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Implementation Fact Sheets on Promising and Model Crime Prevention Programs – 2012

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Aggression Replacement Training (ART)®

The ART® program in a nutshell

The Aggression Replacement Training (ART)® program is a 10-week cognitive behavioural multi-component intervention designed to target youths aged 12 to 17 years old who display chronically aggressive and violent behaviour. The program is centered on skill building, group discussions to enhance perspective taking and reinforcement techniques that enhance transfer of learning from the group sessions to the real world.

What are the goals of the ART® program?

The main goals of the ART® program are to reduce aggression and violence among youth by providing them with opportunities to:

- learn how to control angry impulses;
- build pro-social skills and social competence;
- enhance moral reasoning including how to take perspectives other than their own; and
- reduce aggressive behaviour.

Who is the target population for the ART® program?

ART® program is targeted at youths aged 12 to 17 years old serious aggression and anti-social behaviour, and can be applied across several different populations and from different socio-economic backgrounds. It is recommended that potential participants be screened for risk and severity of aggressive/anti-social behaviour before implementation to assess eligibility for inclusion. This type of assessment often includes the use of clinical instruments to examine the degree of problematic behaviour in youths.

What types of settings are appropriate to implement the ART® program?

The ART® program can be implemented in rural, urban, and suburban community settings. In addition to being implemented in schools, ART® has been used in juvenile delinquency programs and in mental health settings to reduce aggressive and anti-social behaviour and promote anger management and social competence. It can also be used by community-based agencies, and most social services programs and services.

What are the key components for the implementation of the ART® program?

The ART® program consists of three interrelated components, all of which come together to promote a comprehensive aggression-reduction curriculum. Each component focuses on a specific pro-social behavioural technique (action, affective/emotional, or thought/values):

- **Social Skills Training**: youth learn pro-social behaviours through modeling and role-playing that should be applied when encountering stressful or negative situations.

- **Anger Control Training**: youth use examples of recent real-life situations where they encountered something that aroused feelings of anger in them. The group uses these examples to learn how to react in this type of situation.
- **Training in Moral Reasoning**: youth are taught to view the world from the perspective of another person. It is designed to teach the youth about fairness and justice while taking into consideration the rights of the other person.

What are critical elements for the implementation of the ART® program?

Some of the critical elements for the implementation of the ART® program include:

- ART® consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 youth 3 times per week;
- a specific referral process for program participation will need to be put in place in order to target at-risk youth;
- fidelity to the process of teaching social skills (modeling, role-playing, performance feedback and transfer training) is needed as this program relies on repetitive learning and transfer training techniques to teach participants to control impulsiveness and anger so they can choose more appropriate pro-social behaviours; and
- group facilitator attributes are important as guided group discussion is used to correct anti-social thinking.

What are some of the risk factors targeted by the ART® program?

Some of the risk factors targeted by the ART® program are:

- anti-social/delinquent beliefs and behaviour;
- conduct disorders (authority conflict/rebellious/stubborn/disruptive/anti-social);
- exposure to firearm violence;
- few social ties (involved in social activities, popularity);
- general delinquency involvement;
- high alcohol/drug use;
- illegal gun ownership/carrying;
- lack of guilt and empathy;
- mental health problems;
- physical violence/aggression;
- family violence;
- association with antisocial/aggressive/delinquent peers;
- high peer delinquency;
- association with gang-involved peers/relatives;
- peer alcohol/drug use; and
- bullying.

What are some of the protective factors targeted by the ART® program?

Some of the protective factors targeted by the ART® program are:

- resilient temperament;
- involvement in the community; and
- social competencies.

What are the results from evaluation studies of the ART® program?

Evaluation studies of the ART® program have shown the following:

- participation resulted in fewer additional arrests for 80% of the participants;
- improved skills observed in four areas: pro-social skills, pro-social behaviours, ability to manage impulsiveness, and moral reasoning;
- youths displayed an increased ability to express complaints, prepare for stressful situations, respond to anger, and to deal with peer pressures;
- participation resulted in fewer negative behaviours, and where participants displayed negative behaviours, they tended to be less intense and not as frequent as youth who did not participate in the program; and
- both parents and youth reported an improvement in child-teacher relationships and an improvement in the responsibility of the youth.

What are the materials needed for the implementation of the ART® program?

The ART® program is an action-oriented, multimodal intervention that uses specific strategies to address those contributors that cause aggressive and violent behaviours in at-risk youth. G & G Consultants, LLC is responsible for product development as well as overseeing the standards and practices for accreditation, and is also the organization responsible for delivering training and managing requests for basic materials needed for this program. These basic materials include 2 manuals:

- Aggression Replacement Training® (3rd edition, revised and expanded); and
- Aggression Replacement Training®: A Comprehensive Intervention for Aggressive Youth.

What staff is needed to implement the ART® program?

The following staffing requirements must be met to implement the ART® program:

- It is generally implemented in school settings by teachers, in institutional juvenile justice or mental health settings by youth workers, and in community-based agencies or systems by direct line staff;
- In the juvenile court setting, it can be implemented by court probation staff or private contractors.

What training is needed for staff in implementing the ART® program?

It is highly recommended that group facilitators be trained according to the standards set by trademark certifications and those established by Dr. Barry Glick and G & G Consultants, LLC. They provide training at 3 levels: the basic level qualifies staff to implement ART®, the advanced level qualifies them to train others in the program and during the master's level, program staff learn different things depending on their individual needs. The following is a more detailed explanation of the different training phases:

- Phase 1, ART® Training for Group Facilitators: a 5-day 36-40 hour training seminar that combines didactic and interactive learning for individuals who wish to deliver the ART® program.. Individuals take a pre-test and post-test to demonstrate acquisition of learning and skills. They also are required to deliver 3 complete cycles of the ART® program during which time technical assistance with training/implementation issues are provided.
- Phase 2, ART® Training for Trainers: a 5-day 36-40 hour training seminar that deals with pre-screened applicants who wish to be trainers of ART® Group Facilitators. This seminar combines trainer skill development sessions and ART® trainer sessions. Two simultaneous learning groups occur: the trainers' group as well as a group facilitators' training. The ART® Training of Trainers co-facilitate with the ART® Master Trainer, the training of group facilitators. Additional training seminars process the experiential training activities. Participants in the Training of Trainers seminar are then expected to conduct 3 training sessions independently, the first of which is co-trained with the Master ART® Trainer. Training for Trainers participants provide either audio and/or video tapes for review. Master Trainers will provide supervision electronically.
- Phase 3, Master Trainer Training: this training is an individualized independent learning for those Master Trainers who apply and are accepted to be Master Trainers of ART®. Master Trainers are certified to participate in program development, curriculum innovation, and independent ART® consultation.

What are the estimated costs for the ART® program?

Materials and Training

- The tuition fees for the 5-day, 40 hour Institute, the ART® monograph published by Research Press, the Group Facilitator's Manual provided to staff at their first day of training and three months of participant initiated technical assistance for program implementation and clinical supervision is around $3,500 USD per participant.
- The total training costs for 12 staff (minimum required) is around $40,000 USD plus air transportation, car rental, fuel, lodging, meals and incidentals.

Overall Costs for Implementation

- The cost per youth involved in the ART® program is approximately $900 USD. This estimate includes all materials, staff time and salaries, and supervision of youths when practicing their skills in the community.
- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as administrative costs, program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the ART® program?

If implemented correctly, the ART® program is cost effective. Based on a cost-benefit analysis, this program could generate approximately $11.66 USD in benefits from avoided crime costs for every $1 USD spent on implementing the program.

What other programs have been developed based on the ART® program?

The ART® program has been implemented in schools and juvenile delinquency programs across the United States and throughout the world. The ART® monograph presents suggested program procedures and is available in various foreign languages (e.g., Italian, Swedish, Polish, and Spanish). Some materials are also available in French.

Beyond this, the National Crime Prevention Centre (NCPC) is currently not aware of any other program that has been developed based on the ART® program.

Who is the contact for the ART® program?

For more information on this program, please contact:

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Functional Family Therapy (FFT)

The FFT program in a nutshell

The Functional Family Therapy (FFT) program is a multistep, phasic intervention that targets youths 11 to 18 years old who are at risk of or already demonstrating delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behaviour disorder. The program includes 8 to 30 hours of direct services for youths and their families, depending upon individual needs. Generally, sessions are spread over a 3-month period of time. The phases of the intervention include engagement (to reduce the risk of early dropout), motivation (to change maladaptive beliefs and behaviours), assessment (to clarify interpersonal behaviour and relationships), behaviour change (including skills training for youths and parents), and generalization (in which individualized casework is used to ensure that new skills are applied to functional family needs).

What are the goals of the FFT program?

The FFT program has several main goals including to:

- increase efficiency, decrease costs, and enhance the services provided to youth by targeting known risk and protective factors;
- engage and motivate the families of the youth who participate in the program;
- change the maladaptive behaviours of youth and their families as well as reducing the personal, societal, and economic devastation that the disruptive behaviour of youth may cause; and
- use clear plans for each stage of the intervention, monitor processes and outcomes, and believe that families can make the necessary changes and learn from FFT.

Who is the target population for the FFT program?

The FFT program targets youth aged 11 to 18 years old who are at risk for or are engaging in delinquent acts, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behaviour disorder. Often the youth targeted also suffer from additional challenges such as depression. Many youth targeted by the program are at risk for institutionalization if their behaviour does not change.

This program has been applied with success in different ethnic groups under different socio-economic contexts and for different problems (drug consumption, delinquency, and violence). FFT has been shown to be effective when targeting African American and Hispanic youth as well as females. Additionally, the program has been applied to two-parent families as well as single parent families.

What types of settings are appropriate to implement the FFT program?

FFT is an intervention style program with implementation usually occurring in the homes of the clients. However, the FFT model has been successfully replicated across the continuum of juvenile justice, mental health settings, child welfare systems, from prevention and diversion type programs to aftercare and parole, as well as traditional drug and alcohol and school-based programs. As such, the service may also be delivered in clinics, schools, juvenile courts, community-based programs, and at the time of re-entry from institutional placement.

What are the key components for the implementation of the FFT program?

The FFT program has several key steps which are designed to build upon one another to enhance protective factors to reduce risk. These phases consist of:

- **Engagement**: This initial step is designed to identify and emphasize risk factors within a youth's life that put them at risk for delinquent behaviour and to identify protective factors that protect the youth and families from early program dropout and delinquency. During this stage, the therapist develops an alliance with the family that prevents dropout from the program and reduces negative communication among the family members.
- **Motivation**: This second phase is designed to change maladaptive emotional reactions and beliefs, and increase the alliance formed between the therapist and the family through trust, hope, and motivation for lasting change. This phase also involves eliminating negative emotions such as anger and blaming among the family members.
- **Assessment**: The third phase is designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behaviour and how they relate to change techniques. It aims to identify areas in relationships in which problems lie and develop appropriate techniques for change. This process is ongoing throughout the duration of the program.
- **Behaviour Change**: This phase consists of several techniques including parent-child process, communication training, basic parenting skills, contracting, and response-cost techniques. Additionally, during this stage, an individualized plan that sets out steps for change is developed for each family member. The therapist uses techniques such as session structuring, modeling, directing, and training to encourage skill development and behaviour change.
- **Generalization**: During the last phase, family case management is guided by individualized family functional needs, their interface with community based environmental constraints and resources, and the alliance with the FFT therapist/family case manager.

What are critical elements for the implementation of the FFT program?

Some of the critical elements for the implementation of the FFT program include:

- strict adherence to the phases as they are organized in a manner that makes them easy to understand and follow, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption;
- completing each step of the program as they are organized and indicate clear goals for the phase as well as assessment, specific techniques of intervention and procedures that are necessary for the success of FFT;
- the setting should be chosen based on the schedules of the family and therapist, the family's access to transportation, and the family's comfort level;
- the specific location selected should have meeting rooms that are large enough to accommodate an entire family; and
- a specific referral process for program participation will need to be put in place in order to target at-risk youth.

What are some of the risk factors targeted by the FFT program?

Some of the risk factors targeted by the FFT program are:

- anti-social behaviour/alienation;
- high temperament;
- delinquent beliefs;
- general delinquency involvement;
- drug dealing;
- insecure attachment;
- family management problems;
- poor parental supervision and/or monitoring;
- pattern of high family conflict;
- poor family relationships;
- parental substance abuse;
- low social support;
- low socio-economic status; and
- high prevalence of crime in the community.

What are some of the protective factors targeted by the FFT program?

Some of the protective factors targeted by the FFT program are:

- social competence;
- high academic achievement;
- effective parenting;
- supportive family relationships;
- good social support network; and
- positive peer and community influences.

What are the results from evaluation studies of the FFT program?

Evaluation studies of the FFT program have shown the following:

- a reduction in the number of youth who are admitted into more restrictive housing placements;
- a reduction in the number of social service agencies involved with the youth;
- prevention of future delinquent behaviour;
- a reduction in the number of adolescents being tried in the adult criminal justice system;
- an improvement in family communication;
- a reduction in recidivism rates from 50% to 26%;
- an increase in the amount of parent involvement: and
- improvements in ADHD behaviours both at home and within the classroom.

What are the materials needed for the implementation of the FFT program?

To address the key issue of enhancing treatment competence, the FFT program recently developed and implemented a sophisticated web-based application designed to monitor highly structured FFT therapist progress notes, as well as supervisor and client ratings of therapist competence.

To support implementation, FFT has well-developed treatment/training and supervision manuals. FFT also has extensive procedures for training sites during set-up and monitoring aspects of sites during implementation, including well-developed systems for training on-site supervisors and booster trainings. A brief description of these training materials is provided:

- Treatment Manual: FFT utilizes a training manual developed for one primary purpose, to prepare future FFT trainees for Phase 1 of FFT training and certification. The manual includes information about all aspects of the FFT model (pre-treatment activities and in-session activities for all three phases). In addition to the full manual, therapists are provided with a brief pre-training manual to provide an orientation to FFT prior to attending workshops.
- Supervision Manual: FFT follows a prescribed format for conducting weekly group supervision with therapist teams. The procedures for supervision have been refined over the past decade of practice.[1]

[1] Note: Revisions are currently being made to the existing Supervision Manual. The original manual is available upon request.

What staff is needed to implement the FFT program?

The following staffing requirements must be met to implement the FFT program:

- Because the FFT program is based on the clinical model, it is important that only clinicians with relevant training and experience working with delinquent or at-risk youth implement FFT. It is recommended that these therapists have a master's degree, as a minimum, in a related field, but it is only mandatory that the FFT on-site supervisor has a master's degree.
- The FFT treatment team is composed of 3-8 FFT therapists, one of whom eventually becomes the FFT on-site clinical supervisor in the second year of the program.

What training is needed for staff in implementing the FFT program?

Therapists implementing FFT must be trained in all aspects of the program. There are 3 phases of training that occur over a 3 year period:

- Phase I Clinical Training: The initial goal of this phase of FFT implementation is to impact the service delivery context so that the local FFT program builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training or consultation. By the end of Phase I, FFT's objective is for local clinicians to demonstrate strong adherence and high competence in the FFT model. The goal is for Phase I to be completed in one year, and not last longer than 18 months.
- Phase II Supervision Training: The goal of this phase of FFT implementation is to assist the site in creating greater self-sufficiency in FFT, while also maintaining and enhancing site adherence/competence in the FFT model. Primary in this phase is developing competent on-site FFT supervision. During Phase II, FFT trains a site's extern to become the site supervisor. This person attends two 2-day supervisor trainings, and then is supported by FFT through monthly phone consultation and the web-based FFT supervision assessment system. FFT provides one 1-day on-site training during Phase II. This is a year-long process.
- Phase III and On Going Partnership: The goal of this phase of FFT implementation is to move into a partnering relationship to assure on-going model fidelity, as well as impacting issues of staff development, interagency linking, and program expansion. FFT provides a one-day on-site training for continuing education in FFT. Therapists and supervisors maintain case, outcome and adherence tracking in the FFT system. Phase III requirements are renewed annually, and their base of oversight and consultation is considered necessary for a FFT site to remain certified.

What are the estimated costs for the FFT program?

Materials and Training

- For an overview of the individual costs associated with the FFT program materials and training, please contact the program developer.

Overall Costs for Implementation

- The 90-day costs for the FFT program range approximately between $1,600 USD and $5,000 USD for an average of 12 home visits per family. The cost per day of implementing the program is approximately between $15 USD and $40 USD. However, the cost will be higher for individuals requiring more than 12 home visits.
- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as salaries, administrative costs, program support, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the FFT program?

The FFT program has been described as cost-effective. Based on "The Family Project", a replication of the FFT program in Las Vegas (2000), FFT costs during this time were between $700 USD (clinic-based FFT, 12 sessions) and $1,000 USD (in-home FFT, 12 sessions) per family. By contrast, the average cost of detention was at least $6,000 USD per youth for 30 days and the average cost of residential treatment was at least $13,500 USD per youth for 90 days.

What other programs have been developed based on the FFT program?

The FFT program has been replicated in a number of different settings including within a military community, within a youth outreach centre, in a youth services agency, in family preservation programs, and with youth who are substance abusers. Further, in the United States there are numerous adaptations of the traditional FFT model; as a case management practice for juvenile probation and parole officers, as a comprehensive child welfare intervention, and as part of a continuum of evidence-based programs within juvenile justice.

Beyond this, the National Crime Prevention Centre (NCPC) is currently not aware of any other program that has been developed based on the FFT program.

Who is the contact for the FFT program?

For more information on this program, please contact:

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Leadership and Resiliency Program (LRP)

The LRP in a nutshell

The Leadership and Resiliency Program (LRP) is a school- and community-based program for students aged 14 to 19 years old that enhances youths' internal strengths and resiliency while preventing involvement in substance use and violence. Based on a clinical prevention strategy designed to identify and enhance internal strengths and support the building of positive attitudes, the LRP has three core components: resiliency groups, community/service learning and alternative/adventure activities.

What are the goals of the LRP?

The LRP's main goals are to enhance youths' internal strengths and resiliency and promote mental wellness while preventing involvement in substance use and violence. The program has several objectives including to:

- increase participants' perceptions of competence and self-worth;
- improve participant identification with positive roles;
- reduce disciplinary actions in school;
- improve participants' communication and refusal skills;
- increase knowledge of and encourage negative attitudes toward substance abuse and violence; and
- increase community involvement in promoting the healthy development of youth and the valuing of adolescents.

Who is the target population for the LRP?

The LRP is primarily designed for youth of both genders aged 14 to 19 years old. The program has been found to be effective with participants of diverse cultural and ethnic backgrounds. While there are no specific interventions for parents, communication occurs on an ongoing basis between staff and parents. Parents are also encouraged to become involved in the alternative activities.

What types of settings are appropriate to implement the LRP?

The LRP is delivered in the school and/or community setting (rural, urban and/or suburban communities).

What are the key components for the implementation of the LRP?

The LRP has three core components:

- **weekly resiliency groups** in which 7 to 10 participants meet for approximately 1 to 1-1/2 hours per week during school hours throughout the school year;
- **monthly community volunteer/service learning experiences scheduled outside of school hours** including animal rehabilitation, community beautification or puppet projects in which participants learn skits on relevant issues and present them to elementary school students. Each participant is expected to perform a puppet skit at least once during their high school career (and preferably 3 times or more); and
- **monthly alternative or adventure activities** also scheduled outside of school hours which can include camping, white-water canoeing and kayaking, rope courses, hiking and other challenge activities.

Each program component complements the others, and all are considered integral to providing a holistic prevention program. These components and their related activities were chosen specifically for the target population and are developmentally-appropriate. A focus of each component is building leadership and problem-solving skills among the participants while encouraging the development of peer refusal skills, risk management, goal orientation, future-oriented thinking, optimism, empathy, internal locus of control, and conflict management.

What are critical elements for the implementation of the LRP?

Some critical elements for organizations implementing the LRP include a requirement to:

- work under a license from the LRP, adhere to the components of the LRP and agree to participate in the LRP training;
- build on or establish strong relationships with referral sources. As such, LRP requires partnerships among the school or school board and a substance abuse or health service agency along with other community partners. A collaborative approach is used to identify and refer the participants (a specific referral process for program participation will need to be put in place in order to target at-risk youth); and
- ensure a high degree of participation (this may mean that the program must provide transportation, meals, etc.).

Other important considerations:

- the program operates all year round with increased alternative programming when school is not in session;
- for best results, students should enter the program early in their high school career and remain in the program until graduation, however, participants may enter the program at any time;
- implementation requires that youth participate in all 3 program components over the course of 5 months to 1 year for each of the 2 to 4 years they are in the program;
- the start-up period for the program is generally 4 months and includes hiring and training staff, establishing agreements and partnerships with schools, business, and off-site programming;

- for resiliency groups, schools must dedicate space and, ideally, designate a guidance counsellor, social worker or psychologist to partner with resiliency staff; and
- a LRP replication should develop benchmark expectations for program outcomes based on local needs identified.[2]

What are some of the risk factors targeted by the LRP?

Some of the risk factors targeted by the LRP are:

- academic failure;
- negative attitudes toward school;
- peer alcohol use, drug use and delinquency;
- anti-social behaviour and alienation; and
- favorable attitudes toward drug use.

What are some of the protective factors targeted by the LRP?

Some of the protective factors targeted by the LRP are:

- youth participation, involvement, and taking responsibility in school tasks and decisions;
- involvement with positive peer group activities and norms;
- social competencies; and
- commitment to community and school.

What are the results from the evaluation studies of the LRP?

Evaluation studies of the LRP have shown the following:

- reductions in negative attitudes and behaviours: participants achieved a 65-70% reduction in school behavioural incidents, including a 75% reduction in school suspensions and a 47% reduction in juvenile arrests; and
- improvements in positive attitudes and behaviours: participants achieved an increase of 0.8 in grade point average (GPA) based on a 4.0 scale, an increase of 60-70% in school attendance, 100% high school graduation rates, and an increased sense of school bonding. Further, a high percentage of participants either became employed or pursued post-secondary education.

[2] The original LRP has developed benchmark expectations for first year participants that include a 0.5 increase in GPA, a 50% increase in school attendance, a 50% reduction in school disciplinary reports, and an increase in the three resiliency competency areas. If these figures are not achieved, implementation should be examined and, as appropriate, adjusted to improve its effectiveness. To date, the original LRP has consistently exceeded its benchmarked outcomes, further increasing levels of local support for LRP programming. Reports from replication sites indicate similar outcomes.

What are the materials needed for the implementation of the LRP?

For each component of the LRP, there is a curriculum that provides a program description, specific descriptions of several group activities, sample forms and releases, required supplies and replication tips. Organizations must purchase the training manuals to obtain the contents of the curricula. For a suggested preliminary list of materials, contact the developer. Other materials and required resources are identified during the training and in the LRP manual.

What staff is needed to implement the LRP?

The following staffing requirements must be met to implement the LRP program:

- All the LRP staff should be comfortable with process-oriented programming, be creative and flexible with a high energy level. They should possess a strong desire and ability to work with youth in multiple settings, and are expected to participate in the activities as well as provide services.
- The program manager should be an experienced clinician with a master's degree in counseling, social work, psychology or a related field.
- Program leaders should have significant experience working with youth and a degree in a social science or human service field. Program leaders must be able to manage caseloads of up to 50 youth per staff member.
- Volunteers can be used for out-of-school programming when accompanied by the LRP staff.

What training is needed for staff in implementing the LRP?

All staff members working with the youth are required to attend a mandatory 2-1/2 day training session provided by the program developer.

What are the estimated costs for the LRP?

Materials

- LRP License Agreement and Manual-electronic version (purchase of license agreement required): $150 USD;
- bound copy of LRP Manual: $20 USD per copy;
- workshop materials: $20 USD per participant plus shipping;
- VHS tape or DVD "Helping Youth Reach the Top" introductory video: $20 USD; and
- a curriculum for each component of the program is included in the purchasing of the manuals and licensing.

Training

- a mandatory 2-1/2 day training session for all staff; around $3000 USD (per workshop) for up to 15 trainees plus the cost of lodging, transportation and meals for the trainer (for more than 15 trainees, contact the LRP services for the costs);
- an additional approximately $300 USD fee applies if extra travel day is required by trainer to reach training destination; and
- training is offered on- or off-site. LRP implementers can negotiate to have training delivered at multiple locations. On-site training requires notice to ensure availability.

Overall Costs for Implementation

- Consultation and information: initial consultation by phone or e-mail is free (up to 30 minutes), additional program information/consultation is $100 USD per hour, program write-up is free via e-mail.
- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as salaries, administrative costs, program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the LRP?

The National Crime Prevention Centre (NCPC) is currently not aware of any study that has been conducted on the cost-benefit of the LRP.

What other programs have been developed based on the LRP?

The National Crime Prevention Centre (NCPC) is currently not aware of any other program that has been developed based on the LRP.

Who is the contact for the LRP?

For more information on this program, please contact:

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Multidimensional Family Therapy (MDFT)

The MDFT program in a nutshell

The Multidimensional Family Therapy (MDFT) program is a comprehensive, manual-driven and multi-systemic family-based program for substance-abusing youths, youths with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviours such as conduct disorder and delinquency.

Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. Therapists work simultaneously in four interdependent domains: adolescent, parent, family, and community. Once a therapeutic alliance is established and youth and parent motivation is enhanced, the MDFT therapist focuses on facilitating behavioural and interactional change.

What are the goals of the MDFT program?

The MDFT program focuses on achieving behavioural changes in youths such that they are on a safe and healthy development trajectory. The specific areas of change that MDFT focuses on are: substance use, criminal behaviour, school/vocational bonding and success, youth self-efficacy, and family relations. In order to achieve these gains and to make them last, MDFT attempts to improve:

- youth decision-making, emotional regulation, problem solving, impulse control and communication skills;
- parenting practices and parental teamwork;
- family problem-solving skills;
- family emotional connection and relatedness; and
- parent functioning by motivating them to obtain substance abuse or mental health treatment for themselves, if needed.

Who is the target population for the MDFT program?

The MDFT program targets youth aged 11 to 18 years old with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school behavioural problems, and both internalizing and externalizing symptoms. MDFT has been used with youth from diverse ethnic and socio-economic backgrounds; in urban, suburban, and rural settings; and in a variety of contexts.

The MDFT program has general inclusion and exclusion guidelines for youth's participation.[3] To be included in the program, a youth must be within the designated age range and must demonstrate at least one of the following primary presenting problems: cannabis abuse or dependence; alcohol abuse or dependence; other substance abuse; oppositional defiant disorder, and conduct disorder. Also, if the youth meets any of the following criteria, they are not appropriate for MDFT: no parent or functional parent able to participate in treatment program; youth living independently or apart from parent such that family sessions and interactions would be infrequent; concurrent mental health or substance abuse treatment other than medication management; current heroin use, abuse, or dependence; actively homicidal; actively suicidal, or has had a suicide attempt within the last 12 months; psychotic disorders or features; eating disorders, bi-polar disorders, pervasive development disorders; other mental health disorders that require chronic care; or significant violence or threat of violence in the home such that it is unsafe for youth or other family members for youth to reside in the home.

What types of settings are appropriate to implement the MDFT program?

The MDFT program is typically delivered in the home environment (birth family, adoptive, and/or foster home), community-based setting (community agency, day treatment program), hospital and/or residential care facility, school setting.

What are the key components for the implementation of the MDFT program?

A manual-driven intervention, the MDFT program has specific assessment and treatment modules that target four areas of social interaction: (1) the youth's intrapersonal (e.g., self-efficacy, emotion regulation, decision-making) and interpersonal functioning (i.e., with parents and peers) (2) the parents' parenting practices and level of adult functioning independent of their parenting role, (3) parent-adolescent bonding and relationships, communication and problem solving, and (4) communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

The MDFT program is administered in three stages:

- **Stage 1**: includes a comprehensive assessment of problem areas and pockets of untapped or underutilized strength. Strong therapeutic relationships are established with all family members, and influential persons such as school or juvenile justice personnel. Therapists also intervene to enhance motivation to participate in therapy and change in both youth and parents. The themes, focal areas and goals of therapy are established in the first stage and therapists complete the MDFT case conceptualization form.
- **Stage 2**: is the working phase of treatment, where significant change attempts are made within and across the interlocking subsystems (e.g. individual, peers, parents, family, school and community) assessed at the outset of treatment.

[3] This version of the guidelines is for the standard MDFT program, adjustment have been made in the criteria for prevention MDFT or residential MDFT.

- **Stage 3**: reinforces the changes that have been made and prepares the youth and family for their next stage of development, using the knowledge, experience, and skills gained in the treatment.

For at-risk and early intervention with youth, the MDFT program is delivered weekly or twice weekly in 45- to 90-minute sessions with a therapist for the duration of 3-4 months. More severe cases (youth with a substance abuse and/or conduct) may require 2-3 sessions per week (average of 2) with each session lasting 60-90 minutes for the duration of 4-6 months. Youth who are receiving MDFT as an alternative to residential placement usually require 6 months of treatment.

What are critical elements for the implementation of the MDFT program?

Some critical elements for implementing the MDFT program include:

- fidelity to the MDFT interventions is rated on the Multidimensional Intervention Inventory (independent raters score therapists on their use of 16 distinct MDFT interventions in DVD recorded sessions);
- fidelity to the parameters of MDFT (e.g., length of treatment, number and type of sessions delivered, and clinical outcomes) is evaluated quarterly, and feedback and action plans, if necessary, are provided to supervisors and agency administrators;
- each therapist must receive 1-2 hours of case review supervision weekly, 1-2 hours of DVD/videotape supervision each month, and 1 live supervision session each month. Compliance is monitored by MDFT; and
- MDFT therapists and supervisors must complete MDFT paperwork (case conceptualization forms, weekly reports, supervision reports, and checklists). Compliance is monitored by MDFT.

Other important considerations:

- the capacity to hold treatment sessions in the clinic and in the home. This includes clinic treatment rooms large enough to accommodate a family and the ability of therapists to conduct sessions in the family home (transportation to home, reimbursement for mileage, etc.); and
- a specific referral process for program participation will need to be put in place in order to target at-risk youth.

What are some of the risk factors targeted by the MDFT program?

Some of the risk factors targeted by the MDFT program are:

- poor social skills;
- poor school functioning and achievement;
- a lack of attachment and nurturing by parents or caregivers;
- ineffective parenting;
- low parental monitoring;
- poor family management and decision making;
- peer rejection; and
- peer drug use and delinquency.

What are some of the protective factors targeted by the MDFT program?

Some of the protective factors targeted by the MDFT program are:

- adequate decision-making and emotion regulation skills;
- a strong bond between children and parents;
- a strong parent-adolescent emotional relationship;
- parental involvement in the youth's life;
- parent monitoring;
- clear limits and consistent enforcement of discipline; and
- high parental expectations coupled with high warmth.

What are the results from evaluation studies of the MDFT program?

Evaluation studies of the MDFT program have shown the following:

- a 41% to 66% reduction in substance abuse from intake to completion (gains were maintained up to 1-year post-treatment);
- 93% of youth receiving treatment reported no substance-related problems at 1-year post-intake;
- a reduction in negative attitudes/behaviours and an improvement in school functioning; and
- increased involvement of parents in the lives of their youths, improved parenting skills, and decreased stress.

What are the materials needed for the implementation of the MDFT program?

There are numerous written and recorded (DVD) training materials that are provided to trainees at the start of training. These include:

- a treatment and supervision manual, dozens of protocols and specific guidelines, specific forms designed to enhance fidelity and clinical skills, 2 instructional DVDs, as well as other materials. There is also a manual that describes how to implement the MDFT program.
- It is also required to have material equipment to record therapy session for supervision (DVD, videotape), and equipment to play back sessions for supervision;
- the capacity to conduct live supervision sessions; and
- if serving a drug-using or high-risk population, funds to pay for instant urine screen testing that is incorporated into ongoing treatment.

What staff is needed to implement the MDFT program?

The following staffing requirements must be met to implement the MDFT program:

- Therapists involved in the implementation of the MDFT program must have master's degree in counseling, mental health, family therapy, social work or a related discipline. Therapist assistants can have a bachelor's degree or relevant experience.
- Each site that implements MDFT must have at least 2 master's-level therapists, 1 bachelor's-level or paraprofessional case manager, and 1 supervisor. It is possible for a therapist to function as both therapist and supervisor.
- MDFT recommends that clinical supervisors supervise between 5 and 7 therapists.

What training is needed for staff in implementing the MDFT program?

MDFT International, a non-profit organization, provides training. MDFT requires training to certification for therapists and supervisors, and all supervisors must be trained as therapists as well as supervisors.

The initial therapist and supervisor training takes approximately 1 year to complete. All training is provided on-site or via phone or internet. Trainees do not need to travel to complete the training. Therapist training for full certification takes approximately 6 months to complete, and then supervisor training takes an additional 5-6 months. The training includes 4-5 on-site intensive trainings, weekly telephone consultations, weekly written feedback on MDFT forms, access to the online program, review of recordings (DVD/video) of therapist's work, fidelity ratings, and written examinations. Supervisor training includes 1-2 on-site intensive trainings, training in the MDFT therapist professional development plan including written feedback, 4-5 consultation telephone calls, review of 2-4 DVD recordings of supervision sessions for feedback and evaluation of supervision competence.

Yearly booster training is required after the initial certification year to maintain and enhance clinical skills and fidelity to MDFT.

What are the estimated costs for the MDFT program?

Materials and Training

- therapist certification : includes assistance with hiring/selecting appropriate candidates, all implementation materials, manuals and protocols, case consultations, DVD review, live supervision, ratings of recorded sessions, adherence monitoring: around $6,000 (USD) per person (first year of program);
- supervisor certification: includes assistance with selecting appropriate candidates, all implementation materials and manuals, case consultation, DVD review, live supervision, ratings of recorded sessions, adherence monitoring: around $5,000 (USD) per person (first year of program);
- annual recertification activities for therapists, supervisors and agencies: includes one on-site booster, quarterly consultation calls with supervisors, review of DVD recorded therapy and supervision sessions, access to the MDFT implementation database: around $2,000 (USD) per person (second year of program); and
- annual recertification activities for third year and beyond: around $1,500 (USD) per person.

Overall Costs for Implementation

- Other start-up costs are associated with cellular phones for therapists and the case manager, urine test kits for drug testing, ground transportation for conducting in-home sessions, and audiovisual equipment (video camera, tripod, digital videotapes, and digital audio recorder) for recording and reviewing sessions.
- The cost per youth per treatment episode ranges approximately from $2,000 USD to $9,000 USD, depending on local salaries, administrative costs, the youth's problem severity and length and intensity of treatment.

  The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the MDFT program?

Average weekly costs of treatment are significantly less for MDFT ($164 USD) than community-based outpatient treatment ($365 USD). An intensive version of MDFT designed as an alternative to residential treatment provides superior clinical outcomes at one-third the cost (average weekly costs of $384 USD versus $1,068 USD).

What other programs have been developed based on the MDFT program?

To date in the United States, MDFT has been used in over 40 sites in 11 states. Some of the sites have been operating MDFT for over a decade. There is one MDFT program in Canada at Hull Child and Family Services in Calgary. This program has been operating for over 3 years. Internationally, MDFT has been implemented in several European countries, including Belgium, France, Germany, the Netherlands, and Switzerland as part of the five-country collaborative treatment study known as INCANT (International Cannabis Need of Treatment Project). MDFT was also implemented at four sites in Glasgow (Scotland) in a dissemination study funded by the National Institute on Drug Abuse (NIDA). Treatment manuals, protocols, and guides are available in English, Dutch, French and German.

MDFT also offers a MDFT for STD/HIV prevention and intervention that can be integrated into the standard MDFT. The MDFT STD/HIV prevention component is conducted in a structured, interactive multiple family group format. MDFT can be provided with or without the STD/HIV prevention module.

MDFT is a "treatment system" rather than a "one size fits all" approach. Different versions of MDFT have been developed and tested according to study aims, client needs, and treatment setting characteristics.

Who is the contact for the MDFT program?

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Multisystemic Therapy (MST)

The MST program in a nutshell

The Multisystemic Therapy (MST) program is an intensive family-and community-based treatment intervention that focuses on working with families in the settings in which the problem behaviours occur (e.g., home, school, community) rather than with individual youth in detention centres or other residential settings outside of their own families. A treatment plan is designed in collaboration with family members and is, therefore, family driven rather than therapist driven. Over an average of 4 months, MST is intensively involved with the target family, in order to build a network of support that is enduring, realistic and able to sustain the changes made during the program.

What are the goals of the MST program?

The main goals of the MST program are to:

- decrease rates of anti-social behaviour and other clinical problems;
- improve parental discipline procedures;
- improve functioning (e.g., family relations, school performance);
- develop a support network for the youth that includes extended family, neighbours and friends; and
- achieve these outcomes at a cost savings by decreasing rates of out-of-home placement (e.g., incarceration, residential treatment, hospitalization).

Who is the target population for the MST program?

The MST program is most likely to be implemented with youths who have serious clinical problems. The target population are usually youth, aged 12 to 17 years old, at risk of out-of-home placement due to anti-social or delinquent behaviours and/or youth involved with the juvenile justice system.

Inappropriate referrals to the MST program include youth referred for primarily psychiatric behaviours (i.e., actively suicidal, actively homicidal, actively psychotic), youth referred primarily for sex offences (in the absence of other anti-social/delinquent behaviors) and youth with pervasive developmental delays.

What types of settings are appropriate to implement the MST program?

In general, local mental health settings or other provider organizations that deliver mental health services provide the home for most MST programs. In addition to being familiar with the kind of therapy MST utilizes and agreeing to hiring the type of therapists MST requires, the infrastructure of these agencies routinely include processes such as a case record keeping system, staff knowledgeable about issues such as confidentiality, and relations with formal community resources that support the provision of community-based mental health services.

What are the key components for the implementation of the MST program?

Each MST therapist is assigned 4-6 families at a time. They are trained to assess the family relationships and functioning, the peer environment, the school environment and the neighbourhood as well as the individual who is involved or at risk of being involved with the criminal justice system. A plan is developed based on these assessments that target the drivers of the referral behaviours, and generally the family is at the centre of these targeted interventions. They receive supports and evidence-based therapeutic services based on what will work best to reach their goals. Specific treatment techniques used to facilitate the gains are integrated from those therapies that have the most empirical support, including cognitive behavioural, behavioural and the pragmatic family therapies.

The MST program has 9 different principles which serve as the core program elements. These principles are:

- **Principle 1, Finding the Fit**: an assessment is made to understand the "fit" between identified problems and how they play out and make sense in the entire context of the youth's environment. Assessing the "fit" of the youth's successes also helps guide the treatment process.
- **Principle 2, Focusing on Positives and Strengths**: MST therapists and team members emphasize the positives they find and use strengths in the youth's world as levers for positive change. Focusing on family strengths has numerous advantages, such as building on strategies the family already knows how to use, building feelings of hope, identifying protective factors, decreasing frustration by emphasizing problem solving and enhancing caregivers' confidence.
- **Principle 3, Increasing Responsibility**: interventions are designed to promote responsible behaviour and decrease irresponsible actions by family members.
- **Principle 4, Present Focused, Action Oriented and Well Defined**: interventions deal with what's happening now in the youth's life. Therapists look for action that can be taken immediately, targeting specific and well-defined problems. Such interventions enable participants to track the progress of the treatment and provide clear criteria to measure success. Family members are expected to work actively toward goals by focusing on present-oriented solutions, versus gaining insight or focusing on the past. When it is clear the goals are met, the treatment can end.

- **Principle 5, Targeting Sequences**: interventions target sequences of behaviour within and between the various interacting elements of the youth's life—family, teachers, friends, home, school and community—that sustain the identified problems.
- **Principle 6, Developmentally Appropriate**: interventions are set up to be appropriate to the youth's age and fit his or her developmental needs. A developmental emphasis stresses building the adolescent's ability to get along well with peers and acquire academic and vocational skills that will promote a successful transition to adulthood.
- **Principle 7, Continuous Effort**: interventions require daily or weekly effort by family members so that the youth and family have frequent opportunities to demonstrate their commitment. Advantages of intensive and multifaceted efforts to change include more rapid problem resolution, earlier identification of when interventions need fine-tuning, continuous evaluation of outcomes, more frequent corrective interventions, more opportunities for family members to experience success and giving the family power to orchestrate their own changes.
- **Principle 8, Evaluation and Accountability**: intervention effectiveness is evaluated continuously from multiple perspectives with MST team members being held accountable for overcoming barriers to successful outcomes. MST does not label families as "resistant, not ready for change or unmotivated." This approach avoids blaming the family and places the responsibility for positive treatment outcomes on the MST team.
- **Principle 9, Generalization**: interventions are designed to invest the caregivers with the ability to address the family's needs after the intervention is over. The caregiver is viewed as the key to long-term success. Family members drive the change process in collaboration with the MST therapist.

What are critical elements for the implementation of the MST program?

Some of the critical elements for the implementation of the MST program include:

- all MST programs must be licensed by MST Services;
- MST Services created the MST Program Development Method™ (PDM) based on previous experience with implementation and the emphasis is on allowing the local program developer to assess the strengths, identify the weaknesses, locate the opportunities and plan for the threats unique to each organization, within its own community context;
- low caseloads to allow intensive services: MST team consists of 2-4 full-time therapists, a half time supervisor per team, and appropriate organizational support. Each therapist works with 4-6 families at a time. The therapist is the team's main point of contact for the youth, family and all involved agencies and systems;
- delivery of services in community settings: MST is provided via a home-based model of service delivery or other natural environment (e.g., school, neighbourhood center) to overcome barriers to service access, facilitate family engagement in the clinical process, and provide more valid assessment and outcome data;
- time-limited duration of treatment: the expected duration of treatment is 3-5 months (4 months on average) to promote efficiency, self-sufficiency, and cost effectiveness;

- the MST program must have a 24 hour/day, 7 day/week on-call system to provide coverage of services when needed and to respond to crises. MST is proactive, and plans are developed to prevent or mitigate crises. Crisis response can be taxing, but most families are appreciative, and a supportive response can enhance engagement. Moreover, the capacity to respond to crises is critical to achieving a primary goal of MST programs – preventing out-of-home placements;
- a specific referral process for program participation will need to be put in place in order to target at-risk youth; and
- the development of a MST program is a process that requires significant community collaboration and often takes up to 12 months to complete.

What are some of the risk factors targeted by the MST program?

Some of the risk factors targeted by the MST program are:

- anti-social attitudes;
- impulsivity;
- association with delinquent peers;
- poor social/relationship skills;
- poor affective relations between youth and family members;
- harsh, inconsistent or lax discipline;
- parental criminality, drug use, and/or psychiatric conditions;
- lack of supervision;
- low family-school bonding;
- academic problems;
- behaviour problems at school;
- low community support;
- high community disorganization; and
- a criminal subculture.

What are some of the protective factors targeted by the MST program?

Some of the protective factors targeted by the MST program are:

- engagement in pro-social activities;
- strong problem-solving skills;
- conventional attitudes towards anti-social behaviour;
- association with pro-social peers;
- supportive family environment;
- good relationship with parents;
- strong commitment to school; and
- a strong support network.

What are the results from evaluation studies of the MST program?

Evaluation studies of the MST program have shown the following:

- overall, it is a highly effective treatment option for adolescent mental health;
- a reduced amount of behaviour problems and improved family relations among at-risk youth were observed;
- improved problematic parent-child relations;
- smaller rate of recidivism for criminal offences over a period of three years when compared with outpatient counseling; and
- reduced drug use and abuse among juvenile offenders.

What are the materials needed for the implementation of the MST program?

The two treatment manuals (anti-social behaviour and serious emotional disturbance) are available for purchase from Guilford Press. All other MST materials: manuals, books, posters, MST Organizational Manual, MST Supervisory Manual, MST Training handouts, etc. are provided to MST sites. Sites are licensed through MST Services Inc., which has the exclusive license for the transport of MST technology and intellectual property through the Medical University of South Carolina.

What staff is needed to implement the MST program?

The following staffing requirements must be met to implement the MST program:

- The MST program therapists are required to have a master's degree. On some occasions, it may be implemented by a therapist with a bachelor's degree if this individual is highly competent with a minimum of five years appropriate clinical experience, in mental health or child welfare services. Therapists are selected on the basis of their motivation, flexibility and common sense.
- A MST program treatment team is formed, which consists of 2-4 trained therapists. This treatment team is responsible for handling the cases of approximately 30-60 families per year. Members of a treatment team may consult each other regarding their cases, if needed.
- In addition to MST therapists, the program also requires MST supervisors to oversee the work of the MST therapists.

What training is needed for staff in implementing the MST program?

MST Services is at the centre of efforts to disseminate/replicate the MST approach. Their mission is to provide high quality, highly responsive training and consultation services to organizations seeking to deliver home-based services using MST to target populations with which MST has been shown to be effective. The people delivering the training and consultation are doctoral and master's level experts in MST.

The MST program start-up, support, and training program has been developed to replicate the characteristics of training, clinical supervision, consultation, monitoring and program support provided in the successful clinical trials of MST. The core MST clinical training package consists of:

- pre-training program start-up services;
- initial 5-day training;
- weekly MST clinical consultation for each team of MST clinicians;
- quarterly booster training (1-1/2 days); and
- monitoring of fidelity and adherence to the MST treatment model.

What are the estimated costs for the MST program?

Materials and Training

- For an overview of the individual costs associated with the MST program materials and training, please contact the program developer.

Overall Costs for Implementation

- The MST program costs (inclusive of staff, administrative, training, and quality assurance costs) typically range from $6,000 USD to $9,500 USD or more per youth served (in 2010 dollars).
- The majority of these costs are associated with the salaries of MST staff but also includes implementation materials, training costs, program support, and quality assurance materials.
- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as salaries, administrative costs, program support, length of program, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the MST program?

Return on investment studies for the MST program demonstrate that for every $1 USD spent on the MST program a return of $12.40 to $38.52 USD to tax payers and crime victims can be expected in the years ahead.

What other programs have been developed based on the MST program?

As the MST program's effectiveness for treating chronic juvenile offenders became known, pilot studies were set up to explore the feasibility of treating other target populations. These are called MST adaptations. There are currently 13 adaptations being studied with 4 in the later stages of development and implementation: child abuse and neglect, psychiatric, substance abuse, and problem sexual behaviour.

Beyond these adaptations, the National Crime Prevention Centre (NCPC) is currently not aware of any other program that has been developed based on the MST program.

Who is the contact for the MST program?

For more information on this program, please contact:

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Project Venture

The Project Venture program in a nutshell

The Project Venture program is an outdoor experiential youth development intervention developed by the National Indian Youth Leadership Project (NIYLP) that has proven to be extremely effective in preventing substance abuse by Aboriginal youth. Based on traditional Aboriginal values such as family, learning from the natural world, spiritual awareness, service to others, and respect, Project Venture's approach is positive and strengths based. It seeks to reduce negative attitudes/behaviours by helping youth develop a positive self-concept, effective social interaction skills, a community service ethic, an internal locus of control, and decision making/problem-solving skills. The central components of the program include classroom-based activities conducted across the school year; weekly after-school, weekend, and summer skill-building experiential and challenge activities; immersion summer adventure camps and wilderness treks; and community-oriented service learning and service leadership projects throughout the year.

What are the goals of the Project Venture program?

The main goals of the Project Venture program are to:

- prevent substance abuse among Aboriginal youth;
- engage youth in positive projects;
- develop leadership skills among Aboriginal youth; and
- develop and improve social skills as well as decision-making and problem solving skills.

Who is the target population for the Project Venture program?

The target population for the Project Venture program is Aboriginal youth in grades 5 through 9. However, this program can be applied to other ethnicities, and has in the past been applied to youth in grades 4 through 12. Youth who could benefit from a positive youth development experience/process are identified, by teachers, counselors, social workers, etc.

What types of settings are appropriate to implement the Project Venture program?

The Project Venture program is delivered in the school and/or community settings. Although it was initially designed for Aboriginal communities (on reserve) it has since been adapted so that it can be implemented in urban, suburban and rural schools and communities. Given that the in-school component is key to the success of Project Venture, there must be a strong partnership with the local school boards.

What are the key components for the implementation of the Project Venture program?

The Project Venture program uses 4 different components:

Classroom-Based Activities:

- In class-activities are divided into about 20 to 25 sessions delivered throughout the course of the school year. Each session lasts approximately 1 hour.
- Through the classroom component, a smaller number of youth are recruited and enrolled into the program's community-based activities (including outdoor adventure-based experiential activities, adventure camps and treks, team/trust-building exercises, and other increasingly challenging outdoor activities).

Outdoor Activities:

- Each week, after-school activities such as hiking and camping are organized (for approximately 2-3 hours).
- These adventure-based activities challenge youth and help them to develop problem solving and social interaction skills as well as a sense of responsibility.
- Outdoor activities also take place on weekends.

Adventure Camps and Treks:

- During the summer, youth participate in adventure camps and wilderness treks that last from 3 to 10 days, depending on the age of the youth. Elders, positive role models and "cultural" experts accompany participants throughout these activities.

Community-Oriented Service Learning:

- Youth complete approximately 150 hours of community-based activities.
- These activities include meaningful service learning opportunities such as working with Elders or creating art projects for the community to enjoy (4 service-learning projects per year).
- These activities are designed to help youth develop leadership skills.

What are critical elements for the implementation of the Project Venture program?

Some of the critical elements for implementing the Project Venture program include:

- Prior to implementing Project Venture, there must be an initial meeting with NIYLP to determine the proposed site's readiness and capacity to implement the program.
- Continued communication with the developers (NIYLP) due to the complex nature of the program is a key element. Throughout implementation continued training and fidelity checks from NIYLP are strongly encouraged.
- A specific referral process for program participation will need to be put in place in order to target at-risk youth.

- Typically, youth are enrolled in Project Venture for 1 year, although some replications have enrolled youth for 2 and 3 years throughout the middle school grades. Older high-school-age participants (PV graduates) may continue in subsequent years as service staff if they show leadership abilities.

Further, NIYLP has developed a list of requirements necessary for the successful implementation of the Project Venture program:

- minimum of quarterly contact with developer in the first year, and semi-annual contact in subsequent years;
- an implementation plan that can be supported by a local budget;
- formal agreement with participating schools to ensure support;
- use of community/cultural resources to guide program implementation;
- access to recreational space and equipment; and
- a staff-youth ratio of 1:25 for the in-class component and 1:7-15 for the community-based component.

What are some of the risk factors targeted by the Project Venture program?

Some of the risk factors targeted by the Project Venture program are:

- early and persistent anti-social behaviour;
- early initiation of substance abuse;
- favourable attitudes toward substance abuse;
- lack of parental support;
- friends who use substances;
- negative school experiences; and
- lack of commitment to school.

What are some of the protective factors targeted by the Project Venture program?

Some of the protective factors targeted by the Project Venture program are:

- bonding;
- healthy beliefs and clear standards;
- development of individual characteristics;
- opportunities;
- skills;
- positive peer group; and
- positive values.

What are the results from evaluation studies of the Project Venture program?

Evaluation studies of the Project Venture program have shown the following:

- compared with a control group, participants in the program initiated first substance use at an older age, significantly reduced lifetime alcohol and tobacco use, the frequency of inhalant use, and 30-day alcohol, marijuana and other illegal drug use;
- program participants also demonstrated less depression and aggressive behaviour, improved school attendance and improved internal locus of control and resiliency;
- the program leads to reductions in peer drug use; and
- among middle school females participating in Walking in Beauty, reductions in alcohol use in the past 30 days, stress related to drug use, future intentions to use drugs, perceived harm from drug use and attitudes toward drug use improved.

What are the materials needed for the implementation of the Project Venture program?

The typical resources needed for implementing the Project Venture program include:

- Required materials: Project Venture Implementation Guide and Association for Experiential Education (AEE) Accreditation Standards Manual:
- Optional materials: camp and service learning videos, games and initiatives books, activity kits and the optional year-long curriculum which is now available.

It is only through NIYLP that an organization will be able to obtain these materials. NIYLP will also provide information and give guidance on where organizations may find other materials which will assist them in implementing the Project Venture program successfully.

What staff is needed to implement the Project Venture program?

The following staffing requirements must be met to implement the Project Venture program:

- At least one full-time coordinator who has the skill set to be able to deliver direct services to youth is needed.
- Since the community-based activities take place during after-school hours, part-time staff work well, though they need to be available enough to establish regular contact with youth. Community cultural “experts”, Elders and positive community role models may be contracted, paid stipends, or volunteer. Individuals or organizations with technical/hard skills may be contracted as needed. High school-aged service staff (PV graduates) are generally paid a stipend for school year and summer activities.

- Staff should have an undergraduate degree or equivalent experience working with youth in experiential, assets-based, indirect approaches. Special skills may include technical outdoor adventure skills, first aid, and CPR skills. These skills can be acquired over the course of the first year, using contractors for highly skilled activities until staff are adequately trained. The "soft" or interpersonal skills with adolescents are the most critical components.
- The number of staff needed to implement Project Venture varies in accordance with the size of the program and the number of participants. Generally, the in-class program requires one educator per 25 students. The community component requires one educator for every 7-15 youth.
- In addition to the educators, support staff should be made available. It is recommended that this support staff be composed of graduates of the Project Venture program. As example, older high-school-age participants (PV graduate's) are selected and trained as service staff, where they become peer role models during Project Venture's year-long community-based component.

What training is needed for staff in implementing the Project Venture program?

It is only through contacting NIYLP, the developers of Project Venture, that an organization will have the tools necessary to successfully implement the program. NIYLP provides all of the training (on and off site) that is necessary for Project Venture. A minimum of 2 days of onsite training, or training at the Annual Project Venture Gathering Workshop, for direct services staff and key support staff and administrative staff is required.

What are the estimated costs for the Project Venture program?

Materials

- Project Venture Replication Guide ($250 USD
- Association for Experiential Education (AEE) Accreditation Standards Manual ($25 USD purchase from the AEE, mandatory);
- camp and service learning videos ($50 USD purchase from NIYLP, optional);
- games and initiatives books ($200 USD purchase from a list provided by NIYLP, optional);
- activity kits ($1,200-$3,000 USD purchase from a list provided by NIYLP, optional); and
- fidelity self-study instrument (free).

Training

- The developers estimate the cost for training to be around $3,000 (USD).
- See the Additional Information section at the end of this implementation factsheet for a cost breakdown for training components.

Overall Costs for Implementation

- The cost for Project Venture has been estimated at around $100,000.00+ USD per year by program developers.
- See the Additional Information section at the end of this implementation factsheet for a sample budget created by the developers.
- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as administrative costs, program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the Project Venture program?

The National Crime Prevention Centre (NCPC) is currently not aware of any study that has been conducted on the cost-benefit of the Project Venture program.

What other programs have been developed based on the Project Venture program?

Since 1990, the Project Venture program has been implemented in more than 70 sites in more than 23 American states, as well as in Canada and Hungary. Project Venture has been adapted for Native Hawaiian, Alaska Native, Hispanic, and non-Hispanic youth, as well as for youth of mixed ethnicity. The program also has been adapted specifically for female youth.

Connecting to Courage is a Project Venture adaptation that provides services to primarily Hispanic/Latino youth through in-school programming and out-of-school challenge and service activities. Connecting to Courage places high emphasis on parental participation and family involvement; provides comprehensive academic support for participants; and has developed a unique recruiting strategy.

The NIYLP has developed another program that is well along in the process to become evidence-based. Called Therapeutic Adventure for Native American Youth (TANAY), this program is for high risk youth, who might be in juvenile detention, treatment programs, alternative schools, out of school, etc. It has some experiential learning content and service learning, but also has an equine therapy component, a comprehensive staff development component and culturally sensitive mental health services. This program has been implemented in one of the Indian Health Service regional youth treatment centers with good success and recently got a three year grant from a foundation to take TANAY through the rest of the process to become evidence-based.

Additional information on the Project Venture program

Below is a sample budget created by the developers for a typical Project Venture program that has 100 youth in the in-school component and 30 youth in the community-based component, and summer camp and wilderness experiences.

During a first phase of implementation of Project Venture in a Canadian setting by the National Crime Prevention Centre (NCPC), the budget was significantly different from that proposed by the developer. Associated personnel, travel, equipment, material and supply costs are higher than those identified by the developer. The projects implemented through NCPC funding have included on average 1 project coordinator and 2 full-time facilitators, as well as increased travel costs associated with the remote locations of financed projects.

Sample Budget Item	Cost (USD)
Personnel	$50,000
Travel	$7,000
Supplies/incentives	$4,000
Equipment	$7,000
Evaluation	($10,000)*
Camp	$5,000
Facilitator stipends	$3,000
Training	$3,000
Audit	($1,000)*
Operational	$7,000
Other indirect costs	($5,000)*

* The costs in parentheses do not necessarily equate to the National Crime Prevention Centre's reality.

Although the developers estimated $3,000 USD for training in the above sample budget when they break down the costs of training it is evident that training costs could be more than this.

Training Item	Cost (USD)
Mandatory pre-start-up meeting	$600 per person, + travel/lodging
Consultation for assessment of resources for readiness, programming, sustainability, and evaluation (optional)	$1,000 per day + travel/lodging
Mandatory 2-day on-site basic program training (recommended for sites with six or more trainees)	$3,000 + travel/lodging
Off-site training at National Indian Youth Leadership Project (one training is required)	$1000 per day, per person + travel/lodging
Advanced Project Venture programming workshop (optional)	$500 per person
Summer camp training (recommended, not required)	$600 per day per person + travel/lodging
10 hours of follow-up consultation via phone or internet (required)	$2,000 per year
On-site follow-up consultation, coaching and support (required)	$1,000 per day + travel/lodging
Follow-up on site visit upon request	$1,500 + travel/lodging
Training from local providers (first aid/CPR, Challenge Course, etc.)	To be determined locally

Who is the contact for the Project Venture program?

For more information on this program, please contact:

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SNAP® Program (Stop Now and Plan)

The SNAP® program in a nutshell

SNAP® (Stop Now and Plan) is an evidence-based, gender sensitive cognitive behavioural multi-component family-focused model developed at the Child Development Institute (CDI), Toronto, Canada more than 25 years ago. The SNAP® model provides a framework for effectively teaching children and their parents self-control and problem-solving skills. The SNAP® model framework has been incorporated into various SNAP® programs based on needs and risks of different populations of children, youth, families, and communities such as the SNAP® Boys (SNAP® Under 12 Outreach Project; aged 6 to 12); SNAP® Girls (SNAP® Girls Connection, aged 6 to 12), SNAP® for Schools (generally elementary school), SNAP® for Youth Outreach Program (aged 12 to 17) and SNAP® for Youth in Custody.

What are the goals of the SNAP® program?

The primary goal of the SNAP® program is to keep at-risk boys and girls in school and out of trouble. The other objectives are to:

- increase emotional-regulation and self-control skills (children and their parents);
- reduce aggression, delinquency and antisocial behaviour;
- increase social competency;
- prevent future delinquency;
- improve academic success by decreasing behavioural issues at school;
- engage high-risk children and their families in service;
- increase effective parent management skills; and
- connect children and parents to community-based resources.

Who is the target population for the SNAP® program?

To be eligible to receive services through SNAP®, children/youth must score within clinical levels on the conduct, oppositional and/or externalizing scales as assessed by either standardized measures, adapted checklists or through a clinical assessment. Both boys and girls typically present at admission with one or more of the following problems: aggression towards others in the home and/or at school; lying/stealing; hyperactivity/impulsivity; oppositional behaviour; having trouble keeping friends; vandalism; fire setting; lacking self-control and problem-solving skills and having police contact for their own misbehaviour in one or more settings (e.g. at home, in the community, at school).

What types of settings are appropriate to implement the SNAP® program?

With adequate training and support, this program can be successfully replicated and implemented with strong fidelity in a variety of settings. SNAP® fits in the classroom, in the clinician's office and at home. The program can be situated in a variety of diverse community settings and real life community conditions. Currently, a number of SNAP® implementations are being tested in a variety of settings with promising results, such as SNAP® for Schools, SNAP® for First Nation/Aboriginal Communities, SNAP® for youth in custody, SNAP® Aspergers. It may also be implemented by a wide variety of organizations including children's mental health organizations.

What are the key components for the implementation of the SNAP® program?

The SNAP® program employs a multi-systemic approach, combining interventions that target the child, the family, the school, and the community. The program uses a variety of established interventions that are organized: skills training, training in cognitive problem-solving, self-control strategies, family management skills training, and parent training.

Screening and Assessment

- The SNAP® program's screening and assessment procedures involve two interviews at intake (one with the child and one with the parent/ guardian). In addition, children are evaluated with the Early Assessment Risk List.
- This tool is a structured clinical risk/need assessment device for use with aggressive and delinquent children that provides a comprehensive framework to evaluate risk factors known to influence their propensity to engage in future anti-social behaviour. The assessment determines the unique treatment needs of children and their families and assists clinicians with treatment planning.

The SNAP® program includes a number of service components available to children and families based on their level of risk and need. These are:

- **SNAP® Children's Group**: a gender specific manualized core component that focuses on teaching children self-control and problem solving skills. All SNAP® children attend SNAP® Boys or SNAP® Girls Groups once a week for 90 minutes for at least one 12-week consecutive group session.
- **SNAP® Parent Group**: a manualized core component that helps parents learn self-control and problem solving skills and effective child management strategies with a special emphasis on monitoring skills. Tips for Troubled Times and Stop Now And Plan Parenting (SNAPP) are parenting resource tools developed by CDI for use in the SNAP® Parent Groups.

- **Individual Befriending/Mentoring (IB)**: provides children with individualized support with a SNAP® Worker to enhance skills learned in the SNAP® Children's Group and goal attainment. Children are also connected to volunteers to help them join structured recreational activities within their community.
- **Stop Now And Plan Parenting (SNAPP)**: Individualized Family Counseling: based on the SNAPP Manual. It helps families unable to attend the parent group and/or for families who need additional parenting support. Continuing service after the parent group ends may take the form of ongoing individual family counseling or monthly Family Support Nights.
- **Girls Growing Up Healthy (GGUH)**: a manualized core component unique to SNAP® Girls. It is an 8 session mother-daughter group focused on enhancing relationship capacity and physical and sexual health.
- **Leaders in Training Group (LIT)**: a group component that is offered in both the boys and girls programs. It is for youth who have completed the core components of the program and have demonstrated positive change, but continue to be at high risk of involvement in anti-social behaviours. Staff provide concentrated support, in order to prepare at-risk youth for self-sufficiency, improve their workforce career trajectories and reduce their involvement with the law.
- **School Advocacy/Teacher Support**: ensures that SNAP® children receive the best possible education. Teachers of all SNAP® children are contacted at the start of the program to introduce the program and offer behaviour management support if needed.
- **Long Term Connections/Continued Care**: families may continue to be involved in all components of the SNAP® as long as there is a need and interest. In addition to previously listed components this may also include activities such as SNAP® Parent Problem Solving Groups and participation as a Peer or Parent Mentors.
- **Crisis Intervention**: available to assist parents and children involved in the SNAP® program to deal with challenging situations as they arise and/or referral to appropriate crisis services.
- **The Arson Prevention Program-Children (TAPP-C)**: offered to children with fire interest or fire setting as a presenting problem.
- **Victim Restitution**: activities that encourage children to apologize to their victim, redress mischief and begin to learn how to take responsibility for their actions. Activities may include an apology letter to a victim or community service.
- **Homework Club/Academic Tutoring**: provides remedial sessions for children functioning well below grade level. Weekly, 1 hour tutoring sessions with teachers or specially trained volunteers are held in the child's home or community.

What are critical elements for the implementation of the SNAP® program?

Some of the critical elements for implementing the SNAP® program include:

- organizations interested in implementing SNAP® are required to first complete the SNAP® Request for Qualifications Application;
- replications sites must enter into a SNAP® licensing agreement. SNAP® licensing agreements are established with the Child Development Institute (and/or its Centre for Children Committing Offences research, training and dissemination unit). This is to maximize integrity and fidelity and ensure that the model is being implemented and represented as intended. The license creates a mechanism through which program updates and related materials can be communicated and transferred. Licenses are issued once training is completed and a consultation agreement is established;
- replication sites need to have a strong track record of collaborating with other social services and relevant community stakeholders (e.g., police, children-youth-family serving agencies, fire departments, juvenile judges, schools, health departments, and child welfare);
- a specific referral process for program participation will need to be put in place in order to target at-risk youth (typical referral sources are schools, child welfare, police, fire service, and parents);
- use of standardized measurements for assessments of children referred to the program; the Early Assessment Risk List Tools for Boys (EARL-20B) and Girls (EARL-21G) are used to:
    - assist practitioners working within a wide range of disciplines in the identification of risk factors associated with future antisocial behaviour;
    - promote a structured, gender-sensitive approach to risk assessment;
    - help professionals to develop, prioritize and implement risk-reducing treatment options;
    - make scientific research about risk factors accessible to practitioners; and
    - help bridge the gap between risk factor research and clinical practice, and vice versa.
- ensuring a high degree of participation: in some circumstances, the program may have to assist with transportation needs, provide child care services while parents attend parent group sessions and possibly provide meals for children/families attending sessions in the evenings;
- replications should allocate full-time staff to operate the program;
- SNAP® is a cognitive-behavioural multi-systemic intervention. Host organization should be familiar with and have a similar theoretical orientation and be comfortable with ongoing fidelity/integrity checks/audits; and
- the host organization must include development and implementation of written policies regarding cultural competence, parent involvement, privacy of personal information, client complaints and client feedback mechanisms.

What are some of the risk factors targeted by the SNAP® program?

Some of the risk factors targeted by the SNAP® program are:

- poor self-control and problem solving;
- bullying;
- delinquency;
- aggression and violence;
- anti-social values and conduct (child and parent);
- poor parent management strategies (e.g., supervision and monitoring);
- conflictual authority contact;
- school failure; and
- isolation (e.g., from community, peers).

What are some of the protective factors targeted by the SNAP® program?

Some of the protective factors targeted by the SNAP® program are:

- social skills;
- parental support and community connections;
- child supports and positive peer socialization/community connections;
- child and family responsivity/engagement; and
- school achievement and motivation.

What are the results from evaluation studies of the SNAP® program?

Evaluation studies of the SNAP® program have shown the following:

- treatment gains are maintained at 6, 12 and 18 months;
- parents report less stress in their interactions with their children and increased confidence in managing their children's behaviour;
- children report improved quality of interaction with parents, less yelling and a more limited setting;
- children report more positive attitudes, demonstrate more pro-social skills with teachers, peers and family members; and
- longitudinal research analysis showed that 91% of the boys and 97% of the girls had no history of criminal offences by age 14; approximately 68% of the children will not have a criminal record by age 19.

What are the materials needed for the implementation of the SNAP® program?

SNAP® resources and assessment materials are intended for clinicians and professionals experienced in and knowledgeable about working with young girls and boys who have severe behavioural difficulties and their families. SNAP® resource materials are designed to support the delivery of the SNAP® Model, ongoing research activities, and clinical assessments related to childhood delinquency, aggression, bullying and possible gang involvement. These resources have become valuable in education systems, mental health facilities, child care establishments and outreach programs.

Some of these resources are available solely for licensed SNAP® Affiliate Sites (that have undergone training), while other resources are available for parents and professionals wishing to learn more about helping children with disruptive behaviour problems.

Manuals

- Manuals are available to assist in structured group work with boys, girls, and parents. The formats are fully outlined describing activities and group sessions with specific topics for children and/or parents. Topics for girls and boys address issues such as avoiding trouble, stealing, bullying, and lying. Issues pertaining to parents include monitoring and routines, listening and encouraging, school and home relations, and several more.
- SNAP® Boys Group Manual, SNAP® Girls Group Manual, and SNAP® Parenting Group Manual are available through a SNAP® license only. The Stop-Now-and-Plan-Parenting (SNAPP) Manual is available without a SNAP® license.

Assessment Tools

- The Early Assessment Risk List for Boys Version 2 (EARL-20B) and the Early Assessment Risk List for Girls, Consultation Edition (EARL-21G) focus on the prediction of future anti-social behaviour in young boys and girls up to the age of 12 years. The Early Assessment Risk List – Pre Checklist (EARL-PC) is the newest EARL tool designed specifically for those in education and policing that may not have all the necessary information to conduct a full risk assessment. The EARL-PC assesses areas of concern and need and helps users determine where best to refer the child for services.
- The tools are also intended to facilitate multi-disciplinary discussion, aid in secure consensus about what information still needs to be gathered, and identify possible risk management interventions.
- The program developers strongly recommend training for clinicians/professionals that anticipate using the EARLs (EARL-20B and EARL-21G); also, establishing teams or local working groups to undertake practice case studies with peers to regularly review the items and ensure consistency in its use.

Training DVD

- The training DVD is intended to demonstrate the Child Development Institute's SNAP® techniques and the Stopping Stealing Program. It is approximately 30 minutes. The DVD is available through a SNAP® license.

Booklets

- Six educational booklets discuss issues such as stealing, bullying, lying, and the SNAP® technique. Materials are intended to provide additional information for parents, educators, or child care workers dealing with disruptive behaviors in children. These are available in both English and French.

What staff is needed to implement the SNAP® program?

The following staffing requirements must be met to implement the SNAP® program. Depending on the number of children to be served and community needs, there can be variations in staffing numbers. Suggested staffing for a pilot SNAP® Boys or SNAP® Girls program includes:

- 1 full time senior staff person with clinical and administrative skills to oversee the program and provide leadership and clinical supervision;
- 1-2 full-time family ('in-home') workers who are also SNAP® Parent Group Leaders;
- 2 full-time child workers who are also SNAP® Children Group Leaders; and
- other part-time staff as appropriate for: in-take assessments, data entry and outcomes assessments, coordination of volunteers and peer mentors, and coordination and provision of added services to ensure high participation and completion of the program (organization of transportation, day-care, meal).

What training is needed for staff in implementing the SNAP® program?

Training modules are available for professionals and organizations interested in delivering services for children with disruptive behaviour problems. Training can be customized by SNAP® trainers to meet the unique needs of organizations. Training modules are available for all needs (English and French): SNAP® replications, SNAP® For Schools, or the EARL risk assessment tools. All training is didactic and interactive. Participants engage in role-plays, group practice exercises, discussions and pen and paper tasks designed to maximize the learning experience. Training can be offered at either CDI or at home sites (typically at the organization requesting the training).

Current training modules available include:

- Core 5-Day Initial SNAP® Training: for new sites looking to implement a full replication model;
- 2-Day SNAP® Training: for staff at current licensed SNAP® sites;
- SNAP® for Schools: a 2-day training; and
- EARL-20B and EARL-21G Training: explain how to use the structured professional judgment risk need assessment tools. This training is available to professionals working with children at risk of engaging in anti-social behaviour; 1- and 2-day formats).

The maximum number of training participants varies from group to group. Given that group practice exercises are a key training component, a minimum number of attendees are required and maximum numbers may be established for optimal learning.

When training is requested by a new SNAP® Affiliate Site, it is advised that key staff of the broader organization attend the day of training in order to gain a solid understanding of the SNAP® Model and the context in which this model came to be. Full participation is mandatory for any staff member who will be delivering the SNAP® model and/or using the risk assessment tools.

Consultation is negotiated with each SNAP® Affiliate Site on an annual and as-needed basis and is customized to meet the individual organization's needs. This can be done through face-to-face meetings, via telephone or video conferencing methods. Clinical teams and supervisors are all invited to be involved in this process which can include reviews of live or videotaped SNAP® sessions. Part of this process involves treatment fidelity and integrity and implementation audits.

What are the estimated costs for the SNAP® program?

Materials

- SNAP® resource materials ($1,000 CDN)

Training

- SNAP® 2-day lead staff training ($4,800 CDN);
- Initial SNAP® 5-day core training ($12,000 CDN)

Overall Costs for Implementation

- The average cost of providing the SNAP® Boys or SNAP® Girls program for a low-risk child is approximately $1,400 CDN (4-6 month program), $3,500 CDN for a moderate-risk child (6-12month program), and $6,700 CDN for a high-risk child (12-18 month program).
- Cost is based on structured clinical risk assessments dependent on level of risk and need conducted at intake/screening, post–SNAP® groups, treatment reviews, and discharge.

- Please see the Additional Information section at the end of this implementation factsheet for a more detailed overview of the estimated costs associated with the implementation of SNAP® on a yearly basis. The noted costs include the annual consultation fees and the required annual SNAP® license.
- All detailed program budget information are included in Schedule C of the SNAP® Licensing Agreement.

What is the cost-benefit of the SNAP® program?

At this time, a number of SNAP® cost-benefit analyses are being conducted on the SNAP® Boys and SNAP® Girls (mental health models) by several external researchers.[4]

One study examining the social return on investment of the SNAP® program found the following ratios: Year 1= 7.55:1; Year 2= 13.08: 1; Year 3= 16.66:1; for a total 3 year average of 12.58:1.[5]

What other programs have been developed based on the SNAP® program?

SNAP® for Schools

SNAP® for Schools is a whole school approach to keep children in school and out of trouble The current manualized SNAP® for Schools program targets elementary school aged children. It seeks to decrease aggressive, anti-social and bullying behaviour and increase pro-social behaviour in designated elementary and middle schools. As an example, the implementation of SNAP® in high schools has been one component of a broader set of services within the pilot project in Jane/Finch Project (see SNAP® for Youth aged 12 to 17 years below).

A whole school approach to SNAP® means:
- a commitment to measuring outcomes;
- a recognized universal violence prevention program;
- a peer mediation and victim restitution program;
- active engagement for parents;
- teachers teaching SNAP® in their classrooms; and
- teachers integrating SNAP® into their classroom management repertoire.

[4] Drs. David Farrington & Christopher Koegl (Cambridge University, UK): criminological cost-benefit analyses reviewing effect sizes from external random control 3rd party SNAP® evaluation studies; Astwood Strategy Corporation, Dr. Depeng Jiang (University of Manitoba) & Donna Smith-Moncreiffe (Senior Analyst National Crime Prevention Centre, NCPC): Multi-site cost effective analyses on NCPC funded replications.

[5] Society for Safe and Caring Schools and Communities (SSCSC): Alberta 2011, conducted a Social Return on Investment (SROI) on its SNAP® pilot implementation as part of its funding requirements (Justice Alberta); SiMPACT assisted SSCSC with this process.

In addition to the above, members of designated school personal and/or other (e.g., partnering children's mental health workers) conducting individual SNAP® coaching to designated children.

As part of the whole school approach, designated school personnel (Certified SNAP® Users), in conjunction with the classroom teacher conduct 12 weekly 40 minute SNAP® groups in classrooms of targeted children identified by their teachers as having disruptive behaviour problems. As a follow-up to these sessions the classroom teacher continues to use the SNAP® principles learned along with the newly implemented principles of behaviour change. In addition, the classroom teacher will conduct weekly classroom based SNAP® review sessions (approximately 20 minutes) using the SNAP® manualized instruction process.

Consultation sessions with SNAP® schools will be coordinated between clusters of approximately 5 schools with the designated Certified SNAP® Practitioners and other school personnel as deemed necessary. This will occur twice a year and will include ongoing support, training updates and fidelity checks. Further enhancements of this training process are available from CDI on a fee for service basis include: ongoing coaching, consultation and support on-site and by telephone; assistance with SNAP® special days at school and assemblies; and SNAP® parenting workshops.

SNAP® for Youth Outreach Program (aged 12 to 17 years old)

The Child Development Institute is currently piloting the SNAP® Youth Outreach Program. This program is currently located in the prioritized neighbourhood of Jane/Finch (Ontario). The program serves youth (12-17) in schools and community agencies who require preventative skills in order to avoid more clinical interventions and/or future police contact. The overall objective of the program is to improve the quality of life chances of at-risk youth, to regularly attend school and stay out of trouble. These outcomes are facilitated through collaborative provision of multifaceted, accessible and effective services for youth exhibiting mild to serious levels of behavioural and anti-social challenges. The main components of the program include the SNAP® for Youth manualized program (currently in final draft), community outreach, individual mentoring, consultation and training.

In 1996, SNAP® became a continued care model and was then able to deliver long-term services. There is a Boy's Youth Club for high-risk boys, over the age of 12, who have completed the SNAP® Boys Group but still require support, which also includes a Leaders-in-Training component that focuses on skill development and employment readiness training. For girls, there are two Leaders-In-Training (I & II) groups that meet weekly throughout the year that also focus on skill development and employment readiness training. (Please note: these services are only available for those children who have been admitted into SNAP® Boys/Girls before the age of 12).

SNAP® for Youth in Custody

SNAP® For Youth in Custody is currently funded by the Department of Justice Canada under the Guns, Gangs and Drugs Initiative. The SNAP® For Youth in Custody project will work in tandem with Ontario's Ministry of Children and Youth Services' Youth Justice Services Division (YJSD) to develop, train, implement and evaluate a dual intervention approach designed to reduce the risk of further conflict with the law and/or gang membership amongst at-risk youth in custody. This is a 3-year project in which this first year is designed for program development with implementation and testing occurring in years 2 and 3.

Additional information on the SNAP® program

Detailed Overview of Estimated SNAP® Implementation Costs (in CDN):

Description	Start-Up One-Time Cost	Base Ongoing Year 1	Base Ongoing Year 2	Base Ongoing Year 3	Base Ongoing Year 4+
Consultants and Professional Fees					
Pre-Implementation Consult	$1,200				
SNAP® 2-day Lead Staff Training (Rate: $2,400/day)	$4,800				
Initial SNAP® 5-day, core training @ $2,400/day (onsite)	$12,000				
Consultation Fee Structure		$4,800	$4,200	$3,000	$1,000
Annual SNAP® Licensing Fee/Site		$1,000	$1,000	$1,000	$1,000
Professional Development / Travel					
Fidelity and Integrity checks (on-site one or two times/year, dependent on need) [Cost Breakdown: $1,200/visit + travel/accommodations]		TBD	TBD	TBD	TBD
Operations					
Supplies: SNAP® resource materials		$1,000	$1,000	$1,000	$1,000
Capital Cost – (Not included in total): Program Equipment Needs (e.g., video camera, 2 TVs, 2 DVD players, 2 video & audio wall mounted observation equipment, tables/chairs, white/blackboard)	TBD				
TOTAL *	$18,000	$6,800	$6,200	$5,000	$3,000

*Total (excluding capital cost: equipment estimated at one-time cost of $6,000-$8,000), travel and accommodations (estimated between $2,000-$4,000/year); dependent on location and number of on-site visits required. All of these costs are subject to change by the Institute (CDI).

Who is the contact for the SNAP® program?

For more information on this program, please contact:

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For information about how to become an affiliate site, licensing and training, please contact:

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Strengthening Families Program (SFP)

The SFP in a nutshell

The Strengthening Families Program (SFP) is an internationally recognized evidence-based parenting and family strengthening program for families of all risk levels. SFP has been found to significantly reduce problem behaviours, delinquency, and alcohol and drug abuse in children and youth and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

SFP has many versions, including programs for parents and children ages 3-5, 6-11 and 12-16 in higher risk families. SFP consists of parenting skills, children's life skills, and family skills training courses taught together in 2-hour group sessions preceded by a meal that includes informal family practice time and group leader coaching. SFP was designed in 14 sessions to assure sufficient dosage to promote behaviour change in high-risk families. The shorter 7-session SFP 10-14 version for general/universal population families has achieved excellent results for that population with a lower dosage.

As the National Crime Prevention Centre (NCPC) prioritizes targeted interventions for at risk youth, only SFP 6-11 and SFP 12-16 are eligible for funding. The present factsheet will focus on these two versions of the program.

What are the goals of the SFP?

The goal of the SFP is to increase family strengths and resilience and reduce risk factors for problem behaviours in high risk children, including behavioural problems, and emotional, academic and social problems. The other main objectives of the SFP are to:

- reduce youths' behavioural problems (violence, delinquency, aggression, etc.);
- decrease the use and temptation to use drugs, alcohol and tobacco;
- enhance children's social and life skills;
- improve parenting skills; and
- increase family cohesion, communication and organization.

Who is the target population for the SFP?

The target population for the SFP 6-11 and SFP 12-16 programs are high-risk children and youth aged 6 to 16 years old as well as their parents or caregivers; parents/caregivers include biological parents, step- and adoptive parents, foster parents, and grandparents. The SFP 6-11 targets children and youth aged 6 to 11 years old and SPF 12-16 targets youth aged 12 to 16 years old.

What types of settings are appropriate to implement the SFP?

The SFP has been implemented in many different community-based settings, such as schools, drug treatment centers, family or youth services agencies, community mental health centers, housing projects, homeless shelters, churches, recreation centers and drug courts.

What are the key components for the implementation of the SFP?

The SFP consists of child/youth sessions, parent sessions and parent and child practice time in the family sessions to develop positive interactions, communication, and effective discipline:

- **Child/Youth Sessions**: the skills training content of these sessions include communication skills to improve parents, peers, and teacher relationships, hopes and dreams, resilience skills, problems solving, peer resistance, feeling identification, anger management and coping skills.
- **Parenting Sessions**: these sessions review appropriate developmental expectations, teach parents to interact positively with children such as showing enthusiasm and attention for good behaviour and letting the child take the lead in play activities, increasing attention and praise for positive children's behaviours, positive family communication including active listening and reducing criticism and sarcasm, family meetings to improve order and organization, and effective and consistent discipline including consequences and time-outs.
- **Family Practice Sessions**: these sessions allow the parents and children time to practice what they learned in their individual sessions in experiential exercises. This is also a time for the group leaders to coach and encourage family members for improvements in parent/child interactions. The major skills to learn are: Child's Game similar to therapeutic child play where the parent allows the child to determine the play or recreation activity, Family Meetings and effective communication exercises, and Parent Game or effective discipline. Home practice assignments improve generalization of new behaviours at home.

What are critical elements for the implementation of the SFP?

Some of the critical elements for the implementation of the SFP include:

- for the implementation of SFP to be successful, program planning and family referrals and recruitment should be initiated at least 2 months prior to the start date of the program (this is to ensure community participation in the program);
- a specific referral process for program participation will need to be put in place in order to target at-risk youth; and
- to ensure continued participation in the program, it may be helpful to provide incentives for participation (these incentives may include meals or snack). Additionally, it may be helpful to provide transportation to and from the sessions for families who are not able to attend otherwise.

What are some of the risk factors targeted by the SFP?

Some of the risk factors targeted by the SFP are:

- family history of problem behaviour/parent criminality;
- family management problems/poor parental supervision and/or monitoring;
- pattern of family conflict;
- poor family attachment/bonding;
- parental use of physical punishment/harsh and/or erratic discipline practices;
- anti-social behaviour and alienation/delinquent beliefs/general delinquency involvement/ drug dealing;
- favourable attitudes toward drug use/early onset of alcohol and/or drug use;
- early onset of aggression and/or violence; and
- poor refusal skills.

What are some of the protective factors targeted by the SFP?

Some of the protective factors targeted by the SFP are:

- effective parenting;
- good relationships with parents/bonding or attachment to family;
- opportunities for pro-social family involvement;
- having a stable family;
- high expectations;
- social competencies and problem-solving skills;
- self-efficacy;
- healthy/conventional beliefs and clear standards; and
- perception of social support from adults.

What are the results from evaluation studies of the SFP?

Evaluation studies of the SFP have shown the following:

- significant reductions in tobacco, alcohol, and drug initiation and use among the older children of drug abusers and in initiation and drug use among the parents;
- decreased use and intention to use alcohol, tobacco and drugs;
- better and stronger protective factors in youths, in particular social and life skills, resistance to peer pressure and improved communication;
- better parent-child relationship and family cohesion, communication and organization;
- improved parenting skills concerning, for example, parental supervision, effective consequences rather than extreme punishments, greater consistency including family customs, and closer bonds between parents and children;
- fewer youth behavioural problems (e.g., substance abuse, behaviour disorders, aggression, violence and juvenile delinquency) and emotional problems (e.g., depression and psychosomatic disorders); and
- a decrease child abuse, as parents learn to form a strong bond with their children and develop positive parenting skills.

What are the materials needed for the implementation of the SFP?

The typical resources needed for implementing the SFP include 6 books:

- Parent's Skills Training Group Leader's Manual;
- Children's Skills Training Group Leader's Manual;
- Family Skills Training Group Leader's Manual;
- Parent's Handbook;
- Children's Handbook; and
- Implementation Manual.

The manuals contain full lesson plans, worksheets, activity sheets, experimental activities, and homework for the group leaders to implement during the sessions.

What staff is needed to implement the SFP?

The following staffing requirements must be met to implement the SFP:

- A bare minimum of 5 trained staff is needed: 2 group leaders for the parents, 2 for children or teens, and a site coordinator.
- These leaders teach the material provided and act as a facilitator, a teacher, and a coach.
- Group leaders must be trained and must have strong presentation and facilitation skills and have experience working with both parents and youth.
- On average, 8 to 10 families may be recruited to participate in each cohort of the program.

What training is needed for staff in implementing the SFP?

Training of SFP group leaders by SFP-certified trainers and technical assistance for implementation, including quality/fidelity assurance and evaluation, are provided by Lutra Group, Inc. SFP group leader trainings comprise both instruction and participation by trainees and include:

- conceptual basis and origins of SFP;
- overall structure and operation of SFP;
- overview of the parent, child, and family curriculums;
- learning "Child's Game" and "Parent's Game" in SFP 6-11 and "Our Time" and "Clear Directions" in SFP 12-16;
- simulation experience delivering sessions from parent, child, and family courses;
- recruiting and retaining families and decreasing attrition;
- administering evaluation instruments;
- dealing with ethical and legal problems, handling crisis, providing referrals; and
- group leading skills.

What are the estimated costs for the SFP?

Materials

- Children and Parent's Handbooks ($8 USD each); and
- Children's, Parent's, and Family Skills Training Group Leader's Manuals and Implementation Manual ($30 USD a set).

Training

- Fees are around $4,000 USD for a two-day SFP group leader training for 35 or fewer trainees or around $3,500 USD for a training of 15 or fewer. The training fee includes a SFP master set of course materials on CD for one age-variant and site-limited license to reproduce copies for the agency's own use.
- Trainer(s) expenses for 2 or 1 trainer, for the larger or smaller groups, respectively, including travel, lodging, and per diem of $40 USD are reimbursable in addition to the training fee. Upon request Lutra Group, Inc. also offers a comprehensive fee including training, CD, and all travel for trainer(s).

Overall Costs for Implementation

- In addition to the training costs, a 14-week SFP with 10 families will cost approximately between $12,000 USD and $14,000 USD (depending on whether or not the site coordinator is an internal staff member assigned to supervise SFP). This cost includes salaries for group leaders, food, child care, supplies, completion incentives, and material duplication.
- With 6- and 12-month booster sessions, an additional $2,500 USD (approximately) should be added to the total SFP costs.
- The cost of the program will vary depending on the size of the families enrolled in the program (i.e., the number of children participating from each family).
- The overall cost for implementation will vary depending on the local context within which the program is being implemented. Additional expenses such as salaries, administrative costs, program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the SFP?

The National Crime Prevention Centre (NCPC) is currently not aware of any study that has been conducted on the cost-benefit of the SFP.

What other programs have been developed based on the SFP?

In the United States, approximately 50 SFP trainings are conducted each year for more than 450 agencies and 1,000 new group leaders, as such it is difficult to know about all the new populations to which SFP is being applied. The following represents only a sample of new SFP target populations:

- children of criminally involved parents are a new target population;
- child protective services agencies are now employing SFP to reduce child abuse and neglect among reported parents;
- Welfare to Work Programs in New Jersey are using SFP to improve belief in personal change and readiness for change in drug-abusing mothers who have not found jobs and refuse drug treatment;
- youth services agencies in a number of states are using SFP with high-risk youth in low income neighborhoods; and
- Urban and Rural American Indian Tribes and First Nations Families are employing culturally adapted versions of SFP.

Beyond this, the National Crime Prevention Centre (NCPC) is currently not aware of any other program that has been developed based on the SFP program.

Additional information on the SFP

Evaluation of SFP implementations can be conducted through Lutra Group, Inc. Their services are comprehensive, normed against a national data base, and extremely cost-competitive. All evaluations are supervised by the program developer and data is entered, analyzed and evaluated by staff at the Strengthening Families Program national office. A follow-up on-site visit once implementation has begun is often helpful in assuring fidelity and program effectiveness.

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The Ally Intervention Program

The Ally Intervention Program in a nutshell

The Ally Intervention Program is a multimodal intervention program intended for youths who exhibit behavioural problems at school and at home and are considered to be at risk of school and social maladjustment. It was designed to enrich the repertoire of social and interpersonal problem-solving skills for these individuals. To be beneficial in the long term, this type of program requires the direct involvement of the people who have the most impact in the lives of youths, and so proposes a combination of interventions among 3 main socialization agents: family, school, and peers. The Ally Intervention Program makes it possible to intervene in a consistent way that is better suited to life circumstances, and to foster a sense of security in youths while creating a new form of solidarity between parents and the school.

What are the goals of the Ally Intervention Program?

The main goal of the Ally Intervention Program is to prevent the appearance and the aggravation of behavioural problems in school-age children. Its other main objectives are to enhance:

- the potential for youths with behavioural problems to help them better adapt at school (by focusing on the development of cognitive, social and behavioural skills);
- the parents' potential to help their children better adapt at home (by strengthening parenting skills);
- relations of friendships with peers (by thwarting the affiliation with deviant peers); and
- communication and consistency between the various agents of education (teachers, professionals, case workers) working with the troubled youths.

Who is the target population for the Ally Intervention Program?

The Ally Intervention Program is intended for elementary school students aged 8 to 12 years old who exhibit behavioural problems at school and at home and are considered to be at risk of school and social maladjustment.

Participants are selected for participation in the program based on indicators such as aggressiveness, opposition, provocation, difficulties in social relations, the attribution of hostile and negative intentions to others, social rejection by peers, and affiliation with deviant peers. Participants must demonstrate a minimum of functional skills which enable them to benefit from group intervention.

What types of settings are appropriate to implement the Ally Intervention Program?

The implementation of the Ally Intervention Program is best suited for the school setting. Because of its educational mission and the opportunities it offers to work daily with children, the school is a privileged milieu within which to design and implement preventive actions. A team of educators (teachers and professionals) are dedicated to supporting children in their learning and encourage the development of their intellectual, behavioural and social skills.

What are the key components for the implementation of the Ally Intervention Program?

The Ally Intervention Program features 2 intervention components facilitated by professionals in the field:

- **Child component**: in this first component, children with behavioural problems and some peer-helper classmates participate in a program that builds social and interpersonal problem-solving skills through 16 meetings with the children, including roughly 30 activities to help them learn social behaviours such as controlling their emotions and conflict resolution strategies. The suggested ratio is 6 peer-helpers for 6 children with problems, although 1 peer may be paired with 2 students in his or her class.
- **Parent component**: the second component consists of 15 2-hour meetings with parents to improve their parenting and educational skills, and foster their collaboration with the school environment. This includes 30 activities that address various themes, such as managing difficult behaviour, resolving conflicts, and negotiating.

The time required to facilitate the program is divided as follows:

- establishment and recruitment of participants: 25 hours;
- child component: 2 hours of preparation and 1 hour of delivery for 16 meetings; and
- parent component: 2 hours of preparation and 2 hours of delivery for 15 meetings.

What are critical elements for the implementation of the Ally Intervention Program?

Some of the critical elements for the implementation of the Ally Intervention Program include:

- before implementing the program it is important to ensure that the school is already engaged in promoting peaceful behaviour using a universal approach (for example, Vers le pacifique). Consistency between the school team's values and practices and the content and spirit of the program is essential to ensure the program's success;
- The participation of parents is crucial to the program's effectiveness. To encourage parents to participate, schools can provide them with a daycare service, enabling them to attend the workshops designed for them. When necessary, it can reimburse the fees of a babysitter in the home. In addition, the team may systematically call parents before every workshop to urge them to participate.

What are some of the risk factors targeted by the Ally Intervention Program?

Some of the risk factors targeted by the Ally Intervention Program are:

- early and repeated anti-social behaviour;
- rejection from peer group;
- affiliation with deviant peers;
- lack of or inadequate family organization and supervision;
- inappropriate attitudes, ineffective discipline
- poor parenting skills;
- lack of connection with family, school and community; and
- school environments that favour punitive disciplinary practices, have vague rules and expectations and that have high academic failure rates.

What are some of the protective factors targeted by the Ally Intervention Program?

Some of the protective factors targeted by the Ally Intervention Program are:

- developing cognitive, social and behavioural competencies;
- developing problem-solving and interpersonal conflict resolution skills;
- promoting use of non-violent alternatives;
- developing parental competencies (disciplinary practices and parenting skills);
- pro-social friendships; and
- creating a support system at school.

What are the results from evaluation studies of the Ally Intervention Program?

Evaluation studies of the Ally Intervention Program have shown the following:

- participants seek more positive solutions to conflicts (student's evaluation) and are better able to resolve conflicts and show more pro-social behaviours (teacher's evaluation) than their comparative group counterparts;
- girls with externalized behavioural problems derived more benefit from the program than boys and girls also improved their ability to control their emotions and had improved behavioural self-regulation; and
- positive effects were observed in the school environment as perceived by students with problems including a drop in victimization in girls, an increased feeling of security in girls and a greater perception of support for students with problems.

What are the materials needed for the implementation of the Ally Intervention Program?

The typical resources needed for implementing the Ally Intervention Program include the educational package (available in both French and in English) which comprises the following:

- promotional posters, implementation guide, facilitator's guides for both components, and an illustrated story;
- a DVD containing educational vignettes that illustrate certain situations in the parent component; and
- a CD that contains the printable educational material needed to facilitate meetings (child component and parent component), the Ally newsletter to be distributed to teaching staff and parents, activity workbooks (child component and parent component), a behavioural assessment questionnaire, a tool for compiling results to assess the effects of the program, and meeting review forms to document the implementation of the program and report on the experience.

What staff is needed to implement the Ally Intervention Program?

The following staffing requirements must be met to implement the Ally Intervention Program:

- The program is facilitated with the support of professionals in the school setting including teachers, psycho-educators and case workers. A steering committee composed of members of school staff oversees the implementation of the program.
- For the child component, it is necessary to have two facilitators: one professional staff person who is familiar with behavioural problems and another professional in the school setting.
- For the parent component, at least one of the organizers of the child component should be present to make the connection (it may also be the same two facilitators), but it is also possible to make a connection with a service provider who works for a social service agency that works with parents as part of its mandate.

What training is needed for staff in implementing the Ally Intervention Program?

Training is offered with the purchase of the Ally Intervention Program to ensure its optimal and successful use. The program designers offer various training packages and personalized services to support the structure and educators involved in teaching the program. It is possible to receive program training in both French and English.

The cost of the program includes training for a period of 3 hours and telephone support for up to 5 conference calls. Also, there are additional optional services that can be discussed with the developers to see if these services can be offered:

- meeting to present the program for the school team;
- participating in a steering committee composed of members of school staff;
- observing during workshops for feedback; and
- participating in a reporting meeting at year end.

What are the estimated costs for the Ally Intervention Program?

Materials and Training

Mandatory:

- Training Package (per school): this includes 1 educational package and 3 hours of training for those responsible for program implementation ($850 CDN);
- Training package (for school board): this includes 1 educational package and 5 hours of training for those responsible for program implementation ($850 / School for 1-4 schools; 20% discount for 5-9 schools, 25% discount for 10+ schools); and
- Education Package Resource Kit, training and support (per school) ($1,500 CDN).

Optional:

- meeting to present the program for the school team ($50 CDN, 1 hour);
- end of year reporting meeting ($225 CDN, 3 hours);
- support of steering committee ($600 CDN, 4 meetings of 2 hours, Montréal and surrounding area); and
- additional Education Package ($500 CDN).

Overall Costs for Implementation

- The overall cost for implementation will vary depending on the size of the program and the local context within which the program is being implemented. Additional expenses such as salaries, administrative costs, program support, length of program, quality assurance materials, travel and accommodations, participation incentives (food, child care, transportation), completion incentives, etc., should also be considered in implementation estimates.

What is the cost-benefit of the Ally Intervention Program?

The National Crime Prevention Centre (NCPC) is currently not aware of any study that has been conducted on the cost-benefit of the Ally Intervention Program.

What other programs have been developed based on the Ally Intervention Program?

Based on discussions with the program developers, there are no other programs that have been developed based on the Ally Intervention Program.

Who is the contact for the Ally Intervention Program?

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