FAMILIES, YOUTH AND DELINQUENCY: THE STATE OF KNOWLEDGE, AND FAMILY-BASED JUVENILE DELINQUENCY PREVENTION PROGRAMS

Julie Savignac

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Summary

The family, as a learning, discovery and socialization environment, is a key protective factor in the development of children and adolescents. When dysfunctional, it is also regarded as a risk factor for juvenile delinquency.

To better address the relationship between the family, risk factors, protective factors, juvenile delinquency and intervention with vulnerable families, this paper is divided into two main parts.

The first part surveys knowledge about risk and protective factors associated with families. A detailed analysis of risk factors has identified three categories of risk factors in the family environment:

a) risk factors related to family dynamics and functioning (considered proximal risk factors),

b) risk factors related to family characteristics, and

c) risk factors related to the neighbourhood or area where families live.

With regard to protective factors, current knowledge is relatively limited, but documentary research has identified the main protective factors which are related to the family environment. The first part also contains a statistical portrait of Canadian families affected by specific risk factors, and concludes with a brief survey of the situation in Aboriginal communities.

The second part of the paper describes programs that aim to prevent and reduce juvenile delinquency in the family environment. Analysis has shown that three intervention methods are particularly effective with families:

i) parental training,

ii) family therapy, and

iii) the integrated approach.

Based on research reports, longitudinal studies and evaluation summaries, this research is intended as an initial step in extending scientific knowledge of what are called “vulnerable families” or “at-risk families,” and in making better use of knowledge in order to work more effectively with them.

CHAPTER 1

Survey of Knowledge of Risk Factors and Protective Factors Associated With Families

It is generally accepted that the risk of developing a life trajectory oriented towards delinquency is influenced by the number of risk factors to which a youth is exposed.[1] By the same token, it may be suggested that as a youth is surrounded by protective factors, the risks of an orientation towards delinquency are diminished.

Risk Factors

Very briefly, risk factors may be described as characteristics or variables that, when present, make certain individuals more likely than others to adopt behaviours that can cause them harm.[2]

The risk factors related to delinquency are multidimensional in the sense that they are manifested in more than one aspects of the day-to-day lives of individuals. The typology generally accepted by researchers accordingly classifies risk factors on the following basis: individual characteristics, family, school, peers and the community.[3]

It is also accepted that the effects of risk factors vary with age.[4] For example, in childhood the risk factors that have more of an impact are those that exist within the family; as children grow and become more integrated into their environment, risk factors related to peers, school, neighbourhood and community play a more important part.[5] Risk factors related to individual characteristics, such as hyperactivity, anxiety and aggressiveness must be taken into consideration at all ages.

Moreover, it must be remembered that delinquent behaviour is acquired over time in conditions that overlap and in situations presenting multiple problems. The interaction and accumulation of risk factors increase the likelihood of acting out,[6] not only because the effect of risk factors is cumulative, but also because they interact: the effects of one multiply the effects of another, and so on. For example, parental alcohol abuse may generate family conflict, which in turn may increase the risk of problems related to substance abuse.

According to a study by the Social Exclusion Task Force (London), at age 14, the more family risk factors a youth displays, the more likely he or she is to be expelled from school, to be taken in by youth protection services, or to come into contact with the police; the relationship is particularly pronounced in the case of the expulsion from school of youth who present five or more family risk factors.[7]

With regard to risk factors associated with the family environment, a detailed analysis enables us to distinguish between three subcategories:

- risk factors associated with family dynamic and functioning,
- risk factors associated with family characteristics; and
- risk factors associated with area of residence.

TABLE 1—JUVENILE DELINQUENCY RISK FACTORS ASSOCIATED WITH THE FAMILY ACCORDING TO AGE OF CHILDREN AND ADOLESCENTS[8]

Cumulative and interactive effects of risk factors

Cumulative and interactive effects of risk factors

	6-12 YEARS	13-17 YEARS	18 AND OLDER
Family Dynamic and Functioning	• Poor parental practices • Parental and/or siblings criminality • Anti-social parents with attitudes that support violence • Family conflicts • Parents with substance abuse problems • Physical abuse and neglect • Family violence		• Poor parental practices • Parental and/or siblings criminality • Family violence • History of poor treatment
Family Characteristics	• Unstable family income • Broken home • Family mobility • Mental health of parents • Young mother • Number of children in the family • Single parent family • Parental past	• Unstable family income • Broken home • Family mobility	• Unstable family income
Area of Residence	• Poor area • Presence of young offenders	• Poor area • Crime in the area • Presence of youth gangs • Availability of drugs and firearms	• Poverty • Crime • Youth gangs • Drugs and firearms

Risk Factors Associated With Family Dynamic and Functioning

Current scientific knowledge suggests that risk factors related to family dynamics and functioning are closely associated with delinquency.[9]

Ineffective Parental Behaviour

Bad parenting practices, such as a lack of supervision, over-permissiveness, inconsistent or overly strict discipline, a weak bond of affection and the inability to set clear limits, represent significant risk factors for delinquency,[10] drug use,[11] poor academic performance,[12] and membership in youth gangs.[13]

According to researchers, parental supervision and control[14] play a key role in the adoption of delinquent behaviour.[15] As LeBlanc points out, "supervision is the key variable that catalyses the effect of all the other characteristics of family functioning".[16]

The longitudinal Edinburgh Study of Youth Transitions and Crime (ESYTC) identifies seven characteristics of parental conduct and family functioning associated with delinquency in 15 year-olds. The most important are parental supervision, the young person's willingness to communicate with the parents, parent consistency, parent-child conflict and excessive punishment.[17] The results of the study showed that ineffective parenting at age 13 is an important predictor of delinquency at age 15.[18]

Parental Criminality

Parental criminality is a powerful risk factor for delinquency, according to various studies.[19]

The Pittsburgh and Cambridge longitudinal studies show that the criminality of the father, mother, brother or sister is a good predictor of delinquency in boys. The most important factor remains the criminality of the father: 63% of boys with a father involved in criminal activity are at risk themselves of being involved in such activity, compared to 30% of other boys.[20]

Having older siblings involved in crime is also a risk factor for delinquency; this relationship is less important when the siblings are younger.

According to work by Farrington (2002), 8% of families are responsible for 43% of crime. Similar results were obtained in a study by Roché of juvenile delinquency among 13 to 19 year-olds in France: 5% of families were responsible for 50% of minor offences, 86% of serious offences and 95% of trafficking.[21]

Mistreatment During Childhood and Family Violence

A number of studies have confirmed that very early exposure to physical and psychological violence is a strong predictor of physical violence towards the victim, particularly of subsequent violence against the victim's own partner or children.[22]

Witnessing violence in the home is an important risk factor for aggressiveness and delinquency in young people. According to the results of National Longitudinal Survey of Children and Youth (NLSCY), children aged 6 to 11 who have witnessed violence in the home were twice (2.2 times) as likely to behave aggressively as children who had never witnessed violence.[23]

Mistreatment during childhood is also a risk factor for various problem behaviours. Studies comparing adolescents mistreated in childhood with those who were not, show that more of the former exhibit behavioural problems[24] (running away, dropping out of school, early pregnancy), substance abuse problems,[25] carry weapons, exhibit delinquent behaviour, place themselves in intimidating situations[26] and join gangs.[27]

Other studies have also shown that violence experienced at an early age is a factor associated with running away and early departure from the family home, which strongly increases an adolescent's risk of becoming the victim or the perpetrator of various forms of delinquency related to homelessness.[28]

Parental Substance Abuse[29]

The Edinburgh Study of Youth Transitions and Crime (ESYTC) showed that among 15 year-olds, having a parent who uses drugs doubled the risk that they will do so too. On the other hand, young people whose parents drink to excess (21 units a week) are no more likely than other young people to become daily drinkers.[30]

According to the results of the National Longitudinal Survey of Children and Youth (NLSCY), peer influence is a stronger risk factor than parental drinking for consumption of alcohol by adolescents.[31]

Risk Factors Associated With Family Characteristics

In our understanding of the links between the family and juvenile delinquency, these risk factors must be interpreted with caution: their negative effects are sometimes derived from other factors present in the family environment, and sometimes from a combination of several risk factors. Taken in isolation, they are less obviously linked to juvenile delinquency than risk factors related to family dynamic and functioning.[32]

One of the most eloquent examples of the special nature of these risk factors is the discussions around the effects of single parenthood in the manifestation of delinquent behaviour in youth. Single parenthood is considered a risk factor because this family structure is often associated with a lack of supervision, a lack of free time spent with the children, financial vulnerability, a poorer neighbourhood, and so on. In fact, because single parenthood can easily lead to financial insecurity and thus to a situation that is difficult and stressful for families, it represents a family characteristic associated with risks for juvenile delinquency.[33]

Wells and Rankin (1991) found that the connection between broken families and juvenile delinquency is variable, depending on the situation: it is weak or non-existent with regard to serious offences (theft, violent behaviour), somewhat stronger with regard to drug use (particularly soft), and significant with regard to "problem behaviours," such as running away, truancy and classroom discipline problems.[34]

The results of the Cambridge study of juvenile delinquent trajectories showed that while boys from broken families are more delinquent than boys from intact families, they are not more delinquent than boys from intact but conflicted families.[35]

Farrington (1995; 2006) suggested that the circumstances in which the family breakdown occur and the post-separation effects are the most important factors to consider when assessing the risk for juvenile delinquency.

Generally, boys who stayed with their mother after a separation had the same rate of delinquency as boys from intact families with a low incidence of conflict, whereas boys who stayed with their father or other relatives had higher rates of delinquency.[36]

With respect to family transitions,[37] the results of the Rochester study showed clear and statistically significant connections between the number of family transitions, the prevalence of delinquency and drug use. Whereas 64.1% of youth who had never experienced family transition showed signs of delinquency, the rate peaked at 90% for youth who had experienced five family transitions or more. After adjusting for gender, poverty and parental supervision, researchers concluded that a large number of family transitions is significantly linked to higher delinquency and drug use rates.[38]

Risk Factors Associated With Area of Residence

Generally, living in a poorer neighbourhood doubles the risk of delinquency.[39]

A number of risk factors must be considered in relation to the area of residence: the presence of youth gangs and young offenders, the availability of drugs and firearms, neighbourhood crime rates,[40] poor neighbourhood integration, a high level of disorganization, scarce availability of resources and services, and local poverty.

Sampson (1997) proposed a framework for analysis based on social capital and neighbourhood characteristics: the "social capital/collective efficacy model." According to this model, parental practices are influenced by the social context in which families live. Very poor neighbourhoods characterized by family breakdown and a high rate of residential mobility tended to weaken social networks and exacerbate ineffective parental practices.[41]

Similarly, Smith (2004) noted that family functioning is influenced by the surrounding social context. Parents living in a poor neighbourhood and who have few resources have more difficulty in steering their children clear of deviant and at-risk behaviour.

Thus, young children living in a poor neighbourhood and growing up in a family where parental supervision is deficient are at risk of developing delinquent behaviour in adolescence.[42]

The Situation in Canada: A Statistical Portrait of Risk Factors Associated With Family Dynamic and Functioning

Family Violence and Witnessing Violence in the Home

- In 2005, nearly 4 children and youths[43] out of 10 (37%) who were victims of family violence suffered physical injury. Boys were more likely than girls to be injured (44% compared to 33%).[44]
- In 2005, the representation of young parents was disproportionately high among alleged killers of their own children. While parents aged 15 to 24 constituted only 2% of all parents, they were responsible for 60% of homicides involving babies, and 14% of homicides involving children and youths.[45]
- In 2005, according to Homicide Survey, 60 homicides were committed against children and youths under 18; more than a third of these were committed by a family member.[46]
- According to the 2004 General Social Survey, about 33% of the victims of spousal violence said that their children had seen or heard the violence.[47]
- According to Transition Home Survey, between April 1, 2005, and March 31, 2006, admissions of women and children to women's shelters in Canada totalled about 106,000.[48]
- According to the Transition Home Survey, on April 19, 2006, there were 2,912 women in transition home as a result of mistreatment; 51% of them were accompanied by their children.[49]

Mistreatment During Childhood

- In 2003, among all the surveys consulted by researchers for the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), 47% corroborated case of child maltreatment aged 15 or under in Canada (excluding Quebec).[50]
- The incidence rate of maltreatment corroborated cases was 21.7 per 1,000 children.[51]
- Among the cases of maltreatment corroborated, a third were cases of neglect (30%), followed by cases of exposure to family violence (28%). Physical violence represented 24% of cases, psychological violence 15% and sexual abuse 3%.[52]

- According to a study of the incidence and characteristics of situations of abuse, neglect, abandonment and serious behavioural problems reported to Quebec's Youth Protection Branch *(Étude sur l'incidence et les caractéristiques des situations d'abus, de négligence, d'abandon et de troubles de comportement sérieux signalés à la Direction de la protection de la jeunesse du Québec - ÉIC 1998),* 45% of the children for which the report of neglect proved to be justified were living in families affected by alcohol or drug abuse:[53]
  - For 41.7% of families, child neglect coexisted with alcohol or drug abuse and spousal violence.
  - For 32.2% of families, child neglect coexisted with alcohol or drug abuse and criminal activities.
  - For 31.3% of families, child neglect coexisted with alcohol or drug abuse and mental health problems.

Parental Supervision and Delinquency

- According to the results of the Canadian version of the International Youth Survey, the prevalence of delinquency was clearly higher among young people who said that they had used alcohol and drugs, and whose parents exercised little supervision.[54]
- 56% of youth who said that their parents *never* knew who they were with demonstrated delinquent behaviours during the last 12 months, compared to 35% of youth whose parents *did not always know,* and 12% of youth whose parents *always* knew who they went out with.[55]
- Youth who did not get along well with their parents showed higher levels of delinquency.[56] More than a third of youth who said they did not get along well with their father or their mother showed delinquent behaviour during the last 12 months, compared to about 20% of those who said they got along well with their parents.

Substance Abuse

- Available data on drug and alcohol abuse are rarely related to the family context and its consequences.
- Nevertheless, the following are some results from the Canadian Addiction Survey[57] that illustrate a few general aspects of substance abuse problems:
  - High alcohol consumption[58] is most common among Canadians aged 18 to 24.
  - A greater proportion of men than women were habitually drinking at least five drinks per occasion (23.2% compared to 8.8%) and had at least five drinks per occasion at least once a week (9.2%, compared to 3.3%).
  - 10.5% of those taking part in the survey stated that their spousal or family life was negatively affected by third-party drinking; 15.8% had experienced episodes of verbal violence, and 3.2% had been struck or experienced physical assault.
  - Nearly 30% of those aged 15 to 17, and somewhat more than 47% of those aged 18 to 19, had used cannabis in the last 12 months.
  - Of those who had used cannabis in the last 12 months, 4.9% said they had health problems and social or legal difficulties resulting from its use.
  - In the previous year, about 3% of Canadians (4.3% of men and 1.8% of women) said they had used at least one of the five illegal drugs other than cannabis (cocaine or crack; hallucinogens, PCP or LSD; speed or amphetamines; heroin; ecstasy).

The Situation of Families in Aboriginal Communities

There are few studies of the connections between juvenile delinquency in Aboriginal youth and risk factors associated with families; this significantly limits our level of knowledge for the effective prevention of delinquency among young people in such communities.

Among young Aboriginal males, most of the risk factors associated with delinquency are similar to those for non-Aboriginals: a history of criminal behaviour, substance abuse, antisocial attitudes, and association with antisocial peers.[59] However, we cannot say if risk factors such as "family or spousal problems" or "problems at school or at work" apply in a similar way to Aboriginals and non-Aboriginals; the question requires further research.[60]

With regard to family and spousal violence, the figures show that domestic violence is more common in Aboriginal communities.[61] In 2004, 21% of Aboriginals said they had experienced some form of physical or sexual violence on the part of a spouse in the five years preceding the survey, compared to 6% of non-Aboriginals.[62] This translates into a spousal violence rate among Aboriginals that is three times higher than among non-Aboriginals.

With regard to substance abuse and alcoholism in Aboriginal communities, the available statistics rarely make a connection with the family dimensions. The following are some results from the First Nations Regional Longitudinal Health Survey (RHS) 2002-2003:[63]

- Men were more likely than women to have consumed alcohol, with the highest rates among men aged 18 to 29.
- The proportion of heavy drinkers among First Nations adults was higher than in the Canadian population, and more pronounced among men.
- Men aged 18 to 29 used drugs most: 29.1% of respondents said they used marijuana daily. This was followed by the use of prescription drugs, particularly codeine, morphine and opiates.

A study of the connections between family structure and substance abuse problems has been conducted among North American Indians and Inuit (American Indian/Alaska Native – AI-AN).[64] The results suggest that young people from single-parent families are more likely to smoke tobacco and drink regularly, compared to the young people who live with both parents. The probability of marijuana use is also higher among young people in single-parent families, compared to those who live with their parents. Note in this connection that Aboriginal children and young people are much more likely to be members of a single-parent family: in 2001, 35% of Aboriginal children under 15 were living in a single-parent family, twice the proportion of non-Aboriginal children (17%).[65]

Given these results, it is therefore important to continue research into the significance of the family unit as a protective factor for Aboriginal youth. Moreover, as Lonczak H. et al. (2007) note, more detailed studies must be conducted to gain a better understanding of how—family structure aside—parental practices affect substance abuse problems among Aboriginal youth.

Protective Factors

Knowledge of protective factors associated with the family is less extensive than knowledge of risk factors; this places an important limitation on our knowledge for the prevention of juvenile delinquency.

Protective factors inform our understanding of the characteristics and situations that protect youth and steer them away from delinquency.[66] Protective factors are characteristics or conditions that mitigate risks, enable reduction of the negative impact associated with risk factors and help youth address their

situation more successfully.[67] It may be suggested that protective factors, like risk factors, are cumulative and interactive. For example, the negative effects of growing up in a poor environment can be reduced by the involvement, participation and support of parents.[68]

Table 2 below shows the main protective factors associated with families; most are related to a good family functioning and harmonious family relations. Readers should note that current research on protective factors is not detailed enough to allow distinction between them based on age.

- Appropriate parenting practices have been associated with a lower incidence of behaviour such as delinquency and drug and alcohol use.[69]
- Parental supervision, affection for the parent and consistent and continuous discipline are the most important protective factors in promoting the resilience of youth at risk[70] and reducing the chances of their associating with delinquent peers.[71]
- Harmonious family relations and a good relationship with parents offer protection against delinquency at all ages, and among boys as well as girls.[72]
- Parental support and involvement reduce the risk that youth will engage in delinquent activities[73] or use drugs.[74]
- When all the families living in a poor neighbourhood are compared, those with two parents seem to have a stronger protective effect.[75] However, single-parent families living in a safe, quiet neighbourhood are no more at risk than other families.[76]
- Integration of families into neighbourhood life, strong social cohesion, the availability of resources and services within the neighbourhood,[77] and family involvement in extracurricular and school activities[78] are also protective factors.

TABLE 2—PROTECTIVE FACTORS ASSOCIATED WITH FAMILY[79]

AT EVERY AGE

FAMILY DYNAMIC AND FUNCTIONING	FAMILY CHARACTERISTICS	AREA OF RESIDENCE
• Relationship based on family bond • Positive support within the family • Adequate parental supervision • Respect for friends by parents • Closeness between parents and children (affection) • Consistent disciplinary methods • Adequate parental behaviour and practices	• Parental level of education • Financial stability • Stability of the family unit	• Integration of families into the life of the community • Relationships established with neighbours • School activities involving the family

CHAPTER 2

Preventing and Reducing the Risks of Juvenile Delinquency by Working With Families

Current knowledge shows that it is possible to reduce the negative effects of certain risk factors, reinforce protective factors and work effectively with youth at risk and vulnerable families. A number of studies[80] have shown that those programs targeting risk factors contributing to crime and victimization and promoting protective factors are effective and enable a reduction in the incidence of crime and victimization of as much as 70% in some cases.[81]

The Scientific Approach to Preventing Delinquency

The scientific approach to preventing delinquency involves a way of thinking and acting based on scientifically demonstrated and demonstrable facts. Through careful and reliable evaluations, the use of this approach makes it possible to demonstrate that there are effective ways of preventing crime. Evaluation of the effectiveness of programs relies on the following criteria:

- **Effective Results in Preventing or Reducing Problems, Mitigating Risk Factors and/or Reinforcing Protective Factors**

  Show through rigorous evaluation that the programs in place produce positive results in reducing delinquent behaviour, mitigating risk factors or reinforcing protective factors. This criterion is undoubtedly one of the most important for assessing the success and effectiveness of preventive practices and preventive effects.

- **Positive Long-Term Effects**

  Show that the positive effects of programs persist even after their termination, and are apparent in the life of young people over a number of years. They must be sustained effects.[82] This criterion is difficult to demonstrate and assess: only longitudinal studies can satisfy this criterion.

- **Replicability**

  Show that implementation of the same program in different environments reproduces the same positive results each time.

  For example, programs that have shown their effectiveness under different social and economic conditions, with different populations and in different contexts—urban, rural—are generally considered to be very reliable.[83]

- **Rigorous Evaluation**

  Without going into methodological details, it should be pointed out that an evaluation is considered rigorous when it shows a high degree of internal, conceptual and statistical validity and when the measuring and evaluating instruments are scientifically based.[84]

  Experimental evaluations, with or without randomization, and quasi-experimental evaluations are the two types whose results are best with respect to internal validity.[85]

- **Cost-Benefit Analysis**

  A cost-benefit analysis increasingly represents a criterion in evaluating the efficiency of programs. It shows that the funds invested in prevention programs are cost-effective when compared to the resulting benefits.

Cost-benefit analyses of programs put in place for youth at risk and their families, show that some programs save taxpayers 7 to 10 times the program cost.[86] For example, the best programs with a good cost-benefit ratio are Multidimensional Treatment Foster Care (MTFC), where for each dollar invested, the taxpayers save up to $11.60; Multisystemic Therapy (MST), with savings of up to $7.70; and Functional Family Therapy (FFT), with $7.50.[87]

Intervention Strategies: What Works With Families

For programs involving the family, three intervention strategies are considered adequate:

- parental training programs;
- family therapy programs; and,
- integrated approach programs.

The selection criteria that guided the choice of programs[1] were as follows:

- programs had to be family-based: the intervention strategies used had to address both parents and young people;
- risk factors had to be associated mostly with the family environment;
- youth targeted by the programs were at risk of developing delinquent behaviour, or had already been involved in delinquent activity;[88] and
- results had to be supported by rigorous evaluation confirming a reduction in the risk of developing juvenile delinquent behaviour, mitigation of risk factors or reinforcement of protective factors.[89]

Parental Training Programs

Programs based on parental education are designed essentially to improve parental responsibility and behaviours. They seek to teach parents to use appropriate discipline techniques, exercise balanced supervision and control, and set clear and consistent limits for children and young people who tend not to follow rules.[90]

Parental training generally takes place in small groups, with only parents present. Training sessions may be held in various locations: schools, community centres, churches, at work or at home. Sessions are led by a therapist.

Objectives

Parental training uses a structured approach designed to:

- Help parents identify positive and antisocial behaviours in their children, and use appropriate child-rearing techniques.
- Improve family relations by strengthening ties of affection.
- Improve parental skills in such areas as problem-solving, family conflict and self-control.

1 Appendix 1 contains a description of each program listed in this paper: method, evaluation, additional information and references.

PARENTAL TRAINING PROGRAMS

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Preventive Treatment Program	**Age group:** 7-9 years (boys only) Boys from disadvantaged families who present behavioural problems.	**Problems:** • gang-related activities; • delinquency; • substance abuse; • aggression and violence. **Risk factors:** • mismanagement of family conflicts; • poor parental supervision; • use of corporal punishment; • inconsistent discipline.	**Results:** • at 12 years old, the boys who participated in this program commit fewer thefts, are less likely to have substance abuse problems and are less involved in fights; and • at 15 years old, the boys who participated in this program are less involved with gangs, have fewer substance abuse problems, commit fewer delinquent acts and have fewer friends who had been arrested by the police.[92,93] **Rating:** I: exemplary II: ns (not stated)
Parenting With Love and Limits (PLL) Also accompanies family therapy	**Age group:** 10-18 years (girls and boys) Youth who have committed a first offence/ youth at risk of adopting delinquent behaviour/ dropouts.	**Problems:** • gang-related activities; • delinquency; • substance abuse; • aggression and violence; • academic problems. **Risk factors:** • poor parental supervision; • mismanagement of family conflicts; • poor family bonds; • family violence; • siblings with behaviour problems; • use of corporal punishment; • inconsistent discipline.	**Results:** • in the year following PLL, 85% of youth did not have a substance abuse relapse; • compared to a control group, PLL youth reduced their aggressive behaviour, depression and attention deficit problems; and • parents of PLL, compared to those of a comparison group, improved communication with their youth.[94] **Rating:** I: exemplary II: ns

PARENTAL TRAINING PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Focus on Families	**Age group:** 3-14 years (girls and boys) Targets families in which one parent is on methadone treatment.	**Problem:** • substance abuse. **Risk factors:** • parents who are involved in criminal activity or who have a criminal history; • poor parental supervision; • mismanagement of family conflicts; • use of corporal punishment; • inconsistent discipline; • poor family bonds.	**Results:** After 12 months of counselling, the *Focus on Families* parents, compared to a comparison group:[93,95] • reported fewer conflicts; • were better able to ensure house rules were obeyed; • changed their social circle; • reported a 65% reduction in the frequency of heroin use; • were six times less likely to use cocaine in the last month. **Rating:** I: exemplary II: model

Family Therapy Programs

Family therapy programs follow a multidimensional approach combining parental training session, youth training session and improvement in family dynamics. These programs are generally carried out by qualified therapists in a clinical setting.

Family therapy targets two types of families.

First, families in which youth display emotional and behavioural problems (emotional disorders, depression, problems at school and with friends, and so on) but without indications of more serious behaviour (delinquency, crime, early abuse of alcohol and drugs, and so on). This preventive therapy is designed to treat problems before they become more serious.

Second, families in which youth exhibit delinquent behaviour and are clearly identified or diagnosed as such. This type of therapy is designed to rehabilitate and treat youth and their families, reduce the risk of reoffending and prevent more serious delinquency.

Objectives

Regardless of the type of family involved, family therapy programs are designed essentially to:

- Improve communication and interactions between parents and children, and resolve problems that arise.[96]
- Improve family functioning.
- Improve parenting practices.

FAMILY THERAPY PROGRAMS

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Functional Family Therapy (FFT)	**Age group:** 11-18 years (girls and boys) Youth who present delinquent behaviour/ youth currently involved in criminal activities.	**Problems:** • aggression and violence; • substance abuse. **Risk factors:** • poor parental supervision; • mismanagement of family conflicts.	**Results:** • compared to traditional justice service for youth, FFT reduces the risk of recidivism by 50% to 60%;[93] • after one year of counselling, the rate of recidivism in youth who participated in the project was 19.8% versus 36% in other youth;[97] • compared to traditional probation services for youth, residential treatments; and therapeutic approaches, FFT obtained better results.[93] **Rating:** I: exemplary II: exemplary
Multi-Dimensional Treatment Foster Care (MTFC) Also considered to be a program that uses an integrated approach	**Age group:** 11-18 years (girls and boys) Youth with chronic delinquent behaviour who are at risk of incarceration.	**Problems:** • delinquency; • aggression and violence. **Risk factors:** • poor parental supervision; • mismanagement of family conflicts; • parents who are involved in criminal activity or who have a criminal history.	**Results:** • after a 12-months follow-up, MTFC youth, compared to youth placed in traditional placement centres, committed fewer offences (an average of 2.6 offences versus 5.4);[97] • after a 12-months follow-up, MTFC boys aged 12 to 17 spent 60% fewer days in prison compared to boys placed in traditional placement centres, used fewer hard drugs, had a lower rate of recidivism and were more likely to return to their families;[93] • after a 24-months follow-up, MTFC youth had better academic integration.[98] **Rating:** I: exemplary II: exemplary

FAMILY THERAPY PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Brief Strategic Family Therapy (BSFT)	**Age group:** 8-18 years (girls and boys) Youth who present or who are at risk of adopting delinquent behaviour. The therapy also addresses dropouts and youth with substance abuse problems.	**Problems:** • delinquency; • substance abuse. **Risk factors:** • poor parental supervision; • mismanagement of family conflicts; • poor family bonds; • siblings with behaviour problems.	**Results:** BSFT is considered an effective treatment to improve behaviour problems, reduce recidivism among young offenders and improve family relations.[95] **Rating:** I: effective II: exemplary
Multi-Dimensional Family Therapy (MDFT)	**Age group:** 11-18 years (girls and boys) Youth with substance abuse problems and youth who present behaviour problems.	**Problems:** • substance abuse; • aggression and violence. **Risk factors:** • poor parental supervision; • mismanagement of family conflicts; • use of corporal punishment; • inconsistent discipline.	**Results:** • MDFT youth showed more positive changes (45%) than youth in regular group therapy (32%) and youth in multi-family therapy (26%);[93] • after one year, 70% of MDFT youth and 55% of youth who participated in cognitive therapies stopped using drugs;[95] and • MDFT enabled the participating families to improve their functioning and cohesion.[95] **Rating:** I: effective II: exemplary

FAMILY THERAPY PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Positive-Parenting-Program (Triple P) Also accompanies parental training	**Age group:** Youth under 16 years (girls and boys) Youth with behaviour (or emotional) problems.	**Problem:** • behaviour problems. **Risk factors:** • mismanagement of family conflicts; • depressed parents.	**Results:** Compared to families on a waiting list to receive treatment, those who participated in Triple P:[99] • reduced behaviour problems in their children; and • improved parenting practices and skills. **Rating:** I: ns II: ns

Integrated Approach Programs

Integrated approach is based on the principle that a youth and his or her family do not live in isolation. An effective intervention must first, replace the family to its environment; and second, focus on risk factors coming from several areas (for example, community, neighbourhood, school, friends, family and the youth himself or herself); and third, develop an integrated approach that involves participation by a number of key partners: health and social services, education, justice, mental health, substance abuse and so on.

This is a multidimensional approach in which casework is generally coordinated by a case manager. Depending on the project, the case manager works sometimes directly with the family and sometimes in support of caseworkers.

According to a number of US associations, a genuinely integrated approach must essentially satisfy the following criteria:[100]

- Intersectoral collaboration by a number of partners: youth justice, education, mental health, health and social services, community groups and so on. An organization must assume leadership and coordination.
- A well-developed work plan: target clientele, action and services to be delivered, results expected and performance indicators, investments in human and financial resources, and so on.
- Personalized treatment plans developed in conjunction with the various services in the community to respond directly to the needs of the young people, and provide families with advice on the process and the steps to be followed.
- Regular updating of treatment plans reflecting the young person's positive progress and the difficulties encountered.

Objectives

Programs based on an integrated approach are designed to:

- Reduce the use of predetermined traditional treatment programs.
- Support and guide families through the process.
- Improve the care and services available for most at-risk youth.
- Combine a number of services and support networks surrounding young people at risk in a personalized way.

INTEGRATED APPROACH PROGRAMS

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
Multi-Systemic Therapy (MST) Sometimes classified under family therapy	**Age group:** 12-17 years (girls and boys) Youth with chronic violence problems, substance abuse problems and those who are at risk of placement.	**Problems:** • aggression and violence; • substance abuse. **Risk factors:** • mismanagement of family conflicts; • poor parental supervision.	**Results:** • the reduction of recidivism rate varied between 25% and 70%;[97] • the reduction in youth placement rates varied between 47% and 64%;[97] • compared to youth who received traditional services, MST youth experienced a significant reduction in criminal activity;[94] • MST is one of the most effective programs for aggressive and antisocial adolescents;[101] • compared to youth in traditional placement, MST youth reduced their rate of arrest, self-reported delinquency and the number of assaults against other youth.[102] **Rating:** I: exemplary II: exemplary

INTEGRATED APPROACH PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
CASASTART **(Striving Together to Achieve Rewarding Tomorrows)** Also known as *Children at Risk* Also considered to be family therapy	**Age group:** 8-13 years (girls and boys) Youth at risk of being involved in criminal activities or youth who present substance abuse problems.	**Problems:** • delinquency; • substance abuse; • aggression and violence; • academic problems. **Risk factors:** • parents who are involved in criminal activity or who have a criminal history; • poor parental supervision; • mismanagement of family conflicts; • poor family bonds; • family violence; • family instability.	**Results:** After one year, youth who participated in CASASTART, compared to youth from a comparison group:[103] • had a lower drug use rate (56% versus 63%); • sold drugs less frequently (14% versus 24%); and, • committed fewer violent crimes (22% versus 27%). **Rating:** I: effective II: ns
Wraparound Milwaukee Also accompanies family therapy	**Age group:** 13-17 years (girls and boys) Youth who present emotional and behaviour problems/youth who present mental health needs.	**Problems:** • delinquency; • substance abuse; • aggression and violence. **Risk factors:** • parents who are involved in criminal activity or who have a criminal history; • poor parental supervision; • mismanagement of family conflicts; • family violence; • siblings with behaviour problems; • use of corporal punishment; • inconsistent discipline.	**Results:** • pre-and post-test evaluations showed the youth involved in Wraparound reduced their rate of recidivism and improved their performance in school, at home and in the community; and • after one year of counselling, there was a decrease in the rate of violent sex offences (from 14% to 2%), offences against property (from 42% to 15%), assaults (from 20% to 5%) and offences involving firearms (from 11% to 3%).[93] **Rating:** I: promising II: ns

INTEGRATED APPROACH PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
All Children Excel (ACE)	**Age group:** 6-15 years (girls and boys) Youth who present a high risk of chronic delinquency and violence.	**Problems:** • delinquency; • aggression and violence; • academic problems. **Risk factors:** • parents who are involved in criminal activity or who have a criminal history; • poor parental supervision; • mismanagement of family conflicts; • poor family bonds; • family violence; • siblings with behaviour problems; • use of corporal punishment; • inconsistent discipline.	**Results:** • an evaluation from 1999 to 2003 showed that youth who participated in ACE attended school regularly, were accepted to high school and improved their attitudes and behaviour at school;[104] • among youth who present the same level of risk, those who participated in ACE had a lower rate of recidivism (35% versus 57%); and • over a period of 4.5 years, 86% of ACE youth did not face new charges.[105] **Rating:** I: promising II: ns

INTEGRATED APPROACH PROGRAMS (continued)

TITLE	TARGET GROUP	TARGETED PROBLEMS AND RISK FACTORS	RESULTS AND RATING[91]
SNAP™ Under 12 Outreach Project (ORP) Also accompanies family therapy and parental training	**Age group:** 6-12 years (boys only) Boys who have committed offences or who present serious behaviour problems. Note: a program for girls, *SNAP™ Girls Connection,* was established in 1996.	**Problems:** • delinquency; • aggression and violence. **Risk factors:** • poor parental behaviour; • poor parental supervision.	**Results:** Compared to a control group, SNAP™ participants:[93] • had fewer individual problems (anxiety, depression); • improved their social skills (better relations with peers; participation in activities); • reduced their rate of aggression and delinquency; • 60% of high risk children who participated in ORP did not have a criminal record; • showed positive skills after treatment, developed positive ties with teachers, friends and family members and were less likely to associate with "bad friends"; and, • parents had less difficulty in relations with their children and were confident that they could adequately supervise their behaviour. **Rating:** I: exemplary II: ns

Key Success Factors for Family-Based Programs

The previous results show that it is possible to work effectively with vulnerable families to reduce and prevent the risk of juvenile delinquency.[106] Following are some of the key success factors in these programs.[107]

A Combination of Intervention Strategies

- Current knowledge show that programs combining training session for youth and for parents have a more significant impact on the mitigation of risk factors and the reinforcement of protective factors than programs that target only youth or parents.[108]
- Programs that combine diversified intervention strategies, use an integrated approach and involve several stakeholders, have a better chance of success.[109]
- From this point of view, to obtain better effective results, it is mainly recommended to combine intervention in family setting and in school setting.[110]
- Work on risk factors that can be changed (such as dynamic risk factors rather than static ones: parenting practices, supervision, conflict management and so on).

Program Design and Implementation

- Use a structured approach and propose a range of activities.
- Work over a sufficient period of time, particularly with high-risk families, to generate long-term effects. Some projects fail because they are too short-lived and do not give parents enough time to acquire new skills.
- Take the age and gender of the young people into account.
- Also take into account ethnic and cultural characteristics. More detailed research should be conducted on the key factors for successful intervention with ethnic and cultural communities in order to gain a better understanding of the influence of cultural background on the implementation.
- Ensure that staff involved in program implementation and execution have the academic qualifications, expertise and personal suitability.

Conclusion

As the results presented in this paper suggest, prevention and treatment programs for vulnerable families are effective and should therefore be included in a comprehensive approach and strategy to prevent and reduce delinquency and recidivism for youth at risk.

Since the family is a key factor in a young person's development, it goes without saying that working with those who are at risk by offering integrated, personalized treatment plans, individual or family therapy, or parental education activities, is a casework strategy with proven effectiveness.

However, since the family is at the intersection of a number of living environments—peers, school and neighbourhood, to mention only a few—it must be understood as a system of relations influenced by a number of risk factors and protective factors, generated both by the influence of these living environments and by its internal dynamics and characteristics.

In casework, therefore, there is no absolute truth and no single program that applies to all families at risk. The reality of families at risk ranges over a continuum, and personalized, individualized casework taking into account the specific characteristics of each family enables accurate targeting of the central risk factors that must be addressed, as well as the existing protective factors that must be reinforced.

Such targeted casework must be based on an evaluation of families' needs and circumstances, and a strong and current corpus of scientific knowledge about vulnerable families.

With respect to scientific knowledge, this exploratory research has produced an overall picture of existing knowledge, and in so doing, has brought out the limitations to which research is subject. Better knowledge of protective factors and their role with respect to the age of young people, and better knowledge of the situation in Aboriginal families and effective ways of working with them, are the frontiers on which research should be carried out.

Lastly, suggested avenues for future research could include detailed studies of the costs and benefits of mid- and long-term family-based prevention programs in such areas as justice, health, employability, substance abuse treatment and so on, and longitudinal studies could be developed at the same time on the long-term impact that prevention and treatment programs have on the life trajectory of the children of those who take part in them.

Program Descriptions

Preventive Treatment Program

"The Preventive Treatment Program was aimed at disruptive kindergarten boys and their parents, with the goal of reducing short- and long-term antisocial behaviour." (OJJDP)

This program, also referred to as the Montreal Prevention Experiment, is for boys aged 7 to 9 identified by teachers as presenting disruptive behaviour in school.

The program objectives are to reduce:

- delinquency;
- drug use; and
- involvement in gangs.

Method

- The program offers two-year training for parents and boys.

Training for Parents

- Training for parents is based on a model developed by the Oregon Social Learning Center.
- Parents attend training session to learn skills in the management of family crises, positive reinforcement and the use of consistent discipline.
- The objective of parent training is to equip them to exercise a positive influence on their child, and modify their behaviour.
- Boys are invited to attend parent-training sessions, but attendance is not mandatory.
- In all, over a two-year period, parents attend an average of 20 training sessions.
- Caseworkers help parents apply what they have learned in the home, and teachers are encouraged to become involved and participate.

Training for Boys

- Training for boys takes place in the school setting.
- Groups of young people are formed: 1 or 2 disruptive boys teamed with 3 to 5 non-disruptive boys.
- The emphasis is on the promotion of social skills and emotions management through the learning of skills in problem solving, conflict management and self-control.
- The sessions in school use interactive methods, such as coaching and role-plays, and behavioural techniques to achieve positive modification of the boys' behaviour and promote the learning of positive skills and abilities.
- In all, over a two-year period, the boys attend 19 sessions:
    - The first year (9 training sessions) focuses on the development of social skills, such as how to make contact with another person.
    - The second year (10 training sessions) focuses on the promotion of self-control; for example: What do I do when I get mad?

Additional Information

Training for Parents

- The training sessions for parents are led by 4 professionals: 2 social workers specializing in childhood problems, 1 social worker and 1 psychologist. The same people provide training for parents in the home and training for the boys in the school setting.
- Parents attend about 20 group sessions which occur every 2-3 weeks over a 2-year period.
- The duration of parent training depends on their ability to apply the new knowledge and skills acquired; the professionals evaluate them and decide whether training sessions should continue or terminate.

Training for Boys

- Training sessions for boys are led by the same professionals as the training for parents.
- Sessions are held every two weeks and last about 45 minutes.
- They are held from November to April throughout two consecutive years.
- The professionals responsible for the training sessions meet with the teachers to advise them on the kind of reinforcement the boys require.

Evaluation

- At age 12 (three years after the program), compared to non-participants, the boys who took part presented fewer adjustment difficulties in school (22%, compared to 44%) and fewer of them were placed in special education (23%, compared to 43%).
- At age 15, compared to non-participants, the boys who took part were less involved in gangs, committed fewer offences—theft, vandalism, drug use—and had fewer friends who had been previously arrested by the police.

References

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Parenting With Love and Limits (PLL)

"Parenting With Love and Limits® is a parenting education program that integrates the best principles of a structural family therapy approach into a comprehensive program for juvenile delinquent populations." (Brush Dance Clinic)

Parenting with Love and Limits (PLL) is a program that combines group therapy and family therapy. It is for children aged 10 to 18 identified or diagnosed with serious emotional or behavioural problems, drug or alcohol abuse, suicidal ideations, depression or all of these.

The objectives of PLL are to:

- reduce the incidence of problems in young people at risk;
- develop new social skills and abilities in parents and young people; and
- prevent relapses by helping parents and young people make good use of their new skills and abilities in their daily lives.

Method

- PLL uses group therapy and family therapy: in group therapy (about six sessions), parents and young people learn new skills, and in family therapy (four sessions or more), they participate in role playing activities to put into practice what they have learned.
- PLL is based on a six-step scale for change (Savannah Family Institute, Inc.) (pre-contemplation, contemplation, preparation, action, maintenance, closure).
- Group therapy:
  - Groups are made up of a maximum of six families and 15 people (brothers and sisters can participate in group therapy).
  - Groups are supervised by two caseworkers.
  - Group therapy takes place over six weeks, two hours per week.
  - During the first hour the parents and young people meet together, and during the second hour they form two separate groups, each with a caseworker.
- Family therapy:
  - During family therapy, young people and parents meet individually with a caseworker.
  - Family therapy lasts between one and two hours and is used to put the new skills learned in group therapy into practice.
  - Approximately three to four family therapy sessions are recommended for young people who have a lower risk, and up to 20 for those at high risk.

Additional Information

- During group sessions and family therapy, caseworkers are equipped with detailed guides to treatment and procedure.
- Parents and young people have workbooks.
- For information about detailed implementation, go to the Web site: *Parenting With Love and Limits – PLL, An Evidence-Based Treatment Model for Mental Health* at http://www.gopll.com/.

Evaluation

- Compared to a control group, young people who participated in PLL showed a significant reduction in aggressiveness, depression and attention deficit.
- Families participating in PLL also improved parent-child communication.
- After a 12-month follow-up, compared to a control group, young people in PLL had a lower rate of recidivism: 16%, compared to 55%.

References

- **Sells, S.P., T.E. Smith, and J. Rodman**. 2006. "Reducing Substance Abuse through Parenting With Love and Limits." *Journal of Child and Adolescent Substance Abuse,* (15): 105-115.
- **Parenting With Love and Limits – PLL:** http://www.gopll.com/

Focus on Families

"As a result of Focus on Families, parents are expected to have less risk for relapse, to be better skilled to cope with relapse incidents, and to have decreased drug use episodes." (Strengthening America's Families)

Focus on Families is designed for parents with substance abuse problems. It is for families in which one parent is being treated with methadone and who have children ages 3 to 14. It is preferable for the parents to have completed at least 90 days of methadone treatment before the program begins.

The objectives are to:

- prevent relapses;
- help and equip parents to cope with their dependency problems; and
- reduce the risk that children in these families will develop the same substance abuse problems.

Method

- The program combines training for parents and in-home services.
- Eligible families first participate in a five-hour family retreat.
- The retreat is followed by 32 sessions of treatment for the parents (about 16 weeks). Each session lasts an hour and a half and sessions are held twice a week with a group of six to eight families.
- The sessions are led by a trained therapist with work experience in substance abuse treatment.
- Training sessions address the following subjects: identifying family goals; improving family communication; learning how to manage crises; creating opportunities to live in a drug-free family; helping children succeed at school; and teaching children to develop skills.
- The children attend 12 sessions, in which they learn to develop skills with their parents.
- A home-visit service is also offered for nine months by a trained therapist with work experience in substance abuse.
- Home visits begin one month after the start of the training sessions for parents to motivate and encourage them.
- Home visits must continue for about four months after the training sessions end to ensure follow-up.

Additional Information

- The training sessions for parents require two therapists with experience in substance abuse treatment.
- The training sessions attended by the children require two more therapists.
- The program also requires a case manager for the home visits.
- The training manuals and teaching workbooks must be purchased (about $200).
- Training in the program is available from the designers.
- The costs vary with the length and intensity of the training.
- The provision of snacks, transportation and a babysitting service for the youngest children are recommended.

- The program uses feedback from video recordings.
- This project is also known as Families Facing the Future.

Evaluation

- After a 12-month follow-up, compared to those in the control group, parents who took part in the program reported fewer spousal disputes, were better able to secure compliance with instructions in the home, and reduced their consumption of heroin by 65%.
- After a 24-month follow-up, compared to young people in the control group, young people who took part in the program reported fewer behavioural problems and less drug use.

References

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- **Social Development Research Group:** http://depts.washington.edu/sdrg/FOF.htm

Functional Family Therapy (FFT)

"Functional Family Therapy is a short-term approach designed to engage and motivate youths and families to change negative affect." (OJJDP)

Functional Family Therapy is a family-focused prevention and response project for young people aged 11 to 18 with serious behavioural, drug abuse and violence problems. It has been applied successfully with various ethnic groups and in various social and economic contexts.

FFT is a multi-system prevention program designed to:

- reduce the negativism associated with families at risk;
- reinforce the bond of affection within the family;
- improve parents' ability to manage family conflict;
- develop positive behaviour; and
- reinforce parents' skills so that they can provide consistent and structured discipline for their children.

Method

- FFT is a short-term program delivered by therapists in the homes of participating families.
- FFT is based on a clinical approach: in each of the three phases (see below), the therapist identifies the risk factors and protective factors, and works with the family and with each individual.
- The program is delivered in three phases:

  1) engagement and motivation: reducing the negativism associated with families at risk;

  2) changing behaviour: reducing and eliminating behavioural problems and improving family relations; and

  3) generalization: increasing the ability of families to use community resources and avoid relapses.
- A family therapist works with one family at a time.
- When families have multiple problems, family treatment is incorporated into the therapy.
- FFT is usually delivered over a three-month period: from one session of 8 to 12 hours for mild cases, to 30 for families in difficulty, with an average of 12 sessions per family.

Additional Information

- FFT combines and incorporates empirical principles and clinical experience.
- An FFT team consists of three to eight clinicians who receive intensive and continuous training, with follow-up over 12 months in the form of telephone conversations with the program managers.
- FFT is successful because it is a multi-system program that emphasizes the training of therapists, the community, and the clinical system of treatment.
- Program cost: on average, per family, for 12 visits, the cost varies from $1,350 to $3,750 (Lawrence A. et al. 2001).

Evaluation

- Compared to traditional probation services, residential treatment or alternative therapy approaches, FFT gets better results in reducing the rate of recidivism.
- FFT also reduces the chances that the young person's siblings will commit offences.
- FFT reduces the number of placements in specialized treatment centres.
- Very good cost-effectiveness ratio: $700 to $1,000 per participating family, compared to at least $6,000 per young person in placement (Mihalic S., Irwin K., et al., 2001).
- The effectiveness of this approach has been shown in a number of studies over some 25 years. (Greenwood P., 2004).

References

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- **Sexton, T., and J. Alexander.** 2000. "Functional Family Therapy." In *Justice Juvenile Journal.* Washington: Family Strengthening Series, US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- **Functional Family Therapy:** http://www.fftinc.com/

Multidimensional Treatment Foster Care (MTFC)

> *"Community foster families are recruited and trained to provide out-of-home placements for juvenile offenders or children at risk for detention." (OJJDP)*

MTFC, or Multidimensional Treatment Foster Care, offers an alternative to traditional residential placement, incarceration or hospitalization for young people aged 11 to 18 with chronic problems of violence and delinquency. The young people are placed with an MTFC family for six to nine months and receive intensive treatment. During this time, the young person's original family receives therapy, and the parents receive training as well.

The program is based on the social learning theory, whereby social contexts and daily interactions affect both positive and antisocial behaviours in young people.

The goals of the MTFC program are to:

- reduce criminal behaviour and drug use;
- improve participation at school;
- reduce associations with juvenile delinquents; and
- improve young people's skills so that the return to the original family is uneventful and relapses are avoided.

For the original families, MTFC treatment seeks to:

- improve parenting skills through effective and consistent discipline; and
- increase the parents' participation and involvement with their children.

Method

- MTFC involves a number of treatment activities, which include training for the parents of the original family, support for the parents of the MTFC family, family therapy for the biological parents, development of skills in the young people, therapy for the young people, academic support and assistance to involve the school in the process and, if necessary, a psychiatric consultation.
- Treatment for the young person consists of three components that work together:
  1) ***The MTFC family:*** young people are placed with an MTFC family. The MTFC parents receive complete training beforehand, which enables them to supervise the young people properly and work individually with each young person. Every day, the MTFC parents brief the coordinator on the changes in each young person. On the basis of the changes in each case, the coordinator advises the MTFC parents on what they are to do.
  2) ***The original family:*** the parents receive training and therapy. They learn to apply consistent discipline, provide encouragement and use techniques similar to those used by the MTFC family. Their training is also designed to develop positive family relations and reduce conflict when the young person returns to the original family.
  3) ***The project treatment team:*** the team is managed by a coordinator, who also advises the MTFC family, and consists of two therapists—one for the family sessions and one for the individual sessions—an educational psychologist and a secretary.
- There are currently three versions of MTFC, for those aged 3-5, 6-11 and 12-17.

Additional Information

- MTFC families are supported by a coordinator who is responsible for the treatment program, and the family calls every day to brief the coordinator on improvements or problems with the young person.
- Regular contacts between the MTFC family and the coordinator are key to the program's success.
- MTFC families receive 20 hours of training in social learning theory; they also receive financial compensation.
- Such families are sometimes difficult to recruit.
- TFC Inc. was set up in 2002, and its consultants are responsible for advising and supporting case-workers wishing to launch an MTFC program.
- The budget has to cover human resources costs, the cost of equipping staff, financial compensation for the MTFC families, and expenses for the MTFC response team, particularly with respect to travel costs.

Evaluation

- Compared to young people in a control group, after a 12-month follow-up, MTFC participants spent 60% fewer days in jail, were arrested less often and used hard drugs less.
- The same evaluation showed that boys completing the treatment had better mental health, better academic results and a more positive attitude to life.
- MTFC is a program that adapts very well to the special needs of delinquent girls (Sherman F. 2005). After a two-year follow-up, compared to girls in a control group, MTFC girls spent 100 fewer days in detention.
- After a two-year follow-up, savings due to reduced incarceration totalled $122,000 (Mihalic, Irwin, et al., 2001).

References

- **Chamberlain, P. and J. Reid.** 1998. "Comparison of Two Community Alternatives to Incarceration for Chronic Juvenile Offenders." *Journal of Consulting and Clinical Psychology,* 66(4): 624-633.
- **MTFC:** http://www.mtfc.com/index.html

Brief Strategic Family Therapy (BSFT)

"BSFT is based on the assumption that the family—one of the most important and influential systems in the lives of children and adolescents—provides the foundation for child development. As a result, BSFT conceptualizes and intervenes to change youth behavior problems at the family level." (BSFT Web site)

Brief Strategic Family Therapy (BSFT) is designed to prevent and treat behavioural problems in young people aged 8 to 18. It targets young people who display, or are at risk of presenting, behavioural problems, particularly drug use and school abandonment.

The BSFT approach perceives the family as the foundation for child development. The family protects against negative influences, hence the importance of working with the family.

The goals of BSFT are essentially to:

- reduce behavioural problems in young people; and
- improve family functioning by reducing the negative effects of risk factors and reinforcing protective factors.

Method

- Therapy is designed to meet the needs of each family.
- Through coaching, the therapist modifies interactions between parents and child.
- The main techniques used include engagement (family members describe how their family operates), diagnosis (identifying ineffective interactions and the family's strengths), and restructuring (changing negative interactions into positive ones).
- The duration of treatment varies from 12 to 15 sessions over a period of about three months.
- Each lasts 60 to 90 minutes.
- For families with more serious problems, the duration of treatment can be doubled.
- Therapy can take place in the home, in a clinic or in a community centre.

Additional Information

- Staff required to run a BSFT program include therapists and a clinical supervisor.
- A full-time therapist can take care of a maximum of 20 families.
- Therapists must have a graduate degree in mental health, social work or a related discipline.
- It is preferable for therapists to have at least three years' clinical experience.
- Therapists' travel costs is provided.
- The Center for Family Studies offers training for those who wish to implement BSFT, depending on the staff's level of clinical experience and the specific needs of the families requiring treatment. Training takes about five days and costs about $18,000.

Evaluation

- BSFT was developed by the Center for Family Studies, Department of Psychiatry and Social Sciences, University of Miami.
- It has received a number of awards from government and private agencies.
- BSFT is considered highly effective with cultural communities.
- Compared to other forms of family therapy, BSFT achieves a better rate of family participation (81%, compared to 61%), and more families complete the program (71%, compared to 42%).
- BSFT has been certified as a model program by the Substance Abuse and Mental Health Services Administration (SAMHSA).

References

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- **Brief Strategic Family Therapy:** http://www.brief-strategic-family-therapy.com/bsft

Multidimensional Family Therapy (MDFT)

> *"MDFT targets the known areas of risk associated with adolescent drug abuse and delinquency and enhances those protective factors and processes known to promote successful teen and family development." (Strengthening Families)*

Multidimensional Family Therapy is a complete program designed for children aged 11 to 18 with drug use and behavioural problems.

The MDFT approach emphasizes sound functioning for the young person in a number of areas. More specifically, it seeks to change the lifestyle of young people in several areas of life: relations with friends, health, school attendance, and relations with parents.

The program has been applied in various cultural communities, and most of the families treated under the program came from poor neighbourhoods. The young people participating in MDFT are often considered at high risk of demonstrating multiple problems and being involved in activities that can lead them into the youth justice system.

The goals of the program are to:

- reduce or eliminate substance abuse and behavioural problems; and
- improve family functioning.

With regard to the parents, MDFT seeks to facilitate their engagement and involvement, improve communication between them and the child, and alter inappropriate parenting practices. Lastly, for each family, there are two intermediate goals: helping the young people form bonds of affection with their parents, and building positive and lasting relations with peer groups.

Method

- MDFT consists of individual therapy for children, and family therapy.
- It is a flexible program that adapts to the clinical needs of various population groups.
- For example, an intensive version of MDFT can include 16 to 25 sessions (of four to six months), while a less intensive version can include 12 sessions (about three months).
- Therapy sessions take place weekly and can be held in various locations: home, clinic or school.
- Five evaluation and intervention modules make up the MDFT approach: 1) the adolescent module, 2) the parent module, 3) the family module to facilitate change in family relationship patterns, 4) the module for other family members, and 5) the module for outside family members.

Additional Information

- The number of families per therapist varies from 6 to 10.
- The MDFT clinical team consists of a clinical supervisor, two to four therapists, and one or two assistant therapists, depending on the financial resources available.
- MDFT therapists have two to three years' experience in treating drug use in young people, and a master's degree in a related field.
- Training for therapists can vary, depending on client needs. Generally, the therapists who lead sessions have been trained by familiarizing themselves with MDFT therapy, watching videos or participating, with other therapists, in learning and observation sessions.

Evaluation

- MDFT has been certified as a model program by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- In reducing rates of drug use, MDFT therapy gets better results (a 45% reduction) than group therapy (32%) or multi-family therapy (26%).
- Compared to cognitive therapies, MDFT gets better results in terms of the persistence of positive long-term effects. Cognitive therapies and MDFT get good results in terms of behavioural change in young people, but the effects of MDFT are longer lasting.

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Positive Parenting Program – Triple P

> *"Triple P – the Positive Parenting Program – is a unique parenting and family support strategy designed to reduce the prevalence of behavioural and emotional problems in children and adolescents. Triple P is a multi-level system of family intervention, which provides five levels of intervention of increasing strength." (Sanders M., et al.)*

Originating in Australia, Triple P is a multi-level system of family intervention designed to prevent and treat emotional and behavioural problems in children and young people aged 16 and younger.

Based on behavioural and developmental theory, Triple P addresses the risk factors related to the development of affective and behavioural problems in children. The emphasis is on support and practical advice for parents.

The goals of Triple P are to:

- reinforce parenting skills;
- provide support to parents;
- promote sound family functioning;
- promote non-violent behaviours;
- reduce the risk of child abuse; and
- increase the resources available to parents.

Method

- The Triple P program is divided into five levels; the duration and intensity depend on each family.
- According to its needs and the problems it faces, a family can participate at one level without necessarily going through the preceding ones.
- The five levels are broken down over a service continuum:
  - Level 1: universal prevention, with advice for parents on improving basic healthcare for newborns.
  - Level 2: offers one or two kinds of healthcare intervention for parents whose children present minor behavioural problems; there are few contacts with the therapist.
  - Level 3: offers further sessions for parents whose children present affective problems, such as mood disorders.
  - Level 4: targets parents whose children present more serious problems. This level includes intensive behavioural training for parents, and is spread over 8 to 10 sessions.
  - Level 5: designed for families whose functional difficulties are aggravated by a number of risk factors, such as parental depression, parental stress or spousal conflict.
- Level 5 offers an individualized intensive program for dysfunctional families whose children have behavioural disorders. It includes practical sessions to improve parenting skills and the ability to manage mood and stress, particularly for parents who are at risk of mistreating their child.

Additional Information

- Several levels of Triple P intervention can be delivered in a variety of formats: face-to-face conversation, group sessions, telephone assistance or a combination of several formats. This flexibility enables parents to adjust their participation to the program format that suits them.
- The intervention also includes watching videos that address specific family issues.
- Triple P is adaptable to various population groups.
- Depending on the intervention level, practitioners involved in the program are mental health workers, social workers or other support professionals in the healthcare and education field; they have regular meetings with the parents to discuss the behaviour of their child.

Evaluation

- The program, or one of its components, has been used in a dozen countries around the world, particularly China, Germany, New Zealand, Singapore and the United Kingdom (Kruger, et al. 2000).
- Twenty-five years of research and evaluation have shown that the Triple P program is an effective method of family support.

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Multisystemic Therapy (MST)

"The underlying premise of MST is that criminal conduct is multi-causal… effective interventions would address multiple factors in youth ecology: individual, family, peer, school and community." (Leschied A.W. & Cunningham A.)

MST is intensive, family-centered treatment designed for youth aged 12 to 18 who are regarded as having serious behavioural problems (chronic violence, abuse problems, delinquency and so on) and at risk of placement.

MST is based on a multi-dimensional intervention approach that targets the risk factors from various sources: individual characteristics, family, school, friends, neighbourhood. MST helps parents treat behavioural problems in their children, divert them from bad associations and promote academic success.

The main goals of MST are to:

- reduce antisocial behaviour in young people;
- reduce the number of placements;
- enhance the ability of families to resolve problems and conflicts, that is:
  - help parents manage their children's problems better in order to reduce or eliminate placements;
  - teach parents to discipline their children consistently;
  - identify what seems to be preventing parents from using effective parenting techniques (for example, substance abuse and mental health problems in the parents);
  - develop a social support network for parents, including extended family, neighbours, church members and friends.

Method

- The intervention plans, specific to the needs of each child, consist of family therapy, behavioural training for parents, and cognitive behavioural therapy.
- Each therapist works with four to six families.
- Therapists use existing strengths in the child's network to induce them to modify their antisocial behaviours.
- MST can be carried out in various locations: home, school or community centre.
- MST employs a team of two to four therapists and their supervisor; they must be available at all times. Team members have a university degree in an appropriate discipline.
- The average duration of MST is about four months, with 60 hours of family therapy.

Additional Information

- A large portion of the resources are devoted to the training of therapists and continuous clinical consultation.
- MST training and support is provided on site by MST Services, Inc.
- When an MST-based program is implemented, assistance and support for the design, development and execution of the program can be obtained by MST Services.

- Partners in implementation can be drawn from various sectors: youth justice, mental health, school, healthcare and social services, education, and justice.
- Implementing MST is relatively expensive: about US$5,000 per child. On the other hand, MST reduces the rate of recidivism, thereby avoiding the costs associated with treating recidivists.

Evaluation

- A number of evaluation studies have confirmed the effectiveness of MST (for complete evaluation results, go to the MST Web site at http://www.mstservices.com/complete_overview.php)
- Compared to children who received traditional treatment, MST participants showed a significant reduction in criminal activity. MST participants also had fewer mental health problems.
- Compared to children who received traditional treatment, a 2.4-year follow-up showed that MST had doubled the number of young people who had not reoffended.
- Families participating in MST showed better cohesion, more mutual assistance and less conflict and hostility.
- The positive results of MST are apparent up to four years after program completion.

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- **Multisystemic Therapy:** http://www.mstservices.com/

CASASTART (Striving Together to Achieve Rewarding Tomorrows)

"CASASTART is based on the assumption that, while all preadolescents are vulnerable to experimentation with substances, those who lack effective human and social support are especially vulnerable. It seeks to build resiliency in youths, strengthen families, and make neighborhoods safer for children and their families." (OJJDP)

CASASTART (Striving Together to Achieve Rewarding Tomorrows), also known as Children at Risk (CAR), is a community-, school- and family-based program. It was developed for children aged 8 to 13 who display a high risk of involvement in criminal activity or drug use. The children targeted by the program generally come from poor neighbourhoods.

CASASTART brings together families, caseworkers from healthcare and social services, schools and youth justice institutions. It is designed to provide young people with the support and services they need to become responsible, law-abiding citizens, and create a safe environment for young people and their families by reducing drug-related crimes and offences.

The main goals of CASASTART are to:

- prevent drug abuse and drug dealing in the community;
- prevent crime and delinquency;
- improve school attendance;
- develop cooperation between social services agencies, schools and law enforcement (police and justice authorities) in order to satisfy the needs of young people and their families;
- improve communication between young people and their families, and promote exchanges between families, schools and the other participants in the CASASTART program.

Method

To reduce risk factors associated with neighbourhood, family, friends and individual characteristics, the program is based on the following components:

1. An increased police presence in the community, and more police involvement and participation with young people.
2. Case management: caseworkers are assigned to a few families at a time (13 to 18), which enables special attention to the individual needs of young people and families.
3. Youth justice: increased communication between case managers and youth justice departments in order to ensure appropriate planning and supervision for young people subject to a court order.
4. Family services: caseworkers provide various services for families to increase parental involvement in their children's lives: for example, special programs for parents, advice, organized activities and so on.
5. After-school and summer activities for young people, including sports and recreation, as well as development and self-control programs.
6. Education services to reinforce specific skills through individual in-home courses for young people.
7. Mentoring: group or individual, and designed to promote positive behavioural change in young people.

Additional Information

- To establish a successful CASASTART program, the following steps must be completed:
  - Phase I – Initial activities: 1) conduct a community evaluation, 2) identify an agency to assume leadership, 3) identify potential partners, 4) set up an advisory council and recruit members, and 5) define realistic goals. This phase can take six to eight months.
  - Phase II - Execution: 1) develop memoranda of agreement, 2) if necessary, hire additional associates, 3) establish confidentiality agreements, 4) commence service delivery, and 5) begin CASASTART meetings. This phase can take one year.
- The program adapts to the needs and existing strengths at each location; there may be differences in the level of program development from location to location.
- There are monetary and non-monetary incentives for participation in CASASTART activities.
- CASASTART operates with case managers trained by the program leaders. It is preferable for case managers to have at least some experience in social work. Each case manager handles an average of 15 families.
- The cooperation of the police and youth justice agencies is necessary to help young people on probation.
- Training and technical assistance in setting up CASASTART at new locations are available from the program leaders, for the sum of $3,000 a day (in 2005).

Evaluation

- This program was developed by the National Center on Addiction and Substance Abuse at Columbia University and has been certified as a model program by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Compared to children in the control group, after a one-year follow-up, fewer children in CASASTART used marijuana, alcohol, inhalants or tobacco (74%, compared to 64%), or committed violent crimes (22%, compared to 27%).
- On the other hand, for some aspects, there is no significant difference between children in the program and children in the control group: for example, self-esteem, at-risk sexual behaviour, crimes against property, gang membership and contacts with the police.

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- **CASASTART Web site:** http://casastart.org/content/AboutCASASTART.aspx

Wraparound Milwaukee

"Wraparound Milwaukee is a system of community-based care for families of children with severe emotional, behavioral and mental health needs. This wraparound approach is based on an identification of the services families really need to care for a child with special needs." (OJJDP)

Wraparound Milwaukee is an integrated care system for those aged 13 to 17 who present serious emotional or behavioural problems and require mental health services.

The program emphasizes the development of appropriate care for children and their families by providing integrated mental health, substance abuse and social services.

The program was designed to reduce recourse to institutional care in treatment centres and psychiatric hospitals by providing more services for children and their families.

The program is run by Child and Adolescent Services, Milwaukee County Mental Health Division in Wisconsin.

Method

- The program is based on an integrated, personalized approach to care.
- Family participation is a key to successful treatment.
- Key community caseworkers and professional resources are identified to participate in the services provided to young people and their families.
- Young people are referred to the program by probation officers or youth services officers.
- The program is for young people with serious affective problems identified by youth protection services or the juvenile justice system as being at imminent risk of residential, correctional or psychiatric centre placement.
- The program management team includes care coordinators, a child-and-family team (CFT), a mobile crisis team and a network of partners associated with the program.

Care Coordinators:

- Care coordinators are the cornerstone of the program.
- They conduct evaluations, assemble child-and-family teams, lead meetings, help determine needs and resources with the young person and the family, help the team identify the services to meet those needs, arrange the delivery of specific services, and supervise the execution of the treatment plan.
- Coordinators in this program work with a limited number of families at once: a maximum of eight.

The Child-and-family Team:

- This is a support network that includes family members and youth justice probation officers or social workers from youth protection.

The Mobile Crisis Team:

- The mobile crisis team offers continuous service, round the clock.
- The team is available to meet the needs of the young person or family when a care coordinator is not available.
- It is made up of psychologists and social workers trained in crisis intervention.
- Young people in the program are automatically registered for the crisis service, and their treatment plans include immediate recourse to the crisis team, when necessary.

A Network of Partners:

- The network is made up of a broad range of services and resources to meet young people's needs.

Additional Information

- The average monthly cost per family is $3,796 (2006 Annual Report, Wraparound Milwaukee).

Evaluation

- In 1994, Milwaukee County received five-year federal funding for the mental health services centre to launch this integrated care program.
- Pre- and post-test evaluations after one year showed that the Wraparound Milwaukee program led to a reduction among program participants in rates of drug offences (6% to 3%), offences against property (34% to 17%), firearms offences (15% to 4%), assaults (14% to 7%) and sexual assaults (11% to 1%).

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All Children Excel (ACE)

"Deflecting Children from the Path of Violence – Intensive Early Intervention for very young offenders." (Ed Frickson, Project Director)

The ACE (All Children Excel) program is for those aged 6 to 15 who present a high risk of becoming violent and chronic delinquents, who are already involved in delinquency or who are at high risk of being maltreated. ACE seeks to reduce the risk factors and improve the resilience of families and children.

The goals of ACE are to prevent and reduce:

- serious and violent delinquent behaviour;
- the intergenerational transfer of criminal behaviour, neglect or both;
- drug use;
- family violence; and
- school abandonment.

To achieve these goals, the program relies on building positive ties with school, family and friends, improving social skills, and participation in recreational activities.

Method

- Risk factors are identified using a chart developed by program researchers.
- The ACE model is based on integrated intervention by caseworkers drawn from several fields: mental health care, youth justice, education, police and the youth protection system.
- Intervention is also based on cooperation between parents, children, school and community to reduce risk factors and reinforce protective factors.

Additional Information

- A multidisciplinary team provides multidimensional intervention and support for families.

Evaluation

- The project was developed in 1998 by the Ramsey County (St. Paul), Minnesota, Board of Commissioners, to address an increase in the number of juvenile delinquents and the increasingly early onset of delinquency.
- Six months after their initial evaluation, 35% of children in the ACE program committed a new offence, compared to 57% of children in the control group.
- In the community of Ramsey, in St. Paul, Minnesota, 82.7% of children considered at high risk commit a criminal offence by their 13th birthday, compared to 30.5% of children who participated in ACE.
- The daily cost of the ACE program is $22 per child, compared to $100 per child per day for detention in a youth correctional facility.

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SNAP™ Under 12 Outreach Project (ORP)

"SNAP™ helps children and parents interrupt problematic pathways between thinking and doing, to stop and think before they act and to learn more appropriate ways to calm down."

The SNAP™ (Stop Now and Plan) Under 12 Outreach Project is a program based on an integrated approach for boys aged 6 to 11 in contact with the police, at risk to reoffend, or who display serious behavioural problems. SNAP™ was developed by the Child Development Institute of Ontario, Canada.

ORP is based on social learning and cognitive change and uses a multisystem approach targeting the child, the family and the community.

The goals of the program are to:

- prevent boys from having dealings with the police in the future;
- prevent recidivism; and
- facilitate rapid and effective access to a range of services.

Method

The prevention strategy developed by the program involves three steps:

- Step 1: a protocol with police services for boys already involved in delinquency. This type of protocol facilitates cooperation between caseworkers and directs the boys to the appropriate services.
- Step 2: a structured clinical evaluation of risks for young people (boys and girls): the Early Assessment Risk List for Boys (EARL-20B) and the Early Assessment Risk List for Girls (EARL-21G).
- Step 3: application, depending on gender, of the SNAP™ Program, which involves teaching children and families methods of self-control to enable them to stop and think before they act.
- For boys, there is the SNAP™ Under 12 Outreach Project, and for girls the SNAP™ Girls Connection.
- The SNAP™ Under 12 Outreach Project (ORP) is a 12-week program with five components:
  1. The SNAP™ course: group training for children to teach them the SNAP™ self-control and dispute resolution techniques. The examples addressed include how to stop stealing, how to manage the influence of others, how to manage bad emotions like anger and aggression, and how to stay out of trouble.
  2. A SNAP™ parent group: parents learn effective child behaviour management strategies based on SNAP™ principles.
  3. Individual meetings for children who fail to assimilate the SNAP™ principles and need additional support.
  4. Family consultations based on Stop Now and Plan Parenting, or SNAPP.
  5. Make-up courses for children having difficulty in school.
- Parents are key participants in the process: they are encouraged to participate in weekly groups where they can learn SNAP™-based parenting techniques.
- Meetings are held weekly for 12 weeks.

Additional Information

- The average cost of ORP services for a low-risk child is about $1,000 (four-month program), $2,300 for a moderate-risk child (six-month program), and $4,300 for a high-risk child (12-month program).
- SNAP™ is a registered trademark of the Child Development Institute. To obtain authorization to make copies, and the necessary materials, contact the Institute.

Evaluation

- Evaluations of the SNAP™ Outreach Project (ORP) and the Girls Connection (GC) show the positive effects of the treatment.
- Among ORP and GC participants, significant improvements were noted in three areas: personality (anxiety, depression), externality (aggression, delinquency) and social skills (peer relations, participation in activities).
- Studies have shown that children who take part in the program are twice as likely not to have a criminal record by age 18.
- It was found that 60% of high-risk children participating in the program did not have a criminal record by age 18.
- ORP and GC participants have better relations with teachers, peers and family members. They are more aware of the negative effects of associating with delinquent peers.
- Parents taking part in ORP and GC feel less stress in their interactions with their child and have more confidence in their ability to manage their child's deviant behaviour properly.
- The program is now running in various cities in Canada, the United States, Europe and the Scandinavian countries.

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Notes

1. Shader, 2003.
2. Ibid.
3. Hill et al., 2001; Thornberry et al. 1998, 2004.
4. Hoeve et al., 2007; Wasserman et al., 2003; Farrington and Welsh, 1999.
5. Loeber, Farrington and Petechuk, 2003; Wasserman et al., 2003; Lawrence et al., 2001.
6. Loeber et al. 1998.
7. Cabinet Office, Social Exclusion Task Force, 2007, p. 5.
8. McVie and Holmes, 2005; Welsh and Farrington, 2007; Leblanc, 1999; Lacourse et al., 2006; Thornberry, Huizinga, and Loeber, 2004; Wyrick & Howell, 2004; Farrington et al., 2006; Loeber, Farrington and Petechuk, 2003; Hoeve et al., 2007; Claes et al., 2005; Shader, 2003; Wasserman and Seracini, 2001; Wasserman et al., 2003; Éthier et al., 2006, 2007.
9. See in particular, McVie and Holmes, 2005; Loeber, Farrington and Petechuk, 2003; Mucchielli, 2000.
10. Wasserman & Seracini, 2001.
11. Smith, 2004-a; McVie and Holmes, 2005.
12. Claes et al., 2005.
13. Thornberry et al.,1998, 2004.
14. Generally, “supervision” refers to the control parents exercise over their children’s outings, associations, schoolwork, recreational activities, and their knowledge of whether they smoke or use drugs, and so on. Mucchielli, 2000.
15. Ibid.
16. LeBlanc, 1988, pp. 161 and 163, quoted by Mucchielli, 2000.
17. Smith, 2004-a.
18. Smith, 2004-a; McVie and Holmes, 2005.
19. Farrington et al., 2006; Loeber et al., 1998.
20. The problem of intergenerational crime has been associated with numerous risk factors and stressors such as lack of supervision, placements, multiple relocations, poor parental attitudes, embarrassment, isolation and the stigma due to incarceration of the parents. (*Children of Offenders,* unpublished paper).
21. Dossier from Le Front nouveau de Belgique [The new front in Belgium], 2002.
22. According to social learning theory, children who are victims or witnesses of family violence have a greater probability as adults of reproducing the family pattern they grew up in. (Hotton, 2003).
23. Ibid.
24. Shader, 2003.
25. Mayer, M., C. Lavergne, and R. Baraldi, 2004.
26. Lansford, J., et al. 2007.
27. Thompson and Braaten-Antrim, 1998.
28. Kaufman and Widom, 1999.
29. For a better understanding of transmission and the intergenerational consequences of drug use, special attention will have to be paid to the results of the Seattle Social Development Projects – Intergenerational Project (SSDP-TIP).
30. McVie and Holmes, 2005.
31. Hotton and Haans, 2004.
32. Mucchielli, 2000.
33. According to L. Mucchielli, the relationship between delinquency and single-parent families is often the result of a twofold stigma. It first appears as the result of prejudice, whereby a single parent is considered less able to raise and control children correctly than an apparently united stable family. Second, broken families and juvenile delinquents generally come from underprivileged environments, in which case their relationship is merely the effect of social and economic circumstances (Mucchielli, 2000).
34. Ibid.
35. Farrington et al., 2006.
36. Ibid.
37. Family transition refers to a set of events associated with change: for example, in family structure (divorce, remarriage) or in family mobility (moves).
38. As researchers point out, prevention programs must take into account the fact that young people experiencing family transition are more likely to have difficulty in managing their emotions. It is therefore important to improve young people’s abilities and skills in controlling their emotions better during such times (Thornberry et al. 1999).

39. Browning and Loeber, 1999.
40. We should point out for information that works on geocoding in order to break down crime data over a given territory is an important source of information for describing neighbourhoods that have high crime rates. In Canada, analysis of the distribution of crime by neighbourhood characteristics has been carried out in three cities: Regina, Montreal and Winnipeg. In this connection, see **Fitzgerald, R., M. Wisener and J. Savoie.** 2004, *Neighbourhood Characteristics and the Distribution of Crime in Winnipeg.* Ottawa: Statistics Canada, Canadian Centre for Justice Statistics; **Wallace, M., M. Wisener and K. Collins.** 2006. Neighbourhood Characteristics and the Distribution of Crime in Regina. Ottawa: Statistics Canada, Canadian Centre for Justice Statistics; and **Savoie, J., F. Bédard and K. Collins.** 2006. *Neighbourhood Characteristics and the Distribution of Crime on the Island of Montreal.* Ottawa: Statistics Canada, Canadian Centre for Justice Statistics.
41. Turner M., J. Hartman and D. Bishop., 2007.
42. Lauritsen, J., 2003.
43. The terms “children” (*enfants*) and “youths” (*jeunes*) include those under 18. The term *enfants* designates those under 12, whereas *jeunes* means those from 12 to 17. (Ogrodnik , 2007; 24)
44. Ibid.
45. Ibid.
46. Ibid.
47. Canadian Council on Social Development, 2007.
48. Taylor-Butts A., 2007.
49. Ibid.
50. Trocmé et al., 2005.
51. Ibid.
52. Ogrodnik, 2006.
53. Mayer et al., 2004.
54. Savoie, 2007.
55. Ibid.
56. Ibid.
57. Adlaf, E.M., Begin, P., and Sawka, E. (2005). The Canadian Addiction Survey describes the prevalence, incidence and use of alcohol and other drugs among Canadians aged 15 or over.
58. Heavy use means five glasses of an alcoholic beverage or more on one occasion for men, and four or more for women (Ibid).
59. Public Safety and Emergency Preparedness Canada, 2006.
60. Ibid.
61. Canadian Centre for Justice Statistics, 2001.
62. Brozozowski, J-A., A. Taylor-Butts and S. Johnson, 2006.
63. First Nations Centre, 2006
64. Lonczak et al., 2007.
65. Brozozowski, J-A., A. Taylor-Butts and S. Johnson, 2006.
66. Shader, M., 2003.
67. Shader, 2003; Lawrence et al., 2001.
68. Ibid.
69. Claes et al., 2005.
70. Kumpfer and Alvarado., 1998.
71. Shader, 2003; Lawrence et al., 2001; Claes et al., 2005.
72. Claes et al., 2005.
73. Browning et al. 1999.
74. McVie, S. and L. Holmes. 2005.
75. Lauritsen, 2003.
76. Turner M., J. Hartman and D. Bishop., 2007.
77. Sampson et al., 1997; Slee et al., 2006.
78. Smith, 2006.
79. Smith, 2004-a.
80. Sherman et al., 2002; Hastings et al., 2007.
81. Hastings et al., 2007.
82. Mihalic et al., 2001.

83. Ibid.
84. Welsh and Farrington, 2007a, 2007b; Farrington and Welsh, 2003; Sherman et al., 2002.
85. Welsh, 2007.
86. Greenwood, 2004.
87. Ibid.
88. Accordingly, primary prevention programs – those that address families and youth without considering the individual risks they face – were not included in the study.
89. To avoid redundancy, protective factors associated with families were not included in the tables, since essentially it is the same ones that constantly recur: improved parenting techniques, parent involvement in family life, positive family relations, reinforcement of family affection, family stability and the organization of family activities in which children and parents can participate together.
90. Kumpfer and Alvarado, 1998.
91. Explanation of program rating levels:

    I. Office of Juvenile Justice and Delinquency Prevention (OJJDP) - *Model Programs Guide (MPG)*
    - Exemplary: program with a high degree of fidelity that demonstrates robust empirical findings, a reputable conceptual framework and an evaluation design of the highest quality (experimental).
    - Effective: a program with sufficient fidelity that demonstrates adequate empirical findings, uses a sound conceptual framework and an evaluation design of high quality (quasi-experimental).
    - Promising: program demonstrates promising empirical findings, uses a reasonable conceptual framework but requires more thorough evaluation; the evaluation is based only on pre- and post-test measurements.

    II. Strengthening America's Families Project
    - Exemplary: program that has an evaluation of the highest quality, presents positive results and has been replicated several times.
    - Model: program that has been thoroughly evaluated but seldom replicated.
    - Promising: program that requires other research or uses non-experimental evaluation methods; results seem promising but need to be confirmed with more rigorous evaluation methods.
92. Farrington D. & B. Welsh. 1999. *Delinquency Prevention Using Family-Based Interventions.*
93. OJJDP – *Model Programs Guide.* Available from: www.dsgonline.com
94. Community Guide to Helping America's Youth. Available from: www.helpingamericasyouth.gov/
95. *Strengthening America's Families, Effective Family Programs for Prevention of Delinquency.* Available from: www.strengtheningfamilies.org/
96. Krug et al., 2002.
97. Mihalic, S. et al. 2001. *Blueprints for Violence Prevention.* US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
98. Center for the Study and Prevention of Violence. *Blueprints for Violence Prevention,* Available from: www.colorado.edu/cspv/blueprints/
99. *Guide to Effective Programs for Children and Youth.* Available from: www.childtrends.org/Lifecourse/programs/TripleP-PositiveParentingProgram.htm
100. Burns and Goldman, 1999, OJJDP- MPG.
101. Elliott et al., 1998.
102. Henggeler, et al., 1997.
103. Promising Practices Network on Children, Families and Communities. Available from: www.promisingpractices.net/default.asp
104. Ed Frickson, Ramsey County, All Children Excel.
105. Reinhardt, 2007.
106. With regard to programs that operate to a limited extent (evaluation of results and methods), information currently available on these programs was not sufficient to provide explanations.
107. These are taken from the series of OJJDP bulletins: *Effective Family Strengthening Interventions.*
108. Kumpfer et al., 1998.
109. Ibid.
110. The feeling of belonging to the school community being considered an important protective factor against delinquency (Sprott et al., 2005).