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Targeted Prevention of Antisocial Behavior in Children

The Early Risers "Skills for Success" Program

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The onset of aggression and conduct problems during the early childhood years paves the way for the development of a pattern of serious antisocial behavior, including violence, substance abuse, and criminal offending during adolescence and young adulthood (Hinshaw & Lee, 2003). This developmental progression, however, is not inevitable. Indeed, the relative balance between risk and protective factors experienced along this pathway appears to determine whether these aggressive children ultimately experience deviant or healthy outcomes (Tolan, Guerra, & Kendall, 1995).

Risk factors for antisocial behavior emerge across multiple levels. Child risk factors typically pertain to individual characteristics such as difficult temperament, deficient emotional regulation, learning delays, and deficiencies or distortions in social information processing. Parental risk factors include depression, substance abuse, negative attributions, and unrealistic expectations. Familial risk factors center on economic hardship, social isolation, and marital discord. These factors become manifest in coercive

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parent–child relationships, family violence, and instability. Peer rejection, school failure, and affiliation with deviant friends are risk factors that can emerge during the middle childhood years. Social contexts characterized by depraved neighborhoods, substandard schools, and unsupervised recreational facilities can also constitute significant risk factors for children growing up in economically disadvantaged communities (see Hinshaw & Lee, 2003, for a review).

Protective factors insulate children from risks associated with the development of antisocial behavior. They promote a more normative or resilient developmental pathway related to positive developmental outcomes despite the existence of risks. Children's protective factors include academic success, positive social skills, prosocial peer relations, and positive attitudes toward school. Protective factors within a child's environment include having caregivers who employ supportive and authoritative parenting, teachers who encourage children to become connected to their school, and community institutions that provide opportunities and resources for children to develop prosocial skills and positive friendships (see Masten & Coatsworth, 1998, for a review).

The goals of early intervention and prevention programs for aggressive children who are at risk of developing antisocial behavior are to reduce the impact of risk factors and enhance the influence of protective factors. If these goals are accomplished, children are expected to develop more healthy outcomes as they mature into adolescence (Yoshikawa, 1994). Increasingly, a "developmental-ecological and multisystemic" framework has guided intervention and prevention of antisocial behavior (Bloomquist & Schnell, 2002; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Tolan et al., 1995). The goal of this framework is to modify cumulative risk over the developmental age periods and across multiple intersecting systemic domains, including child, parent and family, school, peer, and community contexts. Intervention designs informed by this approach are thus multifaceted with components for the child (e.g., academic enrichment, social competence training), parents (e.g., support, behavioral skills training), and school (e.g., classroom-wide behavioral management systems, life skills curriculum) (see Bloomquist & Schnell, 2002, for a review).

Targeted prevention incorporates both selective and indicated prevention approaches (Gordon, 1983). Selective preventive interventions focus on individuals who are not yet showing any symptoms of developing problems despite being at heightened risk. The risk ranges from imminent to lifetime based on family history, exposure to adverse life events, or living in unhealthy environments. Indicated preventive interventions are directed at high-risk individuals who already display early symptoms of developing a problem.

The most promising targeted prevention programs designed to date are for children at risk for antisocial behavior. These include the Montreal Prevention Experiment (Vitaro, Brendgen, Pagani, Tremblay, & McDuff, 1999); The Fast Track Program (Conduct Problems Prevention Research Group, 2002); the Metropolitan Area Child Study (Metropolitan Area Child Study Research Group, 2002); the Incredible Years: Parents, Teachers, and

Children Training Series (Webster-Stratton & Reid, 2003); and the First Steps to Success Program (Walker et al., 1998). Collectively, findings from controlled studies have demonstrated the beneficial effect of these programs in modifying proximal variables such as children's social skills and parents' behavior management skills. Research evaluating the impact of these programs on distal outcomes, such as reductions in the prevalence of conduct disorders, school dropout, and drug abuse in adolescence and adulthood is currently underway.

The Early Risers "Skills for Success" Program is another example of a targeted prevention program. Early Risers has been developed and evaluated by this chapter's authors.[1] The remainder of this chapter describes the organizational structure, operational structure, and program structure of the Early Risers model. Within each component, evidence-based "best practices" that inform the Early Risers Program are presented. We briefly discuss training, supervision, and fidelity procedures. We conclude this chapter with an overview of research evaluation as well as future plans for wide-scale dissemination of the Early Risers Program.

THE EARLY RISERS MODEL OF TARGETED PREVENTION

The Early Risers model is a targeted prevention program for children who screen positive for the presence of aggression in the early elementary grades, and who often live within a poverty context. Comprehensive and coordinated intervention services are delivered for 2 or 3 years to qualifying children and their families in home or community settings. Child- and family-focused intervention components, known as "CHILD" and "FAMILY," respectively, are provided (see Table 1). The overarching goals of the Early Risers Program are to enhance children's functioning in self-regulation, social, and academic developmental domains, while facilitating family functioning and parenting skills. As a result, it is hypothesized that children's social, behavioral, affective, and academic developmental competencies are enhanced (August, Anderson, & Bloomquist, 1992), and bonds between the child, parents, prosocial peers, and the school institution are strengthened (Catalano & Hawkins, 1996), thereby preventing later antisocial behavior.

Organizational Structure

The Early Risers Program is modeled after a "community systems of care" approach (Burns & Goldman, 1999), and as such, it features comprehensive and coordinated services designed to help the child and family experience a seamless array of education, training, advocacy, support, and specialized health services. Its administrative design includes a partnership of collaborators who represent community schools, community health

[1]Other colleagues who have been part of the program development and evaluation are George Realmuto, M.D., Elizabeth Eagan, Ph.D., and Joel Hektner, Ph.D. at the University of Minnesota.

Table 1. Overview of Early Risers "Skills For Success" Program Interventions Components

CHILD component
1. Summer Program—Children attend a 6- to 8-week summer program focusing on social skills, reading enrichment or tutoring, and recreation.
2 "Circles of Friends" Program—Children attend weekly groups focusing on social skills, reading enrichment or tutoring, and recreation during the school year.
3. Monitoring and Mentoring School Support Program—Each child's academic functioning and school adjustment is systematically monitored and school-based interventions are provided according to each child's level of need throughout the school year. Interventions include goal setting or attainment strategies, reading enrichment, tutoring, consultation with teachers, and facilitating involvement of parents around school issues.
FAMILY component
1. Family Skills Program—A needs-adjusted parent-focused intervention is provided during the school year to enhance parent's knowledge of child development, and parenting skills, and to improve broader family interactions.
2. Family Support Program—Each family's functioning is systematically monitored throughout the duration of the Early Risers Program, and home-based interventions are provided according to each family's level of need. Interventions include goal setting or goal attainment strategies, and assisting families in accessing community services.

Note: These intervention components are delivered over 2 or 3 years, and modified thereafter for booster follow-up services.

or social services agencies, and university-based prevention specialists. Usually one service provider assumes primary responsibility for delivering Early Risers, but community partners contribute resources (e.g., financial, office space, personnel, etc.), or coordinate in service provision. These partners are also jointly involved in ongoing oversight of the Early Risers Program.

Operational Structure

Staffing and Logistics

The program can be delivered within a variety of community sites such as faith centers, neighborhood service centers, YMCAs, and YWCAs. However, schools appear to provide the optimal milieu. Program staff is typically recruited from within the ranks of one of the collaborating community agencies or from the schools. The primary service provider for the program is the community prevention specialist, more commonly referred to as the program's "family advocate." The typical family advocate has a bachelor's degree and several years of professional experience working with children and families in education or human service settings. A full-time family advocate can serve a caseload of up to 25 children and their families. "Child assistants" (i.e., paraprofessionals) help the family advocates deliver the CHILD programs. In a large-scale implementation where more than one family advocate is employed, a program manager is necessary to coordinate program activities, provide onsite supervision of the family advocates, and maintain oversight of program fidelity. In a more recent expansion of

the program, a part-time licensed master's-level mental health professional was added to the program staff. This person is involved primarily with the FAMILY component serving as a consultant for the family advocate, or as a direct provider to those families who are experiencing more serious mental health problems. Whenever possible, consultants from various community agencies are identified to assist family advocates in locating and utilizing appropriate community resources and services for their families.

Child Screening and Recruitment Procedures

In a large-scale implementation of a targeted program, screening is necessary to efficiently identify at-risk children (August, Realmuto, Crosby, & MacDonald, 1995). Population-based screening of at-risk children is a sensitive issue as selection errors are to be expected (e.g., false-positive or false-negative errors). Problems related to labeling, stigma, and iatrogenic effects need to be given careful consideration in designing a screening devise. The Early Risers' Program employs a population-based procedure to identify children in early elementary school (e.g., K, 1st, and 2nd grades) who appear to be at elevated risk for developing antisocial behavior. Screening is typically performed by classroom teachers who are asked to complete a standardized behavior rating scale (e.g., Child Behavior Checklist–Teacher Rating Form) on all eligible students in their classes (eligibility criteria include consent to screen from parents). Children who are qualified for participation in the prevention intervention include those who receive scores on keyed aggressive and disruptive items that place them above a specified threshold. The specified threshold can vary from 10% to 30% of the student enrollment, depending on the community site of the program, perceived need of the program in the community, and available resources.

Children who qualify for participation are subsequently recruited. The family advocate conducts recruitment during a home visit. The family advocate describes the screening results and explains the goals and intended outcomes of the Early Risers Program. Parents are given a brochure that provides details on all program activities and names of staff to contact if questions arise.

Program Structure

CHILD Component

CHILD is offered continuously throughout the year. The recommended sequence begins with the 6-week Summer Program, followed by the "Circle of Friends" Program, and then the Monitoring and Mentoring School Support Program during the regular school year.

Summer Program. Research shows that over the summer months many high-risk children lose ground in academics and social skills (Cooper, Nye, Charlton, & Lindsay, 1996). Hence, a summer program provides opportunities to deliver intensive and focused programming to children who need them most.

The Early Risers Summer Program is adapted from the Pelham and Hoza (1996) summer treatment program for elementary-aged children with attention-deficit/hyperactivity disorder or oppositional defiant disorder. Children in the Pelham and Hoza program receive intensive behavioral, social, milieu, recreational, and education-focused interventions. These interventions are delivered 5 days per week over 8 weeks during the summer. Pelham and Hoza found that children who attended their summer treatment program exhibited significant improvements on ratings by parents, program counselors, teachers, and self-reports in the areas of behavior, social skill development, and improved self-esteem.

Program modifications were made to the Early Risers Summer Program from Pelham and Hoza (1996) to accommodate the slightly younger age group it serves as well as to facilitate its prevention focus. The program takes place Monday through Friday for 6–8 weeks (typically mid-June to mid-August). Previously, the Early Risers Summer Program has been conducted in both full- and half-day formats. The half-day format typically offers social skills training (1 hour), reading enrichment (1 hour), and cultural and creative arts activities (1 hour). The full-day format typically provides an additional 3-hour academic component, as well. Ten to 15 children are organized into a "track" with 2 or 3 staff (i.e., family and child assistants). In previous applications of the program, peer mentors were recruited to serve as positive role models and to provide opportunities for the at-risk children to develop friendships with prosocial children.

"Circle of Friends" Program. Each child is invited to attend the "Circle of Friends" Program during the academic year. The children attend a 90–120 minute group held one afternoon or evening per week. The group focuses on social competence training, which is augmented with reading skills enhancement, homework assistance, and recreational activities. Some children also attend a regularly scheduled after-school program offered by the school or community center on alternative weekdays. One evening per month, family members attend a parent–child activity consisting of food, recognition ceremonies, entertainment, and games.

Monitoring and Mentoring School Support Program. This program is based on an adaptation of Christenson and colleagues' "Check and Connect" model of school-based services for elementary through high-school-aged children (Christenson, Sinclair, Lehr, & Hurley, 2000). In Check and Connect, practitioners engage in systematic monitoring of each child's behavior and academic status at school, and provide advocacy, direct services, and service coordination. The overall goal is to promote coordination among the child, family, and school. In Check and Connect, all students receive "basic interventions" that include monitoring and problem solving about specific issues that emerge in the context of school. Children who are at higher risk receive "intensive services." Services include practical interventions, facilitating home–school collaboration, and assisting the child and family in accessing school-based services. Christenson et al. reported that the Check and Connect program reduced school absences and tardiness in elementary through high school populations. It also improved

children's overall school adjustment, and reduced the likelihood that they would drop out.

In Early Risers, the Monitoring and Mentoring School Support Program is delivered as a needs-adjusted intervention with monitoring of all program children and mentoring tailored to the assessed needs of each child. The monitoring component is implemented in the form of three annual monitoring assessments (fall, winter, spring) conducted in collaboration with the child's teacher. Indicators of child adjustment that are assessed over time include (1) absenteeism per month, (2) behavioral classroom management concerns, (3) academic difficulties, (4) bus incidents or behavioral referrals, and (5) level of parental involvement regarding child problems. Children are then classified into three levels of need, including Level 1 (low need), Level 2 (moderate need), and Level 3 (high need). Subsequent delivery of services corresponds to these levels of need.

Of the approximately 25 children on a family advocate caseload, all qualify for some monitoring, but typically only 5–15 children who are in greatest need require individualized mentoring services. All children enrolled in Early Risers receive the Level 1 monitoring portion of the intervention. The monitoring involves systematic collection and evaluation of pertinent school adjustment information (as discussed above). If a problem is discovered through Level 1 monitoring, children are then eligible for two levels of mentoring services. Level 2 or "basic" mentoring services are provided to children with moderate needs or problems. Level 2 services include at least biweekly visits with the child and episodic consultation with teachers as indicated. Child-centered activities include encouragement of academic achievement, contracting for improved behavior in the school, and individualized training of social skills and problem-solving skills. Level 3 or "intensive" mentoring services include child-focused academic tutoring, intensive individualized social skills training, or referrals for additional school- or community-based services. Early Risers' parents are almost always involved in some fashion with Level 3 mentoring. Often there is a need to coordinate one or more parent–teacher meetings to synchronize home and school. Parents are encouraged to attend school functions and conferences, to communicate with teachers, to assist with homework, to encourage their child's reading, and to share information with the teacher.

FAMILY Component

FAMILY is modeled in part, after the Triple P—Positive Parenting Program (Sanders, Turner, & Markie-Dadds, 2002). Triple P is a multilevel system of parent and family education and support. The Early Risers' FAMILY component includes the Family Skills Program and the Family Support Program. Both programs are organized around a predetermined level of family need. This level of need is determined by either an informal family assessment or a formal interview-based assessment. Family advocates organize available information including their observations, expressed family concerns, and results from standardized questionnaires to determine (1) the child's functioning, (2) the parents' personal functioning, and (3) whether or not

the family's basic physical and emotional needs are being fulfilled. Each family's need is designated on a continuum ranging from Level 1 (low need) to Level 2 (moderate need) to Level 3 (high need).

Family Skills Program. The Early Risers Family Skills Program provides information and specific skills training to enhance a parent's child management and personal coping skills, and broader family interactions. To accomplish this, the interventions utilized in the Family Skills Program include (1) training parents in child management procedures, (2) facilitating the parent–child relationship through play and bonding strategies, (3) teaching personal coping strategies, and (4) improving familial interaction skills. In Early Risers, the Family Skills Program is offered according to the levels of need described earlier. Levels 1, 2, and 3 provide increasingly intensive services.

All parents in the Early Risers Program are offered Level 1 programming. Participating families receive one to two, 60–90-minute sessions delivered in the home. Sessions focus on global parenting and normal child development. Families receive information about normal stages of child development addressing social, emotional, and academic domains, and associated parenting challenges. During the initial in-home session(s), parents are invited to a "Parents Excited About Kids (PEAK)" parent group. The PEAK group is offered at the school or community center. This program is information-oriented and delivered over eight, 90–120-minute sessions. Four of these sessions are based on the Triple P "Tips Sheets" concept (Sanders et al., 2002). The tip sheets give parents ideas to manage common child problems such as self-esteem, homework, behavior at school, chores, bedtime, tantrums, and so on. The final four sessions is based on parent-generated topics that can be delivered by the family advocate with the assistance of outside speakers. If parents are unable or unwilling to attend the PEAK group, an attempt is made to deliver an abbreviated version of this intervention during the in-home Family Support Program visits (described in the next section).

The program manager or mental health professional delivers Level 2 groups known as PEAK-2. This intervention typically involves approximately 15–25% of the families. Parents are encouraged to attend the PEAK-1 group prior to participating in the PEAK-2 group. Parents are invited to attend the PEAK-2 groups if their child is displaying moderate-to-severe behavior problems and the family is judged to be functional. PEAK-2 consists of eight, 60-minute sessions and focuses on behavioral strategies targeting specific problematic behaviors (e.g., aggression, oppositional behavior, and stealing). Topics or areas of focus are selected from a menu to meet the apparent unique needs of the attending families in a particular group. The areas of focus might include promoting children's social and educational development, observing and tracking child behavior, child-directed interaction and play, shaping positive behavior, ignoring mild negative behavior, defusing power struggles, deescalating parent–child conflict, time out or removal of privileges for noncompliance, standing or house rules, and monitoring or supervising children. Again, if parents do not attend the PEAK-2 group, elements of it are offered during Family Support Program home visits.

Level 3 is an in-home intervention delivered by a mental health professional. The focus is on severe child, parent, or family problems. Approximately 5–10% of families need this level of service. Ideally parents or families are referred to this service after they have completed Level 1 and Level 2 interventions. Level 3 is an individually tailored intervention of about eight to twelve, 60-minute sessions. The focus is on behavioral strategies to change targeted child behavior (e.g., aggression, defiance, and stealing), and also on parent or family problems (e.g., parent depression, stress, and relationship problems). Areas of focus are individualized for each family. They might include some child-focused strategies provided in Level 2, as well as use of a token system, specific interventions for stealing, parent stress management, cognitive restructuring of parent thoughts, or family-wide interaction skills such as problem solving, communication, and conflict resolution. In addition, referrals to other more intensive community-based services are also part of this intervention.

The Family Skills Program is provided over 2 years. The first year calls for delivery of the sessions as described above. Year 2 is basically for maintenance and reinforcement of previously learned skills. This takes place as family advocates interact with the families during in-home Family Support Program meetings. During the second year, the PEAK-1 and PEAK-2 groups described for year 1 can also be offered to families who did not previously participate or who may have changed levels over the year. If a third year of family skills programming is offered, it tends to be more informal, activity-based, and centered around topics and activities that are of specific interest to the children and families. The goal of the third year is to maintain previous gains by providing periodic contact with the family members.

Family Support Program. Our approach to family support is modeled after the Family-Centered Intensive Case Management program (Evans, Armstrong, & Kuppinger, 1996). In this program, case managers assess the needs of each family, develop a service plan for each family, link each family to needed services, coordinate meetings between the family and service providers, and monitor each family's ongoing needs and outcomes. Essentially, the case manager provides direct interventions, assists families in developing informal support systems, and functions as an advocate for the family within the community and at school. Evans et al. found that Family-Centered Intensive Case Management resulted in improvements in child and family functioning for children aged 5–12 years who had a wide range of adjustment problems.

Similarly, the Early Risers Family Support Program is a tailored case management-anchored delivery system, composed of three key elements. These core elements include (1) determining a family's level of need by assessing family functioning (discussed earlier), (2) setting strategic goals to achieve family, parent, and child stability, and (3) linking families to community resources and services in order to assist them in meeting the goals for their child or family. Family support services are delivered primarily within the context of a home visitation model. Thus, family advocates typically drive to the home of the family for face-to-face visits or contacts. If needed, however, the family support interventions can be delivered in

a community center, a local restaurant, a child's school, or some other agreed-upon location. Families are assigned a set number of visits or contacts determined by their level of need. They are prescribed a minimum of 4, 6, and 12 visits at Levels 1, 2, and 3, respectively. The exact number of contacts can be adjusted if necessary. The success of the Family Support Program is dependent upon the quality of the relationship between the family advocate and the family, and the ability of the family advocate to assist the family in accessing the community resources it needs.

Of the approximately 25 families on a family advocate caseload, typically only 5–10 families require high-level services at any one point in time. Family advocates work with family members to set and achieve personal and child-centered goals. Progress toward achieving goals is determined via a goal attainment scaling methodology. A menu of brief interventions and service options are made available to the family. These include assisting families in advocating for their child at school, accessing community-based therapeutic services, accessing social or human services, and other such options.

Training, Supervision, and Fidelity

The Early Risers training, supervision, and fidelity protocol is guided by the Multisystemic Therapy Program example (Henggeler et al., 1998). Training for all staff is conducted by university prevention specialists in a standardized fashion. Each staff member is given a detailed Early Risers Program Manual that describes all intervention components and provides many useful forms to assist with screening, recruitment, intervention provision, documentation, and fidelity monitoring. The initial Early Risers training protocol involves a 4-day training seminar. All staff is required to demonstrate mastery over all aspects of service delivery and be "checked out" by training staff before completing training. Thereafter, training staff remains available to intervention staff for ongoing consultation on an as-needed basis.

The program manager provides ongoing supervision of intervention staff in a group format. This format allows opportunities for family advocates to collaborate on program issues, permits staff to brainstorm resolutions to problems or access resources, and furnishes ample opportunities for role play, modeling, and rehearsal. Periodic individual supervision with each family advocate helps provide feedback and correction of intervention sessions and also serves as an opportunity to review case management notes. The program manager and community consultant assist the family advocates in determining the level of child and family need, intervention planning, family goal setting, action plans, intervention options, and assist family advocates in locating resources.

The fidelity of program delivery is monitored throughout. Information is systematically collected and reviewed by the university prevention specialist and the program manager. This includes examination of child and parent attendance, documentation of services provided, direct observation

of intervention provision, and consumer satisfaction data. Adjustments in programming, staffing, and training are made based on fidelity monitoring.

TRANSFERRING EARLY RISERS FROM RESEARCH TO PRACTICE

Early Risers was developed with the ultimate goal of utilization in "real world" practice settings. Efficacy and small-scale effectiveness studies were conducted prior to exporting it to broader practice settings. First, an Early Risers' efficacy study was conducted in schools located in four semirural communities in Minnesota. Across these communities, 20 elementary schools were matched for relevant SES variables and randomly assigned to program or control conditions. Kindergarten children in the 20 schools were screened by their classroom teachers for aggressive behavior. Those who met high-risk criteria were enrolled in the study (124 program, 121 control). The prevention trial began in the summer following the kindergarten year and ran continuously for 5 years. Three of the 5 years included intensive intervention, followed by 2 years of "booster" intervention at which time participants had completed the fifth grade. An evaluation conducted following the first 2 years of intervention indicated that program children made significantly greater gains in academic achievement and classroom behaviors than the controls. Only the most severely aggressive children, however, showed reductions in behavioral problems (e.g., aggression, hyperactivity, and impulsivity) (August, Realmuto, Hektner, & Bloomquist, 2001). These effects were maintained following a third program year and complemented by gains in social skills and adaptability (August, Hektner, Egan, Realmuto, & Bloomquist, 2002). At a 4-year evaluation, evidence for generalization of program effects via peer assessments in the natural school setting was found. Relative to controls, program children were viewed by their peers as higher in leadership and social etiquette, and they chose friends who were lower in aggression (August, Egan, Realmuto, & Hektner, 2003).

With validation of the program established, the next step was to transport the program to a community setting and determine if program effects could be sustained when delivered by community practitioners in a natural practice setting. The Early Risers effectiveness study was conducted in an urban, economically disadvantaged community with mostly African American families. Pillsbury United Communities in Minneapolis was the primary service delivery agency adopting the program. Pillsbury United Communities is a nonprofit agency that offers a network of neighborhood family centers strategically located in high-risk neighborhoods throughout the city. The overall strategy of this effectiveness trial was to provide a program support infrastructure to the agency (e.g., manuals, preprogram training, ongoing supervision and technical assistance, and regular monitoring of intervention fidelity with feedback and correction). However, the host agency was allowed to make program implementation adaptations

in response to constraints faced by the agency. Kindergarten and 1st-grade children enrolled in 10 Minneapolis public schools were screened for aggressive behavior, randomized into program and control conditions, and recruited for the study. The program was implemented over a 2-year period. It included a baseline assessment followed by annual evaluations thereafter. In comparison to the efficacy study, low rates of client participation plagued this effectiveness study. Only half of the child participants attended at least half of the child sessions. Despite these problems, outcome analyses showed program-related benefits. Similar to the results of the efficacy study, the children who participated in the Early Risers Program made significant gains in social competence and school adjustment with only the most severely aggressive children showing reductions in externalizing behavior problems (August, Lee, Bloomquist, Realmuto, & Hektner, 2003). Academic achievement gains found in the efficacy study were not replicated in the effectiveness research.

The next step is to turn the program completely over to community provider systems and determine whether the program can be successfully implemented with minimum program support services provided by the program developers. A pilot practice initiative is currently under way in Hennepin County, Minnesota. In this effort, the same intervention components and administrative units as the Early Risers effectiveness study are being utilized. The Hennepin County Children, Families, and Adult Services Department will provide contractual oversight of the program and pay for the standardized CHILD—Summer, CHILD—Circle of Friends, and FAMILY—Family Skills Programs by unit of service delivered. Medical Assistance Targeted Child Welfare Case Management will be billed by unit of service delivered for the case management-orientated CHILD—Monitoring and Mentoring School Support and FAMILY—Family Support Programs. Maximum effort will be expended to improve attendance of participants in the program by emphasizing school-based and in-home delivery practices. A program evaluation study is planned to determine the level of engagement (feasibility) and pre-to–post-changes (impact).

SUMMARY

In this chapter we presented a comprehensive preventive intervention, the Early Risers "Skills for Success" Program. Early Risers is an example of a targeted prevention intervention designed to alter the developmental pathway leading to antisocial behavior in at-risk children as indexed by the presence of early-onset aggressive behavior. The CHILD and FAMILY components have been designed to reduce risk factors and promote protective factors over time across child, family, peer group, school and community systems. Randomized controlled studies provided evidence for the program's positive effect on child's proximal outcome variables such as reduced aggressive behavior and enhanced social skills. There is also evidence that the Early Risers Program can be successfully implemented by community practitioners in community settings. The Early Risers

Program's effectiveness in preventing the onset and continuation of antisocial behavior as these high-risk children enter adolescence will be determined through ongoing longitudinal research.

REFERENCES

August, G. J., Anderson, D., & Bloomquist, M. L. (1992). Competence enhancement training for children: An integrated child, parent, and school approach. In S. Christenson & J. C. Conoley (Eds.), *Home-school collaboration: Enhancing children's academic and social competence* (pp. 175–213). Silver Springs, MD: National Association of School Psychologists.

August, G. J., Egan, B. A., Realmuto, G. R., & Hektner, J. M. (2003). Parceling component effects of a comprehensive prevention program for disruptive elementary school children: Testing predictors of participation and outcome across individual intervention components. *Journal of Abnormal Child Psychology, 31,* 515–527.

August, G. J., Hektner, J. M., Egan, B. A., Realmuto, G. M., & Bloomquist. M. L. (2002). The Early Risers longitudinal prevention trial: Examination of 3-year outcomes in aggressive children with intent-to-treat and as-intended analyses. *Psychology of Addictive Behaviors 16*, (Suppl. 4), 27–39.

August, G. J., Lee, S. S., Bloomquist, M. L., Realmuto, G. M., & Hektner, J. M. (2003). Dissemination of an evidence-based prevention innovation for aggressive children living in culturally diverse, urban neighborhoods: The Early Risers effectiveness study. *Prevention Science, 4*, 271–286.

August, G. J., Realmuto, G. M., Crosby, R. D., & MacDonald, A. W., III (1995). Community-based multiple-gate screening of children at risk for conduct disorder. *Journal of Abnormal Child Psychology, 23*, 521–543.

August, G. J., Realmuto, G. M., Hektner, J. M., & Bloomquist, M. L. (2001). An integrated components preventive intervention for aggressive elementary school children: The "Early Risers" program. *Journal of Consulting and Clinical Psychology, 69*, 614–626.

Bloomquist, M. L., & Schnell, S. V. (2002). *Helping children with aggression and conduct problems: Best practices for intervention.* New York: Guilford.

Burns, B. J., & Goldman, S. K. (Eds.). (1999). *Systems of care: Promising practices in Children's Mental Health, 1998 Series, Volume IV: Promising practices in wraparound for children with serious emotional disturbance and their families.* Washington, DC: Center for Effective Collaboration and Practice, American Institute for Research.

Catalano, R. R., & Hawkins, J. D. (1996). The social development model: A theory of antisocial behavior. In J. D. Hawkins (Ed.), *Delinquency and crime: Current theories.* New York: Springer-Verlag.

Christenson, S. L., Sinclair, M. F., Lehr, C. A., & Hurley, C. M. (2000). Promoting successful school completion. In D. Minke & G. Bear (Eds.), *Preventing school problems-promoting school success: Strategies and programs that work* (pp. 224–240). Bethesda, MD: National Association of School Psychologists.

Conduct Problems Prevention Research Group. (2002). Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems. *Journal of Abnormal Child Psychology, 30*, 19–35.

Cooper, H., Nye, B., Charlton, K., & Lindsay, J. (1996). The effects of summer vacation on achievement test scores: A narrative and meta-analytic review. *Review of Educational Research, 66*, 227–268.

Evans, M. E., Armstrong, M .I., & Kuppinger, A. D. (1996). Family-Centered Intensive Case Management: A step toward understanding individualized care. *Journal of Child and Family Studies, 5*, 55–65.

Gordon, R. S. (1983). An operational classification of disease prevention. *Public Health Reports, 98*, 107–109.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York: Guilford Press.

Hinshaw, S. P., & Lee, S. S. (2003). Conduct and oppositional defiant disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (2nd ed., pp. 144–198). New York: Guilford.

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist, 53*, 205–220.

Metropolitan Area Child Study Research Group. (2002). A cognitive-ecological approach to preventing aggression in urban settings: Initial outcomes for high-risk children. *Journal of Consulting and Clinical Psychology, 70*, 179–194.

Pelham, W., & Hoza, B. (1996). Intensive treatment: Summer treatment program for children with ADHD. In E. D. Hibbs & P. S. Jenson (Eds.), *Psychosocial treatment for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 311–340). Washington, DC: American Psychological Association.

Sanders, M. R., Turner, K. M. T., & Markie-Dadds, C. (2002). The development and dissemination of the Triple P-Positive Parenting Program: A multilevel, evidence-based system of parenting and family support. *Prevention Science, 3*, 173–189.

Tolan, P. H., Guerra, N. G., & Kendall, P. (1995). A developmental-ecological perspective on antisocial behavior in children and adolescents. *Journal of Consulting and Clinical Psychology, 63*, 579–584.

Vitaro, F., Brendgen, M., Pagani, L., Tremblay, R. E., & McDuff, P. (1999). Disruptive behavior, peer association, and conduct disorder: Testing the developmental links through early intervention. *Development and Psychopathology, 11*, 287–304.

Walker, H. M., Kavanagh, K., Stiller, B., Golly, A., Severson, H. H., & Feil, E. G. (1998). First step to success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders, 6*, 66–80.

Webster-Stratton, C., & Reid, M. J. (2003). The incredible years parents, teachers, and children training series: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents*. (pp. 224–240). New York: Guilford.

Yoshikawa, H. (1994). Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin, 115*, 28–54.