10 hours per week
Duration	Duration not identified
Compatible / not compatible with	Designed to be used in neighbourhoods experiencing high crime rates and other social problems
Evaluation methods & findings	• For the top '50' participants who engaged in YIP there was a 66.5% decrease in arrest rates compared to participants who were not engaged in the YIP who received a 55.6% decrease in arrest rates • 59% of participants were involved in education, training, and employment following the intervention • Behavioural changes were assessed in the youth and parents also noted changes in their children after participating in the YIP for the majority of the participants • The program also supported youth in working toward and achieving their goals One study did not indicate what methods were employed and the other used a quasi experimental pre-/post-test design. (Burrows, 2003; National Crime Prevention Centre, 2013b)
References	Burrows, 2003; Burrows, 2008; National Crime Prevention Centre, 2013b
Existing adaptations	**Canadian Youth Inclusion Program** An adapted YIP was developed for use in Atlantic Canada (National Crime Prevention Centre, 2013b)

3.4 Programs Addressing Youth Gang Involvement

3.4.1 Cure Violence (Formerly "CeaseFire")

Cure Violence (Formerly "CeaseFire")	
Variable	**Description**
Main objectives of the intervention	A public health approach to violence reduction originally developed and implemented in Boston (USA) using principles of problem-oriented policing. Treating violence like a contagious disease or epidemic that can be cured, with a special focus on gun related violence.
Target risk and protective factors	Risk Factors: • Gang or drug organization involvement • Previous incarceration or violent crime • Reputation for carrying a gun • Recent victim of a shooting – potential for revenge/grudge Protective factors: • Non-violent conflict resolution strategies • Community attitudes & norms (toward violence)
Definition & description	The Cure Violence health model uses a three-pronged approach to contain and reverse the spread of violence within communities by: 1. Detecting and interrupting potential violent conflicts. 2. Identifying and intervening with individuals at highest risk of perpetrating violence. 3. Mobilizing the community to change norms around violence and guns.
Universal vs. targeted program	Targeted – neighbourhoods and communities with high rates of violence
Target population	Individuals and communities at high risk for violence
Setting	Community – neighbourhoods
Level of intervention	Individual and community
Components	The model was originally conceived as a 'focused deterrence' strategy (aka 'pulling-levers policing') - reaching out directly to gangs, saying explicitly that violence would no longer be tolerated, and backing up that message by ''pulling every lever'' legally available when violence occurred. The model also focused on providing gang members services and supports through community partnerships, and challenging community norms supportive of violence. Key components are:

	1. Detecting and interrupting potential violent crimes Through community outreach and engagement, Violence Interrupters (VIs) work to gain access to and build relationships with individuals identified as high risk for violence. They then work with individuals to prevent retaliations after a shooting or confrontation, mediate ongoing conflicts in the neighbourhood, and follow-up with high risk individuals to keep conflicts 'cool' therefore preventing escalation to violence. **2. Identifying and intervening with individuals at highest risk of perpetrating violence** Participants recruited to participate in CV must meet at least four of seven criteria: (a) gang-involved, (b) major player in a drug or street organization, (c) violent criminal history, (d) recent incarceration, (e) reputation of carrying a gun, (f) recent victim of a shooting, and (g) being between 16 and 25 years of age. VIs and Outreach Workers (OWs) engage with participants to convince them to reject the use of violence by discussing the cost and consequences of violence and teaching alternative responses to situations. OWs also help connect participants to positive opportunities and resources in the community, including employment, housing, recreational activities, and education. **3. Mobilizing the community to change norms around violence and guns** Cure Violence's staff engage community leaders, residents, business owners, faith leaders, social service providers, and those at highest risk to reject the idea of violence as an acceptable behavior to resolve conflict in their neighborhood in order to de-normalize violence within the community context. This includes: responding to every shooting with community acknowledgement and objection to violence; creating community engagement opportunities; and encouraging positive norms through public education events or materials that convey the message that violence is harmful to everyone, that it is unacceptable behaviour, and that it can be stopped (e.g., media campaigns, signs and billboards, anti-violence marches, post-shooting vigils). (Butts, J. et al., 2015; Cureviolence.org)
Specifics of delivery	Dependent upon partnership between police services, several community based organizations (i.e. faith based organizations, neighbourhood associations, local businesses), hospitals, etc. Each implementation team is comprised of: **Program Manager** – Responsible for target area mapping, weekly staff meetings, building relationships with community to change social norms and further public education around violence, identify partners with resources for participants, plan, implement, and document shooting responses within 72 hrs.

	Outreach Supervisors – Responsible for target area mapping, mediation plans weekly staff meetings, supervision & feedback to VIs, OWs, and Hospital Responders, facilitation of participant activities, caseload of <5 participants. **Outreach Workers** – Responsible for caseloads of up to 15 participants. Provide frequent contact with participants on a monthly basis: • Three visits in or near home • Three additional face-to-face meetings • Eight substantive phone conversations Develop a risk reduction plan including connecting high-risk individuals to positive opportunities and resources in the community (employment, housing, recreational activities, and education) and track participant progress. **Violence Interrupters** – Responsible for making street level connections with potential participants, identifying and detecting violent events, providing conflict mediation, monitoring the "pulse" of the community, and providing links to OWs. *Vis must be seen as credible messengers by high-risk young people, know the daily routines of people involved in criminal lifestyles, cannot be judgmental or perceived as outsiders, or seen as police informants. They are ideally from the same communities in which they are working, and now law-abiding and respected members of the community. They are selected for their own experiences with crime and violence and for their inability to establish relationships with the most high-risk young people in the community. **Hospital Responders** – Responsible for responding to calls from hospitals for patients who have suffered a gunshot wound or other assault related injury. Provide crisis intervention, mediation, alternate dispute resolution strategies, and case management as needed. Attempt to de-escalate family members and friends to prevent retaliatory violence. The implementing agency receives training and program support from Cure Violence national training staff, including initial 40 hours of training plus quarterly 'booster' training sessions. A national Cure Violence worker is embedded in the agency for initial implementation, followed by weekly phone calls and quarterly site visits and assessments. A Cure Violence toolkit of essential resources is provided to the agency, as well as extensive resources available online at Cureviolence.org. (Butts, J. et al., 2015, Cureviolence.org)
Dosage	Individualized - varies based on individual need, participant engagement and involvement, and level of intervention (i.e. community vs. individual).
Duration	**Individual**: Up to 24 months (2 years). **Community**: Ongoing – unspecified amount of time.

Evaluation methods & findings	Originally tested in Boston (Braga et al., 2001) using: • Quasi- experimental design comparing youth homicide trends in Boston relative to youth homicide trends in 39 other U.S. cities and 29 New England cities; • Count-based regression models controlling for trends and seasonal variations used to estimate impact of intervention on time series; • 24-month post-intervention period (June 1996 to May 1998) Findings show statistically significant: • 63% reduction in youth homicides • 25% reduction in gun assaults • 32% reduction in shots fired calls for service • 44% reduction in youth gun assaults in one high-risk district • Displacement/diffusion effects not measured
References	http://cureviolence.org/ Braga, Kennedy, Waring, & Piehl, 2001; Butts, Roman, Bostwick, & Porter, 2015; Fox, Katz, Choate, & Hedberg, 2015; Delgado et al., 2015; Gorman-Smith, & Cosey-Gay, 2012; Henry, Knoblauch, & Sigurvinsdottir, 2014; Picard-Fritsche et al., 2013; Skogan et al., 2008; Webster, Whitehill, Vernick, & Curriero, 2013;
Existing adaptations	CeaseFire / Cure Violence has been replicated and adapted widely across many cities in the United States. Visit this site to review the many US sites: http://cureviolence.org/partners/us-partners/cure-violence-city-sites/ Examples include (but are not limited to): **Ceasefire – Chicago** **2009** CeaseFire in Chicago was evaluated for its process and impacts using a quasi-experimental design. The evaluation included 21 neighbourhood sites, and focused on 7 sites in depth. • Reached target individuals (84%) • Demonstrated strong evidence in support of Violence Interrupter's work • Reduction in shootings (41-73% across sites) compared with non-intervention comparison sites & with intervention sites, pre-intervention

	• Numerous barriers for implementation and evaluation identified (Skogan et al, 2009) **2014** Qualitative evaluation of residents' and clients' perception of safety following Ceasefire implementation, and evaluation of changes in the decision making & behaviour of high risk individuals, and gun-related violence. Interviews were conducted with 75 individuals living in the four targeted police beats. • 100 % of CeaseFire participants interviewed described decreased involvement in crime and violence, with change in behaviour attributed to mentoring, primarily around opportunities for employment. • Across two communities, the lack of visibility of CeaseFire for neighborhood residents and a small number of high-risk non-client participants was an issue. (Gorman-Smith, D. & Cosey-Gay, F. 2014) **2014** Quantitative assessment of 4 police beats in Ceasefire implementation areas over 2 years. Reviewed publically available data on crimes reported by police. • Reductions in: levels of total violent crime (7%), shootings (19%), and homicides (31%) in targeted areas over 1 year intervention. • Variation in effectiveness across sites possibly due to differences in implementation. • Effects of intervention seen immediately (within 1st month). (Henry, D; Knoblauch,S; Sigurvinsdottir; R., 2014) **Safe Streets – Baltimore (2012)** Impact evaluation by John Hopkins University. Comparison of homicides and non-fatal shootings in intervention areas (4 sites) versus non-intervention adjacent neighbourhoods, and high violence neighbourhoods – with controls for other law enforcement activities and changing trends in crime and weapons offences. Surveys (two wave, convenience sample) at 5-6 months and 17 months after launching Safe Streets to examine attitude changes in high-risk youth. Interviews with program participants in 2 sites. • From July 2007 to December 2010 (3 years 5 months) outreach workers mediated 276 incidents. (Webster et al. 2012) • 56% reduction in homicides and 34% reduction of non-fatal shootings in the most positively affected area, other areas saw mixed results. (Webster et al, 2012. Butts, et al, 2015) • No strong evidence for change in youth attitudes toward gun violence. (Webster et al, 2012)

	• 80% of respondents believed their lives were 'better' since becoming a participant of the program. (Webster et al, 2012) • There were protective (ripple) effects for neighbourhoods bordering intervention sites. (Webster et al, 2012) **Save Our Streets (SOS) – Brooklyn, New York (2013)** Process and impact evaluation with **m**atched comparison group of three adjacent police precincts with similar demographic and baseline violent crime rates. Anonymous pre/post survey of one site's residents regarding perceptions of community safety and exposure to gun violence and the community mobilization campaign. The analysis spanned 18 months prior to SOS implementation (pre period) and 21 months following implementation (post period). • Found that gun violence in Crown Heights was 20% lower than what it would have been had gun violence trends mirrored those of similar, adjacent precincts. • High percentage of the community was exposed to the mobilization campaign. • Did not have a significant impact on residents' sense of safety in the neighborhood or opinions of the legitimacy of carrying guns or joining a gang for self-protection. (Picard-Fritsche, S. & Cerniglia, L. 2013) **NYC Cure – New York (2015)** Cure Violence implemented as part of Crisis Management System – a comprehensive response to violence in New York City which also includes mental health supports, job readiness, legal advocacy, conflict mediation, education, community health services. Surveys in 4 neighbourhoods to assess attitudes towards violence, experiences of violence, and awareness of violence prevention efforts. • Respondents reported more violent propensities if they had personally experienced violent victimization or had witnessed someone being threatened. • Majority of respondents reported hearing gunshots in their neighbourhood within the past year (23% heard >10times in 12 months), and experiencing violent victimization such as stabbing or gunfire. • Majority of young males in target areas recognized Cure Violence materials and staff. (Delgado, S., et al. 2015)

	TRUCE Project - Phoenix (2015) Process and impact evaluation including: interviews and observations from TRUCE staff & stakeholders (n=12); review of program database; pre-test/post-test comparisons between intervention sites and comparison areas. The results: • Highlighted the importance and challenges of Violence Interrupters. • Found an overall decrease in most violent events in target areas, primarily decrease in assaults. • Found a slight increase in shootings. (Fox, A. et al, 2015. Butts, J. et al., 2015) Cure Violence emphasizes that the model has been proven successful in multiple independent evaluations in three unique cities in the United States (Chicago, Baltimore, New York) that have each shown large statistically significant reductions in violence due to the program. Overall, across all studies of the model, Butts and colleagues (2015) conclude that "Each evaluation revealed at least some evidence in support of the approach at the level of jurisdictions or communities, but none of the studies could clearly disentangle the results from national and regional trends in violent crime; in addition, there were always confounding effects from factors related to sample design, selection of comparison neighborhoods, and variations in implementation". Cure Violence has also been adopted internationally as described here: http://cureviolence.org/partners/international-partners/ **Cure Violence Halifax (NS) (2014)** The Community Justice Society in Halifax (NS) adopted Cure Violence in 2014 with 10 trained workers. An independent evaluation is underway, and early results show that there have been no killings since the project began, and a downward trend in shootings and violent crime (Ungar et al., 2016).

3.4.2 OJJDP Comprehensive Gang Model (AKA Spergel Model)

OJJDP Comprehensive Gang Model (AKA Spergel Model)	
Variable	**Description**
Main objectives of the intervention	To reduce youth-related gang crime, such as street level violence, theft and drug trafficking.
Target risk and protective factors	Individual: • Involvement in criminal activity • Violence • Antisocial or "delinquent beliefs" • Alcohol and drug use • Life stressors • Peers Family: • Poverty • Family violence and substance abuse • Family conflict and divorce • Family members involved in gangs • Parental attitudes • Low levels of parental supervision School: • Individual school performance • School's effectiveness in engaging students, addressing education needs, and providing role models Community: • Poverty • Social disorganization • High rates of criminal activity • High levels of drug use • Antisocial attitudinal norms • Feeling unsafe (Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997)

Definition & description	A community-based, community-driven model to address crime and violence related to street gang activity. It is a balance of suppression and intervention activities to provide a multi-faceted approach to a multi-faceted issue. It is also described as a coordinated team approach to delivering services and problem solving. (Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997)
Universal vs. targeted program	Targeted - the strategies of the model are intended for gang-involved young people or young people who show multiple risk factors for gang involvement. The model is not intended for all youth in a target area.
Target population	Street-based, youth gang members under 22 years of age. And, more broadly, communities with a serious, violent, and entrenched gang problem. Note that the model was developed and has been implemented mainly in the United States. (Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997)
Setting	Community (through local agencies)
Level of intervention	Individual, family and community.
Components	Five core strategies: 1) **Community Mobilization** – involving local community members (including former gang members) to plan, strengthen, and create new opportunities for gang-involved and at-risk youth; 2***)*** **Social Intervention Through Street Outreach** – engaging and supporting gang-involved young people and linking them to services and supports; 3) **Provision of Opportunities** – providing young people with access to education, training and employment, and social opportunities; 4) **Suppression** – police and social control activities, such as supervision and monitoring; and, 5) **Organizational Change** –developing and implementing policies and procedures within community organizations to best use resources to address gang-related challenges. (Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997)
Specifics of delivery	• Cooperative relationships among community organizations • Delivered by a multidisciplinary intervention team (e.g. law enforcement, probation, outreach personnel, community agencies, schools) who work together on case management in gang intervention within the core strategies • Overseen by a steering committee

	• Implementation is based on an initial assessment (and continuous assessments) of the current gang problem in the community, its potential causes, and contributing factors • An implementation plan is developed following initial assessment, incorporating the five core strategies. Community capacity building is built into the plan • Ongoing data collection and monitoring for evaluation (Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997)
Dosage	Individualized (varies depending on need)
Duration	Individualized (varies depending on need)
Evaluation methods & findings	This model has been tested using quasi-experimental and mixed methods designs with: • Time series measures of pre- and post-intervention trends. • Comparisons of outcomes to other gangs and neighbourhoods where the intervention was not implemented. • Official police data, youth self-reports of criminal involvement, and interviews with staff of agencies involved. It has been tested with 200 young people involved in gangs in Chicago neighbourhoods experiencing high levels of gang-related crime and violence, over a four-year period (1994-1997). Original Chicago model: • Reduced serious violent and property crimes, total violent crime and drug crimes; • Increase in homicides and other serious violent gang crimes was lower in intervention gangs and neighbourhoods compared to those that were not targeted by the intervention; • Improved education and employment outcomes; • Reduced active gang involvement, particularly for older youth; • Increased community organization and mobilization. The program has been found to be more effective with older, more violent gang-involved youth than younger, less violent young people. Note there have been challenges replicating some of these outcomes – implementation varies and there are data collection challenges. (Office of Justice Programs, 2010; Spergel & Grossman, 1997).

References	Arciaga et al., 2009a and 2009b; Arciaga & Gonzalez, 2012; Burch & Kane, 1999; Office of Justice Programs, 2010; Spergel & Grossman, 1997;
Existing adaptations	Adapting the model to meet local needs is a built-in component of the approach itself - see Burch & Kane (1999) for a description of this. The following are some notable adaptations (Arciaga et al., 2009): **Rural Gang Initiative** – implementation in rural areas, where less resources are available and where violence and criminal activity may be less intense/frequent. This adaptation focused on the assessment and implementation plan components of the intervention (Arciaga et al., 2009); 6. **Gang Free Schools and Communities Initiative** - implementation in schools (added a school component) and then linking school-based programming to community-level intervention activities as well. Also focused on leveraging local resources more intensely (Arciaga et al., 2009); **Gang Reduction Program** – targeted additional cities and neighbourhoods across the United States. Focused on reducing gang activity in targeted neighbourhoods. Added prevention and re-entry to the model. Also focused on using existing community resources (Arciaga et al., 2009; McGarrell et al., 2013); **Comprehensive Anti-Gang Initiative** – adapting to additional cities and neighbourhoods in the United States. Largely based on the OJJDP Comprehensive Gang Model, as well as Project Safe Neighbourhoods. It is a "comprehensive model of suppression (enforcement), prevention and re-entry" (McGarrell et al., 2013).

3.4.3 Philadelphia Youth Violence Reduction Partnership

Philadelphia Youth Violence Reduction Partnership	
Variable	**Description**
Main objectives of the intervention	To reduce homicides among young people aged 15-24 (mostly male).
Target risk and protective factors	Individual: • history of gun charges • convictions for violent offenses • arrests for drug offenses • history of incarceration • age at first arrest Family: • family history of abuse and neglect • siblings involved in justice system
Definition & description	The Philadelphia-based Youth Violence Reduction Partnership (YVRP) employs proactive strategies aimed at addressing the root causes of violence by providing high-risk youth with intensive supervision and positive support (McClanahan et al., 2012).
Universal vs. targeted program	Targeted
Target population	Young people aged 14-24 years on probation who are deemed to be at highest risk of being involved in a homicide, either as a victim or perpetrator (see target risk factors above). (McClanahan et al., 2012; Petrosino et al., 2015)
Setting	Community
Level of intervention	Individual
Components	Each young person in the program is assigned to a probation officer and a street worker: • The street worker, a paraprofessional, provides emotional and practical support, addressing areas such as: educational opportunities, meaningful employment, housing, issues around abuse or neglect, peer influence, access to services, and general adult guidance. • The probation officer provides a higher level of supervision than traditional probation. They meet with young people outside their office, in their homes, places of work, neighbourhoods, often on evenings and weekends. Sometimes these visits are with police accompaniment as needed for safety and security. (McClanahan et al., 2012; Petrosino et al., 2015)

Specifics of delivery	Requires "intensive" collaboration among city-wide agencies, including police, probation, and anti-violence/anti-drug organizations. Requires individual agencies to leave their egos at the door and work together in innovative ways to find solutions for youth.
Dosage	Street workers meet with each young person approximately six times a month. Probation officers meet with young person approximately three times a month.
Duration	Duration varies. On average, young people stay in the program a little over two years. Half of young people are in the program for a year or less.
Evaluation methods & findings	The program was evaluated with young people on probation in five police precincts in Philadelphia, using a quasi-experimental design (comparison group). The study: analyzed police homicide data over a 17-year period (1994-2010); measured youth outcomes over an 18-month period, beginning at enrolment in the program, for 150 youth who received the intervention and compared to 211 controls (youth on probation who did not receive the intervention). Results show that: • Young people who received the intervention support were 38% less likely to be arrested for a violent crime than those in the control group, and 44% less likely to be convicted for a violent crime. • The number of contacts with street workers was associated with lower probability of being arrested for a violent crime. • Four of the five police districts showed declines in the number of youth homicides over time. However, there were no statistically significant differences in youth homicide rates between intervention police districts compared to control districts. (McClanahan et al., 2012; Petrosino et al., 2015)
References	McClanahan et al., 2012; Petrosino et al., 2015;
Existing adaptations	The program was expanded from its original two police precincts to six police precincts in Philadelphia. Upon expansion, evaluators noted that the program experienced challenges related to limited resources and lack of funding for staffing. They identified unintentional/undesired adaptation to the program upon expansion, such as limited focus for street workers – only on education and jobs and less on emotional support, recreation, and family intervention. Even within the same city, the program faced a challenge finding the balance between adhering to the original model and adapting to contexts of different neighbourhoods (McClanahan et al., 2012).

3.5 Programs for Offenders

3.5.1 Circles of Support and Accountability (CoSA)

Circles of Support and Accountability (CoSA)	
Variable	**Description**
Main objectives of the intervention	Circles of Support and Accountability (CoSA) is a community justice intervention that supports high-risk sex offenders in reintegrating in the community and maintaining a pro-social lifestyle. CoSA has two mottos: 'No more victims' and 'No one is disposable'. CoSA has three goals: 1. Reduce the risk of re-offence 2. Ease the offender's transition back into the community 3. Address victim fears practically (Hannem & Petrunik, 2007)
Target risk and protective factors	Risk Factors: • Sexual offending • Community demonization Protective Factors: • Social and community support
Definition & description	Traditional, retributive approaches may interfere with offender rehabilitation and do not deal with complex factors that that lead to initial and ongoing offending. CoSA is rooted in Restorative Justice approaches which focus on making communities safer by helping all parties heal and by holding offenders accountable. CoSA is ultimately a blending of Restorative Justice and community safety model. The goal is to remove the blame on the individual and shift the focus from the offender to the offence. (Hannem, 2013; Hannem & Petrunik, 2007)
Universal vs. targeted program	Targeted
Target population	Sexual offenders who have been released from prison
Setting	Community
Level of intervention	Individual
Components	Weekly group meetings and individual meetings bring together volunteer members and core members (high risk sex offenders) (Hannem & Petrunik, 2007)

Specifics of delivery	• Group meetings involve four to seven trained volunteers who work with one core member (offender) over the course of one year • The first meeting involves understanding and agreement to a covenant about volunteer expectations of the core member • Volunteers support the core members in efforts to not offend, integrate in the community, deal with crises, and celebrate milestones; specifically, volunteers support core members by helping them gain employment, housing, access to community resources, creating a relapse plan, and being a general support for their wellbeing • Volunteers also meet with core members in between weekly group meetings to complete errands, offer social support, and assist in times of crisis • There are some criteria that have been found to lead to successful circles: o Defined purpose established by the group o Group cohesion and adherence to CoSA philosophy and restorative justice principles o Volunteers must communicate openly with the professional helpers of the core members o Volunteers must be aware of the potential for the core member to be evasive and manipulative, while ensuring the core member still feels included (Hannem & Petrunik, 2004)
Dosage	Group circles occur weekly and individual sessions
Duration	Circles take place for one year and then relationships between core members and volunteers are reassessed
Compatible / not compatible with	Core members must voluntarily participate in the program, agree to the group covenant, and be willing to share their criminal justice history / clinical files
Evaluation methods & findings	• CoSA has been found to be successful at reducing sexual recidivism when compared to sexual offenders who did not participate in CoSA • Following CoSA, there were reported reductions in non-sexual violent offending, other offending, chance of rearrest, technical violation revocations, and reincarceration • Some studies found that reductions in offending were not significant, perhaps due to difficulties in evaluating interventions for the population being served

	• Non-recidivism related results from CoSA include:
	  o Better community adjustment
	  o A sense of support and acceptance by others
	  o Improvement in emotional wellbeing
	  o Increased engagement in age-appropriate relationships
	  o Better links with family and support networks
	  o Enhanced engagement with employment or education
	• A study reviewing circles in South-East England for 71 participants found core members had lower than expected rates of sexual reconviction, but this was not found to be statistically significant
	• The following factors were found to yield more effective CoSA implementation:
	  o Positive group development
	  o Mutual trust, openness, and clear evaluation
	  o Volunteer acceptance of the core member and ability to build a strong relationship
	  o Members of the circle and professional staff must work together
	• An assessment of the cost effectiveness of CoSA found that for every $1 U.S. spent on the intervention there was an estimated benefit of $1.82, which is an 82% return on investment
	Studies of CoSA used qualitative approaches, case matching, grounded theory approach, and experimental random assignment.
	(Bates, Williams, Wilson, & Wilson, 2013; Elliott & Zajac, 2015; Höing, Bogaerts, & Vogelvang, 2013)

References	Bates, Williams, Wilson, & Wilson, 2013; Elliott & Zajac, 2015; Hannem, 2013; Hannem & Petrunik, 2004, 2007; Höing, Bogaerts, & Vogelvang, 2013;
Existing adaptations	The application of CoSA to various cultural settings is reviewed in the literature; COSA has been used in the United States, South-East England, the Netherlands, and more (Bates et al., 2013; Elliott & Zajac, 2015; Höing et al., 2013). For an example, see the adapted CoSA for use with sexual offenders in South-East England (Almond, Bates, & Wilson, 2015; Bates et al., 2013).

3.6 Key Elements of Practice & Drivers of Quality

3.6.1 Learning from Evaluations and Systematic Reviews of Crime Prevention Programs

As the tables above illustrate, there are many different existing 'pre-packaged' crime prevention programs. Though we reviewed a total of 31 programs in this document, there are in fact many more. With all these different evidence-based programs, it can be difficult to tease out which are and could be most effective, for who, and in what circumstances. Furthermore, many evidence-based programs have shown positive impacts in one setting, but different or even contradictory impacts when replicated and evaluated in a different setting.

The broader literature on crime prevention, including systematic reviews and meta-analyses of program outcomes, highlight some of the more universal effective elements of crime prevention programming. These key drivers of program quality that increase the likelihood of positive results include (see Krug et al., 2002; Lipsey et al., 2010; Sherman et al., 2002; UN ECOSOC, 1995 and 2002; Waller, 2006):

- Focusing on the **specific risk and protective factors** most relevant to the issue at hand;
- Addressing risk and protective factors at **multiple levels** (i.e., at the individual, peer, family, community, and systems levels);
- Matching the **level and intensity** of the intervention to the level of risk of the target population for involvement or re-involvement in the criminal justice system;
- Using **therapeutic principles and practices** versus techniques of control and punishment;
- Ensuring **high quality implementation**, including through key implementation drivers such as adequate leadership, staffing, and organizational capacity; and
- **Appropriate dosage** (amount) and **duration** (length) of intervention to adequately meet individual needs.

3.6.2 Trends in Crime Prevention Programming: From Prevention Science to Strength-Based Approaches and Trauma-Informed Practices

Deficit-Based versus Strengths-Based Approaches

Many crime prevention programs developed over the past few decades have been delivered within the context of 'prevention science' and what is referred to as the deficit lens. Prevention science is based on the central idea that people have risk factors that can lead to negative outcomes. As such, these programs operate within a framework of 'risk' and focus largely on suppressing negative behaviours. Approaches based on prevention science are largely aimed at "preventing the emergence or continuation of psychosocial difficulties or problem behaviours" (Keller, 2007, p. 27). It purports that negative outcomes may not result if risk factors are addressed and significant protective factors are in place.

There are several main tenets associated with prevention science (Cavell & Elledge, 2014):

- A theoretical justification of the cause (risk factors) and effect (reducing the risk factors) to support specific interventions.
- Strategies put in place for determining the most appropriate target population.
- Prevention programs occurring before the risk factors influence more negative outcomes for individuals, so that they can have a meaningful impact.
- The assumption that risks and protective factors are malleable and can be influenced by the intervention.
- Interventions that target general risk and protective factors are more likely to achieve positive outcomes because they can work with different people.
- Outcomes of prevention programs strengthen support for future interventions targeting specified risk and protective factors.

More recently, with advances in research on Positive Youth Development (PYD) and resiliency theory, programs increasingly operate within a strengths-based lens (see Rawana et al., 2009; Ungar, Liebenberg, & Ikeda, 2012). PYD theory puts forth that all youth have the ability to build skills and be successful; young people are particularly malleable and thus they often have greater capacity to change their own mental states and behaviours than adults (Lerner, Brittain, & Fay, 2007; Lerner, Napolitano, Boyd, Mueller, & Callina, 2014). The strength-based philosophy argues that traditional prevention science leads to people being labeled as their deficits and not seen as capable of affecting change in their own lives, resulting in a process of further disempowerment. Research shows that people often report feeling further stigmatized and dehumanized by programs and services that focus on their 'risk' to society (Wilson, Pence, & Conradi, 2013). Alternatively, the strength-based approach views problems as separate from the person. When people are viewed as capable, they are able to draw on current assets and learn new skills to manage their own wellbeing in sustainable ways (Cox, 2008; Hammond & Zimmerman, 2012). Taken another way, a strength-based approach can help people feel hopeful and develop resiliency in the face of obstacles (Cox, 2008). Positive youth development takes into account the strengths and assets people already have; it focuses on harnessing those strengths and developing new ones to enhance positive lifelong outcomes (Roebuck, Roebuck, & Roebuck, 2011).

The Search Institute (1997 & 2000; visit www.search-institute.org) based in the United States published a research-based tool called the *40 Developmental Assets* which became popular within the field of PYD. This can be used by adult supporters or youth themselves to identify positive qualities, areas of strength in their lives and gaps in order to help guide future development. By conducting a large scale review of research on positive youth development, the Canadian company Resiliency Initiatives (see Hammond & Zimmerman, 2012) identified the following traits, which contribute to the positive development of children and youth:

- Building and maintaining social relationships
- Coping with stress
- Problem solving
- Being responsible for oneself and as part of a team
- Having and acting with a set of values
- Setting goals and having confidence about the future
- Developing and practicing emotional intelligence
- Being motivated and having perseverance
- Defining a passion or interests
- Having spiritual connection and awareness

Embracing the idea that positive relationships are essential to helping a young person develop their assets, the Search Institute (see Roehlkepartain et al., 2017) more recently articulated a framework for *Developmental Relationships*, highlighting that youth need people in their lives who express care, challenge growth, provide support, share power, and expand possibilities. Their recent research found that: (1) young people who experience strong developmental relationships are more likely to report a wide range of social-emotional strengths and other indicators of wellbeing and thriving, (2) young people with strong developmental relationships are significantly more resilient in the face of stress and trauma, and (3) young people do better when they experience a strong web of relationships with many people (Roehlkepartain et al., 2017, p. 7-8).

Research shows that a deficit-based approach focused only on risk factors can set up a power imbalance; workers are seen as professionals who have more knowledge about how to help people through problems, rather than relying on the individual's intrinsic strengths and abilities to work through challenges with some support. A strength-based approach positions supporters as partners rather than professionals, who utilize genuine support to act as "facilitators of change" in partnership with the individual (Hammond & Zimmerman, 2012). By employing a more holistic approach, individuals are seen as already 'at potential', so instead of fixing them, workers help them strengthen their core competencies (Cox, 2008).

The following principles can support any organization or program in adopting a strength-based approach (Hammond & Zimmerman, 2012):

- Belief in a person's abilities to affect change in their own lives.
- Belief that challenges are inevitable and can help people build strengths.
- Language can alter people's perceptions of situations and create realities.
- Authentic and caring relationships are the crux of helping people build capacity.
- People are experts in their own lives.
- Supporting people to work toward self-determined goals can help them build confidence.
- Personal development is an ongoing process.
- Difference makes us stronger and can help people develop effective communities of support.

3.6.3 Cultural Safety and Trauma-Informed Practices

Other key strategies that are compatible with a strength-based philosophy and deemed appropriate and effective for supporting diverse individuals and communities in meaningful ways include: (1) ensuring cultural safety, and (2) providing trauma-informed supports. Individuals who face barriers to success often report feeling especially disempowered and excluded given their past life experiences (Potter, 2016). Ensuring *cultural safety* is key in fostering supportive environments and relationships. Cultural safety goes beyond cultural awareness (acknowledgement of difference), cultural sensitivity (respecting difference), and cultural competence (having appropriate attitudes and skills to deal with difference). Cultural safety includes the aptitudes from these previous phases, but also involves a component of self-reflection to recognize our own cultural lens, and develop empathy and advocacy to move towards understanding and positive change (Wabano Centre for Aboriginal Health, 2014).

To foster cultural safety, programs must avoid making assumptions about an individual's culture or sense of cultural identity, and avoid glossing over or ignoring issues of power and privilege. Provide staff, volunteers and participants with training and skills development opportunities in (Wabano Centre for Aboriginal Health, 2014:

- acknowledging dynamics of power and privilege
- positive communication
- conflict resolution
- restorative practices
- collaborative decision-making

Collaborative decision-making respects the right to self-determination and focuses on processing situations with the program participants (rather than for them) so that they understand what the implications might be of any particular course of action. This helps them discover what is truly important to them and develop critical thinking through questions and reflections. This approach communicates respect and trust, and builds healthy decision-making skills, a key developmental asset.

Furthermore, those involved in the criminal justice system – or at-risk of becoming involved in the justice system - are more likely to have experienced trauma (Ardino, 2012; Wright & Liddle, 2013). Traumatic events are experiences that are emotionally painful and distressing, and overwhelm a person's ability to cope. Trauma leaves a person feeling powerless or out of control. Trauma can be a single event (e.g., an assault, shooting, loss / grief), or repeated events (e.g., ongoing child or spousal abuse) (Wilson, Pence, & Conradi, 2013). It can affect an individual or an entire group, and can also be passed down through generations (e.g., 'historical trauma' of residential school survivors and their loved ones) (Potter, 2016; Wright & Liddle, 2013). Trauma-informed practice (TIP) means ensuring an understanding of past and current experiences of violence and trauma into all aspects of programs and supports (Wilson, Pence, & Conradi, 2013; Wright & Liddle, 2013). The main goals are to prevent re-traumatization and to provide opportunities for people to rebuild a sense of control and empowerment by offering them choice, and meeting them where they are at on their healing journey (Wilson, Pence, & Conradi, 2013; Wright & Liddle, 2013). TIP is not a specific type of program or intervention; it encourages service developers and providers to approach their work with the understanding of how common trauma is among those they serve, and how it may surface in behaviours that are often labeled as "risky" but that have their origins in personal trauma (Potter, 2016; Wilson, Pence, & Conradi, 2013; Wright & Liddle, 2013). Working from a trauma-informed lens includes a strong foundational focus on:

1. Recognizing the need for physical and emotional safety above all else, and
2. Providing choice and control in decisions affecting their life (Wilson, Pence, & Conradi, 2013; Wright & Liddle, 2013).

As the previous tables show, several strategies and programs have emerged that are considered evidence-informed by Western standards (i.e., supported by research), responsive to individuals and communities through flexibility and tailoring, and focused on strengths, resiliency, and power sharing (e.g., see "Leadership and Resiliency Program" and "Wraparound").

4. Conclusions & Discussion

There are many different existing 'pre-packaged' crime prevention programs that are considered evidence-based interventions due to their rigorous development and evaluation. This document presents the key elements of thirty-one (31) such evidence-based crime prevention programs. These key elements are described along variables such as the program's main objectives, target population, setting, key components, specifics of delivery, dosage (amount of intervention), and duration (length of intervention).

Though we reviewed a total of 31 programs in this document, there are in fact many more. With all these different evidence-based programs, it can be difficult to tease out which are and could be most effective, for who, and in what circumstances. Furthermore, many evidence-based programs have shown positive impacts in one setting, but different or even contradictory impacts when replicated and evaluated in a different setting.

The broader literature on crime prevention, including systematic reviews and meta-analyses of program outcomes, highlight some of the more universal effective elements of crime prevention programming. These key drivers of quality include:

- Focusing on the specific risk and protective factors most relevant to the issue at hand;
- Addressing risk and protective factors at multiple levels (i.e., at the individual, peer, family, community, and systems levels);
- Matching the level and intensity of the intervention to the level of risk of the target population (for involvement or re-involvement in the criminal justice system);
- Using therapeutic principles and practices versus techniques of control and punishment;
- Ensuring high quality implementation, including through key implementation drivers such as adequate leadership, staffing, and organizational capacity; and
- Appropriate dosage (amount) and duration (length) of intervention to adequately meet needs.

More recent developments in evidence-informed program development and evaluation stress the importance of supporting positive outcomes by combining empirical knowledge with experiential knowledge and contextual information, resulting in services that are informed and inspired by the best available evidence from various perspectives, including different cultural values and teachings. This includes ensuring cultural safety of programs and service delivery environments, promoting community development by working with individuals and communities with a focus on strengths (versus risks or deficits), and providing supports that take into account individual-level and community-level experiences of trauma.

References

Aalborg, A. E., Miller, B. A., Husson, G., Byrnes, H. F., Bauman, K. E., & Spoth, R. L. (2012). Implementation of adolescent family-based substance use prevention programs in health care settings: Comparisons across conditions and programs. *Health Education Journal*, *71*(1), 53–61. http://doi.org/10.1177/0017896910386209

Almond, P., Bates, A., & Wilson, C. (2015). Circles of Support and Accountability: Criminal Justice Volunteers as the "Deliberative Public." *British Journal of Community Justice*, *13*(1), 25–40.

Amendola, M., & Oliver, R. (2010). Aggression Replacement Training Stands the Test of Time. *Reclaiming Children & Youth*, *19*, 47–50.

Arciaga, M., Dougherty, V., Moore, J., Hale, K., Ray, S., & Howell, J. (2009a). *OJJDP Comprehensive Gang Model: A Guide to Assessing Your Community's Youth Gang Problem.* Office of Juvenile Justice and Delinquency Prevention.

Arciaga, M., Dougherty, V., Moore, J., Hale, K., Ray, S., & Howell, J. (2009b). *OJJDP Comprehensive Gang Model: Planning for Implementation.* Office of Juvenile Justice and Delinquency Prevention

Arciaga, M., & Gonzalez, V. (2012). Street outreach and the OJJDP Comprehensive Gang Model. *National Gang Center Bulletin, 7*, 1-10.

Ardino, V. (2012). Offending behaviour: the role of trauma and PTSD. *European Journal of Psychotraumatology*, *3*, 10.3402/ejpt.v3i0.18968. http://doi.org/10.3402/ejpt.v3i0.18968

Augimeri, L. K. (2014). *SNAP ® Boys (formerly SNAP ® Outreach Program – SNAP ® ORP) And SNAP ® Girls (formerly SNAP ® Girls Connection – SNAP ® GC) Research & Program Evaluation Studies*. Toronto, ON.

Augimeri, L. K., Farrington, D. P., Koegl, C. J., & Day, D. M. (2007). The SNAP™ under 12 outreach project: Effects of a community based program for children with conduct problems. *Journal of Child and Family Studies*, *16*(6), 799–807. http://doi.org/10.1007/s10826-006-9126-x

Augimeri, L. K., Walsh, M., & Slater, N. (2011). Rolling Out SNAP ® An Evidence-Based Intervention: A Summary Of Implementation, Evaluation, And Research. *International Journal of Child, Youth and Family Studies*, *2*(1), 330–352.

Axberg, U., & Broberg, A. G. (2012). Evaluation of "The Incredible Years" in Sweden: The transferability of an American parent-training program to Sweden. *Scandinavian Journal of Psychology*, *53*(3), 224–232. http://doi.org/10.1111/j.1467-9450.2012.00955.x

Azevedo, A. F., Seabra-Santos, M. J., Gaspar, M. F., & Homem, T. (2014). A parent-based intervention programme involving preschoolers with AD/HD behaviours: Are children's and mothers' effects sustained over time? *European Child and Adolescent Psychiatry*, *23*(6), 437–450. http://doi.org/10.1007/s00787-013-0470-2

Baglivio, M. T., Jackowski, K., Greenwald, M. a., & Wolff, K. T. (2014). Comparison of Multisystemic Therapy and Functional Family Therapy Effectiveness: A Multiyear Statewide Propensity Score Matching Analysis of Juvenile Offenders. *Criminal Justice and Behavior*, *41*(9), 1033–1056. http://doi.org/10.1177/0093854814543272

Baker-Henningham, H. (2011). Transporting evidence-based interventions across cultures: Using focus groups with teachers and parents of pre-school children to inform the implementation of the Incredible Years Teacher Training Programme in Jamaica. *Child: Care, Health and Development*, *37*(5), 649–661. http://doi.org/10.1111/j.1365-2214.2011.01208.x

Barnoski, R. (2004). *Outcome evaluation of Washington State's research-based programs for juvenile offenders*. *Washington State Institute for Public Policy*.

Barrish, H. H., Saunders, M., & Wolf, M. M. (1969). Good Behavior Game: Effects of Individual Contingencies for Group Consequences on Disruptive Behavior in a Classroom. *Journal of Applied Behavior Analysis*, *2*(2), 119–124. http://doi.org/10.1901/jaba.1969.2-119

Barton, C., Alexander, J. F., Waldron, H. B., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of functional family therapy: Three replications. *The American Journal of Family Therapy*, *13*(3), 16–26. http://doi.org/10.1080/01926188508251260

Bates, A., Williams, D., Wilson, C., & Wilson, R. J. (2013). Circles South East: The First 10 Years 2002-2012. *International Journal of Offender Therapy and Comparative Criminology*, *58*(7), 861–885. http://doi.org/10.1177/0306624X13485362

Bavarian, N., Lewis, K. M., Acock, A. C., DuBois, D. L., Yan, Z., Vuchinich, S., … Flay, B. R. (2016). Effects of a School-Based Social–Emotional and Character Development Program on Health Behaviors: A Matched-Pair, Cluster-Randomized Controlled Trial. *The Journal of Primary Prevention*, *37*(1), 87–105. http://doi.org/10.1007/s10935-016-0417-8

Bavarian, N., Lewis, K. M., Dubois, D. L., Acock, A. C., Vuchinich, S., Silverthorn, N., … Flay, B. R. (2013). Using social-emotional and character development to improve academic outcomes: A matched-pair, cluster-randomized controlled trial in low-income, urban schools. *Journal of School Health*, *83*(11), 771–779. http://doi.org/10.1111/josh.12093

Baydala, L., Kyme, G., Rasmussen, C., Fletcher, F., Letendre, L., & Sewlal, B. (2012). *Life Skills Training (LST) Substance Abuse Prevention Program for Aboriginal Children and Youth*. Edmonton, AB.

Becker, K. D., Bradshaw, C. P., Domitrovich, C. E., & Ialongo, N. S. (2013). Coaching teachers to improve implementation of the good behavior game. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(6), 482–493. http://doi.org/10.1007/s10488-013-0482-8

Beets, M. W., Flay, B. R., Vuchinich, S., Snyder, F. J., Acock, A. C., Li, K.-K., … Durlak, J. (2009). Use of a social and character development program to prevent substance use, violent behaviors. *American Journal of Public Health*, *99*(8). http://doi.org/10.2105/AJPH.2008.142919

Bertram, R. M., Suter, J. C., Bruns, E. J., & O'Rourke, K. E. (2011). Implementation Research and Wraparound Literature: Building a Research Agenda. *Journal of Child and Family Studies*, *20*(6), 713–725. http://doi.org/10.1007/s10826-010-9430-3

Bierman, K. L., Coie, J. D., Dodge, K. A., Greenberg, M. T., Lochman, J. E., McMahon, R. J., & Pinderhughes, E. E. (2002a). Predictor variables associated with positive Fast Track outcomes at the end of third grade. *Journal of Abnormal Child Psychology*, *30*(1), 37–52. http://doi.org/10.1023/A:1014227031125

Bierman, K. L., Coie, J. D., Dodge, K. a, Foster, E. M., Greenberg, M. T., Lochman, J. E., … Pinderhughes, E. E. (2004). The effects of the fast track program on serious problem outcomes at the end of elementary school. *Journal of Clinical Child and Adolescent Psychology*, *33*(4), 650–661. http://doi.org/10.1207/s15374424jccp3304_1

Bierman, K. L., Coie, J. D., Dodge, K. a, Greenberg, M. T., Lochman, J. E., McMahon, R. J., & Pinderhughes, E. E. (2002b). Using the Fast Track randomized prevention trial to test the early-starter model of the development of serious conduct problems. *Development and Psychopathology*, *14*(4), 925–943. http://doi.org/10.1017/S0954579402004133

Bierman, K. L., Nix, R. L., Heinrichs, B. S., Domitrovich, C. E., Gest, S. D., Welsh, J. A., & Gill, S. (2014). Effects of Head Start REDI on Children's Outcomes 1 Year Later in Different Kindergarten Contexts. *Child Development*, *85*(1), 140–159. http://doi.org/10.1111/cdev.12117

Bierman, K. L., & The Conduct Problems Prevention Research Group. (1997). Implementing a Comprehensive Program for the Prevention of Conduct problems in Rural Communities: The Fast Track Experience. *American Journal of Community Psychology*, *25*(4), 493–514.

Blueprints for Healthy Youth Development. (n.d.). Promoting Alternative Thinking Strategies (PATHS). Retrieved October 18, 2016, from http://www.blueprintsprograms.com/factsheet/promoting-alternative-thinking-strategies-paths

Blueprints for Healthy Youth Development. (2016). Blueprints for Healthy Youth Development: Functional Family Therapy. Retrieved October 20, 2016, from http://www.blueprintsprograms.com/factsheet/functional-family-therapy-fft

Bodenmann, G., Cina, A., Ledermann, T., & Sanders, M. R. (2008). The efficacy of the Triple P-Positive Parenting Program in improving parenting and child behavior: A comparison with two other treatment conditions. *Behaviour Research and Therapy*, *46*(4), 411–427. http://doi.org/10.1016/j.brat.2008.01.001

Borduin, C. M. (n.d.). Multisystemic Therapy With Juvenile Sexual Offenders: Clinical and Cost Effectiveness. Retrieved from http://apps.mstservices.com/presentations/borduin.pdf

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic Treatment of Adolescent Sexual Offenders. *International Journal of Offender Therapy and Comparative Criminology*, *35*, 105–114.

Borduin, C. M., & Schaeffer, C. M. (2001). Multisystemic Treatment of Juvenile Sexual Offenders: A Progress Report. *Journal of Psychology & Human Sexuality*, *13*(3/4), 25–42.

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology*, *77*(1), 26–37. http://doi.org/10.1037/a0013035

Botvin, G. J., Baker, E., Dusenbury, L., Tortu, S., & Botvin, E. M. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioral approach: results of a 3-year study. *Journal of Consulting and Clinical Psychology*, *58*(4), 437–446. http://doi.org/10.1037/0022-006X.58.4.437

Botvin, G. J., Griffin, K. W., Diaz, T., & Ifill-Williams, M. (2001a). Drug abuse prevention among minority adolescents: posttest and one-year follow-up of a school-based preventive intervention. *Prevention Science*, *2*(1), 1–13. http://doi.org/10.1023/a:1010025311161

Botvin, G. J., Griffin, K. W., Diaz, T., & Ifill-Williams, M. (2001b). Preventing Binge Drinking During Early Adolescence: One- and Two-Year Follow-Up of a School-Base Preventive Intervention. *Psychology of Addictive Behaviors*, *15*(4), 360–365.

Botvin, G. J., Griffin, K. W., & Nichols, T. D. (2006). Preventing youth violence and delinquency through a universal school-based prevention approach. *Prevention Science*, *7*(4), 403–408. http://doi.org/10.1007/s11121-006-0057-y

Botvin, G. J., Renick, N. L., & Baker, E. (1983). The effects of scheduling format and booster sessions on a broad-spectrum psychosocial approach to smoking prevention. *Journal of Behavioral Medicine*, *6*(4), 359–79. http://doi.org/10.1007/BF00846324

Botvin, G. J., Schinke, S. P., Epstein, J. A., Diaz, T., & Botvin, E. M. (1995). Effectiveness of Culturally Focused and Generic Skills Training Approaches to Alcohol and Drug Abuse Prevention Among Minority Adolescents: Two-Year Follow-Up Results. *Psychology of Addictive Behaviors*, *9*(3), 183–194.

Bowen, E. (2003). Blueprint for violence prevention Functional Family Therapy (FFT). *Journal of the National Medical Association*, *95*(8), 670.

Boyle, C. L., Sanders, M. R., Lutzker, J. R., Prinz, R. J., Shapiro, C. J., & Whitaker, D. J. (2010). An analysis of training, generalization, and maintenance effects of primary care triple P for parents of preschool-aged children with disruptive behavior. *Child Psychiatry and Human Development*, *41*(1), 114–131. http://doi.org/10.1007/s10578-009-0156-7

Braga, A. A., D.M. Kennedy, E. J. Waring, and A.M. Piehl (2001). ''Problem-Oriented Policing, Deterrence, and Youth Violence: An Evaluation of Boston's Operation Ceasefire.'' Journal of Research in Crime and Delinquency 38:195-225.

Braiden, H.-J., McDaniel, B., Duffy, J., & McCann, M. (2011). A pilot study of the Incredible Years BASIC parenting programme with bereaved families. *Journal of Children's Services*, *6*(3), 141–155. http://doi.org/10.1108/17466661111176015

Brännström, L., Kaunitz, C., Andershed, A. K., South, S., & Smedslund, G. (2016). Aggression replacement training (ART) for reducing antisocial behavior in adolescents and adults: A systematic review. *Aggression and Violent Behavior*, *27*, 30–41. http://doi.org/10.1016/j.avb.2016.02.006

Breuk, R. E., Sexton, T. L., Van Dam, A., Disse, C., Doreleijers, T. A. H., Slot, W. N., & Rowland, M. K. (2006). The implementation and the cultural adjustment of functional family therapy in a dutch psychiatric day-treatment center. *Journal of Marital and Family Therapy*, *32*(4), 515–529. http://doi.org/10.1111/j.1752-0606.2006.tb01625.x

Brook, J., McDonald, T. P., & Yan, Y. (2012). An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review*, *34*(4), 691–695. http://doi.org/10.1016/j.childyouth.2011.12.018

Brown, E. C., Low, S., Smith, B. H., & Haggerty, K. P. (2011). Outcomes from a School-Randomized Controlled Trial of Steps to Respect: A Bullying Prevention Program. *School Psychology Review*, *40*(3), 423–433. http://doi.org/10.1037/e550932011-004

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, *55*(2), 171–178. http://doi.org/10.1037/0022-006X.55.2.171

Bruns, E. J., Burchard, J. D., & Yoe, J. T. (1995). Evaluating the vermont system of care: Outcomes associated with community-based wraparound services. *Journal of Child and Family Studies*, *4*(3), 321–339. http://doi.org/10.1007/BF02233966

Bruns, E. J., & Walker, J. S. (2010). Webinar 1: Overview of Wraparound.

Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., … National Wraparound Initiative Advisory Group. (2004). *Ten Principles of the Wraparound Process*. Portland, OR.

Burch, K., & Kane, C. (1999). Implementing the OJJDP Comprehensive Gang Model. *OJJDP Fact Sheet, 112*.

Burke, J. D., & Loeber, R. (2014). The Effectiveness of the Stop Now and Plan (SNAP) Program for Boys at Risk for Violence and Delinquency. *Prevention Science*, 242–253. http://doi.org/10.1007/s11121-014-0490-2

Burke, J. D., & Loeber, R. (2016). Mechanisms of Behavioral and Affective Treatment Outcomes in a Cognitive Behavioral Intervention for Boys. *Journal of Abnormal Child Psychology*, *44*(1), 179–189. http://doi.org/10.1007/s10802-015-9975-0

Burrows, M. H. (2003). Evaluation of the Youth Inclusion Programme, (July).

Burrows, M. H. (2008). Evaluation of the Youth Inclusion Programme, (July).

Butts, J. A., Roman, C. G., Bostwick, L., & Porter, J. R. (2015). Cure Violence: A public health model to reduce gun violence. *Annual Review of Public Health*, *36*(1), 39–53. http://doi.org/10.1146/annurev-publhealth-031914-122509

Carney, M. M., & Buttrell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice*, *13*(5), 551–568. http://doi.org/10.1177/1049731503253364

Carter, S., Straits, K. J. E., & Hall, M. (2007). Project Venure: Evaluation of a Positive, Culture-Based Approach to Substance Abuse Prevention with American Indian Youth. *Leadership*. Retrieved from www.niylp.org

Cavell, T. A., & Elledge, L. C. (2014). Mentoring and prevention science. In D. L. DuBois & M. J. Karcher (Eds.), *Handbook of Youth Mentoring* (pp. 29-43). Thousand Oaks, CA: SAGE Publications, Inc.

Celinska, K., Cheng, C. C., & Virgil, N. J. (2015). Youth and parental perspectives on the functional family therapy programme. *Journal of Family Therapy*, *37*(4), 450–470. http://doi.org/10.1111/1467-6427.12051

Clarke, R. T., Schaefer, M., Burchard, J. D., & Welkowitz, J. W. (1992). Wrapping community-based mental health services around children with a severe behavioral disorder: An evaluation of project wraparound. *Journal of Child and Family Studies*, *1*(3), 241–261. http://doi.org/10.1007/BF01322069

Coleman, M., Pfeiffer, S., & Oakland, T. (1992). Aggression Replacement Training with Behaviorally Disordered Adolescents. *Behavioral Disorders*, *18*(1), 54–66.

Colorado School Safety Resource Center. (2016). *Resources for Child Sexual Abuse and Assault Prevention*. Denver. Retrieved from http://cdpsdocs.state.co.us/safeschools/CSSRC Documents/CSSRC-CSA-Resource-Guide.pdf

Copp, H. L., Bordnick, P. S., Traylor, A. C., & Thyer, B. A. (2007). Evaluating Wraparound Services for Seriously Emotionally Disturbed Youth: Pilot Study Outcomes in Georgia. *Adolescence*, *42*(168), 723–732.

Cox, K. (2008). A roadmap for building on youths' strengths. In E. J. Bruns & J. S. Walker (Eds.), *The Resource Guide to Wraparound* (pp. 19–24). Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&profile

=ehost&scope=site&authtype=crawler&jrnl=10895701&AN=31123751&h=vJS4NgJ59HEzn5YxIju9MzEnX7Mt5+3N7uJN6qoVfVDxabtWjajnImWotbfyEzL/sqvXhsEIhII21vK0CPYwvw==&crl=c

Cox, K. (2008). Tools for building on youth strengths. *Reclaiming Children and Youth, 16*(4), 19 24.

Crean, H. F., & Johnson, D. B. (2013). Promoting Alternative Thinking Strategies (PATHS) and Elementary School Aged Children's Aggression: Results from a Cluster Randomized Trial. *American Journal of Community Psychology*, *52*(1–2), 56–72. http://doi.org/10.1007/s10464-013-9576-4

Crisante, L., & Ng, S. (2003). Implementation and process issues in using Group Triple P with Chinese parents: Preliminary findings. *AeJAMH (Australian E-Journal for the Advancement of Mental Health)*, *2*(3), No Pagination Specified. http://doi.org/10.5172/jamh.2.3.226

Crooks, C., Zwarych, S., Hughes, R., & Burns, S. (2015). *The Fourth R Implementation Manual: Building for Success from Adoption to Sustainability*.

Crooks, C. V., Burleigh, D., Snowshoe, A., Lapp, A., Hughes, R., & Sisco, A. (2015). A case study of culturally relevant school-based programming for First Nations youth: improved relationships, confidence and leadership, and school success. *Advances in School Mental Health Promotion*, *8*(4), 216–230. http://doi.org/10.1080/1754730X.2015.1064775

Crooks, C. V., Chiodo, D., Zwarych, S., Hughes, R., & Wolfe, D. A. (2013). Predicting Implementation Success of an Evidence-based Program to Promote Healthy Relationships among Students Two to EightYears after Teacher Training. *Canadian Journal of Community Mental Health*, *32*(1), 125–138. http://doi.org/10.7870/cjcmh-2013-010

Crooks, C. V., Scott, K., Ellis, W., & Wolfe, D. A. (2011). Impact of a universal school-based violence prevention program on violent delinquency: Distinctive benefits for youth with maltreatment histories. *Child Abuse and Neglect*, *35*(6), 393–400. http://doi.org/10.1016/j.chiabu.2011.03.002

Crooks, C. V., Wolfe, D. A., Hughes, R., Jaffe, P. G., & Chiodo, D. (2008). Development , Evaluation and National Implementation of a School-Based Program to Reduce Violence and Related Risk Behaviours : Lessons from the Fourth R. *IPC Review*, *2*, 109–135.

Daryanani, A., Eckert, R., Kollay, M., Riley, F., Studt, K., & Yager, L. (2009). *The Leadership and Resiliency Program ©^{TM} A Guide to School Based Resiliency and Leaderhip Programming*. Fairfax, VA.

Davies, S., & Witte, R. (2000). Self-Management and Peer-Monitoring within a Group Contingency to Decrease Uncontrolled Verbalizations of Children with Attention-Deficit/Hyperactivity Disorder. *Psychology in the Schools*, *37*(2), 135–147.

Debicki, A. (2002). A Best Practice Model for a Community Mobilization Team.

Delgado, S. A., Blount-Hill, K.-L., Mandala, M., Butts, J. A., Johnjayrec, W., Nyc Delgado, S. A., & S. (2015). Perceptions of Violence: Surveying Young Men in New York.

Della Toffalo, D. a. (2000). An investigation of treatment integrity and outcomes in wraparound services. *Journal of Child and Family Studies*, *9*(3), 351–361. http://doi.org/10.1023/A:1026496524181

Dent, C. W., Sussman, S., & Stacy, A. W. (2001). Project Towards No Drug Abuse: generalizability to a general high school sample. *Preventive Medicine*, *32*(6), 514–20. http://doi.org/10.1006/pmed.2001.0834

DeVore, D. W. (2011). Functional Family Therapy and Multisystemic Therapy: Doing More with Less. *Corrections Today*, (February/March), 20–23. http://doi.org/http://dx.doi.org/10.1037/11621-000

Dion, E., Roux, C., Landry, D., Fuchs, D., Wehby, J., & Dupéré, V. (2011). Improving Attention and Preventing Reading Difficulties among Low-Income First-Graders: A Randomized Study. *Prevention Science*, *12*(1), 70–79. http://doi.org/10.1007/s11121-010-0182-5

Dolan, L. J., Kellam, S. G., Brown, C. H., Werthamer-Larsson, L., Rebok, G. W., Mayer, L. S., … Wheeler, L. (1993). The Short-Term Impact of Two Classroom-Based Preventive Interventions on Aggressive and Shy Behaviors and Poor Achievement. *Journal of Applied Developmental Psychology*, *14*, 317–345.

Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *Journal of Primary Prevention*, *28*(2), 67–91. http://doi.org/10.1007/s10935-007-0081-0

Domitrovich, C. E., Gest, S. D., Jones, D., Gill, S., & DeRousie, R. M. S. (2010). Implementation quality: Lessons learned in the context of the Head Start REDI trial. *Early Childhood Research Quarterly*, *25*(3), 284–298. http://doi.org/10.1016/j.ecresq.2010.04.001

Domitrovich, C. E., Pas, E. T., Bradshaw, C. P., Becker, K. D., Keperling, J. P., Embry, D. D., & Ialongo, N. S. (2015). Individual and School Organizational Factors that Influence Implementation of the PAX Good Behavior Game Intervention. *Prevention Science*, *16*(8), 1064–1074. http://doi.org/10.1007/s11121-015-0557-8

Donaldson, J. M., Vollmer, T. R., Krous, T., Downs, S., & Berard, K. P. (2011). An Evaluation of the Good Behavior Game in Kindergarten Classrooms. *Journal of Applied Behavior Analysis*, *44*(3), 605–609. http://doi.org/10.1901/jaba.2011.44-605

Duncan, T. M., Davey, M., & Davey, A. (2011). Transporting Functional Family Therapy to Community-Based Programs. *The Family Journal*, *19*(1), 41–46. http://doi.org/10.1177/1066480710387269

Educational Program Innovations Charity. (2016). EMPATHIC. Retrieved from http://www.epiccharity.com/special-projects-2003-2009/empathic/

Elliott, I. A., & Zajac, G. (2015). The implementation of Circles of Support and Accountability in the United States. *Aggression and Violent Behavior*, *25*(2012), 113–123. http://doi.org/10.1016/j.avb.2015.07.014

EPISCenter. (2006). *Project TND (Project Towards No Drug Abuse)*. Retrieved from http://episcenter.psu.edu/sites/default/files/ebp/TND FAQ.pdf

EPISCenter. (2013). *Botvin' s Life Skills Training Implementation Manual*. Retrieved from http://www.episcenter.psu.edu/sites/default/files/ebp/LST Implementation Manual 2013 Update - TL.pdf

EPISCenter. (2014). *The Strengthening Families Program 10-14 Implementation Manual with Appendices*. Retrieved from http://www.episcenter.psu.edu/sites/default/files/ebp/SFP Implementation Manual With Appendices-revised 2.2014.pdf

EPISCenter. (2016). *The Strengthening Families Program 10-14 FAQ*. Retrieved from http://www.episcenter.psu.edu/sites/default/files/ebp/SFP 10-14 FAQ.pdf

Fishbein, J. E., & Wasik, B. H. (1981). Effect of the Good Behavior Game on disruptive library behavior. *Journal of Applied Behavior Analysis*, *14*(I), 89–93. http://doi.org/10.1901/jaba.1981.14-89

Flay, B. R., & Allred, C. G. (2003). Long-term effects of the positive action® program. *American Journal of Health Behavior*, *27*(SUPPL. 1), S6–S21. Retrieved from http://www.scopus.com/inward/record.url?eid=2-s2.0-0141687243&partnerID=40&md5=0629e84bb99ea826a4589f07b096ca9a

Flay, B. R., Allred, C. G., & Ordway, N. (2001). Effects of the Positive Action program on achievement and discipline: two matched-control comparisons. *Prevention Science : The Official Journal of the Society for Prevention Research*, *2*(2), 71–89. http://doi.org/10.1023/a:1011591613728

Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008). Ethnic background, therapeutic alliance, and treatment retention in functional family therapy with adolescents who abuse substances. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, *22*(1), 167–170. http://doi.org/10.1037/0893-3200.22.1.167

Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. J. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, *30*(5), 493–501. http://doi.org/10.1016/j.childyouth.2007.11.002

Fox, D. P., Gottfredson, D. C., Kumpfer, K. L., & Beatty, P. D. (2004). Challenges in disseminating model programs: A qualitative analysis of the strengthening Washington DC families program. *Clinical Child and Family Psychology Review*, *7*(3), 165–176. http://doi.org/10.1023/B:CCFP.0000045125.68018.61

Fox, A. M., Katz, C. M., Choate, D. E., & Hedberg, E. C. (2015). Evaluation of the Phoenix TRUCE project: A replication of Chicago CeaseFire. *Justice Quarterly*, *32*(1), 85–115. http://doi.org/10.1080/07418825.2014.902092

Frey, K. S., Hirschstein, M. K., Snell, J. L., Edstrom, L. V. S., MacKenzie, E. P., & Broderick, C. J. (2005). Reducing playground bullying and supporting beliefs: an experimental trial of the steps to respect program. *Developmental Psychology*, *41*(3), 479–490. http://doi.org/10.1037/0012-1649.41.3.479

Friedman, A. S. (1989). Family therapy vs. Parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy*, *17*(5), 335–347.

Gardner, F., Montgomery, P., & Knerr, W. (2015). Transporting Evidence-Based Parenting Programs for Child Problem Behavior (Age 3–10) Between Countries: Systematic Review and Meta-Analysis. *Journal of Clinical Child & Adolescent Psychology*, *0*(0), 1–14. http://doi.org/10.1080/15374416.2015.1015134

Glick, B., & Goldstein, A. P. (1987). Aggression Replacement Training. *Journal of Counseling and Development*, *65*, 356–362.

Glogowski, K. (2015). *What Works in Dropout Prevention: Research Evidence, Pathways to Education Program Design, and Practitioner Knowledge.* Toronto, ON.

Glogowski, K., & Ferreira, M. (2015). *Parental Engagement: Research Evidence, Practitioner Knoweldge, Effective Implementation*. Toronto, ON.

Goldstein, A. P., Glick, B., Reiner, S., Zimmerman, D., Coultry, T. M., & Gold, D. (1986). Aggression Replacement Training: A Comprehensive Intervention for the Acting-out Delinquent. *Journal of Correctional Education*, *37*(3), 120–126.

Gorman-Smith, D., & Cosey-Gay, F. (2012). Residents and Clients' Perceptions of Safety and CeaseFire Impact on Neighborhood Crime and Violence.

Gottfredson, D. C., Kumpfer, K. L., Polizzi-Fox, D., Wilson, D., Puryear, V., Beatty, P., & Vilmenay, M. (2006). The Strengthening Washington D.C. Families Project: A randomized effectiveness trial of family-based prevention. *Prevention Science*, *7*(1), 57–74. http://doi.org/10.1007/s11121-005-0017-y

Graaf, I. de, Speetjens, P., Smit, F., Wolff, M. de, & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on Behavioral Problems in Children: A Meta-Analysis. *Behavior Modification*, *32*(December), 714–735. http://doi.org/10.1111/j.1741-3729.2008.00522.x

Graham, C., Carr, A., Rooney, B., Sexton, T. L., & Wilson Satterfield, L. R. (2014). Evaluation of functional family therapy in an Irish context. *Journal of Family Therapy*, *36*(1), 20–38. http://doi.org/10.1111/1467-6427.12028

Greenberg, M. T., & Kusché, C. A. (1998). Preventive interventions for school-age deaf children: The PATHS curriculum. *Journal of Deaf Studies and Deaf Education*, *3*(1), 49–63. http://doi.org/10.1093/oxfordjournals.deafed.a014340

Greenberg, M. T., Kusché, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology*, *7*(1), 117–136. http://doi.org/10.1017/S0954579400006374

Griffin, K. W., Botvin, G. J., & Nichols, T. D. (2004). Long-Term Follow-Up Effects of a School-Based Drug Abuse Prevention Program on Adolescent Risky Driving. *Prevention Science*, *5*(3), 207–212.

Griffin, K. W., Botvin, G. J., & Nichols, T. D. (2006). Effects of a school-based drug abuse prevention program for adolescents on HIV risk behavior in young adulthood. *Prevention Science*, *7*(1), 103–112. http://doi.org/10.1007/s11121-006-0025-6

Gundersen, K., & Svartdal, F. (2006). Aggression Replacement Training in Norway: Outcome evaluation of 11 Norwegian student projects. *Scandinavian Journal of Educational Research*, *50*(1), 63–81. http://doi.org/10.1080/00313830500372059

Hamre, B. K., Pianta, R. C., Mashburn, A. J., & Downer, J. T. (2012). Promoting young children's social competence through the preschool PATHS curriculum and MyTeachingPartner professional development resources. *Early Education & Development*, *23*(6), 809–832. http://doi.org/10.1080/10409289.2011.607360

Hammond, W., & Zimmerman, R. (2012). A strengths-based perspective. *Resiliency Initiatives*. Retrieved from http://www.resiliencyinitiatives.ca/cms/wp-content/uploads/2013/03/STRENGTH_BASED_PERSPECTIVE-Dec-10-2012.pdf

Hannem, S. (2013). Experiences in Reconciling Risk Management and Restorative Justice: How Circles of Support and Accountability Work Restoratively in the Risk Society. *International Journal of Offender Therapy and Comparative Criminology*, *57*(3), 269–288. http://doi.org/10.1177/0306624X11432538

Hannem, S., & Petrunik, M. (2004). Canada's Circles of Support and Accounability: A Community Justice Initiative for High-Risk Sex Offenders. *Corrections Today*, (December), 98–102.

Hannem, S., & Petrunik, M. (2007). Canada's Circles of Support and Accountability: A Community Justice Initiative for the Reintegration of High-Risk Sex Offenders. *Contemporary Justice Review*, *10*(2), 153–171. http://doi.org/10.1080/10282580701372046

Harris, V. W., & Sherman, J. A. (1973). Use and analysis of the "Good Behavior Game" to reduce disruptive classroom behavior. *Journal of Applied Behavior Analysis*, *6*(3), 405–17. http://doi.org/<a data-auto="ep_link"href="http://dx.doi.org.proxy.bsu.edu/10.1901/jaba.1973.6-405" target="_blank" id="linkhttp:dx.doi.org10.1901jaba.1973.6-405" title="http://dx.doi.org.proxy.bsu.edu/10.1901/jaba.1973.6-405" datatitle="http://dx.doi.org.proxy.bsu.edu/10.1901/jaba.1973.6-405">http://dx.doi.org.proxy.bsu.edu/10.1901/jaba.1973.6405

Harrison, R. S., Boyle, S. W., & Farley, O. W. (1999). Evaluating the outcomes of family-based intervention for troubled children: A pretest-posttest study. *Research on Social Work Practice*, *9*(6), 640–655. http://doi.org/http://dx.doi.org/10.1177/104973159900900602

Henggeler, S. W. (2001). Multisystemic Therapy. *Residential Treatment For Children & Youth*, *18*(3), 75–85. http://doi.org/10.1300/J007v18n03_07

Henggeler, S. W., Cunningham, P., Pickrel, S., Schoenwald, S. K., & Brondino, M. (1996). Multisystemic therapy: an effective violence prevention approach for serious juvenile offenders. *Journal of Adolescence*, *19*(1), 47–61. http://doi.org/10.1006/jado.1996.0005

Henggeler, S. W., Schoenwald, S. K., Liao, J. G., Letourneau, E. J., & Edwards, D. L. (2002). Transporting Efficacious Treatments to Field Settings: The Link Between Supervisory Practices and Therapist Fidelity in MST Programs. *Journal of Clinical Child & Adolescent Psychology*, *31*(2), 155–167. http://doi.org/10.1207/S15374424JCCP3102_02

Henry, D. B., Knoblauch, S., & Sigurvinsdottir, R. (2014). The Effect of Intensive CeaseFire Intervention on Crime in Four Chicago Police Beats, *Quantitative Assessment*, 1–52.

Hirschstein, M. K., Edstrom, L. V. S., Frey, K. S., Snell, J. L., & MacKenzie, E. P. (2007). Walking the Talk in Bullying Prevention: Teacher Implementation Variables Related to Initial Impact of the Steps to Respect Program. *School Psychology Review*, *36*(1), 3–21.

Höing, M., Bogaerts, S., & Vogelvang, B. (2013). Circles of Support and Accountability: How and Why They Work for Sex Offenders. *Journal of Forensic Psychology Practice*, *13*(4), 267–295. http://doi.org/10.1080/15228932.2013.808526

Holman, A., Powers, L., Boyer, S., Janssen, M., & Sweeney, B. (2016). Achieve My Plan: Findings from a Randomized Study of a Youth Engagement Enhancement for Wraparound. Tampa, FL: Children's Mental Health Research and Policy Conference.

Hopson, L., Wodarski, J. S., & Tang, N. (2015). The effectiveness of electronic approaches to substance abuse prevention for adolescents. *E-Therapy for Substance Abuse and Co-Morbidity*, 35–51. http://doi.org/10.1007/978-3-319-12376-9_4

Houlding, C., Schmidt, F., Stern, S. B., Jamieson, J., & Borg, D. (2012). The perceived impact and acceptability of Group Triple P Positive Parenting Program for Aboriginal parents in Canada. *Children and Youth Services Review*, *34*(12), 2287–2294. http://doi.org/10.1016/j.childyouth.2012.08.001

Humphrey, N., Barlow, A., Wigelsworth, M., Lendrum, A., Pert, K., Joyce, C., … Turner, A. (2015). A cluster randomized controlled trial of the Promoting Alternative Thinking Strategies (PATHS) curriculum. *Under Review*, *58*, 73–89. http://doi.org/10.1016/j.jsp.2016.07.002

Hyde, K. L., Burchard, J. D., & Woodworth, K. (1996). Wrapping services in an urban setting. *Journal of Child and Family Studies*, *5*(1), 67–82. http://doi.org/10.1007/BF02234679

Inam, A., Tariq, P. N., & Zaman, S. (2015). Cultural adaptation of preschool PATHS (Promoting Alternative Thinking Strategies) curriculum for Pakistani children. *International Journal of Psychology*, *50*(3), 232–239. http://doi.org/10.1002/ijop.12090

Johnson-Motoyama, M., Brook, J., Yan, Y., & McDonald, T. P. (2013). Cost analysis of the strengthening families program in reducing time to family reunification among substance-affected families. *Children and Youth Services Review*, *35*(2), 244–252. http://doi.org/10.1016/j.childyouth.2012.11.008

Johnson, M. R., Turner, P. F., & Konarski, E. A. (1978). The "Good Behavior Game": A Systematic Replication in Two Unruly Transitional Classrooms. *Education and Treatment of Children*, *1*(3), 25–33.

Jurecska, D. E., Hamilton, E. B., & Peterson, M. A. (2011). Effectiveness of the Coping Power Program in middle-school children with disruptive behaviours and hyperactivity difficulties. *Support for Learning*, *26*(4), 168–172. http://doi.org/10.1111/j.1467-9604.2011.01499.x

Kam, C.-M., Greenberg, M. T., & Kusché, C. A. (2004). Sustained Effects of the PATHS Curriculum on the Social and Psychological Adjustment of Children in Special Education. *Journal of Emotional and Behavioral Disorders*, *12*(2), 66–78. http://doi.org/10.1177/10634266040120020101

Kam, C.-M., Greenberg, M. T., & Walls, C. T. (2003). Role of implementation quality in schools using PATHS curriculum. *Prevention Science*, *4*(1).

Keenan, M., Moore, J. L., & Dillenburger, K. (2000). The good behavior game. *Child Care in Practice*, *6*(1), 27–38. http://doi.org/10.1080/13575270008413191

Kellam, S. G., & Anthony, J. C. (1998). Targeting Early Antecedents to Prevent Tobacco Smoking: Findings from an Epidemiologically Based Randomized Field Trial. *American Journal of Public Health*, *88*(10), 1490–1495.

Kellam, S. G., Mackenzie, A. C. L., Brown, C. H., Poduska, J. M., Wang, W., Petras, H., & Wilcox, H. C. (2011). The good behavior game and the future of prevention and treatment. *Addiction Science & Clinical Practice*, *6*(1), 73–84. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22003425%5Cnhttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC3188824

Kellam, S. G., Rebok, G. W., Ialongo, N. S., & Mayer, L. S. (1994). The Course and Malleability of Aggressive Behavior from Early First Grade into Middle School : Results of a Developmental Epidemiologically-based Preventive Trial. *Journal of Child Psychiatry*, *35*(2), 259–281.

Keller, A. (2007). Youth mentoring: Theoretical and methodological issues. In T. Allen & L. Eby (Eds.), *The Blackwell Handbook of Mentoring: A Multiple Perspectives Approach* (pp. 23-47). Malden, MA: Blackwell Publishing.

Kelly, B., Edgerton, C., Graham, S., Robertson, E., & Syme, B. (2015). Parents and the Preschool PATHS (Promoting Alternative Thinking Strategies) curriculum. *Journal of Children's Services*, *10*(3), 231–241. http://doi.org/10.1108/JCS-03-2015-0012

Kleinman, K. E., & Saigh, P. A. (2011). The Effects of the Good Behavior Game on the Conduct of Regular Education New York City High School Students. *Behavior Modification*, *35*(1), 95–105. http://doi.org/10.1177/0145445510392213

Koegl, C. J., Farrington, D. P., Augimeri, L. K., & Day, D. M. (2008). Evaluation of a targeted cognitive-behavioral program for children with conduct problems--the SNAP Under 12 Outreach Project: service intensity, age and gender effects on short- and long-term outcomes. *Clinical Child Psychology and Psychiatry*, *13*(3), 419–434. http://doi.org/10.1177/1359104508090606

Koposov, R., Gundersen, K. K., & Svartdal, F. (2014). Efficacy of Aggression Replacement Training among Children from North-West Russia. *International Journal of Emotional Education*, *6*(1), 14–24. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=eric&AN=EJ1085611&site=ehost-live

Krug, E.G. et al. (2002). *World report on violence and health*. Geneva: World Health Organization.

Kumpfer, K. L., Alvarado, R., Tait, C., & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8-year-old rural children. *Psychology of Addictive Behaviors*, *16*(4), S65–S71. http://doi.org/10.1037//0893-164x.16.4s.s65

Kumpfer, K. L., & Bluth, B. (2004). Parent/Child Transactional Processes Predictive of Resilience or Vulnerability to "Substance Abuse Disorders." *Substance Use & Misuse*, *39*(5), 671–698. http://doi.org/10.1081/JA-120034011

Kumpfer, K. L., Pinyuchon, M., de Melo, A. T., & Whiteside, H. O. (2008). Culutural Adaptation Process for International Dissemination of the Strengthening Families Program. *Evaluation & the Health Professions*, *31*(2), 226–239.

Kumpfer, K. L., Whiteside, H. O., Greene, J. A., & Allen, K. C. (2010). Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites. *Group Dynamics: Theory, Research, and Practice*, *14*(3), 211–229. http://doi.org/10.1037/a0020602

Kumpfer, K. L., Xie, J., & O'Driscoll, R. (2012). Effectiveness of a Culturally Adapted Strengthening Families Program 12-16 Years for High-Risk Irish Families. *Child and Youth Care Forum*, *41*(2), 173–195. http://doi.org/10.1007/s10566-011-9168-0

Lastrapes, R. E. (2014). Using the Good Behavior Game in an Inclusive Classroom. *Intervention in School and Clinic*, *49*, 225–229. http://doi.org/10.1177/1053451213509491

Lechtenberger, D., Barnard-Brak, L., Sokolosky, S., & McCrary, D. (2012). Using Wraparound to Support Students with Developmental Disabilities in Higher Education. *College Student Journal*, *46*(4), 856–866. Retrieved from http://search.proquest.com/docview/1347460527?accountid=12507%5Cnhttp://openurl.ac.uk/athens:mmu/?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&genre=article&sid=ProQ:ProQ:ericshell&atitle=Using+Wraparound+to+Support+Students+with+Development

Leflot, G., van Lier, P. A. C., Onghena, P., & Colpin, H. (2013). The role of children's on-task behavior in the prevention of aggressive behavior development and peer rejection : A randomized controlled study of the Good Behavior Game in Belgian elementary classrooms. *Journal of School Psychology*, *51*, 187–199. http://doi.org/10.1016/j.jsp.2012.12.006

Lerner, R. M., Brittian, A. S., & Fay, K. E. (2007). Mentoring: A key resource for promoting positive youth development. MENTOR/ National Mentoring Partnership. Retrieved from http://www.mentoring.org/downloads/mentoring_382.pdf

Lerner, R. M., Napolitano, C. M., Boyd, M. J., Mueller, M. K., & Callina, K. S. (2014). Mentoring and positive youth development. In D. L. DuBois & M. J. Karcher (Eds.), *Handbook of Youth Mentoring* (pp. 17-29). Thousand Oaks, CA: SAGE Publications, Inc.

Leschied, A. & Cunningham, A. (2002). Seeking Effective Interventions for Serious Young Offenders: Interim Results of a Four-Year Randomized Study of Multisystemic Therapy in Ontario, Canada. Retrieved from http://www.lfcc.on.ca/seeking.html

Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, *27*(6), 978–85. http://doi.org/10.1037/a0034710

Leung, C., Sanders, M. R., Ip, F., & Lau, J. (2006). Implementation of Triple P-Positive Parenting Program in Hong Kong: predictors of programme completion and clinical outcomes. *Journal of Children's Services*, *1*(2), 4–17. http://doi.org/http://dx.doi.org/10.1108/17466660200600010

Leung, C., Sanders, M. R., Leung, S., Mak, R., & Lau, J. (2003). An Outcome of Evaluation of the Implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process*, *42*(4), 531–544.

Lewis, K. M., Dubois, D. L., Bavarian, N., Acock, A. C., Silverthorn, N., Day, J., … Flay, B. R. (2013). Effects of positive action on the emotional health of urban youth: A cluster-randomized trial. *Journal of Adolescent Health, 53*(6), 706–711. http://doi.org/10.1016/j.jadohealth.2013.06.012

Li, K.-K., Washburn, I. J., Dubois, D. L., Vuchinich, S., Ji, P., Brechling, V., … Flay, B. R. (2011). Effects of the Positive Action programme on problem behaviours in elementary school students: a matched-pair randomised control trial in Chicago. *Psychol Health, 26*(2), 187–204. http://doi.org/10.1080/08870446.2011.531574

Lipman, E. L., Kenny, M., Brennan, E., O'Grady, S., & Augimeri, L. K. (2011). Helping boys at-risk of criminal activity: qualitative results of a multi-component intervention. *BMC Public Health, 11*(1), 364–375. http://doi.org/10.1186/1471-2458-11-364

Lipman, E. L., Kenny, M., Sniderman, C., O'Grady, S., Augimeri, L. K., Khayutin, S., & Boyle, M. H. (2008). Evaluation of a community-based program for young boys at-risk of antisocial behaviour: results and issues. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Académie Canadienne de Psychiatrie de L'enfant et de L'adolescent, 17*(1), 12–9. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2247441&tool=pmcentrez&rendertype=abstract

Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). Improving the Effectiveness of Juvenile Justice Programs. Washington, D.C.: Centre for Juvenile Justice Reform.

Lisha, N. E., Sun, P., Rohrbach, L. a., Spruijt-Metz, D., Unger, J. B., & Sussman, S. (2012). An Evaluation of Immediate Outcomes and Fidelity of a Drug Abuse Prevention Program in Continuation High Schools: Project Towards No Drug Abuse (TND). *Journal of Drug Education, 42*(1), 33–57. http://doi.org/10.2190/DE.42.1.c

Lochman, J. E., Baden, R. E., Boxmeyer, C. L., Powell, N. P., Qu, L., Salekin, K. L., & Windle, M. (2014). Does a booster intervention augment the preventive effects of an abbreviated version of the Coping Power program for aggressive children? *Journal of Abnormal Child Psychology, 42*(3), 367–381. http://doi.org/10.1007/s10802-013-9727-y

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Roth, D. L., & Windle, M. (2006). Masked Intervention Effects: Analytic Methods for Addressing Low Dosage of Interventions. In *New Directions for Evaluation* (pp. 19–32). http://doi.org/10.1002/ev

Lochman, J. E., Powell, N. P., Boxmeyer, C. L., Andrade, B., Stromeyer, S. L., & Jimenez-Camargo, L. A. (2012). Adaptations to the coping power program's structure, delivery settings, and clinician training. *Psychotherapy (Chicago, Ill.), 49*(2), 135–42. http://doi.org/10.1037/a0027165

Lochman, J. E., & Wells, K. C. (2002a). Contextual social – cognitive mediators and child outcome : A test of the theoretical model in the Coping Power program. *Development and Psychopathology, 14*, 945–967. http://doi.org/10.1017.S0954579402004157

Lochman, J. E., & Wells, K. C. (2002b). The Coping Power Program at the middle-school transition: Universal and indicated prevention effects. *Psychology of Addictive Behaviors*, *16*(4 Suppl), S40–S54. http://doi.org/10.1037/0893-164X.16.4S.S40

Lochman, J. E., & Wells, K. C. (2003). Effectiveness of the Coping Power program and of classroom intervention with aggressive children: Outcomes at a 1-year follow-up. *Behavior Therapy*, *34*(4), 493–515. http://doi.org/10.1016/S0005-7894(03)80032-1

Low, S., Frey, K. S., & Brockman, C. J. (2010). Gossip on the Playground: Changes Associated with Universal Intervention, Retaliation Beliefs, and Supportive Friends. *School Psychology Review*, *39*(4), 536–551.

Low, S., Van Ryzin, M. J., Brown, E. C., Smith, B. H., & Haggerty, K. P. (2014). Engagement Matters: Lessons from Assessing Classroom Implementation of Steps to Respect: A Bullying Prevention Program Over a One-year Period. *Prevention Science*, *15*(2), 165–176. http://doi.org/10.1007/s11121-012-0359-1

Lutzker, J. R., & White-Blackburn, G. (1979). The Good Productivity Game: Increasing Work Performance in a Rehabilitation Setting. *Journal of Applied Behavior Analysis*, *12*(3), 488. http://doi.org/10.1901/jaba.1979.12-488

McGarrell, E. F., Corsaro, N., Melde, C., Hipple, N. K., Bynum, T., & Cobbina, J. (2013). Attempting to reduce firearms violence through a Comprehensive Anti-Gang Initiative (CAGI): An evaluation of process and impact. *Journal of Criminal Justice*, *41*, *1*, 33-43.

MacKillop, J., Ryabchenko, K. a, & Lisman, S. a. (2006). Life skills training outcomes and potential mechanisms in a community implementation: a preliminary investigation. *Substance Use & Misuse*, *41*(14), 1921–1935. http://doi.org/10.1080/10826080601025862

Magalhães, C. C. A., & Kumpfer, K. L. (2015). Effectiveness of culturally adapted Strengthening Families Programme 6-11 years among Portuguese families. *Journal of Children's Services*, *10*(2), 151–160. http://doi.org/10.1108/JCS-02-2014-0010

Malysiak, R. (1997). Exploring the Theory and Paradigm Base for Wraparound. *Journal of Child and Family Studies*, *6*(4), 399–408. http://doi.org/10.1111/j.1539-6924.1997.tb00868.x

Matsumoto, Y., Sofronoff, K., & Sanders, M. R. (2010). Investigation of the Effectiveness and Social Validity of the Triple P Positive Parenting Program in Japanese Society. *Journal of Family Psychology*, *24*(1), 87–91. http://doi.org/10.1037/a0018181

McClanahan, W. S., Kauh, T. J., Manning, A. E., Campos, P., & Farley, C. (2012). *Illuminating Solutions: The Youth Violence Reduction Partnership.* Public/Private Ventures.

McConnell, D., Breitkreuz, R., & Savage, A. (2012). Independent evaluation of the Triple P Positive Parenting Program in family support service settings. *Child and Family Social Work*, *17*(1), 43–54. http://doi.org/10.1111/j.1365-2206.2011.00771.x

McIntosh, C. (2015). *Final Evaluation Summary of the Multisystemic Therapy Program*.

Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice*, *19*, 678–685. http://doi.org/10.1177/1049731508329385

Medland, M. B., & Stachnik, T. J. (1972). Good-Behavior Game: A Replication and Systematic Analysis. *Journal of Applied Behavior Analysis*, *5*(1), 45–51.

Miller, A. L., Perryman, J., Markovitz, L., Franzen, S., Cochran, S., & Brown, S. (2013). Strengthening incarcerated families: Evaluating a pilot program for children of incarcerated parents and their caregivers. *Family Relations*, *62*(4), 584–596. http://doi.org/10.1111/fare.12029

Multisystemic Therapy Services. (n.d.-a). *Multisystemic Therapy: An Overview*. Retrieved from http://mstservices.com/files/overview_a.pdf

Multisystemic Therapy Services. (n.d.-b). *Multisystemic Therapy: Clinical Outcomes and Cost Savings*. Retrieved from http://mstservices.com/files/outcomes_1a.pdf

Multisystemic Therapy Services. (2007). *MST Services*. Retrieved from http://mstservices.com/files/msttreatmentmodel.pdf

Muratori, P., Bertacchi, I., Giuli, C., Lombardi, L., Bonetti, S., Nocentini, A., … Lochman, J. E. (2015). First Adaptation of Coping Power Program as a Classroom-Based Prevention Intervention on Aggressive Behaviors Among Elementary School Children. *Prevention Science*, *16*(3), 432–439. http://doi.org/10.1007/s11121-014-0501-3

National Crime Prevention Centre. (2008). *Promising and Model Crime Prevention Programs*. *Prevention*.

National Crime Prevention Centre. (2011). *Promising and Model Crime Prevention Programs Volume Ii* (Vol. II).

National Crime Prevention Centre. (2013a). *Results from the Alternative Suspension (AS) Program*.

National Crime Prevention Centre. (2013b). Results from the Youth Inclusion Program – Atlantic Canada, 3–5.

National Crime Prevention Centre. (2013c). *The Stop Now and Plan Program – SNAP ® Crime Prevention in Action*. Ottawa, ON.

Nix, R. L., Bierman, K. L., Domitrovich, C. E., & Gill, S. (2013). Promoting children's social-emotional skills in preschool can enhance academic and behavioral functioning in kindergarten: Findings from Head Start REDI. *Early Education and Development*, *24*, 1000–1019. http://doi.org/10.1080/10409289.2013.825565

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of triple P-positive parenting program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review, 11*(3), 114–144. http://doi.org/10.1007/s10567-008-0033-0

Nugent, W. R., Bruley, C., & Allen, P. (1999). The Effects of Aggression Replacement Training on Male and Female Antisocial Behavior in a Runaway Shelter. *Research on Social Work Practice, 9*(4), 466–482. http://doi.org/10.1177/104973159900900404

O'Donnell, S. L., Jurecska, D. E., & Dyer, R. (2012). Effectiveness of the coping power program in a Mexican-American sample: distinctive cultural considerations. *International Journal of Culture and Mental Health, 5*(1), 30–39. http://doi.org/10.1080/17542863.2010.547272

Office of Justice Programs (2010). *Best Practices to Address Community Gang Problems: OJJDP's Comprehensive Gang Model.* U.S. Department of Justice.

Ogden, T., & Halliday-Boykins, C. a. (2004). Multisystemic Treatment of Antisocial Adolescents in Norway: Replication of Clinical Outcomes Outside of the US, Multisystemic Treatment of Antisocial Adolescents in Norway: Replication of Clinical Outcomes Outside of the US. *Child and Adolescent Mental Health, Child and Adolescent Mental Health, 9, 9*(2, 2), 77, 77–83, 83. http://doi.org/10.1111/j.1475-3588.2004.00085.x, 10.1111/j.1475-3588.2004.00085.x

Ogles, B. M., Carlston, D., Hatfield, D., Melendez, G., Dowell, K., & Fields, S. A. (2006). The role of fidelity and feedback in the wraparound approach. *Journal of Child and Family Studies*, *15*(1), 115–129. http://doi.org/10.1007/s10826-005-9008-7

Pathways to Education. (2011). *Pathways to Education Canada Results Summary: Spring 2011*. Toronto, ON.

Pathways to Education. (2012). *2011 Results Summary*. Toronto, ON.

Pathways to Education. (2014a). *2013-2014 Results Summary*. Toronto, ON.

Pathways to Education. (2014b). *Pathways to Education: 2013 Results Summary*. Toronto, ON.

Pepler, D. J., Craig, W. M., Ziegler, S., & Charach, A. (1994). An Evaluation of An Anti-Bullying Intervention in Toronto Schools. *Canadian Journal of Community Mental Health, 13*(2), 95–110.

Peterson, M. a., Hamilton, E. B., & Russell, A. D. (2009). Starting Well: Facilitating the Middle School Transition. *Journal of Applied School Psychology*, *25*(3), 286–304. http://doi.org/10.1080/15377900802487219

Petra, M., & Kohl, P. (2010). Pathways Triple P and the child welfare system: A promising fit. *Children and Youth Services Review, 32*(4), 611–618. http://doi.org/10.1016/j.childyouth.2009.12.008

Petrosino, A., Campie, P., Pace, J., Fronius, T., Guckenburg, S., Wiatrowski, M., & Rivera, L. (2015). Cross-sector, multi-agency interventions to address urban youth firearms violence: A rapid evidence assessment. *Aggression and Violent Behavior*, *22*, 87-96.

Picard-Fritsche, S., Cerniglia, L., & Innovations, C. for C. (2013). Testing a public health approach to gun violence: An evaluation of Crown Heights Save Our Streets, a replication of the Cure Violence Model. *Research*, 42. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/SOS_Evaluation.pdf

Poduska, J. M., Kellam, S. G., Wang, W., Brown, C. H., Ialongo, N. S., & Toyinbo, P. (2008). Impact of the Good Behavior Game, a universal classroom-based behavior intervention, on young adult service use for problems with emotions, behavior, or drugs or alcohol. *Drug and Alcohol Dependence*, *95*(SUPPL. 1). http://doi.org/10.1016/j.drugalcdep.2007.10.009

Potter, S. (2016). Reactions to Trauma at the Community Level. Ottawa: Crime Prevention Ottawa. Retrieved from http://www.crimepreventionottawa.ca/Media/Content/files /Publications/Neighbourhoods/Reaction%20to%20Trauma%20at%20the%20Community 20Level%20Final%20EN-Full%20Report%20-%20March%2031%202016(4).pdf

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*, *10*(1), 1–12. http://doi.org/10.1007/s11121-016-0631-x

Public Safety Canada. (2009). *The Aboriginal EMPATHIC Program*.

Public Safety Canada. (2013). *Results from the Stop Now and Plan (SNAP) Program*.

Public Safety Canada. (2016). Leadership and Resiliency Program (LRP) - Crime Prevention in Action. Retrieved October 13, 2016, from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ldrshp-rslncy-prgrm/index-eng.aspx

Pullmann, M. D. (2006). Juvenile Offenders With Mental Health: Reducing Recidivism Using Wraparound. *Crime & Delinquency*, *52*(3), 375–397. http://doi.org/10.1177/0011128705278632

Quick, H., Coldiron, J. S., & Bruns, E. J. (2014). *A comprehensive review of published wraparound literature, 1988-2012*. Portland, OR. Retrieved from http://nwi.pdx.edu/pdf/review-of-published-wrap-literature-08-2014.pdf

Rawana et al. (2009). *Strengths in Motion: A Strengths-Based Approach to Enhance Positive School Climate and Address Issues of Bullying and School Violence*. Retrieved from http://www.oesc-cseo.org/english/BVPfinalReports/lakeheadDSBfinalReport.pdf

Redmond, C., Spoth, R. L., Shin, C., & Lepper, H. S. (1999). Modeling Long-Term Parent Outcomes of Two Universal Family-Focused Preventive Interventions: One-Year Follow-Up Results. *Journal of Consulting and Clinical Psychology*, *67*(6), 975–984.

Riesch, S. K., Brown, R. L., Anderson, L. S., Wang, K., Canty-Mitchell, J., & Johnson, D. L. (2012). Strengthening Families Program (10-14): Effects on the Family Environment. *Western Journal of Nursing Research*, *34*(3), 340–376. http://doi.org/10.1177/0193945911399108

Riggs, N. R., Greenberg, M. T., Kusché, C. A., & Pentz, M. A. (2006). The mediational role of neurocognition in the behavioral outcomes of a social-emotional prevention program in elementary school students: Effects of the PATHS Curriculum. *Prevention Science*, *7*(1), 91–102. http://doi.org/10.1007/s11121-005-0022-1

Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. a. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: individual and systemic effects. *Journal of Family Psychology*, *17*(4), 534–44. http://doi.org/10.1037/0893-3200.17.4.534

Roebuck, B., Roebuck, M.A., & Roebuck, J. (2011). *From Strength to Strength: A Manual to Inspire and Guide strength-based interventions with young people*. Cornwall: Youth Now Intervention Services.

Roehlkepartain, E. C., Pekel, K., Syvertsen, A. K., Sethi, J., Sullivan, T. K., & Scales, P. C. (2017). *Relationships First: Creating Connections that Help Young People Thrive*. Minneapolis, MN: Search Institute. Available from www.search-institute.org

Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced versus coordinated treatment for adolescents with comorbid depressive and substance use disorders. *Journal of Consulting and Clinical Psychology*, *82*(2), 342–8. http://doi.org/10.1037/a0035808

Rohrbach, L. A., Gunning, M., Sun, P., & Sussman, S. (2010). The project Towards No Drug Abuse (TND) dissemination trial: Implementation fidelity and immediate outcomes. *Prevention Science*, *11*(1), 113–113. http://doi.org/10.1007/s11121-009-0155-8

Rohrbach, L. A., Sun, P., & Sussman, S. (2010). One-year follow-up evaluation of the Project Towards No Drug Abuse (TND) dissemination trial. *Preventive Medicine*, *51*(3–4), 313–319. http://doi.org/10.1016/j.ypmed.2010.07.016

Roth, B. S., & Striepling-Goldstein, S. (2003). School-Based Aggression Replacement Training. *Reclaiming Children and Youth*, *12*(3), 138–141.

Roux, G., Sofronoff, K., & Sanders, M. R. (2013). A randomized controlled trial of group stepping stones triple P: A mixed-disability trial. *Family Process*, *52*(3), 411–424. http://doi.org/10.1111/famp.12016

Ruiz-Olivares, R., Pino, M. J., & Herruzo, J. (2010). Reduction of Disruptive Behaviors Using an Intervention Based on the Good Behavior Game and the Say-Do-Report Correspondance. *Psychology in the Schools*, *47*(10), 1046–1058. http://doi.org/10.1002/pits

Saigh, P. A., & Umar, A. M. (1983). The effects of a good behavior game on the disruptive behavior of Sudanese elementary school students. *Journal of Applied Behavior Analysis, 16*(3), 339–344. http://doi.org/10.1901/jaba.1983.16-339

Salend, S. J., Reynolds, C. J., & Coyle, E. M. (1989). Individualizing the Good Behavior Game Across Type and Frequency of Behavior with Emotionally Disturbed Adolescents. *Behavior Modification*, *13*(1), 108–126.

Salmivalli, C., Kaukiainen, A., & Voeten, M. (2005). Anti-bullying intervention: Implementation and outcome. *British Journal of Educational Psychology*, *75*, 465–487. http://doi.org/10.1348/000709905X26011

Sanders, M. R. (1999). The Triple P - Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Clinical Child and Family Psychology Review*, *2*(2), 71–90. http://doi.org/10.1037/a0035997

Sanders, M. R., Kirby, J. N., Tellegen, C. L., & Day, J. J. (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review*, *34*(4), 337–357. http://doi.org/10.1016/j.cpr.2014.04.003

Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P Positive Parenting Program: A Comparison of Enhanced, Standard, and Self-Directed Behavioral Family Intervention for Parents of Child with Early Onset Conduct Problems. *Journal of Consulting and Clinical Psychology*, *68*(4), 624–640.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*, *29*(3), 197–222. http://doi.org/10.1007/s10935-008-0139-7

Sanford DeRousie, R. M., & Bierman, K. L. (2012). Examining the sustainability of an evidence-based preschool curriculum: The REDI program. *Early Childhood Research Quarterly*, *27*(1), 55–65. http://doi.org/10.1016/j.ecresq.2011.07.003

Savoji, A. P., & Ganji, K. (2013). Increasing Mental Health of University Students through Life Skills Training (LST). *Procedia - Social and Behavioral Sciences*, *84*, 1255–1259. http://doi.org/10.1016/j.sbspro.2013.06.739

Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 73*(3), 445–453. http://doi.org/10.1037/0022-006X.73.3.445

Schmitt, S. A., Flay, B. R., & Lewis, K. M. (2014). A pilot evaluation of the Positive Action prekindergarten lessons. *Early Child Development and Care*, *184*(12), 1978–1991. http://doi.org/10.1080/03004430.2014.903942

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). Multisystemic therapy versus hospitalization for crisis stabilization of youth: placement outcomes 4 months postreferral. *Mental Health Services Research*, *2*(1), 3–12. http://doi.org/10.1023/A:1010187706952

Search Institute. (1997). 4*0 developmental assets*. Retrieved from http://www.search institute.org/content/40-developmental-assets-adolescents-ages-12-18

Search Institute. (2000). 4*0 developmental assets*. Retrieved from http://www.search-institute.org/content/40-developmental-assets-adolescents-ages-12-18

Seifer, R., Gouley, K., Miller, A. L., & Zakriski, A. (2004). Implementation of the PATHS Curriculum in an Urban Elementary School. *Early Education & Development*, *15*(4), 471–486. http://doi.org/10.1207/s15566935eed1504

Sexton, T. L., & Turner, C. W. (2011). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Couple and Family Psychology: Research and Practice*, *1*(S), 3–15. http://doi.org/10.1037/a0019406

Sherman, L.W., Farrington, D.P. Welsh, B.C. & MacKenzie, D.L. (2002). *Evidence-based crime prevention.* New York: Routledge.

Skara, S., Rohrbach, L. A., Sun, P., & Sussman, S. (2005). An evaluation of the fidelity of implementation of a school-based drug abuse prevention program: project toward no drug abuse (TND). *Journal of Drug Education*, *35*(4), 305–29. http://doi.org/10.2190/4LKJ-NQ7Y-PU2A-X1BK

Skärstrand, E., Larsson, J., & Andréasson, S. (2008). Cultural adaptation of the Strengthening Families Programme to a Swedish setting. *Health Education*, *108*(4), 287. http://doi.org/10.1108/09654280810884179

Skogan, W. G., Hartnett, S. M., Bump, N., Dubois, J., Hollon, R., Morris, D., & Block, R. (2008). Evaluation of CeaseFire Chicago. Washington, DC: National Institute of Justice, Office of Justice Programs.

Slesnick, N., & Prestopnik, J. L. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, *35*(3), 255–277. http://doi.org/10.1111/j.1752-0606.2009.00121.x

Smith, E. A., Swisher, J. D., Vicary, J. R., Bechtel, L. J., Minner, D., Henry, K. L., & Palmer, R. (2004). Evaluation of Life Skills Training and Infused-Life Skills Training in a rural setting: Outcomes at two years. *Journal of Alcohol and Drug Education*, *48*(1), 51–70. Retrieved from http://ovidsp.ovid.com?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc4&AN=2004-18283005%5Cnhttp://library.newcastle.edu.au:4550/resserv?sid=OVID:psycdb&id=pmid: &id=&issn=0090-1482&isbn=&volume=48&issue=1&spage=51&pages=51 70&date=2004&title=Journal+of+Alcohol+and

Snyder, F. J., Acock, A. C., Vuchinich, S., Beets, M. W., Washburn, I. J., & Flay, B. R. (2013). Preventing negative behaviors among elementary-school students through enhancing students' social-emotional and character development. *American Journal of Health Promotion*, *28*(1), 50–58. http://doi.org/10.4278/ajhp.120419-QUAN-207.2

Snyder, F. J., Flay, B. R., Vuchinich, S., Acock, A. C., Washburn, I. J., Beets, M. W., & Li, K.-K. (2010). Impact of a Social-Emotional and Character Development Program on School-Level Indicators of Academic Achievement, Absenteeism, and Disciplinary Outcomes: A Matched-Pair, Cluster-Randomized, Controlled Trial. *Journal of Research on Educational Effectiveness*, *3*(1), 26. http://doi.org/10.1080/19345740903353436

Snyder, F. J., Vuchinich, S., & Acock, A. C. (2012). Through the Use of a Social-Emotional and Character Development Program : Controlled Trial in Hawai i. *Journal of School Health*, *82*(1), 11–20.

Spergel, I., & Grossman, S. F. (1997). The Little Village Project: A community approach to the gang problem. *The Social Worker, 42, 5,* 456-470.

Spoth, R. L., Guyll, M., & Day, S. X. (2002). Universal Family-Focused Interventions in Alcohol-Use Disorder Prevention: Cost-Effectiveness and Cost-Benefit Analyses of Two Interventions. *Journal of Studies on Alcohol*, *63*(2), 219–228.

Spoth, R. L., Guyll, M., & Shin, C. (2009). Universal intervention as a protective shield against exposure to substance use: Long-term outcomes and public health significance. *American Journal of Public Health*, *99*(11), 2026–2033. http://doi.org/10.2105/AJPH.2007.133298

Spoth, R. L., Randall, G. K., Trudeau, L., Shin, C., & Redmond, C. (2008). Substance use outcomes 51/2 years past baseline for partnership-based, family-school preventive interventions. *Drug and Alcohol Dependence*, *96*(1–2), 57–68. http://doi.org/10.1016/j.drugalcdep.2008.01.023

Spoth, R. L., Redmond, C., & Shin, C. (1998). Direct and indirect latent-variable parenting outcomes of two universal family-focused preventive interventions: extending a public health-oriented research base. *Journal of Consulting and Clinical Psychology*, *66*(2), 385–399. http://doi.org/10.1037/0022-006X.66.2.385

Spoth, R. L., Redmond, C., Shin, C., & Azevedo, K. (2004). Brief family intervention effects on adolescent substance initiation: school-level growth curve analyses 6 years following baseline. *Journal of Consulting and Clinical Psychology*, *72*(3), 535–542. http://doi.org/10.1037/0022-006X.72.3.535

Spoth, R. L., Redmond, C., Trudeau, L., & Shin, C. (2002). Longitudinal substance initiation outcomes for a universal preventive intervention combining family and school programs. *Psychology of Addictive Behaviors*, *16*(2), 129–134. http://doi.org/10.1037//0893-164X.16.2.129

Spoth, R. L., Trudeau, L., Guyll, M., Shin, C., & Redmond, C. (2009). Universal intervention effects on substance use among young adults mediated by delayed adolescent substance initiation. *Journal of Consulting and Clinical Psychology*, *77*(4), 620–632. http://doi.org/10.1037/a0016029

Spoth, R. L., Trudeau, L., Shin, C., & Redmond, C. (2008). Long-term effects of universal preventive interventions on prescription drug misuse. *Addiction*, *103*(7), 1160–1168. http://doi.org/10.1111/j.1360-0443.2008.02160.x

St. Pierre, T. L., Kaltreider, D. L., Mark, M. M., & Aikin, K. J. (1992). Drug prevention in a community setting: A longitudinal study of the relative effectiveness of a three-year primary prevention program in Boys & Girls Clubs across the nation. *American Journal of Community Psychology*, *20*(6), 673–706. http://doi.org/10.1007/BF00942233

Stevens, V., De Bourdeaudhuij, I., & Van Oost, P. (2000). Bullying in Flemish schools: an evaluation of anti-bullying intervention in primary and secondary schools. *The British Journal of Educational Psychology, 70*, 195–210. http://doi.org/Doi 10.1348/000709900158056

Sturrock, F., Gray, D., Fergusson, D. M., Horwood, L. J., & Smits, C. (2014). *Incredible Years Follow-up Study*. Wellington, New Zealand.

Sun, P., Sussman, S., Dent, C. W., & Rohrbach, L. A. (2008). One-year follow-up evaluation of Project Towards No Drug Abuse (TND-4). *Preventive Medicine*, *47*(4), 438–442. http://doi.org/10.1016/j.ypmed.2008.07.003

Sun, W., Skara, S., Sun, P., Dent, C. W., & Sussman, S. (2006). Project Towards No Drug Abuse: Long-term substance use outcomes evaluation. *Preventive Medicine*, *42*(3), 188–192. http://doi.org/10.1016/j.ypmed.2005.11.011

Sussman, S., Dent, C. W., Craig, S., & Ritt-Olson, A. (2002). Self-Instruction Curriculum for an Adolescent Indicated Drug Abuse. *Journal of Drug Education*, *32*(2), 121–137.

Sussman, S., Dent, C. W., Stacy, A. W., & Craig, S. (1998). One-year outcomes of Project Towards No Drug Abuse. *Preventive Medicine*, *27*(5, Pt.1), 632–642. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc3&AN=1998-12674-009%5Cnhttp://openurl.ac.uk/athens:lee/?sid=OVID:psycdb&id=pmid:&id=doi:10.1006%252Fpmed.1998.0420&issn=00917435&isbn=&volume=27&issue=5%252C+Pt.1&spage=766&pages=766&date

Sussman, S., Sun, P., McCuller, W. J., & Dent, C. W. (2003). Project Towards No Drug Abuse: Two-year outcomes of a trial that compares health educator delivery to self-instruction. *Preventive Medicine*, *37*(2), 155–162. http://doi.org/10.1016/S0091-7435(03)00108-7

Sussman, S., Sun, P., Rohrbach, L. A., & Spruijt-Metz, D. (2012). One-year outcomes of a drug abuse prevention program for older teens and emerging adults: Evaluating a motivational interviewing booster component. *Health Psychology*, *31*(4), 476–485. http://doi.org/10.1037/a0025756

Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: A meta-analysis. *Clinical Child and Family Psychology Review*, *12*(4), 336–351. http://doi.org/10.1007/s10567-009-0059-y

Swain, J. J., Allard, G. B., & Holborn, S. W. (1982). The Good Toothbrushing Game: A School-Based Dental Hygiene Program for Increasing the Toothbrushing Effectiveness of Children. *Journal of Applied Behavior Analysis*, *15*(1), 171–176.

Tanol, G., Johnson, L., McComas, J., & Cote, E. (2010). Responding to rule violations or rule following: A comparison of two versions of the Good Behavior Game with kindergarten students. *Journal of School Psychology*, *48*(5), 337–355. http://doi.org/10.1016/j.jsp.2010.06.001

The Conduct Problems Prevention Research Group. (1992). A developmental and clinical model for the prevention of conduct disorder : The FAST Track Program. *Development and Psychopathology*, *4*, 509–527.

The Conduct Problems Prevention Research Group. (1999a). Initial Impact of the Fast Track Prevention Trial for Conduct Problems: I. The High-Risk Sample. *American Psychological Association, Inc.*, *67*(5), 631–647.

The Conduct Problems Prevention Research Group. (1999b). Initial impact of the Fast Track Prevention Trial for Conduct Problems: II. Classroom Effects. *Journal of Consulting and Clinical Psychology*, *67*(5), 631–47. http://doi.org/10.1037/0022-006X.67.5.648

The Conduct Problems Prevention Research Group. (2002). Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems. *Journal of Abnormal Child Psychology*, *30*(1), 19–35. Retrieved from http://solo.bodleian.ox.ac.uk/OXVU1:TN_springer_jour1014274914287

The Conduct Problems Prevention Research Group. (2007). Fast Track Randomized Controlled Trial to Prevent Externalizing Psychiatric Disorders: Findings From Grades 3 to 9. *Journal of American Academy of Child and Adolescent Psychiatry*, *46*(10), 1250–1262. http://doi.org/10.1097/chi.0b013e31813e5d39

The Conduct Problems Prevention Research Group. (2010). Fast Track intervention effects on youth arrests and delinquency. *Journal of Experimental Criminology*, *6*(2), 131–157. http://doi.org/10.1007/s11292-010-9091-7

The Conduct Problems Prevention Research Group. (2011). The Effects of the Fast Track Preventive Intervention on the Development of Conduct Disorder Across Childhood. *Child Development*, *82*(1), 331–345. http://doi.org/10.1111/j.1467-8624.2010.01558.x

The Incredible Years. (n.d.). The Incredible Years Parent, Teacher and Child Programs Overview of Program Details. *The Incredible Years*. Retrieved from http://incredibleyears.com/download/program/incredible-years-series-overview.pdf

Tighe, A., Pistrang, N., Casdagli, L., Baruch, G., & Butler, S. (2012). Multisystemic Therapy for

young offenders: Families' experiences of therapeutic processes and outcomes. *Journal of Family Psychology*, *26*(2), 1–11. http://doi.org/10.1037/a0027120

Tingstrom, D. H. (1994). The good behavior game: an investigation. *Psychology in the Schools*, *31*, 57–65.

Tingstrom, D. H. (2006). The Good Behavior Game: 1969-2002. *Behavior Modification*, *30*(2), 225–253. http://doi.org/10.1177/0145445503261165

Trillingsgaard, T., Trillingsgaard, A., & Webster-Stratton, C. H. (2014). Assessing the effectiveness of the "Incredible Years parent training" to parents of young children with ADHD symptoms - a preliminary report. *Scandinavian Journal of Psychology*, *55*(6), 538–545. http://doi.org/10.1111/sjop.12155

Trudeau, L., Spoth, R. L., Lillehoj, C., Redmond, C., & Wickrama, K. A. S. (2003). Effects of a preventative intervention on adolescent substance use initiation, expectancies, and refusal intentions. *Prevention Science*, *4*(2), 109–122.

Turner, K. M. T., Richards, M., & Sanders, M. R. (2007). Randomised clinical trial of a group parent education programme for Australian Indigenous families. *Journal of Paediatrics and Child Health*, *43*(6), 429–437. http://doi.org/10.1111/j.1440-1754.2007.01053.x

Ungar, M., Liebenberg, L., & Ikeda, J. (2012). Young people with complex needs: Designing coordinated interventions to promote resilience across child welfare, juvenile corrections, mental health and education services. *British Journal of Social Work.* doi: 10.1093/bjsw/bcs147

United Nations Economic and Social Council (UN ECOSOC) (1995). *Guidelines for the prevention of urban crime*. Resolution adopted at the Commission on the prevention of crime and criminal justice. New York: Author.

United Nations Economic and Social Council (UN ECOSOC) (2002). *Guidelines for the prevention of crime*. 11th Commission on the prevention of crime and criminal justice. New York: Author.

U.S. Department of Health and Human Services. (2010). Project Venture: A Positive Youth Development Approach for Native American Adolescents.

Valente, T. W., Ritt-Olson, A., Stacy, A. W., Unger, J. B., Okamoto, J., & Sussman, S. (2007). Peer acceleration: Effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, *102*(11), 1804–1815. http://doi.org/10.1111/j.1360-0443.2007.01992.x

Van De Wiel, N. M. H., Matthys, W., Cohen-Kettenis, P. T., Maassen, G. H., Lochman, J. E., & Van Engeland, H. (2007). The effectiveness of an experimental treatment when compared to care as usual depends on the type of care as usual. *Behavior Modification*, *31*(3), 298–312. http://doi.org/10.1177/0145445506292855

Van De Wiel, N. M. H., Matthys, W., Cohen-Kettenis, P. T., & Van Engeland, H. (2003). Application of the Utrecht Coping Power Program and care as usual to children with disruptive behavior disorders in outpatient clinics: A comparative study of cost and course of treatment. *Behavior Therapy*, *34*(4), 421–436. http://doi.org/10.1016/S0005-7894(03)80028-X

van der Stouwe, T., Asscher, J. J., Stams, G. J. J. M., Deković, M., & van der Laan, P. H. (2014). The effectiveness of multisystemic therapy (MST): A meta-analysis. *Clinical Psychology Review*, *34*(6), 468–481. http://doi.org/10.1016/j.cpr.2014.06.006

Vicary, J. R., Smith, E. A., Swisher, J. D., Hopkins, A. M., Elek, E., Bechtel, L. J., & Henry, K. L. (2006). Results of a 3-year study of two methods of delivery of life skills training. *Health Education & Behavior*, *33*(3), 325–339. http://doi.org/10.1177/1090198105285020

Wabano Centre for Aboriginal Health (2016). Centre of Excellence: Wabano Model of Care. Retrieved from http://www.wabano.com/about/centre-of-excellence/

Wahl, E., Hawkins, R. O., Haydon, T., Marsicano, R., & Morrison, J. Q. (2016). Comparing Versions of the Good Behavior Game: Can a Positive Spin Enhance Effectiveness? *Behavior Modification*, *40*(4), 493–517. http://doi.org/10.1177/0145445516644220

Waldron, H. B., Slesnick, N., Brody, J. L., & Turner, C. W. (2001). Treatment Outcomes for Adolescent Substance Abuse at 4- and 7-Month Assessments. *Journal of Consulting and Clinical Psychology*, *69*(5), 802–813.

Waller, I. (2006). *Less law, more order: The truth about reducing crime*. Westport, CT: Praeger.

Warner, S. P., Miller, F. D., & Cohen, M. W. (1977). Relative effectiveness of teacher attention and the "good behavior game" in modifying disruptive classroom behavior. *Journal of Applied Behavior Analysis*, *10*(4), 737. http://doi.org/10.1901/jaba.1977.10-737

Washburn, I. J., Acock, A. C., Vuchinich, S., Snyder, F. J., Li, K.-K., Ji, P., … Flay, B. R. (2011). Effects of a Social-Emotional and Character Development Program on the Trajectory of Behaviors Associated with Social-Emotional and Character Development: Findings from Three Randomized Trials. *Prevention Science*, *12*(3), 314–323.http://doi.org/10.1007/s11121-011-0230-9

Webster, D. W., Whitehill, J. M., Vernick, J. S., & Curriero, F. C. (2013). Effects of Baltimore's safe streets program on gun violence: A replication of Chicago's CeaseFire program. *Journal of Urban Health*, *90*(1), 27–40. http://doi.org/10.1007/s11524-012-9731-5

Webster-Stratton, C. H., & Reid, M. J. (2010a). Adapting the incredible years, an evidence-based parenting programme, for families involved in the child welfare system. *Journal of Children's Services*, *5*(1), 25–42. http://doi.org/10.5042/jcs.2010.0115

Webster-Stratton, C. H., & Reid, M. J. (2010b). The Incredible Years Parents, Teachers, and Children Training Series: A Multifaceted Treatment Approach for Young Children with Conduct Disorders. In J. R. Wiesz & A. E. Kazdin (Eds.), *Evidence-Based Psychotherapies for Children and Adolescents* (2nd ed., pp. 194–210). The Guilford Press. http://doi.org/10.1300/J007v18n03_04

Webster-Stratton, C. H., & Reid, M. J. (2014). Tailoring the Incredible Years. In J. K. Ghumna & L. L. Greenhill (Eds.), *ADHD in Preschool Children* (pp. 113–131). Oxford: Oxford University Press.

Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., … Guth, C. (2013). An independent randomized clinical trial of multisystemic therapy with non-court-referred adolescents with serious conduct problems. *Journal of Consulting and Clinical Psychology*, *81*(6), 1027–39. http://doi.org/10.1037/a0033928

Wetchler, J. L. (1985). Functional family therapy: A life cycle perspective. *The American Journal of Family Therapy*, *13*(4), 41–48. http://doi.org/10.1080/01926188508251275

Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Stepping stones triple p: An rct of a parenting program with parents of a child diagnosed with an autism spectrum disorder. *Journal of Abnormal Child Psychology*, *37*(4), 469–480. http://doi.org/10.1007/s10802-008-9285-x

Wilson, C., Pence, D. M., & Conradi, L. (2013). Trauma-Informed Care. *Encyclopedia of Social Work*, November. Retrieved from http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001 .0001/acrefore-9780199975839-e-1063

Wolfe, D. A., Crooks, C. V., Chiodo, D., Hughes, R., & Ellis, W. (2012). Observations of Adolescent Peer Resistance Skills Following a Classroom-Based Healthy Relationship Program: A Post-intervention Comparison. *Prevention Science*, *13*(2), 196–205. http://doi.org/10.1007/s11121-011-0256-z

Wolfe, D. A., Crooks, C. V., Jaffe, P. G., & Chiodo, D. (2009). A School-Based Program to Prevent Adolescent Dating Violence. *Archives of Pediatric Adolescent Medecine*, *163*(8), 692–699.

Wright, S. & Liddle (2014). Young Offenders and Trauma: Experience and Impacts. UK: Beyond Youth Custody. Retrieved from http://www.beyondyouthcustody.net/wp-content/uploads/BYC-Trauma-experience-and-impact-practitioners-guide.pdf

Wright, R. A., & McCurdy, B. L. (2011). Class-Wide Positive Behavior Support and Group Contingencies: Examining a Positive Variation of the Good Behavior Game. *Journal of Positive Behavior Interventions*, *14*(3), 173–180. http://doi.org/10.1177/1098300711421008

Wyles, P. (2007). Success with Wraparound. *Youth Studies Australia*, *26*(4), 45–53.

YMCA Alternative Suspension. (n.d.). *Alternative Suspension.* Retrieved October 13, 2016, from www.alternativesuspension.ca

Zazzali, J. L., Sherbourne, C., Hoagwood, K. E., Greene, D., Bigley, M. F., & Sexton, T. L. (2008). The adoption and implementation of an evidence based practice in child and family mental health services organizations: A pilot study of functional family therapy in New York State. *Administration and Policy in Mental Health and Mental Health Services Research*, *35*(1–2), 38–49. http://doi.org/10.1007/s10488-007-0145-8

Zollinger, T., Saywell, R., Muegge, C., Wooldridge, J., Cummings, S., & Caine, V. (2003). Impact of the Life Skills Training Curriculum on Middle School Students' Tobacco Use in Marion County, Indiana, 1997-2000. *Journal of School Health*, *73*(9), 338–346. Retrieved fromhttp://media.proquest.com.ezproxy.cul.columbia.edu/media/pq/classic/doc/515750211/fmt/pi/rep/NONE?hl=&cit:auth=Zollinger,+Terrell+W;Saywell,+Robert+M,+Jr;Muegge,+Carolyn+M;Wooldridge,+J+Scott;et+al&cit:title=Impact+of+the+Life+Skills

Zonnevylle-Bender, M. J. S., Matthys, W., van de Wiel, N. M. H., & Lochman, J. E. (2007). Preventive effects of treatment of disruptive behavior disorder in middle childhood on substance use and delinquent behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, *46*(1), 33–39. http://doi.org/10.1097/01.chi.0000246051.53297.57