*The Journal of Primary Prevention, Vol. 23, No. 4, Summer 2003 (© 2003)*

# Primary Prevention Programs for Children in the Social Service System

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*Providing effective social services for children and their families at high risk for substance abuse problems is a national concern. The paper presents the prevalence and incidence of children in need of social services due to child maltreatment, child poverty, parental incarceration, parental substance abuse, juvenile justice problems, child mental health and substance abuse problems, and homelessness. Next, the paper examines early childhood family education and family support approaches in primary prevention designed to meet the needs of these children. New research to understand developmental pathways that lead to substance abuse problems in these children is recommended.*

**KEY WORDS:** family support; early childhood family education; resiliency; prevention.

## AN ECOLOGICAL, FAMILY-CENTERED PERSPECTIVE ON SERVING CHILDREN IN THE SOCIAL SERVICES SYSTEM

The need to provide effective social services for children and their families at high risk for substance abuse problems has been a growing concern at the federal, state and local community levels. Human service professionals, policy-makers, as well as advocacy groups for children and families in the past 20 years have acknowledged with a growing sense of urgency the need to reform present patterns of delivering social services to children and families. Several recent federal legislative actions in child welfare, in welfare, in mental health and substance abuse, in juvenile justice, in education and in health care have influenced the

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current social services for children and families.[5] Meeting the needs of children in the social service system at high risk for substance abuse problems is complex and requires preventive interventions that focus on multisystem initiatives.

States and local communities are viewed as key stakeholders in the development of services to meet the needs of these children and their families. Increased emphasis is being placed on collaborations across service systems, partnerships between public and private agencies, and accountability for outcomes that promote child safety and well being. New paradigms of human service delivery have emerged (Zlotnik, 1997:11) that:

1. Encourage the provision of services that deal holistically with the multiple needs of children and families;
2. Bring multiple agencies together to provide coordinated services; and
3. Develop partnerships between vulnerable families and service providers.

The delivery of services to children and families in the social services system has increasingly focused attention on addressing individual (both biological and psychological), family, neighborhood, and broader contextual conditions that produce childhood problems (Fraser, 1997). An ecological, family-centered, multisystems perspective to meet the needs of children in the social services system has become the organizing framework for current practice initiatives (Stroul & Friedman, 1986). An ecological framework focuses on both the child in need of social services and on the context (e.g., family, school, peers, neighborhood) (Bronfenbrenner, 1979). The social ecology of childhood can be conceptualized as consisting of interdependent and often "nested" parts of a system (Fraser, 1997, p.4). This perspective requires that those who work with children and their families look holistically at the child, the family, their roots, and their culture as well as the social services delivery system. Family-centered practice emphasizes work with families, rather than exclusively with the child (Cole, 1995; Zlotnik, 1997). According to Johnson (1996), family- centered care includes respect for and support of family decisions, collaborative problem solving, a strengths orientation, information exchange, and family empowerment.

Preventive interventions designed to address the needs of children in the social services system in this perspective must be multisystemic since no childhood problem exists in isolation at any one system level (Fraser, 1997). Key principles that emerge from this perspective include support for continuity of care across the

[5]Family Preservation and Support Services Provisions of the Omnibus Reconciliation Act of 1993 (P.L. 103–66), Adoption Assistance and Child Welfare Act (P.L. 96–272), Adoption and Safe Families Act of 1997 (P.L. 105—89), Foster Care Independence Act of 1999 (P.L. 106–169), Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193), ADAMHA Reorganization Act of 1992 (P.L. 102–321), Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93–415) subsequent amendments 1992, 1998, Individuals with Disabilities Education Act of 1997 (P.L. 105–17) and State Children's Health Insurance Program-Chapter 1-Title XXI of the Balanced Budget Act of 1997 (P.L. 105–33)

service delivery system instead of fragmented services, cross-system collaboration instead of single-system responses, community-based services over out-of-home care for children, and culturally-competent services that incorporate varying racial, ethnic, socioeconomic, and regional values.

This paper will present preventive intervention approaches designed to meet the needs of children in the social services system who are at high risk for substance abuse problems. It will explore what preventive interventions work for these children and their families with multiple risk factors linked to the development of substance abuse problems, and address the outcomes that focus on improved quality of life and development of protective factors in these children. Preventive interventions attempt to prevent problems in functioning for children in the social services system who are at high risk of developing a variety of mental health and adjustment problems, including substance abuse, delinquency, teenage pregnancy and school failure.

The paper will begin with a brief presentation of prevalence and incidence of children in need of social services due to child maltreatment, child poverty, children of incarcerated parents, children living in substance-abusing families, children in the juvenile justice system, children with mental health and substance abuse problems, and children who are homeless/runaways. This will be followed by an examination of risk and resilience research on substance abuse as it relates to these children and their families, and the preventive approaches that are demonstrating positive outcomes for children in the social services system. A discussion of the need for future research development will conclude the paper.

## Prevalence and Incidence of Children in Need of Social Services System Response

### *Child Maltreatment*

In 1998, child protective services agencies investigated 2 million reports alleging the maltreatment of almost 3 million children (U.S. Department of Health and Human Services, 2000). Just over 900,000 children were victims of substantiated child abuse and neglect in 1998 (U.S. Department of Health and Human Services (DHHS), 2000). Among these 53.5 percent of the children experienced neglect, 22.7 percent physical abuse, 12 percent sexual abuse and 6 percent or fewer each of psychological abuse and medical neglect (DHHS, 2000).

Children in foster care numbered more than 520,000 in March 1998, up from 340,000 in 1988 (ACF, 1999). Over 87 percent of perpetrators of child maltreatment were parents, and 60.4 percent of perpetrators were female (U.S. Department of Health and Human Services, 2000).

The *National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families* (Children's Bureau, 1997:ix–xiii)

found:

1. Between 1977 and 1994 there has been a dramatic decline in the number of children receiving child welfare services.
2. The intent of federal policies to shift child welfare from a foster care system to an in-home family-based system has not been realized.
3. Although the average length of stay in foster care has declined overall, more than one-third of the children placed in foster care remains there for more than 18 months.
4. Minority children, and in particular African-American children are more likely to be in a foster care placement than receive in-home services, even when they have the same problems and characteristics as white children.
5. Kinship care does not explain the dramatically longer stays in foster care for African-American and Hispanic children compared to white children.

Faver, Crawford & Combs-Orme (1999, p. 89) reported that "although reports of child maltreatment have steadily increased over the last decade, a growing body of literature suggests that services to maltreated children and their families are increasingly nonexistent, inaccessible or inappropriate." Meddin and Hansen (1985) and Salovitz and Keys (1988) found that in cases investigated for child abuse or neglect, over 50 percent of the families received no services during the investigation. Glisson (1996) found that 52% of the children in state custody in Tennessee had emotional and behavioral problems in the clinical range but mental health services were provided to only 14%. In a California study of 662 children and adolescents in the foster care system, Garland, Landsverk, Hough & Ellis-Macleod (1996) reported that children removed from their homes due to sexual and/or physical abuse were more likely to receive services than those who were removed for neglect and caretaker absence. DePanfilis & Zuravin (1998) reviewed 45 studies that addressed rates, patterns and frequency of child maltreatment recurrences among families known to Child Protective Services (CPS). They found that the current service delivery system is serving many families over and over again.

About half the children in foster care nationally are age 12 or older and many of these youth exit foster care as adults who must live on their own (Stone, 1987). Youth who have left the foster care system experience disruptions in education due to changing placements, inadequate preparation for the workplace, and lack of access to physical and mental health care (Child Welfare League of America, 1999).

Childhood maltreatment is a significant predictor of delinquency after controlling for age, gender and race (Ireland & Widom, 1994). Being abused and/or neglected increased the odds of being arrested as a juvenile (Ireland & Widom, 1994). In addition, child maltreatment is a significant predictor of adult arrests for alcohol and/or drug-related offenses (Ireland & Widom, 1994).

Child maltreatment is a serious, prevalent and costly social problem which requires preventive interventions that address the complex needs of these children and families.

### *Childhood Poverty*

Childhood poverty can have profound short and long-term consequences for children (Sherman, 1997; Harper & Vandivere, 1999). Harper & Vandivere (1999) report that growing up at or near the poverty line ($16,660 for a family of four in 1998) can affect the quality of a family's housing, children's access to nutritious food, adequate health care and educational opportunities for their children. Sherman (1997, p.30) noted that children living in poverty experience double jeopardy. First, children are exposed to more frequent risks, such as family stress, parental depression, and medical illness. Secondly, they experience more serious consequences from these risks than do children from higher socioeconomic status.

In 1998, almost one in five children were poor (36 percent of black children, 34 percent of Hispanic children and 14 percent of white children) (Harper & Vandivere, 1999). Children who live in prolonged poverty, on average, have lower academic achievement, are less likely to graduate from high school and have lower wages and earnings in their adult years (Sherman, 1997; Harper & Vandivere, 1999; Duncan & Brooks-Gunn, 1997). In 1998, almost half (46 percent) of all children living in female-headed families were poor, a proportion that has been roughly the same throughout the 1990's (Harper & Vandivere, 1999). Children in families with lower socioeconomic status are more likely than children in families with higher socioeconomic status to have difficulty performing everyday activities (e.g., learning, communication, mobility, self-care) (Federal Interagency Forum on Child and Family Statistics, 1999). In 1999, 12.3 percent of children ages 5 to 17 had difficulty performing one or more everyday activities with the most common difficulty in the area of learning (Federal Interagency Forum on Child and Family Statistics, 1999). These children often have disproportionately high use of the health care system and many receive special services at school (Federal Interagency Forum on Child and Family Statistics, 1999). More children born in the inner cities of the U.S. were underweight at birth, lived in homes where their parents were on public assistance, and dropped out of high school when compared to children living outside the inner cities (Black & Krishnakumar, 1998). These children are at increased risk for mental health problems, substance abuse, delinquency, violence, maltreatment and posttraumatic stress disorder (Harpham, 1994). Children who live in poor families are likely to have social services system interventions that target the increased risks that these children and their families experience.

### *Children of Incarcerated Parents*

Parental crime, arrest and incarceration have profound effects on children (Johnston, 1995). An estimated 200,000 children in the United States have an imprisoned mother and more than 1.6 million have an imprisoned father (Seymour,

1998). The majority of adults incarcerated in the United States are parents who have limited educational backgrounds, have substance abuse histories, are from low income communities, and have histories of traumatic experiences that include separation from their own parents as children, domestic violence and child maltreatment (Johnston & Gabel, 1995). Johnston & Gabel (1995, p. 3) report that jailed and imprisoned mothers are half as likely to be married as incarcerated fathers, three times more likely to have lived with their children prior to arrest and half as likely to be satisfied with their children's placement during their incarceration. The Children of Offenders Study (Johnston, 1992) reported that over half of the children of women who had been arrested and 77 percent of the children of currently or previously incarcerated women, had prenatal exposure to drugs or alcohol. A review of the studies on children of incarcerated parents found that the ability of children to successfully master developmental tasks and to overcome the effects of trauma, parent-child separation and inadequate childcare is seriously compromised when a parent is incarcerated (Johnston, 1995). Incarcerated parents are at great risk of losing their parental rights when their children are placed in foster care at the time of incarceration (Norman, 1995). Since state child welfare agencies need to develop permanent plans within 6 to 12 months of a child's entry into foster care, incarcerated parents who are awaiting trial or have long prison sentences frequently have their parental rights terminated (Norman, 1995). The average time served in U.S. prisons is 16 months for females and 66 months for males (U.S. Department of Justice, 1993) so most prisoners with children in foster care face the federally mandated deadline for permanent placement of their children before or immediately after their release (Norman, 1995, p. 132).

### *Children Living in Substance Abusing Families*

A family history of substance abuse or alcohol abuse has immediate and future developmental implications for the child (U.S. Department of Health and Human Services, 1999a). It is estimated between 37 percent to 57 percent of American families served by public agencies have a family member who abuses alcohol or other drugs (Werner, Joffe & Graham, 1999; Besinger, Garland, Litrownik & Landsverk, 1999). For 11 percent of all children in the U.S., at least one parent is either alcoholic or in need of substance abuse treatment (U.S. Dept. of Health and Human Services, 1999a). Children living in substance abusing families have increased risks for physical and sexual abuse, conduct disorders, school problems, substance abuse, and illnesses due to neglect and in utero exposure to alcohol and drugs (Werner, Joffe & Graham, 1999). In 50 percent of the families known to the public child welfare system, parental substance abuse is linked to the child maltreatment investigation (Murphy, Jelinek, Quinn, et al., 1991).

*Children in the Juvenile Justice System*

In 1997, an estimated 2.8 million youth under the age of 18 were arrested (Snyder, 1999). The National Center for Juvenile Justice (1998) reported that:

1. Between 1993 and 1997, juvenile arrests for murder declined 39 percent.
2. In about 15 percent of all juvenile arrests in 1997, the most serious charge was drug abuse violation, a liquor law violation, drunkenness or driving under the influence.
3. The proportion of juvenile arrests involving younger juveniles (under age 15) was highest for the offense of arson (67 percent), followed by sex offenses (51 percent), vandalism (45 percent), larceny-theft (42 percent), other assaults (41 percent) and runaways (41 percent).
4. Between 1993 and 1997, juvenile arrests for drug abuse violations increased 82 percent.

Up to 70 percent of youth in the juvenile justice system have a diagnosable mental or emotional disorder and 20 percent have a serious disorder (Petrila, 1998; NMHA, 1998). It has been estimated that each year, of the youth who come into contact with the juvenile justice system, 150,000 meet the diagnostic criteria for at least one mental disorder, 225,000 have a diagnosable alcohol abuse or dependence disorder and 95,000 have a diagnosable substance abuse or dependence disorder (Bilchik, 1998; Cocozza, 1992). Youth of color represent 68 percent of the juvenile population in secure detention and 68 percent of those in secure institutional environments, such as training schools (Sickmund, Snyder, & Poe-Yamagata, 1997).

Loeber et al. (1998) found family risk factors such as, poor supervision, poor parent-child communication and physical punishment increased the risk of delinquency. Male juvenile offenders are more likely to be involved in delinquent activities whereas female offenders more often come from more troubled family backgrounds involving sexual victimization (Dembo et al., 1998). Children of color who enter the juvenile justice system tend to grow up in environments of poverty where chronic violence, high unemployment rates, poor housing, inadequate schools and substance abuse are prevalent (Benjamin, 1997).

*Children with Mental Health and Substance Abuse Problems*

During any year, approximately one fifth of youths have diagnosable emotional or behavior problems that cause at least temporary interference with functioning in family, school or community settings (Cohen, Provet & Jones, 1996). About 9 to 13 percent of these youths have a serious emotional disturbance with substantial functional impairment (Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1998). The prevalence rate of serious emotional disturbance is

higher for youth living in disadvantaged socioeconomic circumstances than for those from higher socioeconomic statuses (Friedman, Katz-Leavy, Manderschied & Sondheimer, 1998).

In 1993, an estimated 43 percent of high school seniors used an illicit drug and 51 percent reported drinking alcohol in the past month (Johnston, O'Malley & Bachman, 1994). An estimated 1.1 million youth age 12 to 17 met diagnostic criteria for dependence on illicit drugs in 1997 (Substance Abuse and Mental Health Services Administration, 1999). Huizinga & Jakob-Chien (1998, p. 48) found that a greater proportion of serious and violent juvenile offenders use alcohol, marijuana and other illicit drugs, and on average, they use these drugs with greater frequency than do other offenders or individuals.

### *Children Who Are Homeless/Runaways*

Homeless and runaway youth are the most understudied and underserved subgroup among the homeless population (IOM, 1989). Estimates of the number of children who run away each year range from 500,000 to 1.3 million (Kaufman & Widom, 1999). Often referred to as "runaways," "throwaways" or "street kids," a majority of adolescents who are homeless come from conflict-laden, violent, and impoverished families (National Network, 1985; Cauce, Paradise, Embry, et al., 1998; Ennett, Bailey & Federman, 1999). Youth who experience a lack of care from a parent or physical abuse are more likely to be homeless than youth who did not experience these adverse risk factors (Herman, Susser, Struening & Link, 1997). Hagan and McCarthy (1997) found that runaways and homeless youth regularly turned to delinquent and criminal behavior to survive on the streets. Kaufman & Widom (1999) noted that childhood victimization increases the risk that a youth will run away from home and that both childhood victimization and running away increase the likelihood of having an arrest as a juvenile. Runaway and homeless youth are at high risk of substance abuse and unsafe sexual behavior (Ennett, Bailey & Federman, 1999). Approximately 70 to 90 percent of homeless and runaway youth in shelters abuse alcohol and 50 to 70 percent abuse drugs (Pires & Silber, 1991). In 1997, 58 percent of arrests for running away from home involved females and 41 percent involved juveniles under the age of 15 (Snyder, 1999). These youth frequently have histories of unsuccessful contact with social service systems, including placements in foster care, group homes and residential treatment programs (Cauce, Paradise, Embry et al., 1998; Rothman & David, 1985).

## Risk and Resilience Research on Children and Families in the Social Services System

Although children are influenced by their psychosocial environment, most can deal with some degree of adverse experiences at home, at school or in the

community. Successful preventive interventions target improving opportunities for resilience in children by improving the environments in which children live (Black & Krishnakumar, 1998).

Resilience emerges as a result of balancing the risk and protective factors across multiple system levels (O'Keefe, 1994; Hawkins, Arthur & Catalano, 1995). Resilience can be characterized as successful functioning in the context of high risk.(Fraser, 1997). Individual resilience may be strengthened by reducing vulnerability and risk, promoting positive outcomes by disrupting "pile-up" stressors, increasing access to available resources and mobilizing protective processes that can buffer the effects of risk factors. (Masten, 1994).

A risk- focused approach seeks to prevent drug abuse by eliminating, reducing or mitigating its precursors (Hawkins, Catalano & Miller, 1992, p. 65). A risk factor may be defined as any influence that increases the probability of onset, digression to a more serious state, or maintenance of a problem condition (Fraser, 1997, p. 10–11). Several risk factors have been identified that influence the healthy development of children and adolescents (Fraser, 1997; U.S. Dept. of Health and Human Services, 1999b). These include biological influences, psychosocial factors, family and genetic factors, stressful life events, childhood maltreatment, maladaptive peer and sibling influences, violent neighborhoods and social injustices (e.g., racial discrimination) which may predispose a child or adolescent to behavioral, emotional or developmental challenges (Fraser, 1997, U.S. Dept. of Health and Human Services, 1999b). Environmental adversities, such as prolonged and repeated child maltreatment, impoverished conditions, unstable family systems, racial discrimination and injustice, and multiple placements, induce in many children emotional, behavioral or developmental problems (U.S. Dept. of Health and Human Services, 1999b) which may result in these youth entering the social services system.

Risk factors occur before drug abuse in children and are associated statistically with an increased probability of drug abuse (Hawkins, Catalano & Miller, 1992, p. 65). Many of the risk factors for drug abuse also predict other problem behaviors in children and are correlated with delinquency, teenage pregnancy and school drop out (Hawkins, Catalano & Miller, 1992). Research on risk factors linked specifically to substance abuse problems in children and adolescents can be classified at environmental, interpersonal, social, and individual levels (Jensen, 1997). Environmental risk factors include cultural norms for substance use, availability of alcohol and drugs, poverty and economic deprivation, low economic opportunity, neighborhood disorganization, population density, and high adult crime rates (Jensen, 1997; Hawkins, Catalano & Miller, 1992; Kilpatrick et al., 2000). Interpersonal and social factors that place children at high risk for substance abuse include family modeling of substance using behavior, poor parenting practices, high level of conflict in the family, low degree of bonding between children and parents, school failure, and association with drug-using peers (Hawkins, Catalano & Miller, 1992; Jensen, 1997; Griffin et al., 2000; Kilpatrick et al., 2000; Reinherz et al., 2000).

Individual risk factors include being physically assaulted, being sexually assaulted, witnessing violence, poor impulse control, chronic health conditions, sensation seeking orientation, and genetic predisposition (Kilpatrick et al., 2000; Hawkins, Catalano & Miller, 1992, Jensen, 1997).

Reinherz et al (2000) identified in a longitudinal study of 360 youth, that as early as age 6 childhood behavior problems such as hyperactivity, poor concentration, aggression and hostility predicted drug disorders for both genders in adolescence. Werner and Smith (1992) reported that two-thirds of children in their 32 year prospective study with four risk factors by age 2 developed learning disabilities, behavioral problems, teenage pregnancy, and/or mental illness or substance abuse. Children in foster care have three to seven times as many acute and chronic health conditions when compared to children not in foster care (Rosenfeld et al., 1997) and on average youth in foster care have 14 individual and interpersonal risk factors (Thorpe & Stewart, 1992). Many children in the social services system live with these risk factors present for prolonged periods of time in their lives. Identification of multiple risk factors at multiple levels for children in the social services system suggests that preventive interventions need to address these multiple levels.

A protective factor is an internal or external force that helps a child or adolescent resist or ameliorate risk (Fraser, 1997). Luther, Cicchetti & Becker (2000) define three types of protective factors: protective stabilizing factors are attributes that provide stability despite increasing risk, protective enhancing factors are attributes that build existing competence, and protective but reactive factors are those attributes that continue to be protective but less under high stress situations. Common protective factors that assist children in balancing the risk factors include self efficacy, presence of a caring/supportive adult, positive relationships, social support, competence in normative roles and opportunities for education and growth (Fraser, 1997). Protective factors in children and adolescents at risk for substance abuse problems include being a firstborn child, experiencing low parental conflict, living in a small family, having positive caring relationships with peers, siblings and extended family members, committed to school achievement, belief in pro-social norms and values, using problem solving skills, living in low stress environments and having high intelligence (Jensen, 1997; Hawkins, Catalano & Miller, 1992). Many of these protective factors are absent in the daily lives of children in the social services system who experience high stress environments, multiple placements, and inconsistent support.

Protecting children and adolescents from risk and promoting resilience requires interventions in the social service system that are ecologically focused and developmentally appropriate. Research on resilience has supported an additive as well as, interactive effects model (Luthar, 1991; Masten, Best & Garmezy, 1990; Rutter, 1987). The additive model of resilience posits that the presence of a risk factor directly increases the likelihood of a particular negative outcome (Luther, 1991). The interactive effects model proposes that protective factors have effect

only in combination with risk factors to buffer, interrupt or prevent risk factors from operating.

Resilience research is beginning to address the complex interactions between risk and protective factors in the internal and external environments of a child. Preventive interventions "should focus on risk reduction and protective factor enhancement to prevent later substance abuse, crime and other social problems" (Pollard, Hawkins & Arthur, 1999, p. 145). The preventive intervention models discussed in this paper build from this resiliency-based framework for understanding ways to work with children, adolescents and their families at high risk for substance abuse.

## The System of Care Philosophy in Work with Children with Multiple Service System Needs

Within the social services system, development of interagency community-based systems of care emerged to meet the needs of children and adolescents with more severe problems that cross system boundaries. The systems of care philosophy requires that services be child-centered, family-focused, culturally-competent, and community-based (Stroul & Friedman, 1986). Services under the systems of care model promote access, individualization of interventions, least restrictive environment, family participation, integration of services, coordination of services, and early identification of needs. The social services system is one of the components of a system of care. The other components include mental health services, educational services, health services, substance abuse services, vocational services, recreational services and operational services such as recreation and transportation (Stroul & Friedman, 1986). Evaluations of system of care models suggest that they are effective in keeping children and adolescents with multiple problems in the community, improving functional behavior, and involving families in the planning and implementation of services (U.S. Dept. of Health and Human Services, 1999b). To date the systems of care models have not demonstrated better mental health clinical outcomes than services delivered in traditional settings for children and their families (Bickman, Guthrie, Foster et al., 1995; Bickman, Summerfelt, Firth & Douglas, 1997).

### *Summary of the Ecological, Family-Centered, Multisystems Perspective*

The challenges facing the social service system in meeting the needs of children and youth at high risk for substance abuse problems are complex and require multiple layers of response across a wide range of systems (e.g., family, school, neighborhood, community). The social service system needs to incorporate an ecological, resiliency-based perspective that involves a combination of simultaneous

multisystems interventions for effectively serving these children and adolescents. As one will note from this brief review, the problems that each group of children and adolescents encounter are often interrelated and emerge in conditions where poverty, unstable family environments, inadequate resources and social injustices delimit the opportunities and hopes of these youth.

Understanding how the social service system can intervene to change the pathways for these children and adolescents requires that one understand what conditions promote child well being and safety. Operating under a system of care framework, many of the preventive interventions that are making a difference in the lives of children and adolescents need to be highlighting and replicated.

## Prevention Research Focusing on Children and Their Families Across the Social Services System

Preventive interventions may target specific groups of children and adolescents in the social services at high risk for substance use and/or broader levels of the social environment, such as families, school settings and communities (National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998). This review examines universal preventive interventions that target all children and families and a few selective preventive interventions that target children and adolescents who are in high risk environments for substance abuse use.

In reviewing preventive interventions it is important to consider how these practices are implemented in "real world" settings by responding to the following questions developed by Hohmann (1999, p.87):

1. How do definitions of prevention effectiveness (what "works") vary across persons? How does the cultural situation affect the definition?
2. How and why is the relationship between the provider of care and the recipient of care "working" or "not working"?
3. How do socio-cultural, historical and psychological characteristics that each bring into that relationship affect how it functions?
4. How do people and structures outside the dyad affect the relationship?
5. What is actually happening within organizations and systems of care—beyond counts of bed days, dollars spent and missed appointments—that might affect organizational, dyadic and individual outcomes?
6. What are the perspectives of organizational staff, clinicians, patients, family, friends, colleagues and how do those people and their perspectives affect care and outcomes?

Current research on the effectiveness of particular preventive interventions addresses some of these questions. Major strides have been made in developing preventive interventions that demonstrate effectiveness for particular groups of

children and adolescents in the social services system. In this paper, we will examine specific preventive intervention approaches that focus on families, schools and communities and that demonstrate outcomes that strengthen youth resilience and development, and reduce substance abuse risk. Each preventive intervention selected for examination has been applied in "real world" settings. These approaches address key risk factors that place children at high risk for substance use, and focus on developing protective factors and resiliency in these children. There are some "promising" preventive interventions that are in the beginning stages of demonstrating effectiveness. Many of the preventive interventions are evolving and their promise encourages further intervention development and evaluation.

Effectiveness research that is linked to preventive interventions needs to look beyond the comfortable and easily measured parts of the service system for answers to the questions of why, for whom, under what circumstances, and how (Hohmann, 1999, p. 87). While several preventive interventions have been used in the social service system, this review reveals that there is minimal research on the effectiveness of these approaches. Few preventive trials or longitudinal studies have been conducted on specific preventive interventions, which limits the evidence-based foundation for most of the current prevention approaches being used. In addition, the tools used to monitor quality of care in prevention programs, intervention fidelity issues, as well as measures for assessing preventive intervention outcomes require further development.

## Preventive Interventions Across the Developmental Spectrum for Children in the Social Services System

Because substance use in children and adolescents in the social service system is influenced by multiple risk factors, the preventive approaches address a combination of interventions that promote consistent opportunities for prosocial behavior at home and school and build skills needed to develop lifestyles that decrease the risk for social, emotional, and behavioral problems. The preventive interventions include early childhood family education and family-centered approaches. These preventive interventions are examined using the American Psychological Association (APA) criteria for "well established" interventions (Lonigan et al., 1998). These criteria require at least two well conducted group design studies or a large series of single-case studies; an intervention manual and the sample characteristics that are clearly specified. The interventions identified as "promising" interventions have begun to demonstrate effectiveness in "real world" settings but do not meet the "well established" intervention criteria. As one will note only one of preventive interventions meets the "well established" intervention criteria.

The early childhood family education and family-centered approaches focus on reducing child abuse and neglect, addressing family violence, providing parent training, reducing parental substance abuse, and building the protective factors

necessary for a child to succeed in school. It emphasizes assessment of child and family needs, coordination of services, cross service system collaboration to meet needs and building resilience in the youth and/or their family. The prevention approaches use an ecological, family-centered, multisystems perspective on serving children in the social services system at high risk of substance abuse problems within a system of care framework.

### *Early Childhood Family Education and Family-Centered Approach*

Early childhood programs can be divided into two categories: child-focused programs and family-centered programs. Child-focused programs include preschool, Head Start, pre-kindergarten and child care programs while family-centered programs include family support programs, such as home visiting, drop-in centers, and two generation programs (Gomby, Larner, Stevenson, Lewit & Behrman,1995) and family strengthening programs, such as family skills and family conferencing interventions.

Barnett (1995) reviewed 26 child-focused early childhood family education studies that focused on model demonstration projects (e.g., Carolina Abecedarian, Early Training Project, Milwaukee Project) and large-scale public programs (e.g., several Head Start programs) to examine the long-term effects of these programs on children from low-income families. Barnett (1995) found that research supports the view that early childhood care and education programs can produce substantial long-term improvements in the cognitive development and educational success of low-income children. Short-term changes in a child's socio-emotional outcomes such as self esteem and social behavior were also found but these effects declined over time (Barnett, 1995). In another review focusing on the development of delinquency behavior, Yoshikawa (1995, p. 55) reported that early childhood programs that reduce multiple risks (e.g., school motivation, poverty, parental substance abuse) may be more successful in preventing chronic delinquency than are those that target only a single risk factor. While the research indicates that early child-focused education makes a difference in cognitive and socio-emotional outcomes, only 35 percent of children living in low income environments receive early childhood education (Barnett, 1995).

Frede(1995) examined the effects of quality in early care and education programs with successful long-term outcomes. Frede(1995, p. 115) reported that effective programs were characterized by combinations of most of the following elements:

1. small class sizes with low ratios of children to teachers;
2. teachers who received support to reflect on and improve their teaching practices;
3. a concentrated or long-lasting intervention;

4. ongoing, child-focused communication between home and school; and
5. use of some curriculum content and classroom processes that are similar to what children encounter in traditional schooling.

The Head Start programs are diverse but must provide comprehensive services in four areas: education, health services, social services and parent involvement. The overall goal of Head Start is to increase social competence in preschool children from low-income families (U.S. Dept. of HHS, 1996). Social competence includes cognitive, intellectual and social development, physical and mental health and adequate nutrition (Devaney, Ellwood & Love, 1997, p. 102). A "promising" intervention, the Head Start High/Scope Perry Preschool Project is an example of an early childhood education prevention program that has demonstrated in a randomized trial positive long-term outcomes for children living in poverty. In the High/Scope Perry Preschool Project which operated in 1962–1967, 67 percent of the children who were in the experimental condition which included home visits and pre-school education graduated high school while only 49 percent of the control group of children graduated from high school (Barnett, 1995). The experimental group had higher scores on achievement tests, better grades, lower rates of special education (37% of experimental children and 50% of control group children), and lower rates of grade retention (Barnett, 1995). At age 19, the experimental condition youth were more likely to be employed and less likely to be on welfare. Youth at age 19 in the experimental condition had fewer arrests (31%) as compared to the control group (51% arrests) (Zigler, 1994). The youth in the High/Scope Perry Preschool Project experimental condition developed several protective factors that promoted more long term pro-social outcomes than youth in the control condition which decreased the risk for these youth to engage in high risk substance use behaviors. While the High/Scope Perry Preschool Project was successful for the youth living in poverty enrolled over the long-term in this study, any replication of this model would need to reflect the changing social environment of children living in poverty today and the increased risks that these youth experience. These changes include such factors as the increase in families with an adult member with substance abuse problems, the welfare-to-work programs which place these youth in child care arrangements for longer periods of the day, the increased numbers of children living in environments where one or more parent may be in prison and the increased violence in many impoverished neighborhoods.

Other longitudinal studies of Head Start program effects include positive outcomes for school achievement beyond third grade and reduced rates of grade retention, enrollment in special education, and delinquency (Barnett, 1995; Yoshikawa, 1995, Devaney, Ellwood & Love, 1997). The Head Start program effects were greater in model program sites where there were high ratios of staff to children, small group sizes and well-supervised teachers (Devaney, Ellwood & Love, 1997; Barnett, 1995). Parent involvement through home visits, classroom participation and parent group meetings produced more long-term positive outcomes

for the Head Start children than programs where parent involvement was minimal (Yoshikawa, 1995).

A parent training program to prevent conduct problems in children was experimentally evaluated with Head Start mothers, where the experimental condition received the parent training and the control group received the regular Head Start program (Webster-Stratton, 1998). The parent training program called PARTNERS involved strengthening parent competence and fostering parent involvement in the children's Head Start program and teacher training that focused on facilitating parent involvement and behavior management skills (Webster-Stratton, 1998). The results after one year found that the intervention children exhibited significantly fewer conduct problems, less noncompliance, less negative affect and more positive affect than the control children (Webster-Stratton, 1998). The parent training program has become part of the Parents and Children Training Series called the Incredible Years Training and targets children between the ages of 3 and 10 years old. This program meets the criteria for a "well established" intervention. Results of 18 randomized trials of this model have demonstrated that parents and teachers are able to significantly reduce children's problem behaviors and increase social competence and academic engagement (Webster-Stratton, 1993). This program increases child protective factors and decreases risk factors that could increase the likely of development in adolescence of substance abuse problems such as, school failure, negative peer involvement and disruption for these youth.

The Early Head Start Program, a "promising" intervention, which service children aged 0 to 3, provides intensive learning and developmental services directly to children and their families and links to other community services to meet family needs (Tarullo, 1998). The program addresses three key components: (a.) intensive child development, (b) parent education and (c) building self-sufficiency for low-income families. These programs are demonstrating positive outcomes on child development measures. Currently performance measures for Early Head Start are being developed to address the unique aspects of infant and toddler development (Tarullo, 1998).

The Carolina Abecedarian Program is another "promising" intervention program that used a randomized trial to examine the effectiveness of a full day preschool child care and a school age parent program (Campbell & Ramey, 1994). Children entered the program as infants and completed the program at age 5 to 8 years. This study followed the children at 8, 12 and 15 years of age. The children who were in the experimental condition earned higher scores on achievement tests at age 15 and were less likely to be in special education programs than the control group (Barnett, 1995). While at age 12, the experimental group had a higher IQ score than the control group by age 15 there were no significant differences on IQ scores (Barnett, 1995). In addition, at age 15, the experimental group had lower grade retention (39%) when compared to the control group (59%) (Barnett, 1995).

While most early childhood education programs are designed primarily to prevent school failure, the evidence suggests that these interventions have long-term impacts on reducing juvenile delinquency rates and substance abuse (Yoshikawa, 1995).

Family-centered programs deliver support services primarily to parents with varying degrees of intensity. Family-centered programs that target early childhood development needs by working primarily through home visiting and parent education programs without any child development or adult job training or education services appear to have modest effects on the child's cognitive development and parent life course outcomes (e.g., earning a high school equivalency diploma, delaying subsequent births) (St. Pierre, Layzer & Barnes, 1995). Yoshikawa (1995) in his review of 40 family support and early childhood programs found that the programs that had the best outcomes focused on enhancing parents' social support, fostering positive parenting and family interactions, facilitating child cognitive development, and reducing family level and community level poverty. Not surprising, child-focused early childhood education programs benefit children more than they benefit adults and the family focused support programs when effective benefit adults more than children (St. Pierre, Layzer & Barnes, 1995; Barnett, 1995; Yoshikawa, 1995).

Two-generation family-centered programs address early childhood educational programs designed to build a child's social competence as well as parent training to enhance parenting skills, education, literacy and job training (St. Pierre, Layzer & Barnes, 1995). These programs were designed to produce effects for adults and children by addressing problems of parents and children living in poverty or in high-risk situations. The goals of these programs focus on increasing school success, reducing delinquency levels, reducing pregnancy rates and improving economic self-sufficiency. The services offered by two-generation programs include developmentally appropriate early childhood education services, parenting education services, and adult education, literacy and job skills training services (St. Pierre, Layzer & Barnes, 1995). Six two-generation programs which used randomized experimental designs were reviewed by St. Pierre, Layzer & Barnes (1995, p. 89). They found the following short-term effects: rates of parent and child participation in program services increased, child development measures improved for children in the two-generation programs, and more parents in the two-generation programs attained their GED.

Family-centered programs that use home visiting as a primary intervention approach demonstrate mix results in randomized trials (Gomby, D., Culross, P. & Behrman, R. (1999). The model home visiting programs initiate services prior to the birth of the child and continue at a minimum until the child is two years old. The programs are designed to promote healthy child development, prevent child abuse and neglect, and increase positive parenting. The intensity of the home visiting services range from biweekly to monthly based on family needs. In a review

of 6 model home visiting programs which used randomized trials, Gomby et al. (1999) found that this preventive intervention revealed some benefits in parenting practices, attitudes and knowledge, but did not support benefits for children as it relates to development and abuse and neglect rates. The Nurse Home Visitation Program model is an exemplar of a "promising" intervention approach using the home visitation model. In this model, nurses during home visits would engage in three primary activities: 1) promoting behaviors thought to affect pregnancy outcomes and the health and development of children, 2) helping women develop supportive relationships with family members and friends, and 3) linking women and their family members to needed health and human services (Olds, Henderson, Cole et al., 1998). In a 15 year follow-up of a randomized trial of the Nurse Home Visitation Program, there were no differences between nurse-visited and comparison-group adolescents in antisocial behavior measures except for youth who lived in single parent homes (Olds, Henderson, Cole, et al., 1998). Youth who lived in poor, single-parent homes in the experimental condition reported significantly fewer incidences of running away, fewer contacts with the juvenile justice system and fewer days having consumed alcohol in the past 6 months than did comparison group youth (Olds, Henderson, Cole et al., 1998). Unmarried poor mothers in the experimental condition demonstrated significant differences 15 years post intervention when compared to the control group in the following risk areas: fewer subsequent pregnancies, fewer months on welfare, fewer problems related to substance abuse, and fewer arrests (Olds, Henderson, Cole et al, 1998).

The Comprehensive Child Development Program (CCDP) was an innovative program designed to ensure the delivery of early and comprehensive services to enhance child development and help low-income families to achieve economic self sufficiency. CCDP did not result in significantly different outcomes for those who participated in the program (St. Pierre, Layzer, Goodson & Bernstein, 1997). The main assumption underlying the design of this program is that poor families have complicated needs and coordinating services for these families through the use of a case manager would help meet the needs of young children and their families. Case managers provided direct services in the home such as, counseling, parent training and life skills training and organized the provision of other child and family services through referrals to community agencies and through the development of new services. The CCDP was evaluated using an experimental design in 21 project sites over a five-year period (St. Pierre et al., 1997). The families served by CCDP were primarily young, minority, very low-income mothers with small children. Both interim and final evaluation results of the CCDP showed that there were no significant differences between the experimental and control conditions. St. Piere et al. (1997) reported no statistically significant impacts on CCDP mother's parenting skills or on the CCDP children's cognitive or social-emotional development when compared to control group families. These findings challenge the assumption that working with the parents through parent education was the

best way to improve child outcomes. The average cost per family per year was $15,768.00 and most families participated for more than three years (St. Pierre et al., 1997).

In the Even Start Family Literacy Program, a "promising" intervention, families participate in early childhood education, parenting education and adult education. St. Pierre, Swartz, Gamse, et.al, 1995) using a randomized trial evaluated the Even Start Literacy Program. They found that the experimental group families had greater improvements in child development at 9 months, were more active in parenting programs, had higher levels of parent GED attainment, and increased participation of parents in adult education programs. These findings were consistent with the Head Start Family Service Center program evaluations (Swartz, Smith, Berghauer, et al., 1994). The Head Start Family Service Center programs which began in 1990 provides the normal Head Start services for 4 year olds but adds adult-focused services such as adult literacy and employment training.

Building parental support has been found to be a powerful predictor of reduced delinquency and drug use by minority youth (King, Beals, Manson, & Trimble, 1992). The Families and Schools Together (F.A.S.T.) program, which started in 1988, is an example of a "promising" family support intervention that focuses on preventing youth violence and chronic juvenile delinquency (McDonald & Howard, 1998). The F.A.S.T. program is an early intervention, multi-family program for pre-school, elementary and middle school youth ages 3 to 14 who are at risk for alcohol and other drug abuse, school failure and juvenile delinquency. The program goals include enhancing family functioning, preventing the target child from experiencing school failure, preventing substance abuse by the child and family and reducing the stress that parents and children experience (McDonald, 1999). The families participate in 8 weekly sessions using a multi-family group process with structured activities followed by two years of monthly family self help meetings to build social connections and reduce social isolation (McDonald, 1999). F.A.S.T. is currently being implemented in 31 states, in over 450 school districts and in five countries. The preliminary evaluations of this program have found statistically significant improvements in youth's school and home behaviors, family communication and increased parent involvement with school at the end of the program and at 6 month follow-ups (McDonald & Howard, 1998). Five major federally funded experimental studies are underway of the F.A.S.T. program focusing on children's resilience (McDonald, 1999).

In 1991, the U.S. Department of Health and Human Services began the "Healthy Start" programs to reduce infant mortality through perinatal care, family planning and infant care, psychosocial services, community development and public education (Earle, 1995). The program goals are to reduce family stress, improve family functioning, improve parenting skills, enhance child health and development and prevent abuse and neglect. The link between violence committed by youth and early child abuse and neglect experiences of these youth led to the development

of this early prevention program (Earle, 1995). One "promising" intervention, Hawaii Healthy Start is beginning to demonstrate positive outcomes for children and their families in reducing the child abuse and neglect rate (Earle, 1995). The program involves paraprofessional home visitors calling on families weekly for the first 6 to 12 months and as needed up to five years. Coordination of health and support services for families enrolled in this program has resulted in improved immunization rates for children, improvement in child age appropriate development and reduction in domestic homicides when compared to the control group families (Earle, 1995). The cost per year for this program is $2,800 per family.

The Strengthening Families Program (SFP), a "promising" intervention, is a family skills training program designed to reduce risk factors for substance abuse and other problem behaviors in high risk children of substance abusers including behavioral problems, emotional, academic, and social problems (Kumpfer, 1993, p. 34). The family skills training program includes three components: parent training, children's skills training and family skills training (Kumpfer, Molgaard & Spoth, 1996). The program has two versions based on the target child's ages (an elementary school program for families of youth age 6 to 12 years and a middle school program for older youth). Parents and youth attend separate skill-building sessions and engage in supervised family activities for 7 weeks. Positive outcomes have been found at 6 months post intervention in youth pro-social skills, parents' parenting skills, family environment and functioning and youth problem behaviors (Kumpfer, 1993). In two-year and five-year follow-up studies, these positive changes have been shown to delay onset of problem behaviors such as substance abuse and conduct problems (Kumpfer, Molgaard & Spoth, 1996; Kumpfer, 2001). The positive outcomes have been noted for a diverse group of high risk families including low-income families, rural and urban families of different ethnic groups, families where child abuse and neglect is documented and families where substance abuse is prevalent.

Family Group Conferencing (FGC) is another family strengthening approach that is community-centered, child and family-centered that is beginning to emerge as a "promising" intervention in the field of child welfare and social services system. Family group conferencing in the child welfare and juvenile justice fields brings families, helping professionals, other significant people in the child's life and the child together for the purpose of designing a service plan to ensure that the child's immediate and long-term safety and well being (Unrau, Sieppert & Hudson, 2000). The initial model emerging from work in New Zealand but it has been adopted by several state child welfare systems in the United States (Burford &Hudson, 2000). This intervention has operationalized several principles of practice which guide the decision-making process during the FGC meeting. The FGC intervention enhances child safety and promotes permanency planning for youth in the child welfare system. Since the extended family members as well as the immediate family members engage in the FGC, multiple system level issues are addressed and interventions target child and family change issues. Currently several

evaluation studies are underway that focus on defining the FGC intervention model and the outcomes that for children. The preliminary results from these small evaluation studies supports the FGC intervention as a "promising" intervention for changing the pathways for children in the child welfare system to more permanent placements and improved family relationships (Maluccio & Daley, 2000; Veneski & Kemp, 2000; Crampton & Jackson, 2000). Since a large number of families who have participated in the FGC have parental substance abuse issues this approach is starting to demonstrate that the preventive intervention helps to engage these parents in substance abuse treatment.

The long-term research on the use of early childhood education and family-centered programs in preventing negative educational and socio-emotional outcomes for children is not uniformly positive. The quality of the services and the hostile environments in which many of the children live create challenges for early prevention efforts. When model early childhood education and family-centered programs are examined, then positive long-term effects are noted, but when these models are disseminated in large-scale community programs many of the positive effects diminish.

## Next Steps

While preliminary data support the further development of preventive interventions focusing on early childhood education and family-centered programs for children in the social services system at high risk for substance abuse, much more research is needed. The growing emphasis on prevention as a primary strategy for addressing the multiple needs of children and their families in the social services system requires rigorous evaluation. The limitations of the current research for addressing the children in the social services system at high risk for substance abuse include:

1. While the goals of many of the preventive interventions focus on reducing drug and alcohol abuse, juvenile delinquency, family violence, emotional and behaviorally-related disturbances it is often difficult to find evaluations that address both short-term and long-term outcomes of these interventions.
2. Many of the preventive interventions currently funded through federal, state and local initiatives are not well defined and the implementation of these interventions are widely varied.
3. Several of the current prevention programs serving children and families have not demonstrated significant differences in outcomes from those children and families that did not receive the prevention programs.
4. Minimal attention is given to factors of diversity (e.g., racial, ethnic, gender, sexual orientation, and socioeconomic status) in the development or implementation of current preventive interventions.

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