Multisystemic Therapy
(MST)

Breaking the cycle of criminal behavior by keeping teens at home, in school, and out of trouble.
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SECTION ONE:
DEFINING EVIDENCE-BASED PREVENTION

DEFINITION OF EVIDENCE-BASED PREVENTION PROGRAMS

Programs recognized as "evidence-based" have met the highest level of evidence of effectiveness based on the criterion below. These programs, if implemented with adherence to the program developer’s model, will be effective at promoting better youth outcomes, reducing future costs for prison, drug treatment, social service and welfare usage, and increasing tax revenue.

- **Effectiveness** demonstrated in rigorous scientific evaluations
  It is important that program effectiveness is demonstrated using a study design with sufficient scientific rigor, preferably multiple independently replicated randomized or time series control trials. This increases confidence that the evidenced program outcomes are the result of the program, as opposed to some other unknown or external factor that might be influencing a change in outcomes. It also increases confidence that the program does not produce any iatrogenic or unintended harmful or negative effects.

- **Effectiveness** demonstrated in large studies with diverse populations or through multiple replications
  Large studies and multiple replications add to the "generalizability" of the findings. Evidence of impact, seen upon diverse populations (e.g., different socioeconomic, racial, and cultural groups) and in diverse settings (e.g., urban, suburban, and rural areas), creates greater confidence that the same results can be generated across different types of populations, schools, and communities.

- **Significant and sustained effects**
  Large longitudinal studies verify that positive effects are sustained over time. Unfortunately, many programs that demonstrate initial success fail to show long-term impacts after the intervention or may even show a decline in effectiveness. Also, programs sometimes have delayed impact and the full effects are not seen by the end of the intervention. Thus, it is important to assess impact, not just immediately following the program, but after sufficient time has elapsed.

In addition, changes in youth development outcomes, such as aggression, youth violence, delinquency, substance use, and school failure, must be large enough (as defined by statistical significance or effect size) to reasonably expect that the program can result in changes at the population level. Evidence-based programs aim to not only impact individual outcomes, but to change the population prevalence rates of a problem.

*Note:* An effect size measures the strength or size of the relationship between two variables. In program evaluation studies, an effect size gives us an idea of how much of an effect the program had on a particular outcome. A relationship that is described as being statistically significant or unlikely to have occurred by chance in research studies may or may not be reflective of a strong effect on participants. It is important to identify a program that addresses the locally prioritized targets and that is backed by strong scientific evidence of a meaningful effect (i.e., an effect size) for the relationship between...
program participation and program outcomes as demonstrated in research studies) in a population similar to the one to be served.

*Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination* reviews the standards adopted by the Society for Prevention Research providing further information on the criteria for evidence-based programs.

Different criteria have been used to identify “effective” prevention programs and a variety of terms have been used to refer to programs or approaches demonstrating varying levels of effectiveness, such as evidence-based, science-based, research-based, empirically supported, best practices, exemplary, model, and promising programs. It is important to recognize that programs promoted as “effective” may not meet all of the above criteria or be considered evidence-based. The lowest levels of evidence are reflected in program assessments conducted through non-experimental designs (e.g., single group pre/post test design) or defined by only endorsements of authorities with clinical experience. Comprehensive, enduring, and effective evidence-based prevention programs have strong study designs and scientific evidence that they reduce negative outcomes and sustain positive impacts.

The Cochrane Collaboration and Campbell Collaboration conduct the most rigorous reviews of evidence-based programs. However, the Center for the Study and Prevention of Violence's (CSPV) conducts reviews and publishes a list of evidence-based prevention programs based on stringent inclusion criteria. Programs listed by CSPV as Blueprints Model and Promising Programs are recognized for their rigorous research design and as prevention programs with demonstrated outcomes and the most evidence of effectiveness. Compared to any other list of effective prevention programs, the Blueprints list is held up as the gold standard.
BLUEPRINTS RECOGNITION

Background of Blueprints for Violence Initiative:
In 1996, the Blueprints for Violence Prevention Initiative began at the Center for the Study and Prevention of Violence (CSPV) with support from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency. The Initiative identifies prevention and intervention programs that meet a strict scientific standard of program effectiveness. Program effectiveness is based upon an initial review by CSPV and a final review and recommendation from a distinguished Advisory Board, comprised of seven experts in the field of violence prevention. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has sponsored the replication of programs sites across the United States. As a result of the funding from OJJDP, the Blueprints Initiative became a comprehensive effort to provide communities with a set of demonstrated effective programs and the technical assistance and monitoring necessary to plan for and develop an effective violence intervention. CSPV has reviewed over 800 prevention programs through the Blueprints Initiative process. Although a variety of organizations and national agencies produce lists of programs of effectiveness, the Blueprints Initiative utilizes the most rigorous set of criteria for program inclusion in the field of prevention science.

Goals for Blueprints for Violence Initiative:
- Identify effective, research-based programs.
- Provide training and technical assistance to transfer the requisite knowledge and skills to implement these programs.
- Monitor the implementation process to provide feedback to sites and ensure that programs are implemented with fidelity to their original intent and design.
- Gather and disseminate information regarding factors that enhance the quality and fidelity of implementation.

Selection Criteria for Blueprints for Violence Programs:
The Blueprints Initiative considered several important criteria when reviewing program effectiveness. Blueprints model program must meet all three of these criteria, while promising programs must meet only the first criterion.

- Evidence of deterrent effect with a strong research design
  - This is the most important of the selection criteria. Relatively few programs have demonstrated effectiveness in reducing the onset, prevalence, or individual offending rates of violent behavior. The Blueprints Advisory Board accepts evidence of deterrent effects for three key indicators -- violence (including childhood aggression and conduct disorder), delinquency, and/or drug use -- as evidence of program effectiveness. Providing sufficient quantitative data to document effectiveness in preventing or reducing the above behaviors requires the use of evaluative designs that provide reasonable confidence in the findings (e.g., experimental designs with random assignment or quasi-experimental designs with matched control groups). Most researchers recognize random assignment studies (randomized trials) executed with fidelity as providing the highest standard of program evaluation. Random assignments offer the most compelling evidence that study results are due to the intervention rather than to preexisting differences between experimental and control groups and/or other threats to internal validity, such as maturation, selection bias, and testing effects.
these studies, assignment to experimental or control conditions is determined solely by chance, and the likelihood of differences being attributed to the assignment process can be assessed.

• When random assignment cannot be used, the Advisory Board considers studies that use control groups matched as closely as possible to experimental groups on relevant characteristics (e.g., gender, race, age, socioeconomic status) and studies with control groups that use statistical techniques to control for initial differences on key variables. As carefully as experimental and control groups are matched, however, it is impossible to determine if the groups may vary on some characteristics that have not been matched or controlled for and that are related to program outcome. Random assignment, therefore, is believed to be the most rigorous of methodological approaches.

• Research designs vary greatly in quality, particularly with respect to several key aspects: sample size, attrition (loss of study participants over time), and measurement issues. At a minimum, the following issues need to be addressed: (1) Sample sizes must be large enough to provide statistical power to detect effects. It is more difficult to detect statistically significant differences between groups when small sample sizes are used. (2) Attrition, or loss of study participants, may be indicative of problems in program implementation or may be a failure to locate subjects during a follow-up period. Attrition is dangerous, particularly because it can compromise the integrity of the original randomization or matching process. It reduces confidence that the original sample and final sample are comparable and that the final experimental and control comparisons reflect only treatment effects. (3) Tests to measure outcomes must be administered fairly, accurately and consistently to all study participants. For example, the use of inconsistent measures over time may produce less reliable test scores. The instruments which are used to measure outcomes should be demonstrated to be reliable and valid.

• School-based Evaluations. Evaluations of school-based programs, with schools as the unit of analysis, typically require multiple schools per condition to perform a main effects analysis with sufficient power to detect effects. Since meeting this criterion requires a complex evaluation which is very costly, it would eliminate most existing school-level evaluations from consideration in the Blueprints Series. Therefore, school-based evaluations that use experimental or quasi-experimental designs with relatively few schools, but more than one in each condition, will be considered in the Blueprints Series if they meet an additional burden of proof. They must demonstrate consistency across effects and across replications with multiple measures from different sources. The theoretical rationale should be well developed, and there should be a rigorous evaluation of theory with evidence that the results are consistently in line with the expectations (i.e., there are changes in the risk and protective factors which mediate the changes in outcomes). Outcomes should be robust, with at least moderate effect sizes. Evidence that the benefits of the program outweigh the costs is helpful. Our decision to accept this level of proof is driven totally by the state of current research, and it should not be assumed that this standard of proof is desirable. Evaluations with multiple schools are most desirable and should be encouraged among funders and researchers.
• **Sustained effect**
  - Although one criterion of program effectiveness is that it demonstrates success by the end of the treatment phase, it is also important to demonstrate that these program effects endure beyond treatment and from one developmental period to the next. Designation as a Blueprints program requires a sustained effect at least one year beyond treatment, with no subsequent evidence that this effect is lost. Unfortunately, many programs that demonstrate initial success fail to show long-term maintenance of the effects after the intervention has ended. Depending on whether effects are immediate or delayed, the full impact of an intervention or treatment may not be realized at the end of treatment. Significant improvement may be realized over time, or a decay or decline may result. For example, if a preschool program designed to offset the effects of poverty on school performance (e.g., Head Start) demonstrates its effectiveness when children start school, it is also important to demonstrate that these effects are sustained over a longer period of time. Unless this protective effect is sustained through high school, it is unlikely to have an impact during this critical period when problem behavior is at its peak: the effect must be sustained if it is to help adolescents maintain a successful life course trajectory. Although programs that have specifically failed to produce a sustained effect do not qualify for the Blueprints model category, programs that have not yet demonstrated long-term effects (because sufficient time has not yet elapsed or follow-up analyses were never planned) may be considered as promising programs.

• **Multiple site replications**
  - Replication is an important element in establishing program effectiveness and understanding what works best, in what situations, and with whom. Some programs are successful because of unique characteristics in the original site that may be difficult to duplicate in another site (e.g., having a charismatic leader or extensive community support and involvement). Replication establishes the strength of a program and its prevention effects and demonstrates that it can be successfully implemented in other sites.
  
  - Programs that have demonstrated success in diverse settings (e.g., urban, suburban, and rural areas) and with diverse populations (e.g., different socioeconomic, racial, and cultural groups) create greater confidence that such programs can be transferred to new settings. As communities prepare to tackle the problems of violence, delinquency, and substance abuse, knowledge that a specific program has had success in various settings with similar populations adds to its credibility.
  
  - Some projects may be initially implemented as a multisite single design (i.e., several sites are included in the evaluation design). When this occurs, the evaluation should check for overall main effects and sources of variation across sites. Becoming a Blueprints model program requires at least one replication that should be with a different sample but does not need to be independent of the developer with demonstrated effects. This criterion does not need to be met to qualify as a promising program.

**Additional Factors**
In the selection of **Blueprints model programs**, two additional factors are considered: whether a program conducted an analysis of **mediating factors** and whether a program is cost effective.

- **Analysis of Mediating Factors.** The **Blueprints Advisory Board** looks for evidence that change in the targeted risk or protective factor(s) mediates the change in violent behavior. This evidence clearly strengthens the claim that participation in the program is responsible for the change in violent behavior, and it contributes to our theoretical understanding of the causal processes involved. In its reviews of different programs, the **Advisory Board** has discovered that many programs reporting significant deterrent "main effects" have not collected the data necessary to complete an analysis of **mediating factors**.

- **Costs versus Benefits.** Program costs should be reasonable and should be less or no greater than the program’s expected benefits. High price-tag programs are difficult to **sustain** when competition is high and funding resources low. Implementing expensive programs that will, at best, have small **effects** on violence is counter-productive. Although **outcome** evaluation research established that Blueprints programs were effective in reducing violence, delinquency, and drug use, very few data were available initially regarding the costs associated with replicating these programs.

- **Two cost-benefit studies involving Blueprints programs -- the RAND Corporation Study and a study by the Washington State Institute for Public Policy -- suggest that Blueprints programs are cost-effective (Greenwood, Model, Rydell, & Chiesa, 1996; Washington State Institute for Public Policy, 1998, 2001).**

The selection criteria identified above establish a high standard, one that has proved difficult for most programs to meet, thus explaining why there are only 11 **Blueprints programs**. This high standard reflects the level of confidence necessary, however, for recommending that communities replicate these programs with reasonable assurances that they will prevent violence. The **Blueprints model programs** are not intended to be a comprehensive list of programs that work, but rather reflect a selection of programs with strong research designs for which we have found good evidence of their **effectiveness** in delinquency, violence, or substance abuse prevention and reduction. There is no implication that programs not on this list are necessarily ineffective. Chances are that there are a number of good programs that have just not yet undergone the rigorous evaluations required to demonstrate **effectiveness**. But our evaluations have also revealed that many programs are ineffective, and a few are iatrogenic (i.e., harmful). Without evaluations, we just don't know. It is in the best interests of our children to evaluate, so we can have confidence that what we are doing for them actually helps. As time goes on and new research findings are published, **CSPV** hopes to add to this list other credible, effective programs which communities can use confidently. **CSPV** will also continue to follow evaluations of Blueprints programs to refine our knowledge of their **effectiveness** for specific populations and over longer periods of time.

**List of Blueprints Model Programs:**
- Midwestern Prevention Project (MPP)
- Big Brothers Big Sisters of America (BBBS)
- Functional Family Therapy (FFT)
- Life Skills Training (LST)
- Multisystemic Therapy (MST)
- Nurse-Family Partnership (NFP)
- Multidimensional Treatment Foster Care (MTFC)
• Olweus Bullying Prevention Program (BPP)
• Promoting Alternative Thinking Strategies (PATHS)
• The Incredible Years: Parent, Teacher and Child Training Series (IYS)
• Project Towards No Drug Abuse (Project TND)

List of Blueprints Promising Programs:
• ATLAS (Athletes Training and Learning to Avoid Steroids)
• Behavioral Monitoring and Reinforcement Program
• Brief Strategic Family Therapy (BSFT)
• CASA START
• FAST Track
• Good Behavior Game (GBG)
• Guiding Good Choices (GGC)
• I Can Problem Solve (ICPS)
• Linking the Interests of Families and Teachers (LIFT)
• Triple P: Community-Wide
• Perry Preschool Project
• Preventive Treatment Program (PTP)
• Project Northland
• BASICS (Brief Alcohol and Intervention of College Students)
• Seattle Social Development Project (SSDP)
• Strengthening Families Program For Parents and Youth 10-14
• Strong African American Families (SAAF) Program
• Raising Healthy Children Program
• Communities That Care (CTC) Program

Click for more information about the Blueprints for Violence Prevention Initiative.
SECTION TWO: SELECTING AN EVIDENCE-BASED PROGRAM

COLLABORATIVELY ASSESSING AND ADDRESSING COMMUNITY NEEDS

The state of Pennsylvania strongly encourages youth development prevention programming to be planned and utilized within the context of a community coalition. Community coalitions allow for diverse stakeholders to assess programming gaps, leverage resources and actualize a shared vision and plan for local positive youth development. Coalitions should be data-driven, identify local risk and protective factors influencing local youth problem behaviors, conduct a resource assessment, collaboratively plan for the selection, implementation, evaluation, and sustainability of proven effective prevention programs, and strive to demonstrate and communicate outcomes.

The Communities That Care Model in Pennsylvania:
The Pennsylvania Commission on Crime and Delinquency (PCCD) has purposely chosen to disseminate the Communities That Care (CTC) community mobilization model, which is a data-driven, community-led prevention operation system, originally developed by researchers at the University of Washington and now owned and supported by the federal government (Center for Substance Abuse Prevention/Substance Abuse Mental Health Services Administration). Through the CTC process a broad-based community prevention coalition made up of key community stakeholders is formed and collects local indicator data to assess the risks that affect youth development. The coalition then selects and implements proven-effective (evidence-based) programs in order to reduce those risks and ultimately prevent and reduce substance abuse, teen pregnancy, school failure, delinquency and youth violence.

Through support from PCCD, communities in most Pennsylvania counties are using the CTC model for comprehensive community-wide prevention planning. Through a structured process, human service and provider organizations, government agencies, schools, the business sector, and the community work cooperatively to plan, implement, and evaluate programs and services for youth. Through its focus on community mobilization and collaboration, CTC helps communities use their existing resources effectively and efficiently to target their unique prevention needs and to positively impact youth development. CTC community prevention coalitions work to collectively identify prevention priorities, thus creating a synergy that has a much greater impact than any organization or sector might have working individually.

The Effectiveness of the Communities That Care Process:
The Prevention Research Center at Penn State University has conducted several studies of CTC in Pennsylvania. One study looked at risk and protective factors, delinquency and drug use among nearly 100,000 youth from 147 Pennsylvania communities. The study found that communities using the CTC process had significantly lower average prevalence of risk factors, higher prevalence of protective factors, and significantly lower rates of delinquency and youth substance use than similar non-CTC communities. The study found significant differences favoring CTC communities at a level 7 to 11 times greater than would be expected by chance alone. Across all risk and protective factors, substance use outcomes, and delinquency outcomes, none of the comparisons favored non-CTC sites, even at a trend level. These results are even more impressive considering the impact was measured at the community level.
level, not at the level of individual children or youth who had participated in a specific program. In a separate follow-up, longitudinal study, many of the effects were sustained over the 5-year period, demonstrating that the combination of CTC and evidence-based programs had actually changed the developmental trajectories of youth living in these communities.

For more information on Pennsylvania’s Communities That Care Initiative, contact the EPISCenter at: 814-863-2568 or EPISCENTER@PSU.EDU

The Substance Abuse and Mental Health Administration (SAMHSA) has full copy rights to educational and training materials for Communities That Care.
STEPS FOR SELECTING AN EVIDENCE-BASED PROGRAM

General Overview of the Selection Process:
Included in this section of the manual is a site readiness and implementation checklist. Please refer to it for detailed information on the steps necessary to effectively select and implement an evidence-based program. Below a general overview of the selection process is delineated.

1. Work with a prevention coalition to document through epidemiological data the community’s needs. Using local data, identify local risk and protective factors and prioritize targets. Click Here to Access a List of Communities That Care Coalitions in Pennsylvania: Insert Link

2. Establish a group of diverse planning and implementation stakeholders to research potential evidence-based programs.

3. Identify a program that addresses the locally prioritized targets and that is backed by strong evidence of a meaningful effect (i.e., an effect size for the relationship between program participation and program outcomes as demonstrated in research studies) in a population similar to the one you serve.

4. Review the key features of the identified program that must be implemented faithfully to achieve the desired effect. To identify these key features, review the program Web site. Talk directly to the developer or program staff to identify the resources necessary to implement the program with high quality and fidelity. Caution: There is strong evidence that seemingly small differences in the way a program is implemented can alter a program’s effects. It is importance to adhere to the model and implement the program as intended to ensure the same outcomes are achieved locally as were demonstrated in the research supporting the program.

5. Conduct a community readiness assessment (link to next page) to assess whether the resources are available to implement and sustain the selected evidence-based program. To learn more about the potential program your community plans to implement, click here.(link to Section 7 of each manual)

6. If your site is deemed to have the appropriate resources to implement a program, work closely with the program developer to ensure appropriate training, implementation, and model adherence.

7. Establish systems to measure targeted outcomes and to monitor the extent of model adherence over time. Use the collected data to monitor implementation quality and model fidelity, to assess participant impacts, and to report to community stakeholders and sustainability sources.
SITE READINESS AND IMPLEMENTATION CHECKLISTS

Checklist for Conducting a Collaborative Community Needs Assessment:

*Prior to selecting an evidence-based program, work with a prevention coalition to document through epidemiological data the community’s needs. The following steps should be completed. Further descriptions of each step are defined on the following pages.*

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Date Completed</th>
<th>Individual/Agency Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish or mobilize a community collaborative.</td>
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<tr>
<td>Complete a community risk assessment.</td>
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<tr>
<td>Complete a community resource assessment.</td>
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<tr>
<td>Prioritize community specific risk and protective factors.</td>
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<tr>
<td>Prepare and disseminate a community assessment report.</td>
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</table>

Site Readiness and Program Selection Checklist:

*Once the community’s risk and protective factor targets have been identified and prioritized, an evidence-based program can be selected. Utilize the following checklist to track the research and planning progress. Further descriptions of each step are defined on the following pages.*

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Targeted Timeline</th>
<th>Individual/Agency Responsible</th>
<th>Progress Comments</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a group of diverse planning and implementation stakeholders.</td>
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<tr>
<td>Identify evidence-based programs proven to address the locally prioritized risk and protective factors.</td>
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<tr>
<td>Research potential evidence-based programs.</td>
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<tr>
<td>Contact the program developers to learn about the programs.</td>
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</table>
Assess which program is the best fit for the community.

**Discussion Questions for Program Selection:**

While researching and comparing possible programs, consider the following questions to determine which program is the best fit for the community -

- Is the program proven to address the community’s prioritized risk and protective factors?
- Are the program’s proven outcomes the same as the outcomes desired locally?
- Is the program appropriate for the demographic you plan to target?
- Do the implementation requirements match the strengths of the community?
- Has an event or circumstance created support for such a program?
- Are the local systems necessary to implement the program, such as the juvenile court, children and youth services, or the school district, aligned with the program’s goals and theory? Are there any potential duplication of services or conflicting priorities?
- Are the organizations that will coordinate and implement the program stable, fiscally responsible, and functional?
- Will those that will be responsible for program administration, coordination, and delivery be supportive and vested in the program and its outcomes?
- Do those that will be responsible for program administration, coordination, and delivery have the skills necessary for successful program implementation? If not, can affordable training be secured in a reasonable amount of time and will the program implementers be able and willing to participate?
- What are the developer’s expectations for quality, dosage, and fidelity? Is this achievable within the existing infrastructure and using the available resources?
- Can the population the program was designed for be locally identified, accessed, and recruited?
- What will it take to sustain the program beyond initial seed funding?
- Are the resources required to sustain the program available and does the ability to acquire the resources exist?
Checklist to Track **Implementation** Progress:

*Once an evidence-based program that matches the community’s needs, resources, and desired outcomes is selected, utilize the following checklist to track implementation progress. Further descriptions of each step are defined on the following pages.*

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Targeted Timeline</th>
<th>Individual/Agency Responsible</th>
<th>Progress Comments</th>
<th>Date Completed</th>
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<tbody>
<tr>
<td><strong>Implementation Planning Steps:</strong></td>
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<tr>
<td><strong>Location:</strong></td>
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<tr>
<td>1. Identify a target service area.</td>
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<tr>
<td>2. Identify space for staff and supplies.</td>
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<tr>
<td>3. Identify the site for program delivery.</td>
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<tr>
<td><strong>Partners:</strong></td>
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<tr>
<td>1. Identify how your initiative fits with existing programs and services. Seek partners.</td>
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<td>2. Generate administrative and staff <strong>buy-in</strong>. For FFT, MST, or MTFC <strong>implementation</strong>, it is important to have <strong>buy-in</strong> from county agencies, <strong>referral sources</strong>, and behavioral health-managed care organizations. (Added—does this make sense?)</td>
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<td><strong>Fiscal Management:</strong></td>
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<td>1. Identify an organization to serve as the fiscal agent.</td>
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<td>2. Select individuals responsible for financial management.</td>
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<td>3. Establish systems for tracking revenue and expenditures.</td>
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<td>4. Establish systems for reporting to collaborative</td>
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board and funding sources.

5. Outline program costs and develop a budget.


**Implementation Steps:**

### People:
1. Identify staff needed and the resources to compensate staff.
2. Outline and initiate the hiring process.
3. Identify/hire a coordinator.
4. Identify/hire program staff.
5. Identify and mobilize program champions.
6. Identify and mobilize community gatekeepers.
7. Generate administrative and staff buy-in.

### Training:
1. Confirm and budget for training costs.
2. Schedule training with the developer.
3. Coordinate facility, food, and materials.
4. Recruit and register teachers, facilitators, and others that will coordinate and deliver the program.
5. Host and evaluate the training.

### Educating the Community:
1. Identify awareness needs and
messages to be conveyed. Emphasize the evidence supporting the program.

2. Create and disseminate program education and promotional materials.

**Supplies/Coordination:**

1. Purchase curriculum.

2. Develop a recruitment plan.

3. Schedule program dates.

4. Confirm site.

5. Confirm supports, such as food, childcare, and transportation.

6. Market program/Recruit program participants.

7. Purchase and prepare program materials.

**Steps for Assessing Program Impact:**

**Outcome Measurement:**

1. Identify intended program and community outcomes.

2. Set targets.

**Model Adherence:**

1. Establish a system to assess model adherence, such as program delivery observations.

2. Utilize the data collected to assess program quality and fidelity.

3. Provide feedback to staff and program facilitators to enhance model adherence.
and delivery quality.

**Program Data Collection:**

1. Identify outcomes assessment tools.

2. Collect intake and demographic information on participants.

3. Administer and collect surveys.

4. Input and analyze data.

5. Prepare data reports for community stakeholders and sustainability sources.

**Community Data Collection:**

1. Collect data from local data sources or administer a community assessment tool, such as PAYS.

2. Analyze data to reassess community risk and protective factors and explore trends.

3. Prepare a report for community dissemination.

**Steps for Sustainability:**

Preparing for sustainability is a process that ideally begins during program selection. Throughout implementation start-up, sustainability partners should be identified and engaged. Once program data is collected, assess the local effectiveness of the selected program and determine whether sustaining the program is beneficial to the community. If so, actively market program outcomes and pursue sustainability funding.

1. Determine costs to be sustained.

2. Identify a sustainability coordinator and committee.

3. Develop a sustainability plan and consider fundraising, sponsorship, and grant seeking strategies.
4. Identify organizations that share the program’s goals.

5. Identify community foundations or other agencies that award grant funding.

6. Identify businesses and corporations that may have a vested interest in the program.

7. Solicit funds through:
   - Local public funds
   - Partnerships and cost sharing with other agencies
   - Fundraising
   - Grants
   - Sponsorship
   - In-kind contributions
Further Explanation of Each Checklist Step:
Prior to selecting an evidence-based program, work with a prevention coalition to document through epidemiological data the community’s needs. The following steps should be completed:

- **Establish or mobilize a community collaborative** - Evidence-based programs are most effective and more likely to be sustained when planned and implemented in the context of a community-based collaborative that embraces a data-driven model of prevention. Communities That Care coalitions are well suited to identifying and advancing evidence-based programs. Broad-based collaboratives represent diverse stakeholders from many facets of the community, such as law enforcement, school administrators and personnel, health and human service providers, business leaders, the faith community, county agencies, such as MH/MR, Children and Youth and Juvenile Probation, and others. This diverse representation increases networking, information sharing, and collaborative support for your selected program. It also helps to keep your efforts data-driven and committed to outcome measurement.

- **Complete a risk assessment** - To identify the evidence-based program with the greatest potential to impact the local community, the risks faced by local youth must be identified through a data collection and assessment process. Examine relevant survey results, such as the Pennsylvania Youth Survey (PAYS). Review state and county juvenile delinquency data from sources such as the PA Electronic Juvenile Justice Databook. Collect data from public records and local agencies, such as children and youth services, juvenile probation, the school district(s), health department, and chamber of commerce. Also consider focus group reports, community forum minutes, and other qualitative information to fully understand perceived community concerns. Collecting data from multiple sources will improve the accuracy of the assessment. However, it is important to focus mostly on the results of a proven, valid survey instrument. Seeking the assistance of individuals trained in data analysis will be invaluable as the coalition tries to understand the statistics, trends, and influences upon problem youth behaviors in the community. College or university researchers or evaluators at service agencies should be approached for their expertise and involvement.

- **Complete a resource assessment** - After a careful review of the data collected, identify existing programs, services, and resources that are working to address the prioritized concerns. Also identify potential partners that may be able to contribute financial resources, materials and in-kind resources (equipment, office space, supplies), human capital (staff, volunteers, program champions), or technical assistance. It is important at this time to also detect potential gaps in services, programs, and resources. This time of networking and planning affords the opportunity for information sharing, creating an understanding of existing services, and garnering the investment of key organizations. It also provides insights into the type of program that can be realistically implemented in the community.

- **Prioritize community risk and protective factors** - With a complete understanding of the challenges facing the community and the potential resources available to address them, proceed with prioritizing locally identified risk factors that are associated with increases in local youth’s involvement in problem behaviors and the protective factors that could buffer local youth from harm, but are lacking in the community.
These identified risk and protective factors should drive the selection of an evidence-based program and will allow for targets to be set for reducing risks, increasing protective factors, and reducing problem behaviors, such as rates of delinquency, substance use, teen pregnancy, school drop-out, and academic failure.

- **Prepare and Disseminate a Community Assessment Report** – Prepare a brief report summarizing the key findings from the risk and resource assessments. Explain the prioritized risk and protective factors. Describe identified strengths and resources being certain to highlight existing positive youth development programs in the community, which may foster future partnering opportunities. Disseminate the report to key leaders, elected officials, and media and press sources.

*Once the community’s risk and protective factor targets have been identified and prioritized, an evidence-based program can be selected. Utilize the following checklist to track the research and planning progress:*

- **Establish a group of diverse planning and implementation stakeholders** - As an evidence-based program is selected, a group of diverse stakeholders representing many facets of the community should be identified. This group should be inclusive of all key partners and the members collectively should possess skills in prevention science, fiscal management, marketing, fundraising, and evaluation. In addition, it is important to garner the early support of program champions or individuals that are well respected and connected in the community and can work to raise awareness of the program.

- **Identify evidence-based programs proven to address the locally prioritized risk and protective factors** - Review sources, such as the Communities That Care Prevention Strategies Guide or Blueprints summaries from the Center for the Study and Prevention of Violence (CSPV), to identify proven, effective prevention programs.

- **Research potential evidence-based programs** - Read summaries of each program under consideration to understand the targeted risk and protective factors, the intended population, learning objectives, goals, proven outcomes, and availability and ease of access to program materials and training.

- **Contact program developers** – Once the selection has been narrowed to a few potential programs, contact the program developers to learn more about training, costs, infrastructure demands, and implementation requirements.

  Click [here](#) to access contact information for the programs funded by PCCD and supported by the Penn State EPISCenter.

- **Assess which program is the best fit for the community/Select an evidence-based program** – Make an informed decision and select the program that best matches your community’s risk and protective factor targets, demographics, and financial resources.

*Once an evidence-based program matching the community’s needs, resources, and desired outcomes is selected, utilize the following checklist to track implementation progress:*

**Implementation Planning** – Once a program is identified, preliminary steps should be taken to begin successful program delivery.
• Identifying and securing referral sources:
   — Especially for FFT, MST, and MTFC, it is important to work with potential referral sources prior to implementation to determine if there will be sufficient referrals to sustain the program. These conversations should be very specific regarding the target population and eligibility criteria for the program, as well as the number of referrals needed per year. Possible referral sources may include the court system and Juvenile Probation Offices, County Children and Youth Agencies, MH/MR case workers, and schools. Once the final “go” decision is made, and hiring and training of staff begin, the program will need to continue to network with and educate referral sources. This should include providing referral sources with educational materials regarding the program’s objectives and goals and the core components of the program, as well as providing very clear information about appropriate vs. inappropriate referrals and directions for how to make a referral to the program. It is helpful to include copies of referral forms with the educational materials. Personal contact with each referral source, presentations about the program to staff members who will be involved in the referral process, as well as other marketing strategies are vital to having adequate referrals. This process does not stop when the program takes its first client; maintaining a strong referral network is an on-going process that often requires considerable time and energy. Additional information about networking with stakeholders and educating referral sources is available in the program-specific section for each treatment program (Section 7 of the Implementation Manual).

• Identifying funding sources:
   — One of the primary reasons for program closure is failure to secure funding after initial start-up. Prior to taking the final steps toward implementation a program (e.g., hiring and training staff), it is critical that a long-term plan for funding is identified. For treatment programs such as Functional Family Therapy, Multisystemic Therapy, and Multidimensional Treatment Foster Care, this should include conversations with the county MH/MR, HealthChoices Program, and Behavioral Health Managed Care Organization (BH-MCO) to determine whether these systems will support the inclusion of the evidence-based program in the community’s network of Medical Assistance funded programs. Whenever possible, there should also be preliminary conversations about what the budget will include and what the rate paid for the services might be, so that the provider can determine if the rate will be sufficient to cover the costs of the program. Discussions should also occur with the County Children and Youth Agency (CCYA) to determine whether county funding will be available to cover costs not paid for by Medical Assistance, such as start-up costs, non-allowable costs, and services provided to youth who are not M.A.-eligible. County funding may come through the Special Grant Initiative, the Needs Based Budget, and/or the Integrated Children’s Service Plan. Additional information about funding is available in the program-specific sections for each Evidence-based treatment program (Section 7 of the Implementation Manual).

• Location:
   — Confirm the geographic and demographic area most affected by the targeted risk and protective factors to identify a target service area.
   — Identify space for staff to coordinate the program from and the site(s) for program delivery. Also assess storage needs and locate a place for supplies.
• Partners:
  — Identify how your initiative fits with existing programs and services and seek to partner with organizations that have similar goals and resources to potentially contribute. Seek to establish relationships early that will increase referrals, recruitment, and administrator and delivery staff’s buy-in.

• Fiscal Management:
  — Identify an organization to serve as the fiscal agent and individuals responsible for financial management.
  — Establish systems for tracking expenditures and reporting to funding sources, program partners, and the collaborative board.
  — Identify the costs associated with implementation, such as training fees, curriculum and supply costs, facility fees, staff salaries, and program delivery expenses. Develop a budget that outlines the program costs and identify and secure funding sources from local sources and public and private grants.

Implementation – After careful planning, action can be taken to prepare for program delivery.

• People:
  — Identify the staff and hours recommended by the developer for program implementation. Once funding is secured for compensation, outline and initiate a hiring process.
  — As prevention programs primarily target youth, identify staff with experience in prevention science, counseling, education, and human development. When identifying a coordinator to drive implementation, experience in grant writing, marketing, fundraising, and program coordination is advantageous.
  — When identifying staff, it is helpful to utilize network connections, but a screening and interview process should still be considered to ensure a fit with the program. In addition, child abuse clearances should be required. For the intervention programs (FFT, MST, and MTFC) FBI and state police criminal background checks will also be required.
  — It is important to garner the early support of program champions or individuals that are well respected and connected in the community, such as the school district superintendent, the police chief, or agency directors. Empower and educate these individuals to raise awareness of the value of the program.
  — Connecting with the population served and recruiting participants through a community gatekeeper is often key to the success of a program. Identify a community member that is enmeshed in the culture, such as a trusted school official, a community elder, or a minister. They can help to counter distrust and promote referrals and registrations.
  — Share the program’s theory of change with staff, program champions, and the community gatekeeper, as well as the proven outcomes. It is important to aid these key program ambassadors in being able to understand and articulate the value and impact of the program.

• Training:
  — Contact the program developer to confirm training costs and to schedule training. Often, developers have limited availability, so it is important to schedule training as early as possible.
The comfort of the participants being trained will maximize learning. Arrange for the training to be a pleasurable experience at a respected facility and with food if possible. Order or prepare the curriculum and all appropriate training materials so they are available during the training.

Encourage staff, administrators, and program champions to participate in the training. The more program partners become knowledgeable of the program content and objectives, the more vested they will be.

Create and administer an evaluation to assess participant’s learning, satisfaction, and any additional training or resource needs. (Make a link to a sample evaluation here)

**Educating the Community:**
- Raising awareness of the new program promotes involvement and investment. Prepare fact sheets or brochures and create and deliver presentations to potential partners, referral sources, volunteer sources, and future funders. Focus on highlighting the research resulting in the program’s recognition as an evidence-based program. To aid in this process, seek fact sheets from the developer or from organizations such as the Center for the Study and Prevention of Violence and the EPISCenter.

**Supplies/Coordination:**
- Program coordination steps and supplies may be outlined by the developer in the curriculum materials. Understand the supplies needed for quality implementation and allow ample time and support in purchasing and preparing supplies.
- To maximize program participation, address potential barriers to participation. Supports such as a meal, transportation, childcare, and incentives may increase interest, registrations, and attendance.
- Explore a variety of marketing venues to match your program’s education and recruitment needs, such as posters, fliers, online community calendars, cable TV ads, newspaper ads, yard signs, classroom presentations, and phone calls.

**Outcome Measurement:**
- Outcome measurement has three primary components: collecting program data, collecting community-level indicators, and monitoring model adherence, quality, and fidelity.
- The EPISCenter will aid you in identifying data collection tools that are program specific. Using these tools will aid you in identifying proximal outcomes in the participants served. Follow-up surveys and measurement tools can be used to assess distal outcomes.
- Population-based changes in the prevalence of delinquency, violence, substance abuse, and other problem behaviors are the ultimate goal. To assess these changes, a community assessment tool, such as the Pennsylvania Youth Survey (PAYS), should be administered according to a regular schedule that allows changes to be tracked over time.
- Model adherence and delivery quality can be assessed with program specific tools and protocols as well as monitoring processes such as observations. The observer should be trained in the program and be capable of providing constructive feedback for program and delivery enhancements. Although observations are the preferred method for collecting fidelity data, for some programs, fidelity checklists filled out by the implementers are recommended by the developer and may be used as an alternative or in addition to the observations.
— All the data collected should be used to ensure that the program is being implemented as intended by the developer and that it is having the desired impact. In addition, data should be shared with the collaborative board, program partners, and potential sources of sustainability.

• **Sustainability:**
  — Create a breakdown of all program expenses and list potential partners of funding sources for each. Use this as a starting point for developing a sustainability plan that considers fundraising, sponsorship, local public funding, cost sharing with community partners, grants, and in-kind solicitations.
  — **Sustainability** is a process which is dependent on the ability to demonstrate the need for and the value of the program. This is achieved through the dissemination of local program evaluation data that demonstrates the program’s impact on targeted outcomes, local youth and families, and the community.
  — Planning for sustainability should begin at program selection and requires a commitment to community education, program branding, data reporting, and proactive exploration and solicitation of potential funders. From the beginning, the objective should be to create a community synergy around the program and to promote focused resource allocation and sharing that helps the community to assume ownership of the program.
IDENTIFYING AN EVIDENCE-BASED PROGRAM

The Pennsylvania Commission on Crime and Delinquency (PCCD) and the Department of Public Welfare has committed to grant funding for a selection of evidence-based programs, which are summarized on the following pages. To identify other programs of proven effectiveness, the following Web sites are suggested:

- Center for the Study and Prevention of Violence's (CSPV) Blueprints
- The Coalition for Evidence-based Policy Help Desk and Social Programs That Work
- The Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Program Guide
- National Registry of Evidence-based Programs and Practices (NREPP)

NREPP is a valuable tool for reviewing the research data behind a program. However, NREPP is NOT a list of evidence-based programs. It lists programs which have undergone some form of study, whether scientifically rigorous or not, and that have produced outcome findings, positive or negative. NREPP does not establish criteria requiring a level of effectiveness to list programs; rather it is left to the reader to make their own judgment about whether the evaluation results represent an "effective" program. Research results are often ambiguous and difficult to interpret and individuals should not assume that if a program is listed by NREPP it is effective.

MATRIX OVERVIEW OF EVIDENCE-BASED RECOGNITION CRITERIA

A matrix overview of program criteria standards prepared by the Center for the Study and Prevention of Violence can be found in Appendix A. The overview explains the standards of twelve sources that recognize programs for their evidence of effectiveness. Each source holds high standards for recognizing proven effective programs and each maintains program lists that are credible sources for identifying evidence-based programs.

CHART OF PCCD SELECTED EVIDENCE-BASED PROGRAMS AND CONTACTS

A summary chart of selected prevention programs that are the focus of the Pennsylvania Commission on Crime and Delinquency’s (PCCD) grant funding can be found in the Appendix B.
SUMMARY OF THE EVIDENCE-BASED PROGRAMS SUPPORTED BY PCCD AND DPW

In 2005, PCCD identified ten evidence-based programs that would be the focus of their future funding. Below are summaries of the programs. The summaries are adapted from program websites and online summaries published by the Center for the Study and Prevention of Violence.

**Big Brothers Big Sisters (BBBS)** is the oldest and largest youth mentoring organization in the United States and is recognized as the most effective. Targeting children ages 6 through 18, BBBS has a mission of helping youth to reach their potential through professionally supported, one-to-one relationships with volunteer mentors. BBBS distinguishes itself from other mentoring programs via rigorous published standards and required procedures, including volunteer screening, youth assessment, a careful matching process, and supervision. Agencies use a case management approach, following each case from initial inquiry through closure. Research has shown that positive relationships between youth and their mentors have a direct and measurable impact on the participating children’s’ lives, particularly when matches last for one year or longer. **Outcomes** found in research studies of BBBS include:

- Youth are less likely to initiate drug and alcohol use;
- Youth are less likely to hit someone;
- Youth have improved academic behavior, attitudes, and performance;
- Youth report higher quality relationships with parents/guardians and peers.

**Functional Family Therapy (FFT)** is an empirically grounded family intervention program for dysfunctional and at-risk youth aged 11-18 and their families; including youth with problems such as conduct disorder, violent acting-out, and substance abuse. Youth often also present with additional co morbid challenges such as depression. FFT is a family therapy model in which the therapist always meets with the whole family. In Pennsylvania, FFT can be funded by Medical Assistance as a home-based service as an alternative to incarceration or out-of-home placement. Treatment ranges from, on average, 8 to 12 one-hour sessions up to 30 sessions of direct service for more difficult situations. Treatment has specific phases, which organize intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Clinical trials have demonstrated that FFT is capable of effectively treating adolescents with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorders, and those who are delinquent and/or violent. FFT interrupts the matriculation of these adolescents into more restrictive, higher cost services, reduces their penetration of social services and the adult criminal system, and prevents younger siblings from entering the system of care. Evaluation of FFT across a wide range of youth and communities has shown these positive outcomes:

- Significant and long-term reductions in youth re-offending and violent behavior,
- Significant effectiveness in reducing sibling entry into high-risk behaviors,
- Low drop-out and high completion rates, and
- Positive impacts on family conflict, family communication, parenting, and youth problem behavior.
The Incredible Years (IY) series is a set of three comprehensive, multi-faceted, and developmentally-based curriculums for parents, teachers and children designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotion problems in young children. The program targets children, ages 2 to 10, at risk for and/or presenting with conduct problems, such as high rates of aggression, defiance, oppositional and impulsive behaviors. In all three training programs, trained facilitators use videotape scenes to encourage group discussion, problem-solving, and sharing of ideas. The BASIC parent series is "core" and a necessary component of the prevention program delivery. Incredible Years Training for Parents includes three programs targeting parents of high-risk children and/or those displaying behavior problems. The BASIC program emphasizes parenting skills known to promote children's social competence and reduce behavior problems such as: how to play with children, helping children learn, effective praise and use of incentives, effective limit-setting and strategies to handle misbehavior. The ADVANCE program emphasizes parent interpersonal skills such as: effective communication skills, anger management, problem-solving between adults, and ways to give and get support. The SUPPORTING YOUR CHILD'S EDUCATION program (known as SCHOOL) emphasizes parenting approaches designed to promote children's academic skills such as: reading skills, parental involvement in setting up predictable homework routines, and building collaborative relationships with teachers.

Incredible Years Training for Teachers emphasizes effective classroom management skills such as: the effective use of teacher attention, praise and encouragement, use of incentives for difficult behavior problems, proactive teaching strategies, how to manage inappropriate classroom behaviors, the importance of building positive relationships with students, and how to teach empathy, social skills and problem-solving in the classroom.

Incredible Years Training for Children (DINA Curriculum) emphasizes training children in skills such as emotional literacy, empathy or perspective taking, friendship skills, anger management, interpersonal problem-solving, school rules and how to be successful at school. The treatment version is designed for use as a "pull out" treatment program for small groups of children exhibiting conduct problems. The prevention version is delivered to the entire classroom by regular teachers, two to three times a week. Multiple randomized control group evaluations of the 3 components indicate significant:

- Increases in parent positive affect such as praise and reduced use of criticism and negative commands.
- Increases in parent use of effective limit-setting by replacing spanking and harsh discipline with non-violent discipline techniques and increased monitoring of children.
- Reductions in parental depression and increases in parental self-confidence.
- Increases in positive family communication and problem-solving.
- Reduced conduct problems in children's interactions with parents and increases in their positive affect and compliance to parental commands.
- Increases in teacher use of praise and encouragement and reduced use of criticism and harsh discipline.
- Increases in children's positive affect and cooperation with teachers, positive interactions with peers, school readiness and engagement with school activities.
- Reductions in peer aggression in the classroom.
- Increases in children's appropriate cognitive problem-solving strategies and more pro-social conflict management strategies with peers.
- Reductions in conduct problems at home and school.

**LifeSkills Training (LST)** is a multi-component substance abuse prevention curriculum addressing social, psychological, cognitive, and attitudinal factors that have been shown to be associated with the use of various legal and illegal substances. The primary objective of the program is to enhance the development of basic life skills, personal competence, and skills related to the resistance of the social influences that promote substance use. LST targets middle/junior high school students and is a three-year intervention designed to prevent or reduce gateway drug use (i.e., tobacco, alcohol, and marijuana), primarily implemented in school classrooms by school teachers. It is initially introduced in grades 6 or 7, depending on the school structure, with booster sessions in the two subsequent years. The program is delivered in 15 sessions in year one, 10 sessions in year two, and 5 sessions in year three. Sessions, which last an average of 45 minutes, can be delivered once a week or as an intensive mini-course. The program consists of three major components which teach students (1) general self-management skills, (2) social skills, and (3) information and skills specifically related to drug use. Skills are taught using training techniques such as instruction, demonstration, feedback, reinforcement, and practice. Evaluations of over a dozen studies show these outcomes for LST:

- Delays the onset of substance use;
- Reduces tobacco, alcohol, and marijuana use;
- Reduces polydrug use;
- Decreases the use of inhalants, narcotics, and hallucinogens.

These studies further show that the program works with a diverse range of adolescents, produces results that are long-lasting, and is effective when taught by teachers, peer leaders, or health professionals.

**Multidimensional Treatment Foster Care (MTFC)** is a cost effective alternative to group and residential treatment placements and incarceration. MTFC targets youth with histories of chronic and severe criminal behavior, as well as youth with severe emotional and behavioral disorders, who have histories of failed placements and failed treatment attempts. Community foster families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community. The community foster family environment provides clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers. Training for the community foster families emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a pre-service training and placement of the youth, MTFC parents attend a weekly group meeting run by a program supervisor where ongoing support and supervision are provided. Foster parents are contacted daily during telephone calls to check on youth progress and problems. Skills coaching and weekly individual therapy is done with the youth. MTFC staff is available for consultation and crisis intervention 24/7. Services to the youth's biological or adoptive family occur throughout the placement and family therapy is provided with the goal of returning the youth back to the home. The guardians are supported and taught to use behavior management methods that are used in the MTFC foster home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents are encouraged to have frequent contact with the MTFC program supervisor to get information about their child's progress in the program. Frequent contact is maintained between the MTFC program supervisor and the youth's case workers, parole/probation officer, teachers, work supervisors, and other involved adults. Evaluations of MTFC have demonstrated that program youth compared to control group youth:
• Spent 60% fewer days incarcerated at 12 month follow-up;
• Had significantly fewer subsequent arrests;
• Ran away from their programs, on average, three time less often;
• Had significantly less hard drug use in the follow-up period;
• Had quicker community placement from more restrictive settings (e.g., hospital, detention); and
• Had better school attendance and homework completion at 24 months follow-up.

**Multisystemic Therapy (MST)** is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement. The multisystemic approach views individuals as nested within a network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. Treatment sessions occur primarily with the caregivers and other involved adults to make changes in the youth’s environment that will in turn result in changes in the youth’s behavior; individual therapy with the youth is not a routine component of MST. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and promote behavior change in the youth’s natural environment. These outcomes are achieved at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community strengths and resources. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral and pragmatic family therapies. Proven outcomes of MST include:

• Reduced long-term rates of criminal offending in serious juvenile offenders,
• Decreased recidivism and re-arrests,
• Reduced rates of out-of-home placements for serious juvenile offenders,
• Extensive improvements in family functioning,
• Decreased behavior and mental health problems for serious juvenile offenders,
• Favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services.

**Olweus Bullying Prevention Program (OBPP)** is a universal intervention for the reduction and prevention of bully/victim problems. The universal program targets students in elementary, middle, and junior high school and school staff has the primary responsibility for the introduction and implementation of the program. Core components of the program are implemented on 3 levels:

• **School-wide components** include the administration of an anonymous questionnaire to assess the nature and prevalence of bullying at each school, a school conference day to discuss bullying at school and plan interventions, formation of a Bullying Prevention Coordinating Committee to coordinate all aspects of school’s program, and increased supervision of students at “hot spots” for bullying.
• **Classroom components** include the establishment and enforcement of class rules against bullying, and holding regular class meetings with students.
• *Individual components* include interventions with children identified as bullies and victims, and discussions with parents of involved students. Teachers may be assisted in these efforts by counselors and school-based mental health professionals.

Results of studies of the Olweus Bullying Prevention Program have shown these positive outcomes:

- Reductions in bullying;
- Reductions in victimization;
- Reductions in antisocial behavior such as vandalism, fighting, theft and truancy;
- Improved “social climate” of classrooms;
- More positive social relationships;
- More positive attitudes toward schoolwork and school.

*Promoting Alternative THinking Strategies (PATHS)* is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children while simultaneously enhancing the educational process in the classroom. The curriculum is designed to be used by educators and counselors in a multi-year, universal prevention model. The PATHS Curriculum was developed for use in the classroom setting with all elementary school aged-children, but it has also been researched with a variety of special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted). Ideally it should be initiated at the entrance to schooling and continue through Grade 5 and be taught three times per week for a minimum of 20-30 minutes per day. The curriculum provides teachers with systematic, developmentally-based lessons, materials, and instructions for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. PATHS lessons include instruction in identifying and labeling feelings, expressing feelings, assessing the intensity of feelings, managing feelings, understanding the difference between feelings and behaviors, delaying gratification, controlling impulses, reducing stress, self-talk, reading and interpreting social cues, understanding the perspectives of others, using steps for problem-solving and decision-making, having a positive attitude toward life, self-awareness, nonverbal communication skills, and verbal communication skills. Information and activities are also included for use with parents.

Research studies have found the PATHS program demonstrate the following positive outcomes:

- Reduced teachers' reports of students exhibiting aggressive behavior;
- Increased teachers' reports of students exhibiting self-control;
- Improved students' ability to tolerate frustration plus their ability -- and willingness -- to use effective conflict-resolution strategies;
- Reduced behavioral problems, such as aggression at school (for both regular and special-needs students);
- Significantly decreased conduct problems and the percentage of aggressive/violent solutions to social problems;
- Reduced depression and sadness among special-needs students.
The Strengthening Families Program for Parents and Youth 10-14 (SFP 10-14) is an empirically supported program targeting adolescents ages 10 to 14 and their caregivers. The parent, youth, and family skills-building curriculum is delivered in seven sessions and is offered as independent, concurrent learning sessions for parents and youth, followed by family sessions. The program uses realistic videos, role-playing, discussions, learning games, and family projects. The goal of the program is to enhance parenting skills, build life skills in youth, and strengthen family bonds and communication. Proven outcomes for SFP 10-14 include:

- Delayed onset of adolescent substance use;
- Lower levels of aggression;
- Increased resistance to peer pressure by youth;
- Increased ability of parents/caregivers to set appropriate limits and show affection and support to their children.

**Chart of National Recognitions**
A chart highlighting the national recognitions awarded each of the programs selected by PCCD and DPW for funding can be found in Appendix C.
SECTION THREE: IMPLEMENTING AN EVIDENCE-BASED PROGRAM

IMPORTANCE OF IMPLEMENTATION FIDELITY

Delivering Evidence-based Programs as Designed by the Developer

The Pennsylvania Commission on Crime and Delinquency’s (PCCD) Research-based Programs Initiative began funding the replication of efficacious prevention programs throughout Pennsylvania in 1998. The goal was the dissemination and adoption of effective prevention and intervention programs across the state by local communities to improve youth outcomes.

The expectation was that sites would implement the selected evidence-based programs with fidelity - as the program developer designed the program and intended it to be implemented – in order to achieve the maximum positive impact on youth and families in Pennsylvania. The following are keys elements for implementing with fidelity:

- Thoughtfully identify community risk and protective factors and select a program that addresses local prioritized needs
- Identify the training and resources needed for implementation and sustainability
- Understand the program’s core theory of change/logic model and associated outcomes
- Carefully plan and effectively implement with quality and fidelity
- Seek on-going coaching, technical assistance, and support from the developer, trainers, network consultants, the EPICenter, and community partners
- Adopt quality monitoring protocols, survey tools, and utilize feedback to improve the quality of implementation
- Avoid program modifications, but if adaptations are necessary to meet the needs of the local community, consult with the program developer to prevent sacrificing the program’s theory of change.
- Prevention science has invested in developing programs on sound theory and testing the efficacy of intervention programs in well-designed studies. However, programs are increasingly implemented outside of the research context under real-world conditions. In order to generate the positive outcomes demonstrated in research trials a commitment to quality implementation and model adherence is necessary.

Implementation quality has been linked to program outcomes and greater fidelity is associated with better youth outcomes. Numerous research studies have shown a positive association between implementation quality and program outcomes. Programs in which implementers more closely adhered to the program model by implementing the program as the developer intended were more effective in producing stronger, more positive changes in family and youth outcomes. Under naturalistic conditions, caution must be taken to avoid program modifications or adaptations that can potentially depreciate program efficacy and be detrimental to program outcomes. Therefore, understanding the program’s theory of change and core components is critical.
Each evidence-based program delineates how it operates and the mechanism through which behavior is changed and positive outcomes are achieved. It is important to review the program’s logic model, understand the risk and protective factors targeted, and know what proximal changes in skills, attitudes, behaviors, and knowledge will lead to long-term outcomes. Helping all staff and program partners to understand the theory of change/logic model creates a shared vision for the desired impact and helps staff to conceptualize why modifications, although often inadvertent or well-intended, can result in program drift, reduced impact, or iatrogenic (harmful) effects.

To maximize the quality of implementation and model adherence, consider the following contributing factors:

**Implementation Systems Model:**

**Implementer Characteristics** –
Possessing the knowledge, skills, and motivation to implement effectively contributes significantly to program success. Understanding the theoretical model of the intervention aids implementers in making informed decisions regarding fidelity and adaptation. Confidence in one’s ability to implement with quality and comprehension of the program’s potential for change in the target population may increase an implementer’s motivation to implement a program as designed. Additional supports such as quality training, on-going technical support, a defined implementation structure, continuous supervision and
support, and positive feedback and reinforcement, serve to capitalize on the implementers’ strengths and promote quality implementation.

**Implementing Organization** –
It is important that an evidence-based programs goals align with the implementing organization’s goals and that the organization is committed to resource allocation. Effective operating standards, such as a defined budget and clear guidelines for managing spending, as well as a clear authority structure ease implementation barriers. In addition, support for staff in the form of administrative buy-in, ample manpower, program champions, and connections to a collaborative system can be contribute to program success.

**Program** –
Faithful implementation is influenced by the quality and availability of materials, training and the complexity of the recommended implementation and delivery strategies. For example, programs with clear instructional manuals and specific delivery strategies offer guidance that eases implementation. Staff’s comfort level with the program materials and delivery strategies also impacts the quality of delivery. Thus, appropriate training from the program developer and on-going technical support is imperative to implementation quality and fidelity. Ideally training should not be passive or simply didactic, but it should allow for behavioral rehearsal. Timing of training is also important. For some programs, offering training months before implementation may result in the loss of knowledge and skills acquisition necessary to implement the program. Research the developer’s expectations and timeline for training in advance and plan accordingly. To the extent possible, include all implementation partners, including administrators, delivery staff, evaluators, and coordinators in the training to ensure that all can champion the program and promote fidelity. Seek on-going coaching and technical assistance to navigate barriers once implementation has begun. The EPISCenter is one source of support. Effective training and on-going support increases staff’s knowledge of the theory of change, provides skills for effective implementation and delivery, fosters an investment in quality, and sparks a drive to produce positive outcomes.

**Recipient** –
Differences in the type of intervention, such as school-based, family-based, and community-based, and the population targets, such as universal or selective, alter the degree of difficulty in recruiting and retaining program participants. Some pools of potential recipients are easier to engage, such as students in a targeted school. However, family-based and community-based programs have a more difficult time attracting and retaining participants due to factors, such as barriers to attendance (e.g. a lack of transportation), willingness to participate, and perceived need or stigmas. For many programs, establishing strong community connections is necessary to raise awareness of the program and to build referral networks. For example, relationships with the criminal justice system may aid in establishing referral systems and mandated participation by at-risk youth and families. Marketing strategies should also be explored with attention to creating attractive recruitment messages, positively branding the program in the community, and targeting the participants through the most readily-seen and cost-effective venues.

**School/Community Context** –
Complex interactions may directly or indirectly influence the quality of implementation, fidelity, and model adherence. The environment in which programs are implemented, such as the school, home, or community, the targeted participants, and the individuals and agencies responsible for implementation all contribute to program implementation. For example, school principal support has been positively
associated with the quality of implementation for school-based programs and thus, positive outcomes for the youth served. The success of a community-based program may be dependent upon collaborative relationships, community leadership, communication systems, or volunteer support. Identifying key partners at program selection, cultivating the necessary relationships, and establishing cooperation and communication systems contribute to program success.
THE RETURN ON INVESTMENT (ROI) OF QUALITY IMPLEMENTATION

Considering the Cost-Benefit Ration of Evidence-based Programs.\(^6\)

Prevention programs not only impact the participants. They alter behaviors, family dynamics, and criminal justice system and social service involvement, which potentially leads to monetary savings for society. Researchers direct attention to four primary targets that are monetarily impacted by successful prevention programs:

1. For prevention programs aimed at delinquent youth, diversion from a criminal path has implications across the youth’s lifespan, not only for the individual youth, but also for their family, multiple other individuals, and the community. By thwarting a “criminal career”, costs that would be incurred by the criminal justice system are greatly reduced, including law enforcement (arrest), adjudication, and placement and incarceration costs. In addition, victim costs, both tangible and intangible, are reduced, including medical costs, lost income, property loss, and a decrease in quality of life.

2. Reductions in delinquency, violence, and criminal activity result in increased productivity by the program participant and potentially increased future earnings and tax revenues across their lifetimes.

3. Decreased public assistance and social service expenditures may be realized as individuals may be less likely to depend upon welfare and other forms of public assistance. Administrative costs and burdens for social service agencies will also be reduced as the demand for services decreases.

4. The burden on special programs aimed at those in need is alleviated, as reductions are realized in the demand for services provided by special education programs, health services, homeless shelters, substance abuse treatment centers, and other programs targeting at-risk individuals.

When calculating the return on investment of a prevention program, the magnitude and timing of expected gains are compared to the investment costs for implementation and delivery. Economic analyses have demonstrated that evidence-based programs not only pay for themselves, but represent a significant “return on investment” to taxpayers. By reducing future costs associated with prison, drug treatment, social service and welfare usage, and increasing tax revenue, (for instance, by increasing graduation rates and employment), evidence-based programs have been found to represent a return of $5 to $25 for each dollar invested.

Cost-Benefit Analysis: \(^7\)

Monetizing Program Benefits and Costs

Cost-benefit analyses are conducted by calculating the economic benefits derived from an intervention and subtracting the costs incurred to implement the intervention. Typically, a cost-benefit assessment of child and youth prevention and intervention programs includes calculations for the following key outcomes:
• Crime (such as costs to process an arrest, prosecutor costs, victim costs, detention and supervision costs, prison operation expenses)
• Education (graduation rates, test scores, post-high school education, special education rates, grade repetition)
• Employment rates and earning potential
• Substance use (abuse of alcohol, tobacco, and illicit drugs)
• Public assistance (including welfare receipt or social services such as foster care)
• Teen birth rates
• Child abuse and neglect
• Health and mental health service needs

In 2004, the Washington State Institute for Public Policy derived economic benefits minus costs for a variety of prevention programs. The scientifically rigorous review and analysis of prevention programs provided credible evidence that well implemented prevention efforts can result in a significant return on investment. To conduct the analysis, a benefit-cost model was constructed that assigned monetary values to observed changes attributed to the prevention programs described below in education, crime, substance abuse, child abuse and neglect, teen pregnancy, and public assistance outcomes. The tables on the following pages summarize the benefits and costs of various prevention programs.

For more information on the Washington State Institute for Public Policy report, Benefits and Costs of Prevention and Early Intervention Programs for Youth.

The Substance Abuse and Mental Health Services Administration has also prepared a cost benefit analysis document, which can be accessed here.
| Table 1
Summary of Benefits and Costs (2003 Dollars) |
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<td>Estimates as of September 17, 2004</td>
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| Table 1 (Continued)  
| Summary of Benefits and Costs (2003 Dollars) |
|---|---|---|---|
| **Measures Benefits and Costs Per Youth** | Benefits | Costs | Benefits per Dollar of Cost | Benefits Minus Costs |
| **(1)** | (2) | (3) | (4) |
| **Youth Substance Abuse Prevention Programs (Continued)** | | | | |
| All Stars ‡ | $160 | $49 | $3.43 | $120 |
| Project ALERT ( Adolescent Learning Exp. in Resistance Training) ‡ | $58 | $3 | $18.02 | $54 |
| STARS for Families ( Start Taking Alcohol Risks Seriously) | $0 | $18 | $0.00 | -$18 |
| D.A.R.E. (Drug Abuse Resistance Education) # | $0 | $39 | $0.00 | -$39 |
| **Teen Pregnancy Prevention Programs** | | | | |
| Teen Outreach Program | $801 | $620 | $1.29 | $181 |
| Reducing the Risk Program ‡ | $0 | $13 | $0.00 | -$13 |
| Postponing Sexual Involvement Program ‡ | -$45 | $9 | -$5.07 | -$54 |
| Teen Talk | $0 | $81 | $0.00 | -$81 |
| School-Based Clinics for Pregnancy Prevention* | $0 | $805 | $0.00 | -$805 |
| Adolescent Sibling Pregnancy Prevention Project | $709 | $3,359 | $0.21 | -$2,641 |
| Children’s Aid Society-Carrera Project | $2,409 | $11,501 | $0.21 | -$9,093 |
| **Juvenile Offender Programs** | | | | |
| Dialectical Behavior Therapy (in Washington) | $322,087 | $843 | $38.65 | $31,243 |
| Multidimensional Treatment Foster Care (v. regular group care) | $26,748 | $2,459 | $10.88 | $24,290 |
| Washington Basic Training Camp § | $14,778 | -$7,586 | n/a | $22,364 |
| Adolescent Diversion Project | $24,007 | $1,777 | $10.54 | $22,230 |
| Functional Family Therapy (in Washington) | $16,456 | $2,149 | $7.89 | $14,316 |
| Other Family-Based Therapy Programs for Juvenile Offenders* | $14,081 | $1,620 | $8.89 | $12,464 |
| Multi-Systemic Therapy (MST) | $14,936 | $5,081 | $2.04 | $9,316 |
| Aggression Replacement Training (in Washington) | $9,540 | $759 | $1.20 | $8,560 |
| Juvenile Offender Interagency Coordination Programs* | $8,859 | $559 | $15.48 | $8,300 |
| Mentoring in the Juvenile Justice System (in Washington) | $11,544 | $5,471 | $1.78 | $5,073 |
| Diversion Progs. with Services (v. regular juvenile court processing)* | $2,272 | $406 | $5.58 | $1,866 |
| Juvenile Intensive Probation Supervision Programs* | $0 | $1,482 | $0.00 | -$1,482 |
| Juvenile Intensive Parole (in Washington) | $0 | $5,952 | $0.00 | -$5,952 |
| Scared Straight | -$11,002 | $54 | -$203.51 | -$11,056 |
| Regular Parole (v. not having parole) | -$19,379 | $2,088 | -$4.95 | -$12,474 |
| **Other National Programs** | | | | |
| Functional Family Therapy (excluding Washington) | $28,756 | $2,149 | $13.25 | $26,216 |
| Aggression Replacement Training (excluding Washington) | $15,606 | $7,759 | $20.56 | $14,846 |
| Juvenile Boot Camps (excluding Washington) § | $0 | -$8,474 | n/a | $8,474 |
| Juvenile Intensive Parole Supervision (excluding Washington)* | $0 | $5,052 | $0.00 | -$5,052 |


More detail is presented in the Appendix to this report, available at <http://www.wsiip.wsipolicy.org/files/04-07-0601a.pdf>. The values on this table are estimates of present-valued benefits and costs of each program with statistically significant results with respect to crime, education, substance abuse, child abuse and neglect, teen pregnancy, and public assistance. Many of these programs have achieved outcomes in addition to those for which we are currently able to estimate monetary benefits.

‡ Cost estimates for these programs do not include the costs incurred by teachers who might otherwise be engaged in other productive teaching activities. Estimates of these opportunity costs will be included in future revisions.

§ The D.A.R.E. program has changed considerably since the last evaluation used in this report. A five-year evaluation of the new program began in 2001.

$ The juvenile boot camp cost in column (2) is a white negative number because, in Washington, youth in the state’s basic training camp spend less total time institutionalized than comparable youth not attending the camp. In column (4), this 'negative' cost is a benefit of the camp versus a regular institutional stay.

* Programs with an asterisk are the average effects for a group of programs; programs without an asterisk refer to individual programs.
History and Purpose of the Evidence-based Programs Initiative:
Pennsylvania is a national leader in recognizing the critical role of prevention in addressing juvenile delinquency, youth violence, and substance use. Under the state’s Evidence-based Programs Initiative (formerly recognized as the Research-based Programs Initiative), which is driven by PCCD, a comprehensive prevention strategy has been shaped and guided by prevention science.

Pennsylvania has purposefully chosen to invest in disseminating proven effective programs targeting youth problem behaviors through grants to local communities. Since 1998, a significant investment has been made in prevention models and programs that have been nationally recognized as effective by federal and state agencies and prevention science organizations. Grants were originally awarded for adoption of the Communities That Care process, followed by funding for research-based prevention programming. In 2008, PCCD narrowed the selection to ten evidence-based programs as the focus of its grant awards. This allowed for resources to be concentrated, for the provision of specific technical assistance, and the creation of networking opportunities.

By focusing on prevention and promoting the use of evidence-based programs, PCCD has asserted a deliberate policy stance aimed at more efficient use of state and federal resources. The objective is to promote positive youth development and to foster strong families and communities with the ultimate goal of reducing future costs related to the youth problem behaviors of delinquency, violence, substance use, teen pregnancy, and school drop-out. The goal is to have a population level public health impact.

Background of PCCD Support for Evidence-based Programs:
In 2008, PCCD shifted its focus exclusively to funding new sites choosing to implement from a selection of ten evidence-based programs, each recognized by the Center for the Study and Prevention of Violence as Blueprint Model or Promising Programs. Pennsylvania has purposefully chosen to invest in disseminating programs throughout the state that are marked by credible evidence of effectiveness garnered under the most rigorous scientific conditions. Resources and efforts have been concentrated on advancing the following evidence-based programs: Big Brothers Big Sisters (BBBS), Functional Family Therapy (FFT), LifeSkills Training (LST), Multisystemic Therapy (MST), Multidimensional Therapeutic Foster Care (MTFC), The Olweus Bullying Prevention Program (OBPP), Promoting Alternative Thinking Strategies (PATHS), Project Towards No Drug Abuse (Project TND), Strengthening Families Program for Parents and Youth 10-14 (SFP 10-14), and The Incredible Years (IYS). Each of the programs selected has been identified nationally as being evaluated using a strong research design, being replicated at multiple sites, and demonstrating evidence of demonstrating evidence of positive outcomes that has been sustained over time. As such, these programs represent the greatest potential for effectively preventing and reducing delinquency in Pennsylvania.

In 2010, the PCCD Evidence-based Programs Initiative narrowed its focus to six evidence-based programs: Big Brothers Big Sisters (BBBS), LifeSkills Training (LST), The Olweus Bullying Prevention Program (OBPP), Promoting Alternative Thinking Strategies (PATHS), Strengthening Families Program
(SFP 10-14), and The Incredible Years (IY). The three intervention programs Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Therapeutic Foster Care (MTFC) are now funded by two offices within the Pennsylvania Department of Public Welfare, the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Children, Youth, and Families (OCYF).

**Resource Center for Evidence-Based Prevention and Intervention Programs and Practices:**
In 2008, PCCD’s Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the PA Department of Public Welfare (DPW) introduced the Resource Center for Evidence-Based Prevention and Intervention Programs and Practices (Resource Center). The Resource Center seeks to support the dissemination of proven prevention and intervention programs aimed at reducing or preventing problem behaviors in children and adolescents. Funding for the Resource Center is provided by Pennsylvania Commission on Crime and Delinquency (PCCD) and the PA Department of Public Welfare’s Office of Children Youth and Families (OCYF).

The Resource Center is a multi-agency collaborative effort that includes PCCD, the Office of Mental Health and Substance Abuse Services (OMHSAS) and the OCYF, the Juvenile Court Judges’ Commission, the Pennsylvania Council of Chief Juvenile Probation Officers, grantees and community-based and residential service providers. PCCD manages the operations of the Center in conjunction with Pennsylvania’s State Advisory Group, the Juvenile Justice and Delinquency Prevention Committee.

The Resource Center has three components:
- Support for quality implementation of established evidence-based program models through the Evidence-based Prevention and Intervention Support Center (EPISCenter)
- Support for incorporating research-based principles and practices in existing local juvenile justice programs through the National Center for Juvenile Justice: Juvenile Justice Local Innovative Program
- Support for community planning and implementation of the evidence-based prevention models, Communities That Care, and Weed and Seed through the EPISCenter.

**The Role of the Evidence-based Prevention and Intervention Support Center (EPISCenter):**
Since 2001, the Prevention Research Center at the Pennsylvania State University has provided technical assistance to research-based and evidence-based program grantees funded by the Pennsylvania Commission on Crime and Delinquency (PCCD). From this effort, the EPISCenter was created in 2008 as a part of the Resource Center for Evidence-based Prevention and Intervention Programs and Practices to further advance community-based and outcome-focused prevention in Pennsylvania. Intended as a comprehensive statewide-resource, the EPISCenter’s primary goals are to ensure high quality implementation, evaluation, and sustainability of PCCD and Department of Public Welfare (DPW) funded programs, and to promote the greater use and support of evidence-based programs throughout Pennsylvania. The EPISCenter strives to maximize the investment of PCCD and DPW and to champion quality implementation by evidence-based program grantees.

Strategically preparing to become a central source of technical assistance, the EPISCenter is striving to increase strategic outreach, in-state training capacity, and implementation supports through marketing, advocacy, technology, and partnerships with program developers and trainers. To support and advance the use of evidence-based programs, the EPISCenter:
• Directs outreach and advocacy efforts to foster recognition, at federal, state, and community levels, of the value and impact of proven prevention and intervention programs,
• Provides technical assistance to communities to improve implementation quality, promote the collection and use of program impact data, and foster proactive planning for long-term program sustainability,
• Develops and provides educational opportunities and resources to disseminate current prevention science research and facilitate peer networking, and
• Conducts original research to inform more effective prevention practice and the successful dissemination of evidence-based programs.

The Role of the Office of Mental Health and Substance Abuse Services (OMHSAS):
The Office of Mental Health and Substance Abuse Services (OMHSAS) is an office within the Pennsylvania Department of Public Welfare (DPW). OMHSAS includes several bureaus, including the Bureau of Children’s Behavioral Health Services (a.k.a. Children’s Bureau) and the Bureau of Operations which includes four regional Field Offices.

OMHSAS is committed to improving consumer access to evidence-based programs (EBP) that involve a behavioral health treatment component, primarily through Medical Assistance (M.A.) funding for such programs. The first evidence-based program to receive M.A. funding was approved in 2003. In the seven years since, over 30 providers have accessed M.A. funding for evidence-based treatment programs, primarily Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Treatment Foster Care (MTFC). These three programs serve youth with severe behavioral issues while enabling them to remain in the community.

The Children’s Bureau reviews and approves service descriptions submitted by providers who want to access M.A. funding for an EBP, responds to questions that arise regarding the application of existing mental health regulations and policies to EBPs, and provides technical assistance to providers regarding how to ensure their EBPs meet DPW regulations and requirements. The Children’s Bureau has provided trainings to educate stakeholders about EBPs, including how they fit into the M.A. system. The Children’s Bureau and Field Offices monitor the quality of services and ensure program compliance with state regulations and policies through on-site reviews of many EBP providers. OMHSAS collaborates with PCCD, OCYF, and the EPISCenter through regular meetings to discuss the implementation of EBPs in Pennsylvania.

The Role of the Office of Children Youth, and Families:
The Office of Children, Youth, and Families (OCYF) is an office within the Pennsylvania Department of Public Welfare (DPW) and includes both Child & Family Services and Juvenile Justice Services. The OCYF has regional offices that work with county Children and Youth and Juvenile Probation agencies.

Historically, OCYF has provided funding to EBPs through county needs-based budgets. More recently, in 2008, OCYF launched a Special Grants Initiative to encourage counties to implement evidence-based treatment programs. Through this initiative, counties request grant funds for Multisystemic Therapy (MST), Functional Family Therapy (FFT), and/or Multidimensional Treatment Foster Care (MTFC), and, if awarded, receive a 95% state match. The amount of funding requested by counties in this manner has grown dramatically over the first three years of the initiative.
Through Special Grant funding, OCYF covers evidence-based program (EBP) related expenses that cannot be covered by other funding streams, such as Medical Assistance. OCYF works closely with other state agencies (i.e., PCCD, OMHSAS, and the EPISCenter) to support the dissemination and implementation of EBPs.

Cross-Systems Efforts to Support Evidence-Based Programs:
Since early 2008, state partners involved with supporting evidence-based programs have met on a regular basis to collaborate regarding the support provided to new evidence-based providers. Participants include representatives of PCCD, OCYF, OMHSAS Children’s Bureau, and the EPISCenter. This collaboration addresses issues such as funding, technical assistance, and monitoring efforts.

TECHNICAL ASSISTANCE RESOURCES

The Evidence-based Prevention and Intervention Support Center (EPISCenter):
The EPISCenter provides the following technical assistance to evidence-based programs (EBPs) funded by the Pennsylvania Commission on Crime and Delinquency (PCCD) and the Department of Public Welfare (DPW):

- Program Selection
- Program Start-up
- Outcome Measurement
- Quality Assurance
- Implementing with Fidelity to the Model
- Data Management
- PCCD Reporting Requirements (such as the performance measures, developer quality assurance review process in year 2 of funding, and the outcomes report required in year 3 of funding)
- Sustainability Planning
- Marketing and Community Awareness

Communities interested in EBPs can receive information on a program’s logic model, risk factors to be addressed, identified barriers to implementation and sustainability, key contacts for training and networking, and implementation timelines and benchmarks for each of the PCCD-funded programs. The EPISCenter is prepared to provide program specific information related to the following ten programs, but can also provide general information on implementing EBPs in general.

- Big Brothers Big Sisters (BBBS)
- Functional Family Therapy (FFT)
- The Incredible Years (IYS)
- Life Skills Training (LST)
- Multidimensional Treatment Foster Care (MTFC)
- Multisystemic Therapy (MST)
- Olweus Bullying Prevention Program (OBPP)
- Promoting Alternative Thinking Strategies (PATHS)
- Strengthening Families Program 10-14 (SFP 10-14)
For more information, please contact the EPISCenter at: 814-863-2568 or EPISCenter@psu.edu.

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Elizabeth Kulling, Administrative Assistant
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Mailing Address:
Evidence-based Prevention and Intervention Support Center (EPISCenter)
The Pennsylvania State University
206 Towers Building
University Park, PA 16802

Pennsylvania Commission on Crime and Delinquency (PCCD):
The Pennsylvania Commission on Crime and Delinquency, as an evidence-based program funder, employs analysts responsible for grant compliance monitoring. The analysts provide technical assistance for:

- Funding Inquiries
- Grant and Project Modifications
- Reporting
- E-grants Quarterly Report
- Grant Requirements (such as developer quality assurance review process in year 2 of funding and the outcomes report required in year 3 of funding)

For further information, please phone PCCD at 1-800-692-7292 or contact the following analysts:

Christina Cosgrove-Rock
717-265-8478

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717-265-8483

Kim Nelson
717-265-8458

Melissa Shetrom
717-265-8477

Mailing Address:
Pennsylvania Commission on Crime and Delinquency (PCCD)
Office of Juvenile Justice and Delinquency Prevention (OJJDP)
P.O. Box 1167
Harrisburg, PA 17108
Office of Mental Health & Substance Abuse Services (OMHSAS):
The OMHSAS Bureau of Children’s Behavioral Health Services can be contacted for questions regarding Medical Assistance (M.A.) funding, service description submissions and approvals, waiver requests, and M.A. regulations and policies.

PA Department of Public Welfare
Office of Mental Health & Substance Abuse Services
Bureau of Children’s Behavioral Health Services

Courtney Coover
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The OCYF can be contacted with questions regarding needs-based budgets and Special Grants funds.

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NETWORKING AND INFORMATION SHARING AMONG GRANTEES

Networking and information sharing among grantees can lead to more efficient and effective implementation. The EPISCenter Prevention Coordinators will work with sites implementing the same programs to provide these opportunities.
SECTION FIVE: DATA COLLECTION AND REPORTING REQUIREMENTS

THE ROLE OF DATA COLLECTION

Data Utilization at the State Level:
Pennsylvania is investing in a strategy guided by prevention science to effectively prevent and reduce youth delinquency, violence, and substance use. Through grants to local communities, the state has purposefully chosen to invest in the wide-scale dissemination of proven effective programs targeting youth problem behaviors. Each evidence-based program selected has demonstrated evidence of positive outcomes sustained over time through scientifically rigorous evaluations and multiple replications.

To achieve the same outcomes that were demonstrated in the research and to positively impact youth development in communities across the state, quality implementation is essential. PCCD requires grantees to collect data and to report their process and outcomes data in the E-grants performance measures quarterly. DPW requires providers receiving Medical Assistance (MA) reimbursement or grant funding for Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Treatment Foster Care (MTFC) to collect data and report it to the EPISCenter quarterly. This data is aggregated from all the funded sites to enable the state to justify the investment, demonstrate the impact, and secure additional funding partners and resources.

Data Utilization at the Local Level:
At a local level, grantees can strategically use data for the following purposes:

- To monitor quality and promote effective and efficient implementation
- To demonstrate local outcomes and impact
- To improve the quality of their implementation
- To promote program support and sustainability
- To fulfill the data collection requirements of funders

It is imperative that sound evaluation tools are selected and administered at the appropriate time points (e.g., pre and post implementation of the program). The developer’s recommendations should be followed and the EPISCenter can guide selection, administration, and analysis of outcome measurement tools. Beyond collecting data, a system for quality data analysis must be established and the data produced must then be shared in a format that is concise and easy for individuals to understand.

Using Data to Communicate Impact:
Carefully collecting and reporting outcomes data allows grantees to communicate impact to their collaborative board, community partners, and potential funders. Incorporating outcomes data in community reports and marketing materials:

1. Promotes Respect for the Program
   - Strengthens the credibility of the program
• Increases funder’s confidence that their investment is having an impact

2. **Enhances Marketing Messages**
   • Quantifies and allows for impact to be articulated
   • Demonstrates the value of the program to a wide audience
   • Allows targeted appeals to be crafted for specific populations, such as potential program participants, partners, volunteers, and funders
   • Provides a tool that contributes to branding the program

3. **Raises Community Awareness**
   • Encourages involvement and volunteerism
   • Garners local support and program advocates
   • Enhances the commitment of key leaders, administrators, and policy-makers
   • Increases recruitment of program participants

4. **Cultivates Investment and Sustainability**
   • Enhances the appeal of the program to sustainability sources
   • Initiates opportunities for funding requests and proposals
   • Motivates in-kind contributors
   • Increases county-level funder’s awareness of community support for the program and increases the likelihood of the allocation of public funds
   • Furthers the desire of businesses and other funders to be associated with the program
   • Builds the trust and respect of host agencies and sites

**Data Utilization to Advance a Community Prevention Infrastructure:**
On a broader scale, each individual PCCD grantee’s data collection and reporting contributes to a collective endorsement for a community prevention infrastructure. A public commitment to prevention will shift society away from relying on costly and ineffective interventions and incarceration and away from dealing with problems after they arise. Proving to public funders and policy-makers that prevention is more effective requires a clear demonstration that prevention results in positive outcomes and cost-savings. Accurate and convincing data can lead to the development of community prevention infrastructures that will:

- Address youth’s basic developmental needs before problems arise
- Encourage wide-scale dissemination of effective prevention programs
- Allow for expansion of programs through public and private funds
- Promote positive youth development through skills, opportunities, and recognition
- Strengthen family and community dynamics that articulate clear standards and foster healthy behaviors in youth
- Reduce the demand for and expense of costly and ineffective interventions
- Decrease incarceration rates and costs
- Advance a collective responsibility for nurturing youth and creating caring communities
THE PENNSYLVANIA YOUTH SURVEY (PAYS)

Background of PAYS:
Since 1989, the Commonwealth of Pennsylvania has conducted surveys of secondary school students on their behavior, attitudes, and knowledge concerning alcohol, tobacco, and other drugs, and violence. The effort is sponsored and conducted by the Pennsylvania Commission on Crime and Delinquency (PCCD). Currently, the Pennsylvania Youth Survey (PAYS) is administered to 6th, 8th, 10th, and 12th grade public school students and is conducted every two years through the involvement and support of local communities. The first survey was administered in 2001 and data gathered in 2001, 2003, 2005, 2007, and 2009, as well as data collected from the Generation at Risk Survey, a biennial study of drug-use prevalence rates that was conducted from 1989 through 1997, has been used to drive prevention initiatives across the state.

The PAYS is based on the Communities That Care® Youth Survey (CTCYS), which was developed from the work of Dr. J. David Hawkins and Dr. Richard F. Catalano. The CTCYS was developed from research funded by the Center for Substance Abuse Prevention of the U.S. Department of Health and Human Services. The resulting surveys are designed to identify levels of risk factors related to problem behaviors such as alcohol, tobacco, and other drug-use and to identify the levels of protective factors that help guard against those behaviors. In addition to measuring risk and protective factors, the CTCYS and the PAYS also measure the actual prevalence of drug-use, violence, and other antisocial behaviors among surveyed youth.

In 2007, three new categories of data were collected from Pennsylvania youth. For the first time, PAYS assessed the use of prescription medicines, including amphetamines, sedatives, tranquilizers, and narcotics, and their use for non-medical purposes. Questions were also included to assess students’ experiences with gambling. In 2003, PAYS included questions about students’ feelings – sadness, hopelessness, and worthlessness – potential symptoms of depression. In 2007, for the first time, the depression data was reported. However, it has been acknowledged that the questions are not indicative of clinical signs or symptoms of depression or suicide.

Pennsylvania outcomes are measured against national outcomes in the “Monitoring the Future” study conducted by the University of Michigan. This allows for local communities, prevention planners, and policy makers to contrast local and state data to comparable national findings. Trends in risk and protective factors, substance use, and problem behaviors can be assessed against national trends.

State Support and Funding for PAYS:
The Pennsylvania Commission on Crime and Delinquency (PCCD) sponsors the survey and has collaborated with other state agencies, such as the Department of Education, Department of Health, Liquor Control Board, and Department of Public Welfare. In addition to surveys administered with the support of local communities, students reflective of varying urban, suburban, and rural demographics are randomly selected to participate in a state survey analysis. PCCD values the tool for the local and aggregate state data garnered and utilizes the data to drive prevention efforts. To promote data collection in more communities, PCCD is currently working with its state partners to reduce testing duplication and demands upon schools and communities through the creation of a comprehensive survey that meets the data collection needs of various state agencies.
**Validity of PAYS:**

Four strategies are used to ensure the validity of the surveys:

1. Surveys of students that appear to exaggerate drug use or antisocial behaviors are eliminated. For example, the surveys of students who report four or more daily uses of inhalants, cocaine, hallucinogens, ecstasy, methamphetamine, or heroin are eliminated.
2. Surveys of students that report an unrealistically high frequency – more than 80 instances in the past year – of antisocial behaviors, including attacking someone with the intent to harm, stealing a vehicle, being arrested, and getting suspended, are eliminated.
3. Surveys of students who report any use of fictitious drugs are removed from the analysis.
4. Inconsistencies in logical responses are detected. For example, a survey would be eliminated if a student reported that they had used alcohol 3 to 5 times in the past thirty days, but had also reported that they never used alcohol in their lifetime.

**Purpose of PAYS:**
The data gathered in the PAYS provide an important benchmark for alcohol, tobacco, and other drug use and delinquent behavior among Pennsylvania youth, as well as provide school administrators, state agency directors, legislators and local communities with critical information concerning changes in patterns of use and abuse of harmful substances and behaviors. The survey assesses risk factors that are related to problem behaviors and the protective factors that help guard against them. This information allows community leaders to prioritize prevention targets and to direct prevention resources to areas where they are likely to have the greatest impact. Not only does the data aid in the selection of proven prevention programs, but it also helps to evaluate and document whether prevention and treatment programs are achieving their intended results.

**Survey Administration:**
The survey is generally administered in school settings between September and November with results reported in the spring. The survey is administered in the classroom and takes approximately one class period to administer. The survey has been offered as a paper and pencil survey and as an internet-based survey. In 2009, the cost was $1.25 per paper/pencil survey or $1.00 per internet survey. Student participation is voluntary and responses are anonymous and confidential. Students can skip any questions they are not comfortable answering.

**Online information and past results of the state-wide sample can be accessed at:**

www.pays.state.pa.us

**For more information or technical assistance, contact:**

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Summary of the Risk and Protective Factor Prevention Model:
The premise of the risk and protective factor model developed by Dr. J. David Hawkins and Dr. Richard F. Catalano, along with their colleagues at the University of Washington, Social Development Research Group, is that in order to promote positive youth development, it is necessary to address those factors that predict and prevent the problem behaviors. Risk factors are characteristics of school, community, and family environments, coupled with individual characteristics of youth and their peer groups that are known to predict increased likelihood of drug use, delinquency, school dropout, teen pregnancy, and violent behavior. Protective factors exert a positive influence or buffer against the negative influence of risk, thus reducing the likelihood that adolescents will engage in problem behaviors. Included in this section is a chart listing the 20 risk factors that research has linked to substance use, delinquency, teen pregnancy, and violence, as well as a description of each risk factor. Protective factors that have been identified through research reviewed by Drs. Hawkins and Catalano include social bonding to family, school, community and peers; healthy beliefs and clear standards for behavior; and individual characteristics. Descriptions for the risk and protective factors are included below. By assessing risk and protective factors in a community, prevention programs can be selected and implemented with a data-driven and targeted approach toward the reduction of elevated risk factors and the promotion of existing and lacking protective factors.

Description of Risk Factors:10

Community Risk Factors

Availability of drugs: The availability of cigarettes, alcohol, marijuana, and other illegal drugs in a community, increases the risk of adolescents abusing these substances. Perceived availability of drugs in school is also associated with increased risk. A higher rate of drug abuse occurs in schools where youth believe that drugs are more available and used more readily.

Availability of firearms: Firearms, primarily handguns, are the leading mechanism of violent injury and death in the United States. There has been an increase in the availability of firearms since the 1950’s and a corresponding increase in the number of crimes, including homicides, committed by adolescents. The availability of handguns is related to a higher risk of crime and substance use by adolescents. Research has also shown that communities with a greater availability of firearms have higher rates of violent crime, including homicide.

Important note: Firearms available to youth intent on committing crimes are the focus of this risk factor; this does not necessarily refer to rural communities with a high prevalence of hunting guns.

Community laws and norms favorable toward drug use, firearms, and crime: Community norms -- the attitudes and policies a community holds in relation to problem behaviors -- are communicated in a variety of ways: through laws and written policies, informal social practices, media, and the expectations
parents and other members of the community have of children. Laws, tax rates, and community standards that favor or are vague about substance use or crime are associated with increased delinquency rates for youth. Research has shown that legal restrictions on alcohol and tobacco use, such as increases in the legal drinking age, restricting smoking in public places, and increased taxation have resulted in decreases in consumption. In addition, national surveys of high school seniors have demonstrated that shifts in normative attitudes towards substance use have been followed by decreases in the prevalence of use.

**Media portrayals of violence:** Research over the last three decades indicates a positive association between media portrayals of violence and the development of aggressive and violent behavior in youth. Evidence is mounting that media violence influences community acceptance of violence and increases rates of aggressive and violent behavior. Both long and short-term effects have been documented.

**Transitions and mobility:** Community and personal transitions and mobility can predict increases in problem behaviors. Neighborhoods or communities characterized by high rates of residential mobility have higher rates of juvenile crime and drug trafficking. Youth who endure frequent residential moves and stressful life transitions have been shown to have higher risk for school failure, delinquency, and drug use. Even normal transitions, such as when youth move from elementary school to middle or junior high, may precede significant increases in problem behaviors and therefore, may be an opportune time for intervention.

**Low neighborhood attachment:** A low level of bonding to one’s neighborhood or community is related to higher levels of juvenile crime and drug trafficking. If key social providers, such as teachers, merchants, and law enforcement officers, do not live in the community, resident’s commitment to their neighborhood is less. Lower rates of voter participation and parental school involvement are reflective of low attachment. Low attachment and community disorganization hinder the passing on of prosocial values and norms within schools, churches, families, and other community organizations.

**Community disorganization:** Research has shown higher rates of adult and juvenile crime and drug trafficking in neighborhoods and communities that have a high population density, physical deterioration, high rates of vandalism, and low surveillance of public places. This condition is not limited to low income neighborhoods; it can also be found in more affluent areas. A primary influence is whether or not people feel they are capable of making a change in their lives and contributing to their community.

**Extreme economic deprivation:** Children who live in deteriorating, crime-ridden neighborhoods where there is little hope for a better future are more likely to become engaged in problem behaviors. Residing in neighborhoods with extreme poverty, poor living conditions, and high unemployment increases the likelihood that youth will experience delinquency, teen pregnancy, school dropout, and violence during adolescence and in adulthood. Also, children who have behavior and other adjustment problems early in life, and who come from economically deprived areas, are more likely to develop drug abuse problems with age.

**Family Risk Factors**

**Family history of the problem behavior:** Children raised in a family with a history of antisocial or problem behavior, such as substance abuse or violence, are at increased risk of engaging in the same behaviors. This risk factor applies to both male and female children, and for both there appears to be an
environmental as well as a genetic component. The risk of alcoholism, for instance, appears to be twofold for children born into an alcoholic family. Similarly, children raised in a family with a history of addiction are more at risk of developing drug problems. Children born to a teenage mother are more likely to become a teen parent. Children of school dropouts are more likely to drop out themselves.

Family management problems: Poor family management practices, such as excessively severe or inconsistent punishment, increases the likelihood of substance use and problem behaviors. Parent’s failure to provide clear expectations and to monitor their children makes it more likely that the youth will engage in drug abuse whether or not there are family drug problems.

Family conflict: Persistent, serious conflict between caregivers or between caregivers and children appears to increase risks for children raised in these families. Conflict between family members appears to be more important than the family structure (e.g., single parent vs. two-parent homes). Children raised in families with high conflict appear to be at risk for delinquency, school dropout, teen pregnancy, and substance use, whether or not the child is directly involved in the conflict.

Favorable parental attitudes and involvement in problem behavior: If parents are involved in one of the problem behaviors or are tolerant of the children’s involvement in such behaviors, children are much more likely to become involved in those problem behaviors. In families where the parents or caregivers use illegal drugs, heavily use alcohol, or are tolerant of a youth’s use, youth are more likely to become drug abusers during adolescence. The risk is further increased if the parent involves the child in their drug or alcohol using behavior; for example, asking a child to light a parent’s cigarette or get a beer from the refrigerator for a parent. Children who are excused for breaking the law are more likely to develop juvenile delinquency problems and children whose parents engage in violent behavior are at greater risk for exhibiting violent behavior.

School Risk Factors

Academic failure beginning in late elementary school: Academic failure beginning in grades 4 to 6 increases the risk of all five identified problem behaviors. It appears that the experience of failure -- not necessarily ability -- increases the risk of problem behaviors.

Low or lack of commitment to school: This refers to young people who do not view the role of student as a viable one in their lives. Surveys of high school seniors have shown that students who expect to attend college have significantly lower rates of use of hallucinogens, cocaine, heroin, stimulants, sedatives, and non-medically prescribed tranquilizers. Factors such as liking school, spending time on homework, and perceiving coursework as relevant are also negatively related to drug use.

Individual/Pear Risk Factors

Early and persistent antisocial behavior: Boys who are aggressive in grades K-3 or who have trouble controlling impulses are at higher risk for substance abuse, delinquency and violent behavior. When a boy’s aggressive behavior in the early grades is combined with isolation, withdrawal, and/or hyperactivity, there is an even greater risk of problems in adolescence. This risk factor also includes persistent antisocial behavior in early adolescence, such as misbehaving in school and getting into fights with other children. Both boys and girls who engage in these behaviors in early adolescence are at increased risk for all five problem behaviors. Early initiation of drug use predicts later involvement in drug use, greater frequency, and misuse. Use prior to age 15 is a predictor of drug abuse. A later age of
onset has been shown to predict lower drug involvement and a greater possibility of discontinuation of use.

At one time, this problem behavior used to be listed in the school domain, but was moved to the individual/peer domain because, while some studies relied partially on school reporting to measure early antisocial behavior, most studies describe antisocial behavior as a range of behaviors that could occur either in or out of school.

**Early initiation of the problem behavior:** The earlier a problem begins, the more easily it becomes entrenched, and the more difficult it becomes to resolve. For example, research shows that drug experimentation before the age of 15 places youth at twice the risk of having drug problems as those initiating use after the age of 19. For alcohol use, the age of first use can be a predictor of alcoholism. Those initiating use under the age of 15 are three times more likely to develop alcoholism than those who initiate use at age 21. The earlier youth drop out of school, begin using drugs, commit crimes, or become sexually active, the greater the likelihood that they will have chronic problems with these behaviors later in life.

**Rebelliousness:** Young people who feel they are not part of society, are not bound by rules, don’t believe in trying to be successful or responsible, or who take an actively rebellious stance toward society are at greater risk of abusing drugs. High tolerance for deviance, a strong need for independence and normlessness have all been linked with drug use. Furthermore sensation seeking or seeking opportunities for dangerous, risky behavior increases the risk for drug use and problem behaviors.

*This risk factor used to be known as “alienation and rebelliousness.” Alienation is the opposite of bonding, a fundamental component of the Social Development Strategy-make link. See the section on protective factors for a description of the Social Development Strategy-make link.*

**Friends who engage in the problem behavior:** Interaction with antisocial peers is one of the most consistent predictors research has found. Young people who associate with peers who engage the problem behaviors of delinquency, substance abuse, violent activity, sexual activity, and dropping out of school are much more likely to engage in those behaviors. Peer drug use has consistently been found to be one of the strongest predictors of substance use among youth. Even youth from well-managed families with limited exposure to other risk factors, are at greater risk of using drugs if they spend time with friends who use drugs. Youth that receive rewards for antisocial behavior, from peers or adults, are at higher risk of engaging further in anti-social behavior and substance use.

**Gang Involvement:** Recent research suggests that children who have delinquent friends are more likely to use alcohol and other drugs and to engage in violent or delinquent behavior than children who do not have delinquent friends. But the influence of gang involvement on alcohol and other drug use, delinquency and violence exceeds the influence of delinquent friends on these problem behaviors. Gang members are even more likely than children who have delinquent friends to use alcohol and other drugs, and to engage in delinquent or violent behavior.

**Favorable attitudes toward the problem behavior:** In elementary school, most children express anti-drug, anti-crime, pro-social attitudes. In middle school, as others they know participate in such activities, their attitudes often shift toward greater acceptance of these behaviors. Initiation is often preceded by values favorable to substance use or problem behaviors and youth that express favorable attitudes towards problem behaviors are more likely to accept, condone, and engage in a variety of
problem behaviors. In addition, young people that do not perceive drug use to be risky are far more likely to engage in drug use.

**Constitutional factors:** Factors that contribute to problem behaviors may have a physiological or biological base, such as fetal alcohol effects, head trauma, and attention deficit and hyperactivity disorder. Constitutional factors are often seen in young people exhibiting the behaviors of sensation seeking, low harm-avoidance, and lack of impulse control. These factors appear to increase the risk of young people abusing drugs, engaging in delinquent behavior, and committing violent acts.

**Risk Factor Matrix:**
A risk factor matrix can be found in Appendix E. Research has identified risk factors in four areas of influence, known as domains: Community, Family, School and Peer and Individual. In the matrix, identified risk factors are categorized under each domain. At the top, the adolescent problem behaviors of substance use, delinquency, teen pregnancy, school drop-out, and violence are listed. Below each problem behavior, the risk factors with evidence of an association with the problem behavior are marked with a dot.

**Description of Protective Factors:**
Protective factors buffer youth from risks and hold the key to understanding how to reduce risks, promote healthy social development, and encourage positive behavior. Protective factors are described below and depicted in the Social Development Strategy enclosed (see page 57 and the appendices).

**Individual Characteristics**
Some children, from birth, inherently have characteristics that help protect them against problems as they age, even if they are exposed to risk. The following are examples of characteristics that may buffer youth from risk:

- **Gender**
  Given equal exposure to risks, research shows that girls are less likely to develop health and behavior problems in adolescence than boys.
- **Resilient** temperament
  Children who adjust to change or recover from disruption easily are more protected from risk.
- **Outgoing** temperament
  Children who are outgoing, enjoy being with people and engage easily with others are more protected.
- **Intelligence**
  Bright children appear to be protected from risk. However, intelligence does not protect children from substance abuse.

**Healthy Beliefs and Clear Standards**
Parents, teachers and community members who hold clearly stated expectations regarding children and young people's behavior are helping to protect young people from risk. Parents who develop and reinforce clear family rules about drug use, school attendance and performance, sexual behavior, and behavior in the family and the community are creating a buffer for their children as they move into the high–risk adolescent years. When family rules and expectations are consistent with and supported by other key influences on a young person, such as school, peers, the media, and the larger community, it is as though a protective shield surrounds the young person and buffers them from risk.
Bonring
One of the most effective ways to reduce the risk of a youth developing problem behaviors is to strengthen their bonds with family members, teachers and other socially responsible adults. Research shows that children living in high-risk environments can be protected from behavior problems by a strong, affectionate relationship with an adult who cares about and is committed to their healthy development. That adult can be a parent, a teacher, an extended family member, a coach, an employer, an adult from the child's faith community - any caring adult. For bonding to serve as a protective influence, it must occur through involvement with peers and adults who communicate healthy values and set clear standards for behavior. The most critical aspect of a relationship is that the youth has a long-term investment in the relationship and believes that the relationship is worth protecting. This investment is what motivates young people to abide by the healthy beliefs and clear standards held by these important peers and adults in their lives.

Protective Processes
Research has also identified three protective processes that build strong bonds between young people and the significant adults in their lives:

- Opportunities for prosocial involvement
  Strong bonds are built when young people have opportunities to be involved in the activities and responsibilities of their families, schools and communities—to make a real contribution, participate meaningfully, and feel valued for it.

- Skills for successful involvement
  In order for young people to take advantage of the opportunities provided in their families, schools and communities, they must have the skills to be successful in that involvement. These skills may be social skills, academic skills or behavioral skills.

- Recognition and rewards for prosocial involvement
  Recognition for their positive involvement encourages and motivates young people to continue to contribute in meaningful ways. When parents, siblings, and other family members praise, encourage, and attend to things done well by the youth and when school and community members provide recognition and rewards for positive participation in activities, youth bond to their school, family, and community and therefore, are less likely to engage in substance abuse and problem behaviors.

Other Peer and Individual Protective Factors
Additional factors, such as family attachment, religiosity, social skills and social competence, and a belief in the moral order (a belief in “right” and “wrong”) serve to protect youth from risk.

The Social Development Strategy Model
In the appendices, a graphical model of the Social Development Strategy can be found. The strategy and depicted model was developed in 1979 by David Hawkins and Richard Catalano of the Social Development Research Group in Washington to aid in the development of effective prevention strategies that reduced risky youth behaviors.

The Social Development Strategy begins with the goal of healthy, positive behaviors for young people. In order to develop healthy behaviors, young people must be immersed in environments that nurture their individual characteristics (strengths and skills) and consistently communicate healthy beliefs and clear standards for behavior. The Social Development Strategy emphasizes two key protective factors:

- bonding to pro-social families, schools, communities, and peers; and
• adoption of clear standards or norms for behavior. (make links)

Research indicates that young people who have strong bonds to their families, schools, and communities are more invested in following the beliefs and standards held by these groups. These bonds are created by:
  • providing opportunities for young people to be involved in productive, meaningful, and prosocial roles;
  • providing skills for successful involvement; and
  • offering consistent recognition for and reinforcement of young people’s prosocial involvement. (make links)

These factors protect against problem behaviors and lead to healthy behaviors. The Social Development Research Group has shown that they reduce the development of conduct problems, school misbehavior, truancy and drug abuse.

The graphical model of the Social Development Strategy can be found in Appendix F and can be accessed online from the Substance Abuse and Mental Health Services Administration (SAMHSA) here.
Registering for Use:
PCCD’s E-grants system is an electronic online application processing system that manages all phases of the grant from response through closure. In order to apply for funding through PCCD’s E-grants System, BOTH you and your agency MUST be registered.

Website address for E-grants: www.pccdE-grants.state.pa.us

Getting Started FAQ's

1. Why do I need to register before using E-grants?
Without a unique User ID and password, you will not be able to access PCCD’s E-grants system. Unique User IDs and password allows PCCD to communicate with users. It also allows for secure information.

2. How do I register to use E-grants?
There is a tutorial on the E-grants system within the E-grants Help Center that you may find helpful to review before beginning the registration process. Detailed instructions for registering in E-grants are available and can be found in the following Quick Start Guides and forms located in the E-grants help center. The online guides can be found here.

- Online Registration Quick Start Guide
- Security Roles Quick Start Guide
- E-grants User Registration Request Form

Brief instructions are also available in the PCCD E-grants Tutorial located within the E-grants Help Center.

3. How long should I allow for registering in E-grants?
Depending upon activity level, it can take several days to "complete" the registration process at PCCD, so it is important not to wait until the date a response to a funding announcement is due.

4. What information will I need to know to register in E-grants?
You will need to decide upon a User ID, a password and you will need to know the name of the Applicant Agency for the grant for which you are applying. You will also need to know which of the roles in E-grants you need.

5. What roles do I need to register in E-grants?
A minimum of three roles needs to be assigned within your agency before you will be able to complete the registration process and begin your application. They include Project Creator, Financial Creator, and Submission. More detailed information may be found in the Security Roles Quick Start Guide.

Getting Started In E-grants System
In addition to registering your agency and the people who will be using the E-grants system, all registered users must be assigned roles. "This is a three-step process". Carefully read and follow the steps below in the order they are presented.
Step 1 - Registering your Agency

If your agency has never directly received funds from PCCD in the past, you will need to register your agency. To register your agency:

- Complete the Agency Registration Request Form.
- Upon completion, an authorized official who has a legally binding signature for your agency must sign it. "Without an authorized signature, your agency cannot be registered".
- Fax the completed form to the number stated on the form. "The form cannot be completed online".
- Allow several business hours after faxing the form for the agency registration process to be completed. If submitted (faxed) after 3:00 p.m., it may be the next business day before the agency registration process is completed.

Step 2 - Registering Individuals

Once your agency is registered in E-grants, individuals that will enter information in E-grants, or be a contact for the proposed concept paper or application, MUST also register to use E-grants. Register by following the steps outlined in the Online Registration Quick Start Guide. The guide offers a step-by-step approach to guide you through the registration process.

Note: During the online Registration process, you will be asked to choose a User ID and a Password. After choosing a user ID and Password, please write them down and put them in a safe place for future reference. E-grants Support CANNOT TELL YOU YOUR PASSWORD; it is your responsibility to secure and remember it.

Please also note:

- The Project Director, Financial Officer and Primary Contact identified on the Main Summary page must be registered E-grants users and associated with your agency with at least one security role. Therefore each person to be named in the grant must complete steps 2 and 3 of this document before you can complete the application.
- E-grants requires that the Project Director, Financial Officer and the Primary Contact be at least two different individuals. The Project Director can also be the Primary Contact or the Financial Officer can also be the Primary Contact, however, the Project Director and Financial Officer cannot be the same person.
- These users must also have security access to the specific Grant ID number in order to access it. If the individual’s name does not appear in the dropdown list as a selection for the Project Director, Financial Officer or Primary Contact, then the individual is not a registered user with security access to the grant. To remedy this, the individual must register in E-grants to obtain a User ID and Password and/or obtain appropriate security to the specific grant.
- The Project Director, Financial Officer and Primary Contact identified on the Main Summary page must be registered E-grants users and associated with your agency with at least one security role. Therefore each person to be named in the grant must complete steps 2 and 3 of this document before you can complete the application.
- E-grants requires that the Project Director, Financial Officer and the Primary Contact be at least two different individuals. The Project Director can also be the Primary Contact or the Financial Officer cannot be the same person.

Officer can also be the Primary Contact, however, the Project Director and Financial Officer cannot be the same person.

- These users must also have security access to the specific Grant ID number in order to access it. If the individual’s name does not appear in the dropdown list as a selection for the Project Director, Financial Officer or Primary Contact, then the individual is not a registered user with security access to the grant. To remedy this, the individual must register in E-grants to obtain a User ID and Password and/or obtain appropriate security to the specific grant.

**Step 3 - Assigning Roles**

- Once you and your agency are registered, roles can be assigned to you. Roles are required in order to complete various sections of the online application or concept paper.
- Carefully review the various types of roles available in the E-grants System and select the one(s) most appropriate for you. You may have more than one role. A description of the roles is available in the Security Roles Quick Start Guide.
- When you have decided on the roles appropriate for you, request the roles by completing the User Registration Request Form and have it signed by an authorized agency official.
- Fax the completed form to the number stated on the form. Please allow several business hours for the requested roles to be assigned to you. If submitted (faxed) after 3:00 p.m., it may be the next business day before the role assignment process is completed.
- Once the roles have been assigned to you, you can begin working in E-grants.

**Next Steps -**

After the requested roles are approved, you can apply for funding through E-grants. If you are completing a concept paper, please review the Online Concept Paper Quick Start Guide. If you are completing an application, please review the Application Processing Quick Start Guide.

For a complete tutorial to E-grants, please visit the [PCCD E-grants Help Center](#).

**Performance Measures:**

A performance measure is a quantitative characterization of a grantee's fulfillment of their grant objectives and progress towards achieving the proven outcomes possible for their selected evidence-based program. Performance measures are established for each PCCD grantee to monitor grant compliance, but more importantly to allow for the aggregation of data outcomes across funded sites and programs to demonstrate the impact of the state’s investment in evidence-based prevention.

PCCD has identified the goals and objectives of each of the funded evidence-based programs, as well as the outcomes demonstrated through research. It is PCCD’s goal to see similar outcomes replicated in funded communities. Performance measures have been crafted to enable grantees to quantify the impact they are having on the targeted risk and protective factors and problem behaviors that their selected evidence-based program was designed to address and as identified as a priority by their community.

To assess outcomes, grantees are required to report numeric results in E-grants quarterly. The information requested involves both process measures and outcome measures. Grantees are asked to identify targets for each performance measure at the start of their grant and to strive towards those
targets over the life of their grant. Data collected is reported quarterly and demonstrates efficiency, quality, fidelity, model adherence, and effectiveness.

Grantees should continuously review the data reported in E-grants to assess progress made towards the goals of their grant. The data can be used to monitor program quality. It also allows grantees to assess and demonstrate program impact to their collaborative board, community partners, and potential funders, which plays an important role in sustainability.
DEVELOPER QUALITY IMPLEMENTATION ASSURANCE REVIEW PROCESS

Overview of the Process:
One of the requirements of the evidence-based grant funding will be for the program developer or their designee to conduct a quality assurance review process of your site indicating whether or not the program is being implemented with sufficient quality and fidelity in your community.

The developer quality assurance review process is an integral part of promoting model adherence, implementation quality, and demonstrating program outcomes and impact. Demonstrating program outcomes and tying them to high-quality program implementation will advance Pennsylvania’s dedication and financial commitment to supporting evidence-based programs.

The process will involve sharing the implementation data you have been collecting with the developer or their designee and discussing the strengths and challenges of program implementation. In most cases, the developer or their designee will conduct an onsite visit to the program. Through this process, sites will have the opportunity to receive feedback directly from the developer or their designee and make any recommended corrections to improve implementation quality and fidelity. As program outcomes have been clearly associated with the quality and fidelity of implementation, PCCD believes it is essential to ensure that programs are being implemented with adherence to the model.

The PCCD review process should not be confused with certification processes established by the developer of the program being implemented. The purpose of the review process is to fully assess a site’s functioning, their data collection process, and their ability to demonstrate and communicate impact. PCCD is asking developers to assess implementation quality, model adherence, and fidelity based on reasonable expectations for the length of time in which the site has been implementing.

Program developers (or their designees) are asked to assess grantees between October and December during Year 2 of the grantee’s funding, and subsequently provide a letter to PCCD that rates the implementation quality and fidelity of the site and describes the site’s strengths and weaknesses. Sites are rated according to the following three categories:

- The site is implementing with sufficient quality. Given the current implementation, it is reasonable to expect future positive outcomes from the program. At this time, the areas identified as needing improvement are limited and as to be expected for the length of implementation time.

- The site needs to make significant changes to their implementation and is currently not implementing with the level of quality that is expected for the amount of time it has been implementing. For programs in this category, it is PCCD’s intention to work with the developer and grantees to articulate a plan of corrective action and timetable to bring the program into compliance with the developer’s requirements.

- The site is not implementing the program as designed and the developer does not believe that the site’s implementation quality is correctable within a reasonable amount of time. Funding for year 3 is contingent upon successful completion of the quality assurance process and designation as implementing with sufficient quality. If a plan of corrective action is deemed necessary and improvements in implementation quality can be achieved within a reasonable
amount of time, the developer or their designee, PCCD, the Penn State EPISCenter, and the grantee will work together to formulate a plan of action to help the site improve implementation quality.

Developers are expected to identify areas of strength and recommend modifications to enhance implementation quality. All sites are working towards, but are not expected to have achieved full fidelity or capacity and it is anticipated that each will receive recommendations for stronger implementation. PCCD and the EPISCenter will work with the site based on the developer’s suggestions to strengthen implementation. The recommendations provided by the developer are intended to enhance implementation and should not be viewed by the developer or the site as a threat to continued grant funding or implementation. Termination of funding will not be considered unless the site is implementing very poorly and has no potential for improvement or impact.

Timeline of Review Process and Documentation Submission:
- Contact Primary Contact for Developer Certification (click here for chart) to set up site visit with Developer or their Designee.
- Participate in site visit and share data and program implementation information with Developer or their Designee between October 1st and December 31st.

January 31st is the deadline for the Developer or their Designee to send a letter to PCCD assigning the site one of three possible designations above. The letter should be mailed to:

Kim Nelson
Office of Juvenile Justice and Delinquency Prevention
Pennsylvania Commission on Crime and Delinquency
3101 North Front Street
Harrisburg, PA 17110

PCCD and EPISCenter Contacts for Developer Quality Implementation Assurance Process:

Who to contact if you have questions about the Developer Quality Implementation Assurance Process?
Contact the Penn State EPISCenter at (814) 863-2568 or EPISCenter@psu.edu.

Who to contact if you have not budgeted funds for a visit for the Developer Quality Implementation Assurance Process?
Contact your PCCD Analyst:

Christina Cosgrove-Rock  
717-265-8478

Kim Nelson  
717-265-8458

Geoffrey Kolchin  
717-265-8483

Melissa Shetrom  
717-265-8477

Chart of Developer Contacts for the Quality Implementation Review Process: A chart listing the contact information for the program developers or designees can be found in Appendix H.
OUTCOMES REPORT PROCESS

Overview of the Process:
Since 2005, a requirement has been included in each Research-based and Evidence-based Initiative grant awarded by PCCD obliging all grantees to prepare and submit an outcomes report. The required report must be submitted by the end of the third quarter of the third year of grant funding for four year grantees and by the end of the third quarter of the second year of grant funding for two year grantees. It is to be submitted through E-grants as an attachment with the quarterly report.

The outcomes report serves the purpose of allowing grantees the opportunity to summarize their grant execution and their impact on the target population, local community, and identified community risk and protective factors over the course of the grant. The report should be reflective of quantitative data indicated by the performance measures and survey data collected, and qualitative data, reflective of feedback from participants, staff, and program partners.

For each program funded by PCCD, a template for completing the outcomes report is provided in section seven of the implementation manual. The template outlines the minimum content required by PCCD; however, sites are invited to incorporate any other available information that demonstrates the program’s impact on individuals or communities. In addition, PCCD is interested in understanding the successes experienced, and also the challenges faced. This information can prove extremely valuable in PCCD’s efforts to support future grantees and program replications. PCCD is also interested in learning about the ways in which grantees plan for sustainability, as their hope is that programs will continue beyond initial PCCD funding. The information shared in the outcome reports also affords PCCD the opportunity to aggregate data across sites and use it to demonstrate the impact of the state’s investment on targets such as academic performance, anti-social behavior, delinquency, out-of-home placements, recidivism, and substance use.
SECTION SIX:  
SUSTAINABILITY

OUTREACH AND MARKETING RESOURCES

Planning a Kick-off Event:
The objective of a kick-off event is to grab the attention of your community, to inform them of the new program and to educate them on the benefits of implementing an evidence-based program. A kick-off event motivates and encourages not only those who will be directly working with the program, but also can be used to draw attention and gain community support for your program. Garnering community support and generating a sense of ownership from the inception of the program fosters sustainability.

Planning your event -

1-Determine your target audience.
Choosing your target audience will help you focus your event planning. Do you want to reach the community-at-large? Or do you want to keep the event focused on a specific sector or group such as youth, families, service providers, or community stakeholders/leaders? Carefully defining your target audience will help you focus on your objectives and provide a framework for your event.

2-What are your objectives for the event?
Think about what you would like to achieve with your event, how you would like to engage your audience, and what is realistic. Here are some examples:

- Raise awareness of your program in your community.
- Generate community interest in your organization’s work and recruit new participants for continued dialogue.
- Motivate service providers and/or participants of the program to the importance of the program in your community.
- Encourage collaboration with other providers or agencies.
- Help local leaders and funders understand the role of the program.

3-Consider how your event will achieve your objectives.
There are many different ways to set up a kick-off event. Consider the type of program you are implementing and what might work best for your target audience. Here are some examples:

- Panel Discussion- Have staff who implement the program and youth and/or parents who have participated in the program discuss their experiences.
- Meet and Greet- Host an informal gathering with light refreshments and have program staff available to talk with participants as well as display information about the program. Have a short presentation on the benefits of the program and how it will help your community.
- Keynote Speaker- Invite the program developer, a designee or a person with experience implementing the program to speak about the background of the program, the research behind
the program, outcomes associated with the program, and the program’s relevance to your community’s implementation.

These are just a few ideas, take time to brainstorm with your colleagues to come up with an event that will fit with your program and community.

**Planning Checklist -**

Once you have defined your target audience, objectives and how you will engage the participants, begin planning the event. Below is a general checklist, you can adapt it to fit with the timeline of your event.

**Preliminary Planning-about 6 weeks before event**
- Book the place where event will be held.
- Recruit local partners to help broaden your reach.
- Determine who will be speakers, panelists, or moderator (if applicable).

**Logistical Planning-about 3-4 weeks before event**
- Create a flyer or invitation to publicize event.
- Create an email blast to publicize your event electronically.
- Contact local media. Include print, radio and TV stations.
- Secure food if applicable.
- Draft a “to do” list, who is responsible for each item, and the deadline for completion.
- Consider drafting a short survey for participants to gauge success of event.

**Final Planning-about 1 week before event**
- Make copies of any handouts or information that you want to distribute to participants.
- Review “to do” list and prepare for any last minutes items that need completed.
- Touch base with speakers or panelists to address any needs they may have in relation to technology or other items such as a podium, etc.
- Contact venue to make final plans for event in relation to set up of the room, food, etc.

**Engaging Media in Providing Coverage for Your Kick-off Event:**

It is important to call media outlets and not just send a press release (link to template). Call them first to tell them about your event and then follow up by sending them a press release or other information you have about your event.

When you call, make sure to ask if the person has time to discuss your event. If not, ask them when would be a good time to call them back. Being courteous and aware that the reporter or editor may be busy can help your chances of getting coverage for your event.

It is ok to leave a message if the person is not available, but keep the message very short and end the message with your phone number. If you don’t get a response, try again until you get the actual reporter or editor on the phone.

Relate your event to a current trend or statistic to help engage the reporter or editor. For example, if your community has seen an increase in the number of youth cited for underage drinking or if a recent car accident involved youth that were under the influence, relating the need for and effectiveness of a
substance use prevention program may be timely. Offer them something that is exciting and relevant to your community.

If the reporter or editor is interested, have a press release ready to send. Send it out as soon as possible either by email or priority mail.

Follow up to see if the reporter or editor received your press release. Ask if they have had a chance to look through it and if they are interested in attending your event.

Examples of when you may want to issue a press release:

- To introduce new service or program that will be offered in your community when a grant application has been approved.
- To draw attention to a kickoff event for the new program.
- To promote a community stakeholders meeting at the start of a program.
- To relate the research outcomes of your selected program to community needs or current news/events.
- To highlight a culminating activity at the end of a program.
- To emphasize a special event highlighting a speaker/topic relevant to your program and the community.
- To stress the importance of and disseminate outcomes data/program impact to community and stakeholders annually.
Template of Kick-off Press Release:

Agency Logo

FOR IMMEDIATE RELEASE

Contact:

Phone:
Email:

MAIN TITLE OF PRESS RELEASE (ALL CAPS)
Subtitle (Upper and Lower Case)

The first paragraph of the press release should include the who, what, where, when and how of the event. Just state the facts and don’t add in any extra information.

The second paragraph should include a short summary of the evidence based program, its goals and why it is being implemented in your community. Also include relevant research and facts to substantiate how the evidence based program will have a positive impact on your community.

If you would like more information about this event, or to schedule an interview with (insert name of contact) please call (phone number) or email (email address).
LOCAL LEGISLATOR IS A LEADER FOR FAMILIES
Picnic Honoring Supporters of the Strengthening Families Program

The Mountaintop Family Center will host a picnic for families that have participated in the nationally recognized and proven effective Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) on June 4, 2009 from 1:00 to 5:00 p.m. at Bubbling Creek Park in Pleasantville, PA. Senator Williams and other community leaders will be presented awards recognizing their program support and financial contributions, which has enabled the program to serve over 60 Pleasantville families this year.

SFP 10-14 is a proven effective, family program offered locally to families of 5th and 6th grade students. In 2007, Pennsylvania Youth Survey (PAYS) data showed that local youth face elevated risks for attitudes favorable to substance use and family management problems. As a result, SFP 10-14 was selected for implementation. As an evidence-based prevention program that promotes positive communication, family bonding, and joint problem solving skills, the program has demonstrated many positive outcomes for healthy youth development. It has been proven to delay youth initiation of substances, to reduce youth use of alcohol, tobacco, and other drugs, to reduce youth aggressive and destructive behavior, and to increase parent’s ability to show affection and set appropriate limits for their youth. In addition, the Partnerships in Prevention Science Institute found a return of $9.60 for every dollar spent implementing SFP 10-14.

For more information or to register for the picnic, please phone the Mountaintop Family Center office at 819-867-2568 or send an email to ssmith@internet.com.

If you would like more information about this event, or to schedule an interview with Susan Smith, please call 819-867-2568 or email ssmith@internet.com.
As the use of evidence-based programs is growing, research on the sustainability of evidence-based programs is slowly emerging. Implementation and sustainability is unique to each program and is further complicated by the uniqueness of each implementer and community. In this section, general strategies are outlined.

Securing Local Support:
Garnering community support, and ultimately sustainability funds, must begin with implementation planning. A great deal of energy and planning is invested in program start-up, but recognition of the funds needed for sustainability and the early development of key relationships early fosters a strategic focus on developing the program with a long-term vision for stability.

The success of the majority of evidence-based programs is driven by commitment, enthusiasm, and good intentions. However, this energy is not automatically rewarded with funds. Sustainability requires building on existing strengths and seeking expertise in skills that may be very different from those needed for program coordination and delivery.

The following are key components of engaging in a process of successful sustainability:

- At program initiation, involve key stakeholders in the planning to foster ownership and emotional investment from the beginning (see below). 
- Implement the program with a commitment to quality and fidelity and establish the program as one of value and credibility by using local data to demonstrate the impact on youth and families in your community.
- Establish solid data collection systems and consistently collect and analyze program outcomes, striving to demonstrate positive outcomes and a strong impact on the population served and the community.
- Market the program with three key objectives: 1) raise awareness of and brand the program (i.e., generate name recognition), 2) create a demand for the services provided, and 3) highlight program outcomes and impact.
- Mobilize program champions to educate community members and potential funders of the value and impact of evidence-based prevention and to encourage community support.
- Engage the needed manpower to plan and enact sustainability strategies. It is unrealistic to expect that the program coordinator can assume full responsibility for garnering operational funds. Consider forming a development committee with representatives that have business, grant writing, and fundraising skills and/or explore contracting with development professionals familiar with corporate, foundation, and individual giving and grant procurement.
- Know your program costs. Breakdown expenses, so that stakeholders and funders with a potential interest in each category or item can be identified.
- Develop a case for support. Identify why your program is needed and how the community benefits from it. Doing so helps you to identify program advocates, points for demonstrating need, and potential partners and stakeholders that may have a vested interest in supporting your program. Approaching funders is easier and more effective if you can concisely articulate...
what you are raising funds for and why a program should be funded. In addition, it creates confidence in funders that you will strategically use their funds for a specified impact.

- Strategically plan for **sustainability** by designing a fundraising and development plan that fits with the program’s mission. By focusing on the desired **outcomes**, you will avoid **program drift** or conforming to different funder’s objectives.
- Nurture relationships with potential **stakeholders** by providing brief and polished reports highlighting data, inviting their participation in special events, and maintaining phone, email, and in-person contact. Community and agency leaders, county commissioners, referral source directors, state and federal funders, local foundation directors, business and corporate executives, and legislators are crucial targets.
- Identify agencies and partners that share your program’s service population or mission and seek to collaborate and leverage resources.
- Stay informed and be knowledgeable of existing local funding opportunities and grant cycles.
- Think broadly in your request for support. Meeting expenses is not necessarily depend on monetary contributions. In-kind contributions and volunteer hours may meet financial needs, such as a restaurant that donates a meal, an agency that allows staff to provide volunteer hours, or a local store that donates supplies or incentives. Marketing materials may offer an incentive for them to make such a contribution, such as acknowledgement on a program brochure.
- Seek to diversify funding to prevent dependency on one source of funding. Varying the number of grant sources (federal, state, and local public contributors), individual donors, and fundraising activities will bolster stability in unexpected reductions in any one source of funding.

**Evidence-based programs** seeking to garner **sustainability** support should develop a toolkit consisting of, but not limited to:

- A fact sheet summarizing the program, its population targets, demonstrated **outcomes**, and return on investment calculations (See section seven of the program specific **implementation** manuals.)
- A brochure outlining the criteria for and benefits of program participation to be used to promote referrals and recruitment
- A PowerPoint presentation that provides an overview of the program, the **outcomes** proven through research, the details of local **implementation**, and highlights of local impact and **outcomes** data. Participant testimonials or quotes can also powerfully demonstrate the value of the program.
- A regularly updated **outcomes** report showing the number of participants, highlights of the data **outcomes**, **fidelity** scores, and indicators of participant satisfaction and impact on community systems.
- A comprehensive and regularly updated email and mailing list of key **stakeholders**

**Materials and worksheets collected from a variety of sources, which can be used in sustainability planning can be found in Appendix I.**

**Ways to Involve Key **Stakeholders**:**
It is imperative, at program **initiation**, to involve key **stakeholders** in the planning to foster ownership and emotional investment from the beginning. When **stakeholders** are actively engaged and involved in collaborative decision making, increases are seen in teamwork, sense of group belonging, and
commitment to serve. It is also important to invest in building relationships and fostering instrumental partnerships with community leaders and organizations that may not be actively involved in planning and delivery, but that can play a supportive role, such as influencing policy, securing funding, and promoting referrals. Broad educational and outreach efforts also help to promote community adoption of core values focused on proven effective prevention practices.

Effective stakeholder involvement in implementation and sustainability requires:

- Communicating the potential of the selected program to address needs identified through a local needs assessment
- Maintaining stakeholder attention to the purpose of the program and the expected outcomes
- Building a sense of shared ownership among stakeholders through education and awareness efforts, broad involvement in program planning, delivery, and assessment, and promotion of collaborative decision making
- Empowering stakeholders in understanding and being able to communicate the need for, purpose, and outcomes of the program
- Ensuring that stakeholders can translate their vision for prevention and the program into quality practice (model adherence) and promotion
- Collecting data to monitor quality and impact and utilizing the data to further community investment

Tips for Fostering Stakeholder Involvement:

- Identify champions or individuals that have influence and are able to harness their capital and resources to advance the program. These individuals can serve as advocates, teaching others about the program and building support for the program.
- Connect the purpose of the program and the intended outcomes with the immediate priorities and interests of stakeholders. Develop tailored communication or a strong “pitch” that can be used to garner community-wide support.
- Use social networks to build or activate community or organizational partnerships. Through formal presentations or informal conversation strive to educate as many stakeholders as possible of the program. Embed positive information about the program, statistics of its proven impact, and positive participant stories into community discourse.
- Share program or participant success stories to increase stakeholders’ knowledge of the program and to help stakeholders to visualize the program. Also share materials, like the curriculum manual, program props, or video clips to help stakeholders ‘experience’ the program.
- Create opportunities for stakeholders to discuss best practices and emerging implementation issues. Involvement in planning, brainstorming quality improvement strategies, and exploring strategic planning or sustainability strategies will promote a collaborative culture.
- Provide clarity in roles and responsibilities as role identification promotes a sense of stability and collegiality among stakeholders. It also leads to greater purpose and productivity.
- Define aspirations for the program and articulate the standards for quality. Build a collective commitment to these hopes and goals, which can be used to rally the community around a shared vision and lead to celebration as success is demonstrated.
- Avoid limiting capacity building efforts to the training and education of staff or those assuming responsibility for program coordination or delivery. Broader awareness and involvement efforts can lead to the development of “human infrastructures” or a variety of vested stakeholders that can provide the foundation for sustainability in the long-term.
Grants, Fundraising, and Sponsorship:
According to Giving USA 2009, charitable giving in the United States reached an estimated $307.65 billion in 2008. Although many fear that the recent down-turn in the economy will impact charitable giving deleteriously, according to the Foundation Center, during past recessionary periods in the United States (1980-82, 1990-91), foundation giving actually slightly increased.15

Diversification of funding leads to sustainability. Evidence-based programs can generate revenue to sustain operations through the following sources:

- Fees for services
- Public (government financed) funding streams
- Grants
- Private underwriting through donors or sponsors
- Fundraising

Grants:
Enclosed in this section of the manual is a listing of Web resources (make link) that includes sources that award grants in Pennsylvania. In addition, prevention and data sources are included to aid in developing a case statement that demonstrates need.

Although it can be tempting to “chase” grant funding, it is important to focus on the program’s mission and not conform to a funder’s guidelines simply to alleviate money shortages, as program drift can result. The diversion of resources to preparing applications that do not match the program’s goals results in less time and resources that can be contributed to long-term strategies and capacity building.

When submitting a grant application, present it clearly and concisely in the format requested. If allowable, include items that demonstrate your outcomes and local community support, such as data reports, newspaper articles, and letters of support.

Most grant applications request the same basic content, such as a program description, an explanation of the target population, or summary of need. Electronically maintaining and updating this information will ease the burden of preparing grant applications and meeting short-turnaround submission deadlines.

Approaching Community Foundations:
- View the contact as a personal relationship that must be nurtured. Schedule a meeting to learn more about the foundation’s mission and funding goals.
- Research the foundation by reviewing the foundation’s website, annual report, guidelines for funding, and other publications.
- Query other non-profit colleagues to assess their experience and learn more about the foundation’s funding priorities and process.
- Include the foundation on your mailing list, so that they receive any annual reports, outcome reports, or press coverage that highlights your program’s achievements.
- Become a resource for the foundation by offering to help inform them of community needs or to coordinate community activities aimed at addressing community problems.
Sponsorship and Generating Revenues:

- To effectively fundraise and cultivate sponsorship, a development plan must be crafted to create a long-term strategy for building a base of support from private funding sources, such as individuals, local businesses, corporations, and foundations. Funds can be solicited for start-up, operations, or capital expenditures.
- Relationship building is key as people give to people and organizations of credibility and stability that they trust with their investment.
- It is important to exude enthusiasm, commitment, and confidence in the program.
- Utilize connections to maximize giving. For example, provide the board with training and ask each of them to play a role in generating giving among their contacts.
- Demonstrate public demand and support for your program.
- Consider cost-sharing with other organizations, such as jointly purchasing goods in bulk or sharing office space or equipment.
- Solicit membership dues from board members, alumni groups, or others.
- Charge a fee for services, products, or resources, such as program participation, a parenting resource guide, or a newsletter.
- Encourage volunteerism. Ensure that volunteers feel useful and appreciated to retain their services.
- Host special events.
- Solicit gifts from alumni, parents, and community members.
- Know the donation programs available in your local community through stores such as Macy’s and Target.

In appendix I there are documents that include additional suggestions, from a variety of sources, on fundraising and attracting donors. They include information on development initiatives, benefit events, donation programs, 501 C(3) status, and creative fundraising products and activities.

WEB RESOURCES

Data Resources:

**PA Department of Public Welfare’s ChildStat** - PA ChildStat is a county child outcomes indicators project that uses the available data to measure the educational, social, economic, and physical well-being of children at the county level.

Reports published by the **Penn State Prevention Research Center**, including:

- **The Economic Return on PCCDs Investment in Research-based Programs: A Cost-benefit Assessment of Delinquency Prevention in Pennsylvania**
- **Reducing Youth Violence and Delinquency in Pennsylvania: PCCDs Research-based Programs Initiative**
- **PA Communities That Care (CTC) Statewide Evaluation**

**PA Electronic Juvenile Justice Databook** – The Pennsylvania Electronic Juvenile Justice Databook provides access to a broad range of county level data tables that describe the status of youth across the
Commonwealth of Pennsylvania. The contents of the Databook are organized into 9 chapters: population, health, economic, education, abuse/neglect, reported crime, arrests, juvenile court cases, custody.

**Kids Count, Annie E. Casey Foundation** – The Annie E. Casey Foundation’s KIDS COUNT Data Center includes community-level data in addition to city, state, and national data. It consists of 100 indicators of child well-being, including economic status, health, safety, and risk factors. It also allows one to create maps, graphs, and charts for use in presentations or on a website.

**Child Trends Databank** – The site provides national trends and research on over 100 key indicators of child and youth well-being. A series of data briefs that draw from multiple indicators to examine broad topics and special populations of greatest concern to policy makers, service providers, the media, and the general public are also available.

**Centers for Disease Control and Prevention – Snap Shots of State Population Data (SNAPS)** - SNAPS provides local-level community profile information nationwide. It can be browsed by county and state and searched by zip code.

**Penn State Cooperative Extension Economic and Community Development** – The site provides profiles, trends, quick facts, and fact sheets for counties and the state and includes information on topics such as families, income, employment, government spending, and land use.

**Fight Crime: Invest in Kids** – Fight Crime: Invest in Kids is a national, bipartisan, nonprofit anti-crime organization providing research and policy information on topics such as early education, child abuse and neglect, after-school programming, and youth delinquency.

**Pennsylvania Spatial Data Access (PASDA)** - PASDA is the official public access geospatial information clearinghouse for the Commonwealth of Pennsylvania and has served for twelve years as Pennsylvania’s node on the National Spatial Data Infrastructure, Geospatial One-Stop, and the National Biological Information Infrastructure. The Data Access Wizard combines a search engine with powerful web-based geoprocessing and visualization capabilities to provide users with a variety of county, state, and national statistical and data resources as downloads.

**PA Department of Health Epidemiological Query and Mapping System (EpiQMS) and Behavioral Health Risks Surveillance System (BRFSS)** - An interactive health statistics web tool where you can create customized data tables, charts, and county/regional assessments for behavioral risk statistics as well as birth, death, infant death, teen pregnancy, cancer, sexually transmitted disease, other communicable disease and population statistics. Results of the BRFSS for adults are available by year.

**Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance System (YRBSS)** – The YRBSS monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments. The site provides survey results, trends, and information, such as fact sheets and data files.

**Carsey Institute** - Provides access to socio-economic indicators for rural, suburban, and urban parts of each region of the United States.
FedStats – FedStats provides access to a full range of official statistical information produced by the Federal Government without having to know in advance which Federal agency produces which particular statistic. The site allows convenient access to data from more than 100 agencies that provide data and trend information on such topics as economic and population trends, crime, education, health care, aviation safety, energy use, farm production and more.

School Matters – A public source for information and analysis about our nation’s public schools. Provides information, and search and comparison tools to help research the stories behind the numbers, and further the discussion about how to improve student performance.

U.S. Census Bureau - USA Counties - Features over 6,000 data items for the United States, States and counties from a variety of census sources. Information is derived from the following general topics: age, agriculture, ancestry, banking, building permits, business patterns, crime, earnings, education, elections, employment, government, health, households, housing, income, labor force, manufactures, population, poverty, retail trade, social programs, veterans, vital statistics, water use, and wholesale trade.

The PEW Center on the States - The Pew Center on the States conducts ground-breaking research in many areas of critical importance to state policymakers, such as public safety, education, foster care, with the intent of helping states to make sound, data-driven policy choices.

American Community Survey - A nationwide survey designed to provide communities information on how they are changing. It includes data tables, ranking tables and surveys on demographic, social, economic, and housing data for over 800 geographical areas.

Trust for America’s Health – Summarizes state-based health, population, public health, and economic indicators.

Kaiser Family Foundation – Provides direct access to national and state facts and data about the nation’s health care system and programs. It also allows for the creation of customizable PowerPoint slides.

Prevention Resources:

Pennsylvania Commission on Crime and Delinquency (PCCD) - PCCD has the mission of improving the criminal justice system in Pennsylvania and on their website provides criminal justice trends, Pennsylvania Youth Survey data, and information on prevention initiatives, such as Communities That Care, Weed and Seed, and Evidence-based Programs Initiatives.

Center for the Study and Prevention of Violence Blueprints (CSPV) - CSPV provides an Information Clearinghouse focused on evaluation of research and information concerning youth violence. Abstracts of violence related research and literature, national statistics and comparisons by state, and overviews of proven, recognized Blueprint programs are provided.

OJJDP Model Program Guide – A Model Program Guide offers a database of scientifically-proven programs that cover the entire continuum of youth services from prevention through sanctions to
reentry that address a range of issues, including substance abuse, mental health, and education programs.

**Communities that Care (CTC)** – CTC resources provided as part of the Center for Substance Abuse Prevention (CSAP) toolkit:

**Society for Prevention Research** – The Society for Prevention Research seeks to advance science-based prevention programs and policies through empirical research. Resources provided include standards of evidence, advocacy guidelines, and published research, and training and career opportunities.

**Collaborative for Academic, Social, and Emotional Learning (CASEL)** – CASEL has the mission of establishing social and emotional learning (SEL) as an essential part of education.

**National Institute on Drug Abuse** – The site includes a variety of resources including funding, news, publications, and educational materials for health professionals, researchers, parents, educators, and youth. It also hosts a research based guide for preventing drug use among youth and lists research-based universal, selective, indicated, and tiered programs.

**Community Toolbox (CBT)** - The CTB Team at the Work Group for Community Health and Development at the University of Kansas, and partners nationally and internationally, have tried to identify what intended users might need to know to be able to build healthier and more equitable communities. The Tool Box provides over 7,000 pages of practical information to support work in promoting community health and development. The focus is on specific practical skills, such as conducting a meeting or participatory evaluation, that help create conditions for health and human development.

**John Hopkins Center for the Prevention of Youth Violence** – Created through grant funds from the Centers for Disease Control and Prevention, the Center brings together academic institutions, city and state agencies and organizations, community groups, schools, youth groups, and faith organizations to collaborate on both positive youth development and the prevention of violence. The site provides resources, as well as information and links evidence-based program listings.

**Partnerships in Prevention Science Institute (PPSI)** – PPSI’s mission is to conduct innovative research promoting capable and healthy youth, adults, families, and communities—through partnerships that integrate science with practice. Research on a variety of topics is available, including strategies for diffusion, family participation factors, needs assessment, and intervention efficacy.

**National Registry of Evidence-based Programs and Practices (NREPP)** - As a service SAMHSA, NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities. NREPP lists programs which have undergone some form of study, whether scientifically rigorous or not, and that have produced outcome findings, positive or negative. NREPP does not establish criteria requiring a level of effectiveness to list programs; rather it is left to reader to make their own judgment about whether the evaluation results represent an "effective" program.

**Centers for Disease Control and Prevention** – The Guide to Community Prevention Services provides resources in the categories of policies, research, programs and services, education, funding, and general use to improve health at a community level.
Find Youth Info – Federally-developed interactive tools and other resources to help community organizations and partnerships support youth. Included are tools and resources to form effective partnerships, assess community assets, understand risk and protective factors, generate maps of local and federal resources, and search for evidence-based youth programs.

CESAR – Center for Substance Abuse Research: CESAR Fax provides a weekly, one-page overview of timely substance abuse trends or issues.

Community-Anti-Drug Coalitions of America (CADCA) - Resources to build drug-free communities and support coalition development.

Environmental Strategies Resources - Resources aimed at promoting policy changes and substance use reductions through environmental strategies.

Society for Research in Child Development - The Society is a multidisciplinary, not-for-profit, professional association of researchers, practitioners, and human development professionals from over 50 countries that promotes multidisciplinary research in the field of human development, fosters the exchange of information among scientists and other professionals of various disciplines, and encourages applications of research findings.

Funding Resources:

PA Specific Funding Sources:

Pennsylvania Department of Education Center for Safe Schools - Grants to schools and intermediate units throughout Pennsylvania to improve school safety and prevent violence.

Pennsylvania Department of Education - An E-grants system was developed by the PA Department of Education to enable submission of applications over the Internet. A variety of federal and state grants are listed. Currently the Adult Basic & Literacy Education, Career and Technical Education, Major Federal Programs, Special Education/Early Intervention and Safe and Drug Free Schools are using the E-grants system for grant applications.

Pennsylvania Commission on Crime and Delinquency (PCCD) – PCCD awards grants of federal and state funds to help local governments and non-profit organizations throughout the Commonwealth to prevent and reduce crime, improve the justice systems and help victims of crime.

The Center for Rural Pennsylvania – The Center focuses on mandated research areas, which are rural people and communities; economic development; local government finance and administration; community services; natural resources and the environment; rural values and social change; and educational outreach. Grants and resources specific to rural PA communities are available on the site.

Other Funding Resources:
The Grantsmanship Center – Web links for top grantmaking foundations, community foundations, and corporate giving organizations in PA are listed.

The Foundation Center – An extensive online foundation directory requiring a subscription that has searchable databases for 98,000 grantmakers, companies, grants, and 990s.

The Rural Assistance Center – The site provides a searchable database for funding available for rural communities. It also offers a variety of resources, including grant writing, data and mapping tools.

Guidestar - GuideStar is a source of information about U.S. nonprofits with a database of 1.8 million IRS-recognized organizations. The site allows for finding charities, benchmarking a nonprofit's performance, providing information on the programs and finances of non-profits.

GrantsAlert - The site is dedicated to education grants and funding opportunities for education related organizations, schools, school districts, consortia and state education agencies.

GRANTS.GOV – The site is managed by the U.S. Department of Health and Human Services and lists all discretionary grants offered by the 26 federal grant-making agencies.

National Institute on Drug Abuse – The site includes a variety of resources including funding opportunities and grant writing resources.

The Chronicle of Philanthropy - The Chronicle Guide to Grants is a database containing foundation, corporate, and nonprofit grants listed in The Chronicle of Philanthropy since 1995. The database contains information on hundreds of thousands of grant listings and on average, more than $200-million in new grant listings are added to the database every two weeks. Access is available for a fee.

Fundsnets Online Services – Grantwriting and fundraising resources are provided for a wide variety of categories.

Jankowski Research - Resources and a grant database that is searchable across 14 data elements for a fee.

U.S. Department of Education - Discretionary Grants

U.S. Department of Education - A forecast of funding document lists virtually all programs and competitions under which the Department has invited or expects to invite applications for new awards and provides actual or estimated deadline dates for the transmittal of applications. The lists are in the form of charts, organized according to the Department's principal program offices, and include programs and competitions previously announced, as well as those anticipated.

SchoolGrants - A listing of grants and a collection of resources and tips to help K-12 educators apply for and obtain special grants for a variety of projects.

Twenty-First Century Foundation – A national foundation/public charity that makes grants to support African American community revitalization, education and leadership development.

eSchool News – Technology news and resources, including funding opportunities, for educators.
Teachersplanet – Information on preparing grant applications and links to potential funding sources.

Michigan State University Fundraising Resources - This site provides information for those interested in learning more about foundations, fundraising, proposal writing, it is tailored for elementary and secondary school administrators and teachers.

Resources for Non-Profits:

Duquesne University Non-profit Leadership Institute – Information, trainings, and resources for nonprofit governance and leadership.

The Finance Project - The Finance Project is a specialized non-profit research, consulting, technical assistance, and training firm for public and private sector leaders nationwide. The Youth Programs Resource Center provides information and resources related to supporting and sustaining youth programs, initiatives and policies.

Techsoup – TechSoup provides a range of technology services for nonprofits, including articles, a blog, discussion forums, Webinars, and discounted and donated technology products. Donated and discounted technology products for nonprofits and public libraries. Choose from over 340 products from companies such as Microsoft, Adobe, and Symantec.

Network for Good – The Network for Good aids nonprofits, of any size, to recruit donors and volunteers via the Internet.

National Mentoring Center – Materials related to sustainability planning and resource development for youth mentoring programs.

NOZA – NOZA provides free access to a database of 990-PF tax returns. The project was started by Grantsmart and contains publically-available data received from the IRS on more than 1,000,000 foundation grant records.

The Gilbert Center – The Gilbert Center is a research institute, consulting firm, and publishing house working to support and empower nonprofits and aid them in communicating effectively.

The Center for Philanthropy and Nonprofit Leadership – The site provides a resource library for nonprofit and foundation professionals, students, and volunteers.

RGK Center for Philanthropy and Community Service – The site provides information for volunteers, best practices and volunteer management resources, a virtual volunteering component, and a document library with information related to volunteerism.

Volunteer Match – The organization offers a variety of online services to support a community of nonprofit, volunteer and business leaders committed to civic engagement. The service welcomes millions of visitors a year and is an Internet recruiting tool for more than 68,000 nonprofit organizations.
**The Alliance for Justice** – The Nonprofit Advocacy Project provides information and resources on advocacy and lobbying.

**The Leadership Learning Community (LLC)** – LLC is a national organization dedicated to developing leadership that addresses a range of social issues. LLC connects a diverse group of leadership development practitioners, grant-makers, and thought leaders who identify successful practices, conduct research, evaluate current leadership efforts, and exchange information and tools. Through its peer learning methodologies, consulting services, and digital resources, LLC promotes leadership support and development.

**Alliance for Nonprofit Management** - A professional association of individuals and organizations devoted to improving the management and governance capacity of non-profits. The Alliance convenes an annual conference, networks colleagues year-round online, and provides member discounts on books and other publications. The Alliance provides visibility to its members in the online "Find a Consultant or Service Provider" directory, the People of Color Roster, **Alliance Insights** eNewsletter, Member Spotlights and membership directory.

**American Society of Association Directors (ASAE)** – ASAE offers learning experiences, publishes Associations Now Magazine and the Journal of Association Leadership, provides web-based tools and resources, helps members connect in 14 professional interest sections, conducts future-focused and market research, hosts ASAE & The Center's Annual Meeting & Exposition and the Springtime Exposition, and acts as an advocate of the association profession.

**Nonprofit Gateway** – Official information and services of the U.S. government on funding, management, operations, and tax information.

**Nonprofit.org** - Provides links to resources of interest to non-profits.

**Action Without Borders** - An interactive site where people and organizations exchange resources and ideas, locate opportunities, and supporters.

**Compass Point - Nonprofit Genie** – Originally developed through the California Management Assistance Partnership (CMAP) under a grant through The California Endowment, the site has a variety of resources, including a free FAQ’s written by leading experts from around the country.

**Nonprofit Times** – A business publication for non-profit management

**Nonprofit Risk Management Center** – The Nonprofit Risk Management Center was established in 1990 to provide assistance and resources for community-serving nonprofit organizations. They offer a wide range of services (from technical assistance to software to training and consulting help) on a vast array of risk management topics (from employment practices, to insurance purchasing to internal controls and preventing child abuse).

**Association of Fundraising Professionals** - Sets standards and provides resources for professional fundraising.

**BoardSource** - Resources for non-profit governance
Executive Service Corps Affiliate Network - A network of non-profit consulting organizations

Independent Sector - A leadership forum for charities, foundations, and corporate giving programs committed to advancing the common good in America and around the world. The nonpartisan coalition of approximately 600 organizations leads, strengthens, and mobilizes the charitable community.

The Web links listed in this document are provided for informational purposes only and do not necessarily reflect support or endorsement by the EPISCenter.
SECTION SEVEN: PROGRAM SPECIFICS

DETAILED DESCRIPTION OF MULTISYSTEMIC THERAPY (MST)

Program Summary: Multisystemic Therapy (MST) is an evidence-based program developed to treat delinquent youth by intervening in the various systems in which the youth is embedded (i.e., family, school, peer, community) to change factors that contribute to or maintain problem behaviors. MST is a practical and goal-oriented treatment that draws from social-ecological and family systems theories of behavior. In MST, a single therapist delivers services to 4 – 6 families. For the purposes of supervision, consultation, training, and monitoring, clinical staff are organized into teams of 2 – 4 therapists led by an MST Supervisor. The therapist meets with the youth or family at least weekly throughout most of the treatment and often multiple times per week, depending on need. Services occur in the family’s home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their clients, and therapists and/or their supervisors are on-call for families 24/7. On average, a youth receives MST for 3 to 5 months, and typically no longer than 6 months.

MST components include:

- Assessment
- Ongoing treatment planning
- Family therapy
- Parent counseling (related to empowering caregivers to parent effectively and addressing issues that pose barriers to treatment goals)
- Consultation to and collaboration with other systems such as school, juvenile probation, children and youth, and job supervisors
- Referral for psychological assessment, psychiatric evaluation, and medication management if needed
- Individual therapy may occur, but is not the primary mode of treatment since MST emphasizes working with the youth’s ecology

MST emphasizes a collaborative approach and empowering caregivers to make necessary changes to the youth’s environment. Treatment is always guided by the 9 Principles of MST.

Specific treatment techniques draw from therapies with the most empirical support, such as cognitive, cognitive behavioral, behavioral, and strategic and structural family therapy. Interventions are developed based on an assessment of the “fit” for a specific behavior (specifically, what factors are driving the behavior, which are always individualized). Interventions always target specific, well-defined problems, focus on present conditions, and are action oriented. Families are often given “assignments” that require daily or weekly efforts, capitalize on strengths, build skills, and encourage responsible behavior by the youth and family. By empowering caregivers to address their families’ needs, MST
interventions promote generalization and maintenance of positive changes. The help of natural supports such as extended family or school is often enlisted. Therapists are fully responsible for engaging the family and other key participants in the youth’s environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement).

A general overview of the MST treatment model is available on the MST Services web-site.

**Target Population:** 18, 19, 20

MST Services, in its *MST Preferred Service Description/Medicaid/Funding Standard*, suggests the following admission criteria for MST programs:

- Ages of 12-17
- Youth is a chronic or violent juvenile offender
- Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting
- Externalizing behavior symptomatology... [Common diagnoses among MST-referred youth include Conduct Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, and Disruptive Behavior Disorder NOS, although the specific diagnosis is less important than the presence of significant acting out behaviors. Youth may have other mild to moderate comorbid psychiatric disorder(s).]
- Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
- Less intensive treatment has been ineffective or is inappropriate

Youth accepted into MST are often involved in the juvenile justice or child welfare system due to their behaviors, have past or current criminal charges, and have previous treatment failures. A parent or caregiver must be willing to participate in the youth’s treatment.

Youth that are typically *not appropriate* for the service include those who:

- have an autism spectrum disorder
- present with a primary internalizing disorders and minimal acting out behaviors
- exhibit substance abuse in the absence of other delinquent or antisocial behavior
- are referred primarily due to sexual offending or due to sexual offending in the absence of other acting out behavior
- are referred primarily due to suicidal, homicidal, or psychotic behaviors
- are living independently or for whom a primary caregiver cannot be identified despite extensive efforts to do so

MST is designed to address “willful” behaviors; youth whose acting out is driven by serious mental illness (such as schizophrenia or a manic episode) are generally not appropriate for the service.

The target population above applies to “traditional” MST, designed to treat chronic juvenile offenders. Adaptations of the original model, such as MST for Problematic Sexual Behavior (MST-PSB), have different admission criteria. For example, an MST-PSB team may accept youth for whom sexual offending is the primary concern. (Note: While the majority of MST programs in Pennsylvania are for the juvenile justice population, there are a small number of providers with MST-PSB teams.)
Geographical Considerations: MST has developed specific guidelines for determining the appropriate coverage area for one MST team. (A team is comprised of a supervisor and 2 – 4 therapists, each with his/her own caseload.) Following these guidelines for an appropriate coverage area is essential to ensuring that staff can attend to families when crises arise and the team can meet regularly for group supervision, training, and support.

The guidelines from MST Services include the following: “(1) Referrals for families should be restricted to a geographical area no larger than what would be normally considered to constitute 90 minutes travel time under normal daytime or evening conditions. (2) That each therapist should travel no more than 90 minutes (each way) to visit any family on their caseload under normal daytime or evening conditions. (3) That within any MST team, therapists should not be based more than 90 minutes from each other’s ‘work location.’”

Supervision, Consultation & Program Monitoring: Intensive supervision, ongoing consultation from an MST Expert, and regular monitoring of model fidelity are hallmarks of an MST program. MST teams, comprised of 2-4 therapists and a supervisor, meet for approximately 2 hours each week to participate in group supervision. In addition, the team receives one hour each week of consultation from an MST Expert – a masters or doctoral-level clinician experienced in MST, who is employed by MST Services or an MST Network Partner Organization licensed by MST Services. A number of processes, described in the subsection “Ensuring Model Adherence,” are used to ensure the team adheres to the MST model.

Adaptations of MST: MST was originally designed to treat chronic juvenile offenders. Research is underway to examine the effectiveness of adaptations of MST for other treatment populations. The adaptations are in various stages of research and not all are available yet for widespread dissemination. MST Services has developed a paper summarizing the adaptations that are being developed and the adaptation process.

The vast majority of MST programs in Pennsylvania are “traditional” MST programs for serious juvenile offenders. There is also one team in Pennsylvania delivering MST for Problematic Sexual Behaviors (MST-PSB).

Program Web-site: http://www.mstservices.com

Program Contact: Melanie Duncan, MST Services General Office
(843) 856-8226 or Melanie.Duncan@mstservices.com
BACKGROUND ON THE DEVELOPER & HISTORY OF THE PROGRAM

MST was developed by Scott Henggeler, Ph.D., in the late 1970s to address the treatment needs of youth with antisocial behavior. In 1992, the Family Services Research Center was established at the Medical University of South Carolina. The mission of FSRC is “develop, validate, and study the dissemination of clinically and cost effective social-ecological interventions for youths, adults, and families experiencing mental health, substance abuse, and other serious health problems.” At the Center, Dr. Henggeler, Dr. Sonja Shoenwald, and their associates have continued to develop and study the MST model. In 1996, MST Services and the MST Institute were established in response to requests from community providers wishing to be trained in the MST model.

MST Services is a university-affiliated organization tasked with implementing MST in communities while ensuring that fidelity to the MST model is maintained. The MST Institute supports this work by providing a mechanism for MST teams to monitor their fidelity as well as program outcomes, through an on-line database that is used to collect a wide range of team-specific data. MST Services provides implementation assistance, consultation, training, and supervision to MST teams throughout the world. As the number of MST teams has increased, MST Services has created a system of Network Partners – organizations that are sanctioned and licensed by MST Services to provide direct support to MST teams on their behalf. Network Partnerships are closely monitored by MST Services. Pennsylvania currently has two Network Partners (click here for list).

More information about MST Services is available on their web-site.

NATIONAL AND GLOBAL RECOGNITIONS

Over the past 30 years, MST has gained recognition as an evidence-based program, meaning that the program meets specific standards for research demonstrating its effectiveness. Below is a list of organizations that have recognized MST:

- **Blueprints Project of the Center for the Study and Prevention of Violence, University of Colorado**: MST is one of only 11 programs to achieve the highest possible rating of “Model” program.
- **Coalition for Evidence-Based Policy**: MST is identified as a highly promising program for crime/violence prevention.
- **National Alliance for the Mentally Ill (NAMI)**: MST is recognized by NAMI as an evidence-based treatment.
- **National Institute on Drug Abuse (NIDA)**: MST is identified by NIDA as an effective treatment approach for adolescents who abuse substances.
- **Office of Juvenile Justice and Delinquency Prevention (OJJDP)**: MST received a rating of Exemplary, the highest rating possible, from OJJDP in its Model Programs Guide.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**: MST for Juvenile Offenders (MST), MST for Youth With Problem Sexual Behavior (MST-PSB), and MST With Psychiatric Supports (MST-Psychiatric) all received perfect Readiness for Dissemination ratings in SAMHSA’s National Registry of Evidence-based Programs and Practices. According to MST
Services, in 2000 MST received an Exemplary Substance Abuse Prevention Program Award from SAMHSA’s Center for Substance Abuse Prevention (CSAP).

- **U.S. Surgeon General:** MST is one of only five programs identified as a Model Program for Violence Prevention in the *U.S. Surgeon General’s Report on Youth Violence*.
- **Washington State Institute for Public Policy (WSIPP):** MST is one of several evidence-based programs funded by the Washington State Legislature for use in the state’s juvenile courts and evaluation by WSIPP.

**LOGIC MODEL**

**Explanation of a Logic Model:**
A logic model is a way to visually represent the underlying rationale for the behavioral changes associated with an evidence-based program. A logic model explains how and why the program is effective.

A logic model shows how specific program components or activities influence risk and protective factors and the skills, knowledge, attitudes, intentions, and behaviors of the program participants, both immediately following the program (short-term or proximal outcomes) and in later years (long-term or distal outcomes). The logic model for a program is based on an established theory of how specific risk and protective factors are related to youth development. Typically, a program’s components are designed to increase certain protective factors and decrease certain risk factors that have been shown through research to predict future development.

In most programs, one can expect to see changes in specific risk and protective factors and in participant’s skills, knowledge, attitudes and intentions prior to changes in their actual behaviors. Knowing this helps one to have realistic expectations about when and what changes can be expected in the youth or families that are participating in a program and helps guide evaluation of the program’s impact.

**MST Logic Model:**
Research has shown that antisocial behavior is caused by a combination of individual, peer, family, school, and community factors. The MST treatment model is based on causal modeling studies (i.e., studies that identify the factors that predict antisocial behavior) and social-ecological models (models that look at complex interplay among different factors in the environment and how they influence behavior).

**Theoretical Rationale of MST:**
The MST model is built upon social-ecological and family systems theories. MST views the youth as embedded within a number of interrelated systems (e.g., community, neighborhood, school, peers, family, and individual), each of which has an influence on the youth through both protective and risk factors. By identifying the factors that “drive” a problem behavior and intervening to modify those factors, change will occur.
MST places a high value on research to guide the development of the model as well as the choice of interventions used in each case. When addressing a problem behavior, therapists use interventions that have documented research support whenever possible, such as cognitive-behavioral, behavioral, behavioral parent training, and strategic and structural family therapy approaches. In addition, the MST process includes on-going monitoring of the client response to interventions and modification of the intervention, if it is not effective.

PENNSYLVANIA MST PROVIDERS 30, 31

There are currently 13 mental health or social service agencies providing MST in Pennsylvania, serving at least 52 counties. In Pennsylvania, there are 50 MST teams, with the number of MST teams per provider ranging from 1 to 13. A listing of all MST providers and their teams, as well as their MST-licensure status, can be found on-line.

In addition, there are 2 Licensed Network Partner Organizations operating in Pennsylvania. Providers interested in identifying a Network Partner can find a listing of all Licensed Network Partners on-line.

There are over 470 MST teams around the world. While most of the teams are in the United States, there are also teams in Australia, Canada, Denmark, Iceland, Ireland, The Netherlands, New Zealand, Norway, Sweden, Switzerland, and the U.K.

Over 10% of the world’s MST teams are located in Pennsylvania.

TARGETED RISK AND PROTECTIVE FACTORS 32

Research has consistently found that association with delinquent peers, family relations, and school difficulties are related to delinquent behavior. MST recognizes the influence of these factors and prioritizes them in the process of intervention. Because association with deviant peers is one of the strongest predictors of antisocial behavior, and family functioning impacts association with deviant peers and impacts antisocial behavior directly, MST interventions often focus on working with the family to improve family functioning and decrease the youth’s association with negative peers.

At the same time, MST has the ability to address a comprehensive range of risk and protective factors that are predictive of antisocial behaviors. For each case, assessment involves identifying which factors are most salient, so that the specific risk and protective factors addressed by MST can be individualized for each case. MST often focuses on the following risk and protective factors:

Risk Factors:
- **Peer Level**: Association with antisocial peers; peer rejection; poor peer relationships
- **Family Level**: Low family warmth; high family conflict; harsh, inconsistent, or lax discipline; lack of supervision; low social support for the family
- **School Level**: Low school-family bonding; academic problems; behavior problems at school
- **Community Level**: High mobility; low community support; high disorganization
• **Individual Level**: Antisocial attitudes; hostile attribution bias; impulsivity; negative affect

**Protective Factors:**

- **Peer Level**: Association with prosocial peers; involvement in prosocial activities
- **Family Level**: Attachment to parents; supportive family environment; marital harmony; natural support network
- **School Level**: Commitment to schooling
- **Community Level**: On-going involvement in community activities; strong natural support network
- **Individual Level**: Conventional attitudes; problem-solving skills

**GOALS & DEMONSTRATED OUTCOMES** 33, 34, 35, 36

MST focuses on achieving three “ultimate outcomes” – keeping a youth in the home, successful engagement in school or work, and avoiding new arrests.

The effectiveness of MST has been evaluated in 18 published outcome studies, including 16 randomized control trials and two studies with quasi-experimental designs. While the majority of the studies have focused on the effectiveness of MST for delinquent youth (8 studies), others have applied MST to adolescent sex offenders, youth with serious emotional disturbance, youth who abuse or are dependent on substances, maltreating families, and inner-city youth with chronic and poorly controlled Type 1 diabetes. (In some cases, these studies have used adaptations of MST for special populations.) Research has compared MST to a variety of other services, including diversion services, parent training, individual counseling, probation services, “services-as-usual” in the community, and “usual” child welfare services. Several studies have examined outcomes one year or more post-treatment, including one study that evaluated the impact of MST 14 years post-treatment. A brief overview and a download of a comprehensive summary of research findings are available at the MST Services web-site.

When compared to other treatment and social service approaches, youth receiving MST have generally had more favorable outcomes than youth in comparison groups. Research has shown that many of the positive outcomes are maintained over several years. For example:

*Juvenile offenders and delinquent youth who received MST showed*

- Less criminal activity and 25-75% decreases in long-term rates of rearrest
- 47-64% decreases in long-term rates of days of incarceration
- Decreased behavior problems and internalizing symptoms
- Increased social competence
- Improvement in self-reported family relations and observed family interactions
- Reduced substance use and decreases in long-term rates of drug-related arrest

More recently, MST has developed an adaptation specifically for youth with problematic sexual behavior, MST-PSB. In 2009, two randomized clinical trials comparing MST-PSB to “treatment as usual” were published.
Compared to juvenile sex offenders who received treatment-as-usual (TAU), those who received MST-PSB showed

- Greater reductions in sexual behavior problems, delinquent behavior, substance use, and self-reported externalizing symptoms at 12-months post-referral
- Lower rates of out-of-home placement at 12-months post-referral
- Lower rates of recidivism for sexual offenses at 8-year follow-up (8% for MST-PSB vs. 46% for TAU)
- Lower rates of recidivism for nonsexual offenses at 8-year follow-up (29% for MST-PSB vs. 58% for TAU)
- 70% fewer arrests overall and 80% fewer days in detention facilities at 8-year follow-up

The complete research articles are available on the MST-PSB web-site.

Numerous studies have shown that therapist adherence to the MST model is strongly associated with positive outcomes.

RETURN ON INVESTMENT AND COST-BENEFIT INFORMATION 37, 38

An Explanation of Return on Investment Calculations:
A cost-effective prevention program is doubly appealing from a societal standpoint, as such a program can successfully prevent or reduce delinquency and problem behaviors in youth and it results in a future reduction in the financial burden of interventions to taxpayers. For example, a program that diverts a youth from a criminal path will spare society the justice system expenses associated with processing offenses, such as police, court, and prison costs. In such a case, the necessary resources for the prevention program are worth the investment as they prevent other future expenses. In addition, cost-effective prevention programs have now been shown to also provide a return-on-investment or fiscal benefits above and beyond the program costs for taxpayers.

In 2004, the Washington State Institute for Public Policy conducted cost-benefit analyses for a variety of prevention programs by calculating the economic benefits derived from specific prevention programs and subtracting the costs incurred to implement the programs. The scientifically rigorous review and analysis provided credible evidence that well implemented prevention efforts can result in a significant return on investment.

To conduct cost-benefit analyses, monetary values are assigned to observed changes that are attributed to prevention programs in the following key outcomes:

- Crime (such as costs to process an arrest, prosecutor costs, victim costs, detention and supervision costs, prison operation expenses)
- Education (graduation rates, test scores, post-high school education, special education rates, grade repetition)
- Employment rates and earning potential
- Substance use (abuse of alcohol, tobacco, and illicit drugs)
- Public assistance (including welfare receipt or social services such as foster care)
- Teen birth rates
- Child abuse and neglect
• Health and mental health service needs

To view a chart of the economic benefits of prevention programs and for more information on return on investment research, please see the Return on Investment subsection in Section Three of this implementation manual.

The potential economic benefits of a successful prevention or intervention program can be readily demonstrated to policymakers and the public in general. Programs that both reduce problems identified by local communities while also reducing costs to society are especially important as state and local governments become more accountable for both costs and outcomes. Given typical budget constraints, policymakers seek to fund crime prevention programs that will at least “pay for themselves” while delivering necessary services to their community. It is important for prevention programs to communicate the return-on-investment figures derived by economic experts and their locally assessed impacts.

**MST Return on Investment Calculations:**
In the 2004 Washington State Institute for Public Policy report, *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, it was determined that there was a return of at least $2.64 for every dollar spent on MST and a cost benefit of at least $9,316 per youth. In Pennsylvania, the Penn State Prevention Research Center released a 2008 report demonstrating that, for 12 sites implementing MST in Pennsylvania, there was a statewide return on investment for of over $30 million, which reflected a savings in future crime costs. The estimated average economic benefit was $2.5 million per community.

The table below summarizes the cost benefit derived for Multisystemic Therapy (MST) by the Washington State Institute for Public Policy (WSIPP) and the Penn State Prevention Research Center (PRC):

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<th>MINUS COSTS</th>
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<td>WSIPP Report*</td>
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<td>PRC Report**</td>
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<td>$6,402</td>
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*Figures are in 2003 dollars.
**Figures are in 2007 dollars.


**TRAINING AND CLINICAL SUPPORT**

**MST-Specific Training & Support:**
Clinical supervisors and therapists are required to participate in a 5-day initial training as well as quarterly booster trainings specific to the MST model. Initial trainings are offered by MST Services and Network Partner agencies at a variety of locations, including locations in Pennsylvania, throughout the year. These trainings are required for the clinical staff (i.e., therapists, supervisors), but administrators and stakeholders may also benefit from attending the first day of training which focuses on program rationale, procedures, etc. Therapists receive at least one day each quarter of booster training, while supervisors receive an additional half-day each quarter. Booster trainings are held for teams, agencies, or groups of agencies. Topics for booster trainings are chosen based on their unique training needs of a team, as identified by the team and its MST consultant. All trainings must be delivered by MST Experts who are licensed by MST Services.

In addition to these formal trainings, on-going training occurs through frequent clinical supervision and consultation:

- Each MST team meets face-to-face for 2 hours/week for group supervision.
- Each team receives one hour/week of phone consultation from its assigned MST consultant.
- The team supervisor receives monthly phone consultation from the MST consultant.

Training, supervision, and consultation are designed to promote maximum adherence to the MST model and allow opportunities to discuss and problem-solve challenging cases. Several studies have found that therapist adherence to the model is essential to maximizing positive outcomes (See the comprehensive overview of outcome studies at the MST Services web-site for a review of relevant research.)

MST Services and Network Partners also provide organizational support to help sites address barriers that may affect the clinical integrity or compromise the outcomes of a program.

**Other Training:**
MST programs are under the umbrella of Medical-Assistance-funded mental health services in Pennsylvania and should follow best practices for treatment providers. In addition to the MST-specific trainings described above, staff should receive training in areas such as HIPAA, documentation, client-therapist boundaries, CPR/First Aid, mandated reporting requirements, crisis management, psychotropic medications and side effects, and so forth.
PROGRAM COSTS \textsuperscript{42, 43}

The costs associated with an MST program vary depending on a number of agency-specific factors. For example, program size, staff salaries, the amount of travel associated with the region covered by the program, and the arrangements made for MST training, all affect the budget and consequently the cost per case served. MST Services and Network Partner organizations have costs estimators available that can guide interested programs in determining their expenses. In the United States, the cost per youth generally ranges from $6000 to $9500.

Staff salaries can vary widely. MST Services advocates for providing competitive salaries that will serve to attract and retain well-qualified clinicians. Research has shown that low salaries are associated with more turn-over in staff. Staff turn-over, of course, can result in increased program expenses associated with recruiting, hiring, and training new staff, and may also affect program morale, reputation, and service quality. MST Services provides guidelines that may be useful for determining a competitive salary for your community.

The costs outlined below are intended to give a general idea of the expenses of implementing an MST program and are based on cost estimators included in the appendices of the Multisystemic Therapy Organizational Manual as well as information provided by an experienced MST Director (G. Soltys, personal communication, August 12, 2010).

- **Start-Up Costs**: This includes consultation and program development fees paid to MST Services or a Network Partner Organization, as well as reimbursement to MST Services or a Network Partner for travel costs associated with consultation and program development services.
- **MST-Specific Fees**: These fees can be divided into two categories. 1) Providers pay annual licensing fees to MST Services for their agency and for each MST team. 2) Program Implementation Support costs are paid annually to MST Services or a Network Partner. This pays for a variety of support services including weekly phone consultation and monthly supervisor consultation from an MST Expert, quarterly booster trainings for staff, periodic program reviews to ensure model fidelity, and data collection through the MST Institute web-site. Providers must also reimburse travel costs incurred by the MST Expert in the course of providing program support services, including travel for quarterly booster trainings.
- **Training costs**: There are separate fees for the 5-day orientation training, which may be paid for an entire team (such as when a new team is being established) or per therapist (such as when replacement staff are hired to an existing team). Providers should also factor in training-related travel costs.
- **Staffing**: Staff costs include salaries and benefits. Staff should include a Clinical Supervisor, Therapists, a Program Manager, and support staff.
- **Operational Expenses**: This includes but is not limited to office space, cell phone plans for clinical staff and supervisors, internet fees, and staff travel expenses (e.g., mileage).
- **Equipment & Furnishings**: MST programs need an office to serve as “home base” where staff can meet for supervision and meetings, documentation can be completed, files can be stored, and so on. An example of equipment and furnishings for one team may include a meeting table with chairs; a desk and office chair for the clinical supervisor; work space for therapists (tables and chairs); a computer work station equipped with a PC, printer, and scanner; laptops for therapists; fax machine; office phone; copier; bookcase; storage cabinet; and large filing cabinet.
• **Office Supplies**: This includes items such as writing instruments, paper, file folders, staples, tape, staplers, a hole punch, and so forth.

• **Flexible Spending Fund**: While not required, MST Services recommends that programs have available a flexible spending fund that can be used to help families meet needs that are interfering with treatment.

**STAFFING REQUIREMENTS**

**Overview:**
MST is delivered by individual therapists who are organized into MST teams. Each team consists of at least two and no more than four therapists and a clinical supervisor. It is important that therapists are full-time employees assigned solely to the MST program. Therapists should not have non-MST responsibilities in the agency or work other part-time jobs outside of the agency. (See Fidelity Recommendations below.) The MST Clinical Supervisor can supervise one or two teams and is assigned to the MST program a minimum of 50% time per MST team (i.e., a half-time supervisor can supervise one team, while a full-time supervisor can supervise two teams). Although using one MST Clinical Supervisor to cover two MST teams in close geographical proximity is cost-effective, teams often need more than half-time supervisory support and programs may benefit from assigning each team its own full-time supervisor to ensure that teams have sufficient support and resources.

Each program should also identify someone to fill the role of MST Program Manager. This person may be full-time or part-time. Depending on the size and characteristics of the program, the role of Program Manager may be filled by an MST Supervisor, an administrator who has other duties within the agency, or an individual hired solely to serve as Program Manager. The Program Manager is responsible for “managing the overall performance of the MST program that may include staffing issues, referral agency relationships, systems issues, interagency collaboration issues, etc.” (Multisystemic Therapy Organizational Manual, 2009, p. 76).

Other positions to consider include a case manager, a person responsible for data collection and data entry, and/or office support staff. Programs may spend a considerable amount of time helping youth become M.A. eligible, obtaining authorizations for care, and entering required data (e.g., therapist and supervisor adherence measures) into the MST Institute web-site. Funding entities such as OCYF require that programs collect data and submit quarterly performance measures to the state. Programs may also want to collect information about client outcomes at designated intervals after discharge, in order to evaluate the long-term impact of the MST. It is not only more cost-effective to identify specific staff to assist with these tasks rather than place the responsibility on clinical staff, but it also allows clinical staff to focus their time and energy on providing care to clients and their families.

**Caseloads:**
Each therapist, who must be full-time to the MST program, carries a caseload of 4 to 6 clients. Exceeding 6 clients violates required program practices, which reduces model adherence and compromises treatment outcomes. A supervisor can also carry a small caseload of 2 clients, so long as the supervisor is assigned only one team and has sufficient time to fulfill his/her supervisory responsibilities. On average, an MST therapist serves 15 youth per year. A team serves 30 to 60 youth annually.
Staff Qualifications:
A critical part of the hiring process for MST is assessing the “fit” of a candidate with the MST model. Ideal candidates are willing to work non-traditional hours, open to constructive feedback, motivated, flexible, have common sense and strong interpersonal skills, and are committed to adhering to the MST principles and model. Hiring staff who do not fit well with the MST model has a detrimental effect on the program in a number of ways. MST Services has created Therapist and Supervisor Recruitment Toolkits to guide the hiring process and the identification of the strongest candidates for these positions. These Toolkits are available to new and existing MST providers as part of the MST Organizational Manual.

MST Supervisors should be doctoral-level clinicians or highly experienced masters-level clinicians. Supervisors should have training in behavioral, cognitive behavioral, and pragmatic family therapies such as structural or strategic family therapy, and parent-child behavior management.

MST Therapists should be masters-level clinicians, but may also be highly-skilled bachelor-level staff. If bachelor-level staff are hired, they should make up no more than 1/3 of the therapist positions on an MST team. MST Services further suggests that bachelor-level hires have 5+ years of previous, appropriate clinical experience in child welfare or mental health services. Ideally, therapists will come to the team with training in behavioral, cognitive behavioral, and pragmatic family therapies.

Providers should be aware that, if they bill Medical Assistance (M.A.) for MST services, all staff must meet the minimum qualifications stated in their OMHSAS-approved service description. Service descriptions may include additional parameters regarding acceptable fields of study (e.g., social work, psychology, counseling), years of experience, and so on. Before hiring a candidate that deviates from the qualifications established in the service description, a provider should contact the OMHSAS Bureau of Children’s Behavioral Health Services. In addition, if hiring staff before submitting and obtaining service description approval from OMHSAS, providers should be aware that M.A. will not pay for services delivered by staff who does not meet certain minimum qualifications. Therefore, it is beneficial for providers to have a conversation with OMHSAS about expected staff qualifications for M.A. funded programs before hiring staff.

Staff Activities:
MST Therapists spend their time engaged in a number of clinical activities. The motto of MST is “whatever it takes,” and this applies to staff activities as well. MST does not prescribe a certain number of hours for each activity, but instead emphasizes that staff time should be spent in a manner that “gets the job done,” providing effective treatment and positive outcomes. This is one of the reasons that MST Services advocates strongly for weekly or case rates, rather than fee-for-service billing.

Therapists spend their time engaged in:
- Direct care or face-to-face contact with youth, family and other systems involved with the family (e.g., probation, child welfare, school, employer, etc.)
- Phone contacts with the family and other systems
- Traveling to and from appointments
- Clinical documentation, which includes an extensive Weekly MST Summary that must be completed for every client to guide clinical planning, documentation required for M.A. billing, and in some cases documentation requested by the referral source
- Supervision and consultation (this occurs for a minimum of 3 hours/week)
• MST-specific training, as well as agency trainings

The specific time spent on each responsibility varies depending on intensity of client need during a given week, therapist need for additional supervision, geography, etc.

Therapists spend at least 4 days/year in MST booster trainings, while Supervisors spend at least 6 days/year in MST booster trainings. All MST staff should spend additional time in agency-specific trainings (e.g., HIPAA, cultural competency, etc.).

**FIDELITY RECOMMENDATIONS** 48

Based on extensive research, MST Services has clearly identified 18 required program practices, 8 recommended program practices, and 15 potential indicators of threats to program adherence and successful implementation. Adherence to these practices is critical to ensure that the MST model is implemented with fidelity and to maximize positive outcomes for youth and the community.

A complete list of the required and recommended practices can be found in the Appendix J. Some highlights of required practices include:

- having salaried, full-time therapists devoted solely to the MST program and able to work flexible schedules
- operating in teams of 2-4 therapists
- maintaining appropriate caseloads of 4-6 clients
- delivering short-term treatment, while ensuring discharge is based on outcomes rather than length of treatment
- serving only youth that fit within the MST target population
- avoiding referrals to other services while the youth is involved with MST and limiting aftercare referrals to those that are clearly needed (i.e., involvement in other treatment services, such as family therapy, group therapy, or drug and alcohol counseling at the same time as MST violates the MST model)
- team participates in weekly supervision and consultation
- having a 24/7 on-call system

It is essential that the provider agency and local stakeholders are willing to support the program’s adherence to required and recommended program practices, and do not make requests of the program that encourage drift away from the MST model.

In addition to these program practices, the MST Clinical Supervisor and Therapists follow a number of clinical guidelines and processes that make up the MST treatment model. These include following the 9 MST Principles, using intervention strategies that are supported by research, and using the MST Analytic Process to ensure that interventions are matched to the “drivers” of target behaviors and that the effectiveness of interventions is monitored.
IMPLEMENTATION PLANNING

The reader is directed to Section 2 of this manual for information about selecting an evidence-based program and a detailed implementation checklist. The information below is intended to supplement Section Two of this manual by providing information specific to MST.

Overview:
MST Services or a licensed MST Network Partner organization provides support throughout the implementation planning process. MST Services has developed a Program Development Method™ (PDM) to ensure that MST is a good fit for the targeted population, community, and agency, and that the program can be sustained long-term. The PDM™ includes six stages:

- **Stage A:** Initial information collection (no charge)
- **Stage B:** MST Needs Assessment (no charge)
- **Stage C:** MST Critical Issues session (program development fees apply)
- **Stage D:** Site Readiness Review meeting (program development fees apply)
- **Stage E:** Staff recruitment & orientation training (program development fees apply)
- **Stage F:** Ongoing implementation support (annual support fees)

Network Partner organizations may not use the PDM™ specifically, but will follow a similar process and use many of the same materials for implementation planning with an interested provider.

In Pennsylvania, there are also unique steps that providers must take in order to access funding and these steps may affect the timeframe for implementation as described in the next subsection. Providers hoping to access Special Grant funds from OCYF should be aware that counties must request these funds in August prior to the next fiscal year. For example, funds for 2011/2012 must be requested in August 2010. In order to access Medical Assistance dollars, providers must submit a service description to the OMHSAS Children’s Bureau and must work with their local BH-MCO which may need to plan several months ahead in order for funding to be available.

**Time Frame for Start-Up:**
The length of the planning and implementation process depends on a number of factors, including how long it takes a provider or community to complete “assignments” at each stage of the PDM™. The start date of a program may depend on when funding becomes available, as noted in the previous subsection. The process may also be affected by agency factors such as whether the agency has office space readily available for the program or whether the program serves a rural area where qualified staff are more difficult to find.

Once a provider makes the decision to implement MST (end of Stage B), and if funding is readily available, it typically takes 3 – 6 months to complete the rest of the planning process and be ready to accept clients. The majority of this time is spent recruiting staff and scheduling the orientation training (Stage E). Hiring staff who are a good “fit” for the model has a significant impact on a program – it improves model adherence and service quality, can enhance program reputation, and reduces staff turnover which cost a program both time and money. Therefore, programs are strongly encouraged to hire staff carefully and selectively. Rushing through the hiring process, while it may result in an earlier start date for services, can be harmful in the long run.
Benchmarks for MST Start-Up and Implementation:
The benchmarks below integrate the stages of the PDM with steps that are specific to the Pennsylvania system. Readers are also encouraged to review Section 2 of this manual, which includes steps for selecting an evidence-based program and detailed site readiness and implementation checklists.

☐ Contact MST Services for information about MST and the program development process (Stage A of the PDM™).

☐ Conduct needs assessment and evaluate program feasibility (Stage B of the PDM™). In Pennsylvania, Stage B should include:
  o Discussions with the county MH/MR to secure its support.
  o Discussions with county child welfare and juvenile probation offices regarding need.
  o Discussions with the local Behavioral Health Managed Care Organization (BH-MCO) responsible for M.A. to determine if it will bring a new MST provider into its network and, if so, the process and time frame for doing so.
  o Determine if and when county funding will be available, and what type of funding it will be (i.e., Special Grant funds, ICSP grant).
  o Ensure that the community has a sufficient number of youth to refer to the MST program. Depending on the size of its team(s), a successful MST program needs to serve 30-60 youth per year, per team.
  o It may be useful to obtain a sample MST service description from the OMHSAS Bureau of Children’s Behavioral Health Services.

☐ Decision is made whether to pursue MST. If so, continue on to next benchmarks.

☐ Specific program planning occurs, including the development of a program description, procedures, and policies (Stage C of the PDM™). If planning to obtain Medical Assistance funding, this stage should include:
  o Submit a service description to the OMHSAS Children’s Bureau for review and approval. (See below for more information.)
  o Follow the BH-MCO process for becoming an enrolled MST provider.
  o Development of a Service Agreement with other programs (see below)

☐ Site Readiness Review Meeting is held on-site (Stage D of the PDM™).

☐ Recruit and hire clinical staff (Stage E of the PDM™).

☐ Staff attends 5-day orientation training (Stage E of the PDM™).

☐ Begin serving youth.

Accessing Medical Assistance Dollars:
As a general rule, MST providers need to access Medical Assistance (M.A.) funding in order to sustain their programs. Because county MH/MR support and the willingness of the local BH-MCO to bring the program into network are essential to accessing M.A. funding and sustaining a program, conversations with these two entities should occur early in the implementation process. If support exists, providers should begin the process of M.A. enrollment as early as possible. See the Funding section below for detailed information about obtaining M.A. funding.

Providers should be wary of proceeding with implementation without the support of their county MH/MR and BH-MCO, since in Pennsylvania failure to obtain M.A. funding is a serious threat to program sustainability.
Accessing OCYF Special Grant Funding:
County Children and Youth Agencies (CCYA) can request funding specifically for evidence-based treatment programs through the Special Grant Initiative from the Department of Public Welfare, Office of Children, Youth, & Families (OCYF). These grants can be used to pay for start-up costs and ongoing costs.

This funding must be requested by the county when it submits its Needs-Based Budget; therefore, the money must be requested almost a year in advance. (Budgets are submitted in August for the next fiscal year, to begin July 1 of the following year.) If the county and its identified MST provider intend to utilize Special Grant funds for the MST program, advance planning is needed. Providers considering implementing an MST model should have conversations with their CCYA as early as possible in the planning process to discuss the possibility of Special Grant funds to help support the program.

A benefit of using Special Grant funding is that it requires a 5% local match rather up to 50% local match required for child state welfare funds. The request for Special Grant funding represents a commitment by the county to the implementation of specific evidence-based programs.

Service Agreements:
During the implementation planning process, providers should also establish a Service Agreement with other agencies and services to facilitate smooth referrals of youth served by the MST program to different levels of care or supplementary services when necessary. For example, the Service Agreement should include inpatient psychiatric services, partial hospitalization programs, alternative education programs, outpatient therapy programs, residential drug and alcohol programs, psychiatrists, and so forth.

FUNDING

As stated by MST Services in its position statement memo, Medicaid Funding for MST Programs:
Medicaid funding has emerged as an important part of the MST landscape and is playing a critical role in the financial sustainability of many MST programs across the United States. However, we caution stakeholders against viewing Medicaid funding as a ‘silver bullet’ solution to their funding troubles... (p. 1)

Sustaining an MST program requires the ability to braid together multiple streams of funding. The main sources of funding used are Medical Assistance and Special Grants awarded by OCYF to counties, although other sources of funding exist as well. Details about each type of funding, what it can be used for, and how the funding is accessed are described below.

Medical Assistance:
Medical Assistance dollars can be used to pay for treatment related costs. As of July 2010, a rate of $20.42 per quarter hour is billed in Fee-For-Service when specific treatment services are delivered. While certain treatment related activities such as travel and clinical documentation are not directly billable, staff time spent on these activities is included as an M.A. allowable cost in the budget used to establish the M.A. rate. Providers should contact the OMHSAS Bureau of Financial Management and
Administration for information about allowable costs and what is included among billable services in Fee-for-Service.

The rates paid in HealthChoices vary and are established through individual negotiations between the provider and BH-MCO. During rate negotiations, detailed communication between the provider and BH-MCO is critical. The provider should have a clear understanding of the budget on which the rate is based (e.g., expected caseloads, allowable costs, etc.) and what services will be billable (which affects the anticipated units of service and in turn affects the rate). MST Services highly recommends a case rate or weekly rate, rather than an hourly rate, in order to prevent specific productivity requirements from negatively impacting model adherence. However, BH-MCOs vary in their willingness to consider an Alternative Payment Arrangement (APA) for MST.

Providers may also benefit from reading MST Services’ position statement memo, Medicaid Funding for MST Programs, which outlines strengths and weaknesses of using M.A. funding for MST.

In order to be eligible for M.A. funding, a provider agency must have:
- support of the program at the local level (specifically from the county MH/MR)
- a valid base mental health license (i.e., outpatient psychiatric clinic, partial hospitalization, or family-based) or a waiver of this requirement from the Secretary of Public Welfare
- a licensing agreement with MST Services
- a contract for training and support with either MST Services or a Licensed Network Partner organization
- team licensure from MST Services (it is acceptable to submit a service description to OMHSAS for review before the team license is granted)
- a service description approved by the OMHSAS Bureau of Children’s Behavioral Health Services

While M.A. enrollment is a detailed process, there are four general steps that must be taken. Steps 2-4 occur with both the state and the BH-MCO, representing two separate but necessary parallel processes:

1. **Collaboration:** The provider must work with county MH/MR, Health Choices coordinator, and the Behavioral Health Managed Care Organization (BH-MCO) responsible for M.A. in the county(s) to be served to garner support at the local level. Note that while support from C&Y or JPO is typically needed to sustain referrals to the program, support from MH/MR is essential to obtain M.A. funding. This is also a time to learn about the BH-MCO process for becoming an in-network MST provider and to become familiar with the expectations that the state has for M.A. providers (see Frequently Asked Questions About Medical Assistance).
2. **Service Description:** The provider must submit a service description to the OMHSAS Bureau of Children’s Behavioral Health Services for review and approval. The provider should contact the Children’s Bureau in advance to obtain a copy of the sample service description for MST; using the sample is not required, but will save a good deal of time. Each BH-MCO has its own process for reviewing program proposals.
3. **Rate-Setting:** Rates are established for the program, both in fee-for-service and HealthChoices. See the beginning of this section for more information about rate setting for MST.
4. **Enrollment:** MST providers must be enrolled as a Provider Type Specialty Code 340 (“program exception”). If the agency does not currently have this Specialty Code on its PROMISe file, an enrollment application must be submitted to OMHSAS for the code to be added. Each BH-MCO has its own process for finalizing enrollment of a program in its network.
Frequently Asked Questions about accessing M.A. and the expectations of OMHSAS are available at the EPISCenter web-site. Providers are strongly encouraged to read these FAQs, as well as the section below titled *Utilizing M.A. as a Funding Source*.

**OCYF Special Grants:**
In Fiscal Year 2008-2009, the Department of Public Welfare, Office of Children, Youth, & Families (OCYF) launched a Special Grants Initiative to support evidence-based programs and promising practices. As noted above, county Children and Youth offices can request Special Grant funding specifically for evidence-based treatment programs from the state OCYF. This request is made as part of the Needs Based Budget Plan submitted by the county to the state, but the Special Grant is separate from Needs Based Budget monies.

When Special Grant funds are used, OCYF expects that the MST provider will enroll quickly as a Medical Assistance provider so that M.A. dollars can be used to pay for treatment costs whenever possible. At the discretion of the individual county, Special Grant funds can be used for the following:

- Start-up costs, including initial fees paid to MST Services or a Network Partner organization
- On-going training costs (e.g., sending a new hire to the 5-day orientation training)
- When the referred youth is not eligible for M.A., the youth is M.A.-eligible but services have not yet been authorized, or the youth is M.A.-eligible but M.A. Fee for Service or the BH-MCO has determined that MST is not medically necessary.

A benefit for the county of using Special Grant funding is that it requires a 5% local match rather than up to 50% local match required for child welfare state funds.

**HealthChoices/BH-MCO Funding:**
See the above subsection “Medical Assistance” for information about how BH-MCOs pay for MST services that are provided to specific youth. Providers should speak with their county and BH-MCO to determine if there are any administrative dollars available for costs besides direct service and, if so, what this money can be used for and how it might be accessed.

**Integrated Children’s Service Plan (ICSP) Grants:**
Each year, all counties in Pennsylvania prepare an Integrated Children’s Service Plan (ICSP). The development of the ICSP is a collaborative process involving numerous county and local systems, and it occurs alongside planning for the county Needs Based Budget and Plan.

Counties who self-designate as Tier 1 (“Accelerated Integration Counties”) in their ICSP can request funding to support integrated prevention activities, such as the start-up or expansion of an MST program or other promising practice or evidence-based program. In FY 2010/2011, 47 counties identified as Tier 1.

Additional information about Integrated Children’s Service Plans is available at the Department of Public Welfare web-site. The web-site includes the Guidelines for FY 2011/2012 and a map of Tier 1 counties.

**PCCD Grants:**
In the past, the Pennsylvania Commission on Crime and Delinquency (PCCD) included MST among the evidence-based programs eligible for the evidence-based initiative grants to assist with program start-up or expansion. Beginning in 2010, MST and the other evidence-based treatment programs (i.e., Functional Family Therapy, Multidimensional Treatment Foster Care) are no longer eligible for PCCD.
Evidence-based grant funding. However, providers may want to monitor the PCCD web-site for other 
PCCD grant announcements that may be relevant to their MST program.

Other Grants:
Additional source of grant funding can also prove useful to MST programs, providing a means of paying for costs that a program is having difficulty covering otherwise. An extensive list of resources for identifying available grants is included in Section Six of this manual, under Web Resources.

INVOLVING YOUR COLLABORATIVE BOARD AND OTHER STAKEHOLDERS

Local Collaborative Boards:
Local collaborative boards can play an important role in program development and sustainability. A collaborative board can be defined as a board of diverse community partners who work together to organize, plan, and implement prevention strategies. Examples of collaborative boards include but are not limited to: Integrated Children’s Service Plans (ICSP); Communities That Care (CTC) Delinquency Prevention Policy Boards; Balanced and Restorative Justice Teams; State Health Improvement Coalitions; State Incentive Grant Planning Boards; Criminal Justice Advisory Boards; and Weed and Seed Assistance for Impact Delegation (AID) Teams or other collaborative boards, including those established to focus on implementing healthy community objectives. It has been demonstrated that those prevention programs planned and implemented through a collaborative board structure are more likely to be implemented with fidelity and more likely to be sustained. Consequently, providers benefit from identifying and working with their local collaborative board when planning an MST program and throughout implementation. It is especially important that MST providers work closely with their county MH/MR, child welfare, and juvenile probation agencies and the local BH-MCO, who will likely be represented on the collaborative board.

Providers should consider the following activities in relation to their collaborative board:

- Work closely with the collaborative board to ensure that MST is a good fit for addressing the community’s needs as identified through a careful assessment of local risk and protective factors.
- At start up, share information about MST, such as the research behind MST, local goals for the program, a brief overview of the model, and the logic model. While presentations help to build enthusiasm and provide an opportunity for discussion, board members will also appreciate handouts such as a fact sheet and logic model.
- Help board members to understand ways that they can contribute to the program’s local success, such as helping to identify funding sources and referring families.
- Identify potential program champions or community gatekeepers that can help to build relationships that may lead to program support or increased referrals of clients.
- Provide board members with frequent verbal reports on the program’s impact.
- At least annually provide a written summary of program outcomes. Plan an annual meeting / luncheon to review the program’s outcomes, highlight successes, and discuss needs for the upcoming year.
Other Stakeholders:
While many stakeholder agencies will be represented on local collaborative boards, many of the individuals who impact a program’s success may not be board members. For example, there are likely to be a number of probation officers, caseworkers, guidance counselors, and mental health professionals who make referrals to MST. Care managers and provider relations representatives from BH-MCOs interface frequently with MST programs. The success of an MST program also depends largely on good communication and strong relationships with its stakeholders. There are several reasons for this:

- County staff, which makes the majority of referrals to most MST programs in Pennsylvania, may not be familiar with evidence-based programs and the importance of maintaining fidelity to a specific model. Education regarding the research-demonstrated outcomes, the importance of model adherence, and specific MST program practices helps to ensure that the community-at-large engages in practices that support fidelity (e.g., making appropriate referrals, not “stacking” other treatment services on top of MST).
- Ongoing communication “reminds” potential referral sources of the existence of the MST program.
- Strong, positive relationships (as well as demonstrated outcomes) result in more referrals to a program.
- Due in part to staff turnover within county agencies, relationship-building and education must be on-going processes.

Like collaborative board members, all stakeholders will appreciate information about the MST program and frequent updates about the program’s impact. Strategies include:

- Develop handouts for stakeholders emphasizing key points of the program as it relates to their systems. For example, caseworkers and probation officers will appreciate a one or two page handout that provides a brief overview of the service, highlights appropriate referrals, and includes the program’s contact information. To get referral sources started, attach a referral form to the handout.
- Offer periodic trainings for groups of stakeholders (e.g., judges, caseworkers, probation officers, care managers) to educate them regarding the clinical model. Working with the leadership at the relevant agency (e.g., JPO, C&Y, etc.) as you develop the training will help to tailor the material to the audience.
- Disseminate a periodic e-newsletter with highlights of the MST program. The e-newsletter can include news items related to program outcomes, successful cases, interviews with families who have completed the program or with satisfied referral sources, and therapist bios, for example, and can be sent regularly to stakeholders and other interested parties.
- Plan an annual meeting / luncheon to review the program’s outcomes, highlight successes, and discuss needs for the upcoming year. Invite your referral and funding sources, as well as collaborative board members.
- When working with a school district, develop relationships with and educate the spectrum of staff about the treatment principles. This includes but is not limited to staff from Special Education, Guidance, Administration, and Student Assistance Programs.
- It is also important to develop clear expectations about roles and responsibilities with your referral sources.
General Guidelines for Working with Collaborative Boards and Other Stakeholders:

- To the extent possible and where clinically appropriate, be responsive to stakeholders’ and referral sources’ requests for information. Provide information in a timely manner and, when information cannot be provided, explain why.
- Meet with stakeholders at times and locations that are convenient for them. Be as flexible as possible.
- Be open and honest about what MST is and what it is not. It is important to be clear about the target population.
- Remember that working with your collaborative board and other stakeholders is an on-going process that needs to continue throughout the life of your program.

ENSURING MODEL ADHERENCE

The MST model has a Continuous Quality Assurance System. This system includes a number of practices to monitor each team’s adherence to the MST model and ensure quality implementation.

Every six months, the team collaborates with its assigned MST Expert to complete a Program Implementation Review. This review includes an assessment of whether the team is adhering to the required and recommended program practices, and a plan for addressing any practices that are not being followed. The review also includes a look at program data, including TAM-R and SAM data (described in the paragraph below) and outcome data.

To ensure therapist adherence to the MST model, families regularly complete the Therapist Adherence Measure-Revised (TAM-R). The therapist participates in weekly supervision and consultation, and attends regular booster sessions. Supervisor adherence is monitored via the Supervisor Adherence Measure (SAM) completed by the therapists on his/her team and by monthly phone consultation with an MST Expert. Each therapist and supervisor has a professional development plan that addresses any challenges related to model adherence. The MST Expert reviews the teams TAM-R and SAM scores regularly, to assist with professional development plans and as part of the team’s semiannual review.

OUTCOME ASSESSMENT PROCESS AND REPORTING REQUIREMENTS

MST providers must currently report on program performance and outcomes to several sources – the MST Institute, county agencies, the BH-MCO(s), and the state. The MST Institute gathers information pertinent to monitoring a team’s fidelity and key outcomes, but does not collect all of the information that is of interest to state and local stakeholders in Pennsylvania such as information about referral sources, aftercare services, diagnosis, etc.

While the requirements outlined below may appear cumbersome, providers should know that by the end of 2010 the INSPIRE system, being developed through the EPISCenter, will be in place to assist with data collection and facilitate more efficient reporting. Once INSPIRE is available, providers will enter data into the MST Institute’s Enhanced Web-site and then log into INSPIRE on-line to report additional
data not currently collected through the MST Institute. Providers will eventually be able to run customized reports that meet the needs of their local stakeholders as well as fulfill state reporting requirements.

Programs should give thought to how they will meet reporting requirements and ensure data is entered in a timely and efficient manner. While some data must be entered directly by clinical staff, other data can be entered by support staff.

**MST Model Requirements:**
MST emphasizes accountability and has a well-developed system for evaluating the outcomes of its teams. The MST Institute has an on-line information system into which all MST teams enter data regarding cases. Providers can run reports that summarize data for a specific period of time. Data and outcomes gathered through the MST Enhanced Web-Site include:

- Number of youth served
- Percent of youth who successfully complete treatment, and reasons for non-completion or unsuccessful treatment
- Percent of youth who achieve each of the 6 Instrumental Outcomes (improvements in parenting skills, family relations, and network of support, success at school or work, involvement with prosocial peers or activities, and sustained changes)
- Percent of youth who achieve each of the 3 Ultimate Outcomes (remaining in the home, in school or working, and avoiding re-arrest)
- Average length of treatment
- Average scores on the Therapist and Supervisor Adherence Measures, as well as collection rates for each

The data collected in the Enhanced Web-Site is used for monitoring teams’ model fidelity and effectiveness, but many programs also find it useful for communicating with stakeholders.

**Local Requirements:**
Each county and BH-MCO is able to specify its own requirements for providers to report program data, including outcomes. These requirements may be consistent with the data collected through the MST Institute’s Enhanced Web-Site, but in many cases local entities have unique reporting requirements.

**State Requirements:**
MST providers are required by the Pennsylvania Office of Children, Youth, and Families to collect and report data on program outcomes and key performance measures. Currently, this information is reported by submitting a quarterly spreadsheet with data on performance measures to the EPISCenter. The information must be collected and tabulated by the provider. When INSPIRE is implemented, the necessary data will be collected and reported through INSPIRE.

**PROGRAM MONITORING**

MST programs are monitored by a number of entities including their assigned MST Expert and the MST Institute, OMHSAS, and BH-MCOs.
MST Expert and the MST Institute:
Every MST team is assigned an MST Expert from MST Services or a Licensed Network Partner organization to support the team. Through the processes described above (see Ensuring Model Adherence), the MST Expert monitors each program’s adherence to model practices and therapist and supervisor fidelity to the MST treatment model.

Through the MST Institute’s Enhanced Web-Site, data is gathered pertaining to therapist and supervisor model adherence, adherence to MST program practices, client characteristics, length of treatment, case completion rates, and outcomes. (See Outcome Assessment Process and Reporting Requirements above.) This data is used by the program and its MST Expert to monitor the program.

While MST Services or the Network Partner will work closely with teams who drift from the MST model to help them get back on track, MST Services may revoke or move to “partial” licensure status the MST license of a team that persistently violates MST practices.

OMHSAS Monitoring:
The process and extent to which OMHSAS monitors each MST program depends in part on the provider’s licensure status. Providers with a waiver of the base mental health license are reviewed annually to ensure compliance with state regulations and policies. Providers with a base mental health license are subject to review at the discretion of OMHSAS. The site reviews are a joint effort between the OMHSAS Bureau of Children’s Behavioral Health Services and the OMHSAS Regional Field Offices. Additional information about this process is available in the FAQ Regarding M.A. under #17. OMHSAS also monitors program performance by reviewing data from the MST Institute web-site and may utilize the INSPIRE system once it is available.

BH-MCO Monitoring:
Each Behavioral Health Managed Care Organization (BH-MCO) has its own process for monitoring behavioral health programs and providing quality assurance for the services in its network. Providers should have a conversation with the funding BH-MCO about its process and the different types of reviews in which the provider can expect to participate. BH-MCO reviews may have a different focus than the OMHSAS review, which examines a program’s adherence to its approved Service Description and state requirements.

UTILIZING MEDICAL ASSISTANCE AS A FUNDING SOURCE

What to Know:
In Pennsylvania, MST programs are enrolled in Medical Assistance as a Behavioral Health Rehabilitation Service (BHRS), which falls under EPSDT in the Pennsylvania State Plan. MST is not on the Medical Assistance (M.A.) Fee Schedule of Programs; as a result, it is considered a “program exception” or an “outpatient wraparound mental health service not currently included in the M.A. fee schedule,” and must adhere to Medical Assistance Bulletin 1153-95-01. MST providers must also comply with other general requirements that apply to all M.A. programs.
The MST program must follow its OMHSAS-approved service description in all respects and obtain approval from the [OMHSAS Children’s Bureau](#) before implementing any changes to the service description.

The process for becoming an M.A.-enrolled program is described above (see the subsection *Funding*, above).

**Youth M.A. eligibility:**
While the MST model has clear parameters for the population served by MST, youth whose services are paid for by M.A. must meet additional requirements:

- The youth must fit in the [target population](#) described in the provider’s OMHSAS-approved service description.
- The service must be deemed medically necessary by the payer (Fee-for-Service or the BH-MCO).
- The service must be prescribed by a licensed physician or licensed psychologist who has recently evaluated the youth.
- The service must be recommended by the youth’s Interagency Service Planning Team (ISPT), which must include not only the youth, family, and provider, but also a representative of the county MH system and BH-MCO, and representatives of all relevant child-serving systems for that youth, such as school, C&Y, and JPO. The prescribing physician or psychologist should attend whenever possible.
- The youth must have a treatment plan developed by the ISPT, with input from the youth and family.

Youth in Pennsylvania may be M.A.-eligible based on income, emotional or physical disability, or both. At times, a youth will be eligible for but is not yet enrolled with M.A. and it will take time for the youth to become enrolled. Even for youth already enrolled in M.A., it takes time to go through the authorization process. The time frame for eligibility and authorization vary depending on local dynamics and the BH-MCO process. In order for services to start immediately, providers often make arrangements for the county to pay for services until the youth becomes enrolled with M.A. and services are authorized.

**Documentation of Services:**
When billing services to [Medical Assistance](#), providers must document treatment contacts in a manner that is consistent with state regulations. This means completing documentation that is above and beyond what the MST model requires, since the model’s requirements for documentation are designed to guide clinical care rather than to meet the requirements of funders or regulatory agencies. Providers should familiarize them with the documentation requirements of OMHSAS and their BH-MCO and ensure that the forms being used meet their requirements. The following are valuable resources for information about documentation requirements:

- [Chapter 1101, General Provisions](#) in the Medical Assistance Manual in the Department of Public Welfare regulations
- [Medical Assistance Bulletin 29-02-03](#), “Documentation and Medical Record Keeping Requirements”
- [PROMISe Provider Handbook and Billing Guide](#) for Mental Health and Substance Abuse providers

Sample paperwork has been developed by OMHSAS in collaboration with MST Services, in an effort to help providers meet the requirements for M.A. billing with the most efficiency possible. This [paperwork](#)
and a training module are available on-line. (Note: In order to log into the training module, viewers must first set up a Friends of Penn State account. Please contact the EPISCner if you encounter difficulty with this process.)

Expanding or Making Changes to Services:
Once an MST program is M.A.-enrolled it is not common to make changes to the service design, since MST follows a specific treatment model. However, many providers find that they want to expand their program by adding another MST team and/or serving additional counties. Any changes, including expansions, must be reviewed and approved by the OMHSAS Children’s Bureau. See #11 of the Frequently Asked Questions About Medical Assistance for more information.

Other aspects of being an M.A. provider are addressed elsewhere in this Section (e.g., see the subsections above titled Funding and Monitoring). Providers are encouraged to read the Frequently Asked Questions About Medical Assistance available on the EPISCner web-site.

ADDRESSING COMMON BARRIERS TO IMPLEMENTATION

Below are some common barriers encountered when implementing MST. Planning for these in advance can help providers and communities avoid implementation delays or disruptions.

Funding Issues:
The specific nature of funding challenges varies from county to county but may include difficulty obtaining timely authorization and reimbursement for services, difficulty working with the County Assistance Office to get youth MA eligible, confusion or lack of information about different funding streams, and county dynamics that impact the accessibility of county funding.

It is critical that providers are proactive and collaborative when working with their counties, which will assist with learning about and access available county funding. For example, providers should talk with their counties about including MST in a county application for Special Grant funds from OCYF well before the application is due, so that the provider knows whether the county will be requesting a Special Grant and can advocate for its program’s need.

While M.A. funding is necessary to sustain MST programs in Pennsylvania, there are challenges associated with M.A. funding. (See the Funding and Utilizing Medical Assistance As A Funding Source subsections above for guidance related to M.A. funding.) When providers encounter challenges with their BH-MCO, they should attempt to resolve the issues through direct communication with the BH-MCO. Persistent problems should be brought to the attention of the OMHSAS. The EPISCner is also available to provide technical assistance.

To assist with getting youth onto M.A. and obtaining authorizations, providers should identify support staff within the agency or county staff who can help with the process. Providers should have a conversation with their counties to determine whether county funds will be available to pay for services provided to youth who are not yet M.A.-enrolled or for whom services are not deemed “medically necessary” and therefore not covered by M.A.
Unit Billing:
The requirement to bill for units of service in M.A. Fee-for-Service and certain BH-MCOs is a concern for providers and one that is uniquely affected by the MST model which explicitly recommends a case rate or weekly rate. M.A. Fee-for-Service payments are limited to direct unit billing. The majority of BH-MCOs are willing to pay for MST using an Alternative Payment Arrangement (APA), such as a weekly rate, but there are exceptions. As described in the Funding subsection above, providers should have very detailed discussions with their BH-MCO during rate negotiations to ensure that the rate to which they agree will cover their allowable expenses.

Educating Referral Sources About the MST Model:
The importance of collaborating with stakeholders and referral sources to create buy-in and support for the model cannot be underestimated. Providers must continuously engage potential referral sources to maintain a steady flow of referrals and to educate referral sources about the MST model. As staff turnover within county agencies occurs, education must begin anew. Specific areas on which referral sources often need on-going information include:

1. Appropriate referrals and the necessity of serving only youth who fit the target population for MST. In some cases, often due to the success of the MST program, providers experience pressure to accept youth who are not appropriate for the model.
2. The value of an ecologically-centered model, as opposed to the child-centered model, and the benefits of referring to MST rather than other in-home programs with which many referral sources are familiar.
3. The fact that “stacking services” on top of MST, especially when those other services are not compatible with the MST model, reduces model fidelity and compromise outcomes.
4. Encouraging probation offices to allow youth to complete MST rather than be placed, if a probation violation occurs during the course of MST but the youth has been making progress within treatment. At a minimum, providers should try to develop a clear understanding with probation about the types of offenses or probation violations that will result in placement so that all agencies involved with the youth are working from the same page.

Providers spend considerable amounts of time and energy educating and working with referral sources around these issues. The subsection above titled Involving Your Collaborative Board and Other Stakeholders includes strategies for working with stakeholders, including referral sources.

Familiarity with the Medical Assistance System and Its Requirements:
If billing Medical Assistance, which virtually every MST provider in the Commonwealth will do, you must be familiar with the requirements of the Medical Assistance system. This includes regulations pertaining to documentation, interagency teams, client rights, Child Protective Services Law, and billing, among other topics. Providers must also comply at all times with their OMHSAS-approved service description.

OMHSAS and the EPISCenter are available to provide technical assistance to providers. A list of the policies and regulations that providers are expected to know and follow is included in the Frequently Asked Questions About Medical Assistance (see #15), although the list does not claim to be exhaustive. Providers can request from the OMHSAS Children’s Bureau a copy of the survey tool that is used during site visits and outlines many of the M.A. requirements that apply to MST programs. Sample paperwork has been developed by OMHSAS in collaboration with MST Services, in an effort to meet the requirements for M.A. billing with the most efficiency possible. This paperwork and a training module are available on-line. (Note: In order to log into the training module, viewers must first set up a Friends of Penn State account. Please contact the EPISCenter if you encounter difficulty with this process.)
Administrative Demands:
MST staff are often faced with a number of administrative demands, particularly documentation requirements, from the various systems with which MST works (e.g., OMHSAS, BH-MCOs, referral sources). Each BH-MCO has its own paperwork requirements and processes, which can be difficult for providers who work with more than one BH-MCO to manage. Providers report concern about the impact of administrative demands on therapists’ clinical work.

Providers can minimize these demands by ensuring that support staff are responsible for any non-clinical activities that do not require therapist involvement. Providers can have discussions with funding sources about whether they will accept the forms developed by OMHSAS (see Familiarity with the Medical Assistance System and Its Requirements above), which could help to streamline the documentation being used across different counties and BH-MCOs.

Challenges Associated with Serving Rural Areas:
Serving rural areas means that therapists often spend large amounts of time traveling between homes, which can affect therapists’ ability to meet families’ needs as well as increase travel costs. The MST model has geographical restrictions on the area a team can serve (described under the Detailed Description of the Program subsection) and it can be difficult for teams to generate enough referrals in very rural areas. MST Services suggests increased drive times can be counteracted by reducing caseloads, which of course increases the cost of the service. If serving a rural area, this is an important factor to discuss with your local collaborative board and funding sources.

OTHER RESOURCES FOR PROGRAM INFORMATION

- [www.mstservices.com](http://www.mstservices.com) – The web-site for MST Services includes a wealth of information about the treatment model, implementation process, effectiveness of MST, cost-benefit for information, training, and the history of MST Services. The site also includes numerous resources, including but not limited to fact sheets and handouts and the MST newsletter “In The Loop.”

- [www.mstinstitute.org](http://www.mstinstitute.org) – The web-site for the MST Institute includes information about the Institute’s purpose, the web-based data management services available from the Institute, the MST Quality Assurance program, and contact information.

- [http://www.mstpsb.com](http://www.mstpsb.com) – The web-site for MST Associates, the organization that supports the dissemination of the adaptation of MST for youth with problematic sexual behaviors. The site includes a brief description of the adaptation and research outcomes.

- [http://academicdepartments.musc.edu/psychiatry/research/fsrc/abt_fsfc.htm](http://academicdepartments.musc.edu/psychiatry/research/fsrc/abt_fsfc.htm) - The home page for the Family Services Resource Center at the Medical University of South Carolina, where MST was developed, includes an overview of MST and a list of FSRC’s publications.
CITATIONS


52 Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs. (1995). *Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance*


*MST Services updated its web-site during the summer of 2010. As a result, a limited number of documents are no longer available on-line.

**APPENDICES**

A – Matrix Overview of Evidence-based Recognition Criteria

B – Chart of PCCD Selected Evidence-based Programs and Contacts

C – Chart of National Recognitions

D – Risk Factor Matrix

E – Social Development Strategy

F – Chart of Developer Certification Contacts

G – Sustainability Resources

H – Fundraising and Sponsorship Resources-Development 101

I – Fundraising and Sponsorship Resources -501 C(3)

J – MST Required and Recommended Program Practices
Glossary

Adaptation
Any change or modification made to an evidence-based program that alters how the program was designed to be implemented.

Adjudication
To hear and settle a case by judicial procedure.

Attrition
A gradual decrease in number or research participants who withdraw or are removed from a research study prior to its completion.

Buffer
To insulate youth against risk factors and delay the onset of or prevent negative outcomes and problem behaviors.

Buy-in
To create an understanding and excitement for the importance of an initiative in a community before and during implementation by those who are coordinating and delivering the program and those who will be responsible for funding and sustaining the program.

Community coalition/Community collaborative
A broad-based group of people from many facets of the community, such as law enforcement, school administrators and personnel, health and human service providers, business leaders, the faith community, county agencies, and others who come together to plan and implement evidence-based programs for the community.

Community gatekeeper
A community member that is enmeshed in the local culture, such as a trusted school official, a community elder, or a minister. They can help to counter distrust and promote referrals and registrations for evidence-based programs by articulating the value and potential impact of the program for the local community.
<table>
<thead>
<tr>
<th><strong>Community norms</strong></th>
<th>The commonly accepted behaviors and beliefs of a given community.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community risk factors</strong></td>
<td>Characteristics of a community that are known to predict an increased likelihood of negative youth outcomes and problem behaviors, like substance use, delinquency, school dropout, teen pregnancy, violence, and depression and anxiety.</td>
</tr>
<tr>
<td><strong>Community-based program</strong></td>
<td>One type of evidence-based program that targets a selected community (e.g., grassroots efforts, efforts by a local civic group, or a specific population within a community).</td>
</tr>
<tr>
<td><strong>Comparison/Control Group</strong></td>
<td>A group of individuals that is not exposed to the evidence-based program under evaluation and is used to determine the effectiveness of a particular intervention. By comparing the outcomes of those individuals in the control group to those in the intervention group (who received the program), researchers can attribute more confidently any changes in the intervention group to the effects of the program.</td>
</tr>
<tr>
<td><strong>Cost analysis</strong></td>
<td>The most basic type of economic analysis. It is the systematic collection, categorization, and analysis of all the costs associated with an intervention/prevention program.</td>
</tr>
<tr>
<td><strong>Cost-benefit analysis</strong></td>
<td>An economic analysis that determines if the economic benefits associated with the implementation of an evidence-based program equal and/or exceeds the costs associated with the implementation of that program.</td>
</tr>
<tr>
<td><strong>Demonstrated effectiveness</strong></td>
<td>To show through scientifically rigorous evaluation studies that a program is having an intended or expected positive effect on the targeted outcomes.</td>
</tr>
<tr>
<td><strong>Deterrent effect</strong></td>
<td>The impact of an evidence-based program on preventing or discouraging the occurrence of problem behaviors in youth.</td>
</tr>
</tbody>
</table>
Didactic
Involving lecture and textbook instruction rather than demonstration or participatory learning.

Dissemination
Wide-scale distribution, such as proliferation of an evidence-based program in real-world service systems and communities.

Distal outcomes
Behavioral outcomes that an intervention/prevention program is designed to impact at long term follow-up.

Domain
Spheres of influence in which risk and protective factors operate and prevention activities can have an impact. Domains are usually considered to include individuals (self and peers), school, workplace, family, community, and society.

Effect
The change in an outcome that results from an evidence-based program.

Effects size
A statistical measure of the strength of relationship between two variables. An effect size is calculated to indicate the impact of a program in standard units. The larger the effect size the greater the program’s impact on youth outcomes. When evaluating programs, it is often suggested that an effect size (or d) of 0.2 is a small effect, 0.5 a moderate effect and 0.8 a large effect. The effect sizes are based on standard units derived from the mean and standard deviations. A small effect size (of say d = 0.1) does not necessarily mean an unimportant effect. Many prevention and early intervention programs demonstrate only small or moderate effects.

Effectiveness
A measure of the ability of an evidence-based program to produce a specific desired effect or result that can be qualitatively measured.

Efficacy
The impact of a program under ideal, highly controlled research conditions. Efficacy indicates the capacity for beneficial change from a given evidence-based program.

Epidemiology
The scientific study of factors that influence the health and illness of populations.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based practice</td>
<td>Utilizing researched <strong>outcomes</strong> to guide the selection and <strong>implementation</strong> of <strong>evidence-based programs</strong> with an emphasis on impacting change through programs and policies that have strong scientific validation that they are effective, efficacious, and cost-effective.</td>
</tr>
<tr>
<td>Evidence-based program</td>
<td>A program that meets certain rigorous criteria including <strong>effectiveness</strong> demonstrated in scientific evaluations through <strong>randomized controlled trials</strong> or quasi-experimental design; large longitudinal studies or multiple <strong>replications</strong> (results that demonstrate the <strong>generalizability</strong> to diverse populations); and significant and sustained <strong>effects</strong> on targeted <strong>outcomes</strong>. The effects have to be large enough to reasonably expect that the program could result in changes at the population level. In addition, results must be sustained beyond immediate post-intervention in order to change <strong>outcomes</strong> long-term.</td>
</tr>
<tr>
<td>Experimental design</td>
<td>A type of evaluation research design in which participants are randomly assigned to either receive the intervention program or not.</td>
</tr>
<tr>
<td>Family risk factors</td>
<td>Characteristics of a family that are known to predict increased likelihood of negative <strong>outcomes</strong> and problem behaviors, such as substance use, delinquency, school dropout, teen pregnancy, violence, and depression and anxiety.</td>
</tr>
<tr>
<td>Fee for service</td>
<td>The amount of money charged to participate in an <strong>evidence-based program</strong>.</td>
</tr>
<tr>
<td>Fidelity/Model Adherence</td>
<td>The degree to which an <strong>evidence-based program</strong> is delivered as designed by the developer.</td>
</tr>
<tr>
<td>Generalizability</td>
<td>The ability to use an <strong>evidence-based program</strong> in a real world setting. The degree to which the program achieves similar <strong>outcomes</strong> across diverse settings and populations”.</td>
</tr>
<tr>
<td>Iatrogenic effect</td>
<td>A potentially negative or adverse <strong>effect</strong> caused by an <strong>evidence-based program</strong>.</td>
</tr>
<tr>
<td><strong>Implementation</strong></td>
<td>Execution of an evidence-based program using the design and curriculum materials created by the developer. Delivery as intended by the developer increases the likelihood of the program’s impact.</td>
</tr>
<tr>
<td><strong>Individual/Peer Risk factors</strong></td>
<td>Characteristics of an individual or peer that are known to predict increased likelihood of negative outcomes or problem behaviors, such as substance use, delinquency, school dropout, teen pregnancy, violence and depression and anxiety.</td>
</tr>
<tr>
<td><strong>Initiation</strong></td>
<td>The time at which a youth begins a negative behavior such as alcohol or drug use.</td>
</tr>
<tr>
<td><strong>Logic model</strong></td>
<td>A logic model is a way to visually represent the underlying rationale for the proven behavioral changes of an evidence-based program. A logic model explains the theory of change or how and why a proven program will work.</td>
</tr>
<tr>
<td><strong>Longitudinal study</strong></td>
<td>The study of a group of individuals at regular intervals over a relatively long period of time.</td>
</tr>
<tr>
<td><strong>Mediating factors</strong></td>
<td>The mechanisms that help explain an observed relationship between an independent variable (predictor) and a dependent variable (outcome). In the case of mediation, the independent variable causes the mediator variable, which in turn causes the dependent variable. For instance, in the context of prevention, an evaluation study may show that a drug prevention program (predictor) has a positive impact on youth binge drinking (outcome). One mechanism which may help explain this relationship is improved drug resistance skills. In other words, the prevention program improves their ability to resist drug offers which in turns leads to reductions in binge drinking. Evaluation research studies that help identify mediating factors for specific programs help us understand not only if a program works but how it works.</td>
</tr>
<tr>
<td><strong>Medical Assistance</strong></td>
<td>The government entity that purchases services through contracts with managed-care organizations and under an</td>
</tr>
</tbody>
</table>
indemnity, or traditional, fee-for-service system. A medical provider is required to enroll in the program and must meet applicable national, federal and state licensing and credential requirements.

**Model Adherence/Fidelity**

The degree to which an evidence-based program is delivered as designed by the developer.

**Needs assessment**

A systematic process to acquire an accurate, thorough picture of a system or community’s strengths and weaknesses, in order to improve it and meet existing and future challenges.

**Normlessness**

A state in which there are no established norms or values on which people can base moral action or choices.

**Outcome measure**

Assessed targets aimed at demonstrating the effect or results of services provided to a defined population through a prevention program. Outcomes measures can include assessments of changes in targeted knowledge, attitudes, skills, and behaviors.

**Outcomes**

The results of a particular evidence-based program. Typically this includes changes in targeted knowledge, attitudes, skills, behaviors, or conditions that occur between the start of a program and subsequent points of measurement. Depending on the nature of the evidence-based program and the theory of change guiding it, changes can occur during the program’s implementation, immediately following the program’s completion, and/or several months or years following the program’s completion.

**Performance measure**

An established number (magnitude/how much) and unit of measure (what) associated with a goal or objective (the target) that assures accountability of state grant funds and provides information about a program’s impact and implementation quality. Performance measures can be represented by single dimensional units like hours, meters, nanoseconds, dollars, number of reports, number of errors, or length of time, etc.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process measure</td>
<td>Process measures describe inputs to the delivery of an intervention/prevention program. They do not measure outcomes, but rather factors related to implementation of an evidence-based program, such as dosage, and staffing.</td>
</tr>
<tr>
<td>Program champion</td>
<td>A person in the community who embraces evidence-based programming and communicates the importance and need for it in their community.</td>
</tr>
<tr>
<td>Program drift</td>
<td>Straying away from the mission, goals, or model adherence of an organization or a program.</td>
</tr>
<tr>
<td>Protective factor</td>
<td>A characteristic of an individual, family, peer-group, school, or community that reduces the impact of risk factors on negative outcomes and is associated with lowering the likelihood of problem behaviors. Protective factors exert a positive influence or buffer against the negative influence of risk, thus reducing the likelihood that adolescents will engage in problem behaviors.</td>
</tr>
<tr>
<td>Proximal outcomes</td>
<td>The results of a particular evidence-based program that occur immediately following the program’s completion.</td>
</tr>
<tr>
<td>Qualitative data</td>
<td>Information gathered in the context of a research study or program evaluation that is descriptive but not quantified for statistical analysis, such as participant testimonials.</td>
</tr>
<tr>
<td>Quantitative data</td>
<td>Information gathered in the context of a research study or program evaluation that is quantified using numbers and frequencies for statistical analysis.</td>
</tr>
<tr>
<td>Quasi-experimental study design</td>
<td>A type of experimental design in which subjects are not randomly assigned to experimental or control groups.</td>
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<tr>
<td>Randomized controlled trials</td>
<td>A type of experimental design in which participants (individuals, families, classrooms, schools, communities) are randomly assigned to either receive or not receive the intervention and includes observations of both groups, both prior to and after program implementation to determine a program’s impact. In theory, because the groups are randomly assigned, they should not differ in any way except that one group received the intervention and the other did not. Because this design results in</td>
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equivalent groups, it is considered the “gold standard” for determining the causal effects of a program.

**Referral source**
An agency or organization that works with a population targeted by an evidence-based program and is willing and/or able to refer their target population to the evidence-based program to receive its services.

**Replication**
The process of reproducing or duplicating the evaluation design and results of a particular program evaluation by someone other than the program’s developer (i.e., an independent researcher).

**Resilient**
The ability to recover from or adapt to adverse events, life changes, and/or life stressors despite exposure to factors that put an individual at risk for poor outcomes.

**Risk factors**
Characteristics of an individual, family, peer-group, school, or community that precedes and is associated with a higher likelihood of negative outcomes and problem behaviors.

**School risk factors**
Characteristics of a school that are known to predict increased likelihood of negative outcomes or problem behaviors, such as substance use, delinquency, school dropout, teen pregnancy, violence and depression and anxiety.

**School-based intervention**
An evidence-based program selected for and conducted within a school environment.

**Stakeholder**
A person who has a vested interest in the activities, outcomes and sustainability of an evidence-based program.

**Sustain/Sustainability**
The likelihood that a program will continue after grant funds for initial start up and implementation are no longer available.

**Target population**
The group of individuals to which a given an evidence-based program is directed.
Theory of change

A well-substantiated explanation based on past research and existing knowledge of how and why the program produces changes in the targeted outcomes.

Universal prevention programs

Evidence-based programs that address the general public or a segment of the entire population with an average probability of developing the targeted problem.

Validity

The extent to which a measure of a particular construct/concept actually measures what it purports to measure.

SOURCES USED TO CREATE THE GLOSSARY


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