

Chapter 2

Family as the Model for Prevention of Mental and Physical Health Problems

Carl C. Bell and Dominica F. McBride

Abstract In this chapter, the authors discuss the family as a model for a prevention delivery system for a wide range of mental and physical health problems. Accordingly, the chapter highlights multiple examples of family-based prevention interventions that seek to prevent various mental and emotional disorders and behavioral problems of youth. Because family processes have a profound impact on bolstering and maintaining healthy behavior in adolescence, the chapter mainly focuses on family-based prevention interventions for adolescents that have been shown to decrease their risky sexual behaviors. Evidence exists that shows family-based interventions can prevent problems that occur during the prenatal and postnatal periods (e.g., maternal depression) and high-risk pregnancies among teenagers. These interventions thereby prevent other problems, such as genetic anomalies; poor maternal nutrition; maternal smoking, alcohol and drug use; exposure to neurotoxins; maternal depression or stress; low birth weight; and peri-natal insults (Institute of Medicine [IOM], 2009). In addition, there is research indicating that family-based prevention intervention strategies can prevent problems of child maltreatment, aggression, and other problem behaviors (e.g., substance abuse, antisocial behavior) (IOM 2009). Further, the potential of the family as a means to cultivate resiliency in children is underscored. Finally, efforts to move family-based prevention interventions into day-to-day life and how we can create a healthy future for our children are discussed.

2.1 Introduction

In this chapter, the authors will discuss the family as a model for a prevention delivery system for a wide range of mental and physical health problems. The chapter will highlight multiple examples of family-based prevention interventions that seek to prevent various mental and emotional disorders and behavioral problems of youth.

Adolescence is a phase in human development that has a significant influence on subsequent adult behavior. Because family processes have a profound impact on bolstering and maintaining health behavior in adolescence, the chapter will mainly focus on family-based prevention interventions for adolescents that have been shown to decrease their risky sexual behaviors. Available evidences support that family-based interventions can prevent problems that occur during the prenatal and postnatal period (e.g., maternal depression) and prevent high-risk pregnancies among teenagers. These interventions thereby prevent other problems, such as genetic anomalies; poor maternal nutrition; maternal smoking, alcohol and drug use; exposure to neurotoxins; maternal depression or stress; low birth weight; and perinatal insults (National Research Council and Institute of Medicine 2009). In addition, there is research indicating that family-based prevention intervention strategies can prevent problems of child maltreatment, aggression, and other problem behaviors (e.g., substance abuse and antisocial behavior) (National Research Council and Institute of Medicine 2009). Further, the potential of the family as a means to cultivate resiliency in children will be underscored. Finally, efforts to move family-based prevention interventions into day-to-day life and measures to create a healthy future for our children are discussed.

2.2 Introduction to the Family as a Vehicle for Prevention of Mental and Physical Health Problems

Because of the relatively slow development of the human brain, beginning at conception and ending in early adulthood, we are vulnerable during this period of our lives. From bottom up and from inside out, brain development starts with the vegetative, appetitive parts and ends with the cognitive, judgmental components of the central nervous system. Humans need families to ensure optimal survival and to provide cognitive, social, emotional, and behavioral competencies. Families are essential for developing survival skills, such as the capacity for connectedness, learning, socialization; for providing protection, monitoring, and self-esteem, and for sources of “mastery experiences for infants, children, adolescents, and young adults.” Families have the potential to inculcate healthy behaviors and stave off illness-generating behaviors; therefore families are ideal systems to prevent mental, emotional, and physical health problems (Pequegnat and Stover 2000). The National Institute of Mental Health (NIMH) Consortium on Families and HIV/AIDS defines family as a network of mutual commitment (Pequegnat and Bray 1997; Pequegnat and Szapocznik 2000). Although many individuals are resilient and do well despite their family’s limited capacity to provide mutual commitment, the family has a great deal of influence on the success of an individual’s outcomes.

The “stress-diathesis model” is clear that behavior is multi-determined. Three major threads that determine behavior are genetics, environment, and their interaction.

Thus, if a child is born with genetics that protect the child from maladaptive reactivity to trauma, then a traumatogenic family will not overtly harm that genetically fortunate child. If, however, a child is born with genetics that make the child vulnerable to being overly and harmfully reactive to trauma, then the capacity of the family to protect the child from being exposed to trauma is critical to the child's development. Furthermore, should a child be exposed to trauma, how the family responds to a child that is genetically vulnerable to the impact of trauma is critically important. Finally, since we may not be able to identify who is who genetically, we need to nurture all children by protecting them from trauma or helping them cope with trauma should they get exposed.

For more than 15 years, the NIMH's Consortium on Families and HIV/AIDS has been developing family-based prevention strategies to prevent HIV infections in adolescents and young adults. In addition, family-based prevention strategies have also been applied to prevent high-risk pregnancy among teenagers; problems during the prenatal period and infancy (e.g., alcohol and drug use or maternal depression or stress); peri-partum depression; child maltreatment; and aggression and other problem behaviors, including substance abuse, antisocial behavior, and violence (National Research Council and Institute of Medicine 2009). This chapter largely draws on the work of members of the NIMH Consortium on Families and HIV/AIDS and the work described in the NRC and IOM's report on *Prevention of Mental Disorders, Substance Abuse, and Problem Behaviors in Children, Adolescents, and Young Adults* (2009). This report addresses the family's role in prevention of mental and emotional disorders, substance abuse, and problem behaviors in children, adolescents, and young adults.

2.3 Scope of the Problem

The capacity of the US to identify mental, emotional, and behavioral disorders in youth that could respond to family-based prevention interventions is sorely limited (National Research Council and Institute of Medicine 2009). As emphasized in Dr. Satcher's *Report of the Surgeon's Conference on Children's Mental Health: A National Action Agenda* (US Public Health Service 2000), we have information that half of all mentally ill adults recalled that their mental disorders began by their mid-teens, and three-quarters by the mid-20s (Kessler et al. 2005). Further, some studies show that the prevalence of behavioral and emotional difficulties among preschool children is similar to the rates observed for older children. McDermott and Weiss (1995) found 33% of children in nonselective, community samples evidence sub-clinical psychological symptoms, which have a detrimental impact on quality of life and compromise functioning in domains such as school, family life, or social relations outside the home. Mash (2003) found that 8–10% of preschool children had conditions that meet the DSM-IV criteria for diagnosable mental disorders. Fourteen to 22% had conditions that caused impairment but did not qualify for a

formal DSM-IV diagnosis. The 2003 National Survey of Children's Health found the most commonly diagnosed problems among children 6–17 years of age were learning disabilities (11.5%), attention-deficit/hyperactivity disorder (ADHA; 8.8%), and behavioral problems (6.3%) (Blanchard et al. 2006). These results are close to other surveys for specific diagnoses, such as ADHD (7%) and learning disabilities (8–10%) (Dey and Bloom 2004), behavioral and conduct problems (5–7%) (Guevara et al. 2003), anxiety or depressive disorder (2–4%) (Costello et al. 2003), and alcohol or drug abuse (19–22%) (Office of Applied Studies 2003). As one would expect, Blanchard et al. (2006) found that, among preschoolers, speech problems (5.8%) and developmental delay (3.2%) were most common, and children with developmental problems had lower self-esteem, more depression and anxiety, and more problems with learning. In addition, these children missed more school and were less involved in sports and other community activities which are potential protective factors facilitated by the family that could mediate and moderate their increased risk. Blanchard et al. (2006) also found that, despite the rates of mental disorders, substance abuse, and problem behaviors of children and adolescents matching other surveys, rates of parental concerns about emotional, developmental, or behavioral problems were much higher. For example, 41% of parents surveyed had concerns about learning difficulties and 36% about depression or anxiety.

More recently, from a six-state study, using the ABLE (Attention, Behavior, Language, and Emotions) screening tool, we know parents identified 18.4% and pre-kindergarten teachers identified 10.5% of children with severe behavioral, emotional, and language problems (Barbarin 2007). By kindergarten, the proportion of children identified by their teachers with serious problems more than doubled to 23%, and inattention/over-activity and behavior problems were the greatest identified. However, fewer than 14% of public, pre-kindergarten, children identified with serious problems had received mental health services by the end of kindergarten (Barbarin 2007).

In 1982, we began developing significant evidence that relatively large proportions of children are exposed to domestic and community violence [i.e., experience trauma (Bell 1987; Bell and Jenkins 1991)]. Subsequent to this early work, numerous scientists confirmed the observations that at least 20% of youth experienced the trauma of witnessing violence in childhood, and, in some communities, the risk for exposure to violence is even higher (Jenkins and Bell 1997). In the late 1990s, the landmark Adverse Childhood Experiences (ACE) Study was conducted (Felitti et al. 1998) that highlighted the potential negative impact of adverse childhood experiences on youth's mental and physical health outcomes in adulthood (Division of Adult 2008).

The ACE study of 17,000 mostly European-American, middle-class, working adults revealed that more than half the respondents had experienced at least one category of adverse childhood exposure (psychological abuse, physical abuse, sexual abuse, violence against mother, living with household members who were substance abusers, living with household members who were mentally ill or suicidal, and living with ex-offender household members) (Division of Adult 2008). Furthermore, 6.2% of the sample reported experiencing four or more

adverse childhood exposures increasing their risk for mental and physical health problems. Compared to those who had no exposure to adverse childhood experiences, persons who experienced four or more had: a 7.4-fold increased risk for alcoholism; a 10.3-fold increased risk for drug abuse; a 4.6-fold increased risk for depression; a 12.0-fold increased risk in suicide attempts; a 2.2-fold increased risk in smoking; a 2.2-fold increased risk poor self-rated health; a 3.2-fold increased risk in having 50 or more sexual partners; a 2.5-fold increased risk in sexually transmitted disease; a 2.2-fold increased risk in ischemic heart disease; a 1.9-fold increased risk cancer; a 3.9-fold increased risk in chronic lung disease (bronchitis and emphysema); a 1.6-fold increased risk in skeletal fractures; and a 2.4-fold increased risk in liver disease.

This work illustrates that childhood trauma places youth at risk for engaging in health behaviors that result in later adult mental and emotional disorders and behavior problems. It should be apparent that children exposed to adverse childhood experiences are several times more at risk for behaviors that would result in contracting HIV infections. It should also be apparent that, in addition to being at risk for increased mental and emotional disorders (i.e., depression and suicide attempts), children exposed to trauma are more at risk for developing chronic physical illness in adulthood. Thus, in an effort to ensure the public's health research scientists, health professionals, policy makers, and others should be figuring out how to protect children from trauma in childhood and/or how to prevent the negative impact of trauma in childhood.

Despite the enormity of the problem, we should not lose hope, and we can do this by taking a lesson contained in the IOM report on suicide prevention (Goldsmith et al. 2002). Drawing on the Adverse Childhood Experiences Study (1998), this milestone report appropriately noted that childhood trauma has emerged as a strong risk factor for suicidal behavior in adolescents and adults. The IOM Report on Reducing Suicide noted the official rate of child victimization in 1999 was approximately 12 per 1,000 (rates are even higher in surveys of children and parents) (Goldsmith et al. 2002, p 3 and 160). In 2003, young children (birth to 3 years of age) had the highest rate of victimization at 16.4 per 1,000 children in the national population (US Surgeon General 2005). Independent of psychopathology and other known risk factors, child sexual abuse has been reported in 9–20% of suicide attempts in adults. Despite the weak quality of data on suicide attempts, the goal for 2010 is to reduce adolescent suicide attempts by 1% each year (US Department of Health and Human Services [DHHS] 2000). One national school-based study of youth found high 1-year prevalence rates for suicide attempts (7.7%), ideation (20.5), and making a plan (15.7) (Kann et al. 1998). Joe et al. (2006) noted that the lifetime prevalence of suicide attempts among Caribbean black men was around 7.5%. According to a recent Centers for Disease Control and Prevention (CDC) report, the prevalence of attempted suicide for white and black high school students (7.3 and 7.6%, respectively) was roughly equal (Eaton et al. 2006). The lesson for hope here is simple. In examining the poor health outcome of suicide, we learn that 20,000/100,000 suffer a mental disorder; using high estimates, rates of suicide attempts are 8,000/100,000;

and the overall suicide rates are approximately 11–12/100,000 in the course of a year (US DHHS 1999). Clearly, there must be protective factors shielding the 7,988 suicide attempters and 19,988 mentally ill individuals from completing suicide; this reality illustrates the maxim, “Risk factors are not predictive factors due to protective factors.”

2.4 Research Innovations to Address the Problem

“Families are the most central and enduring influence in children’s lives ... the health and well-being of children are inextricably linked to their parent’s physical, emotional and social health, social circumstances, and childrearing practices” (Schor 2003). Because of the existence of the NIMH Consortium on Families and HIV/AIDS, we have a much better understanding of the reality that families have a significant influence on their children’s sexual risk taking (Paikoff et al. 2007; Pequegnat and Szapocznik 2000). Research has determined that the quantity and quality of family communication with adolescents is a significant influence on risky sexual behaviors. Specifically, comfortable and frequent family communication tends to delay sexual debut (Bell et al. 2007, 2008; Biglan et al. 1990; Donenberg et al. 2003; McKay and Paikoff 2007; Pequegnat and Szapocznik 2000; Resnick et al. 1997; Wilson and Donenberg 2004). Depending on what parental expectations are and how adolescents perceive them, parental expectations also influence adolescent behavior. Adolescents listen when parents communicate their approval of responsible sexual behavior. When such communications are absent, adolescents misjudge their parents’ in ways that suggest sexual risk taking is acceptable (Jaccard et al. 1998). Conversely, family conflict and negative affect are associated with behavioral problems (Szapocznik and Kurtines 1993), such as early sexual debut (Paikoff 1995), generally risky sexual behavior (Biglan et al. 1990), violence and conduct problems (Borduin et al. 1985; Brody et al. 2008; Henggeler et al. 1992; Farrington 1989; Gorman-Smith et al. 1996; Tolan and Lorion 1988), and drug use (Brody et al. 2004; Wills et al. 2003, 2007).

Research has also shown that parental monitoring and an authoritative parenting style are associated with adolescents who engage in less risky sexual behavior, have fewer sexual partners and less pregnancy, and increased condom use (Baumrind 1966; Bell et al. 2007, 2008; Biglan et al. 1990; Donenberg et al. 2002; Flay et al. 2004; Rai et al. 2003; Yang et al. 2007; Paikoff 1995). These family-based prevention interventions focus on improving parent–child communication and supportive parental behaviors, and increasing parental monitoring and limit-setting. Unfortunately, because of the variety of study designs, there are no meta-analyses of these programs. Fortunately, there is sufficient evidence that family-based HIV prevention interventions are efficacious and effective (Brody et al. 2002; DiIorio et al. 2007; Jemmott et al. 2005; Krauss et al. 1997; McKay and Paikoff 2007; Murry et al. 2005; Wills et al. 2003, 2007; see also Chap. 1).

At-risk behaviors do not occur in isolation. Thus, youth who engage in risky sexual behaviors are also likely to be engaging in risky behaviors involving substances, violence, suicide, and truancy and dropping out of school. Some studies have been assessing outcomes in multiple domains to describe this constellations of risk behaviors better (Brody et al. 2001, 2003, 2004, 2005, 2006a, b, 2008; Bannon and McKay 2007; Prado et al. 2007).

In summary, the evidence is very clear that family-based prevention interventions are ideal and effective for changing health behaviors in adolescents. Further, since there are such common threads (improving parent–child communication and supportive parental behaviors, and increasing parental monitoring and limit-setting) connecting various family-based interventions, it should be possible to adapt and implement such prevention interventions so they become ubiquitous, especially in high-risk populations.

2.5 Family-Based HIV Prevention Interventions

An example of a successful, cross-contextual (i.e., having success in different contexts) family-based HIV prevention intervention is the Chicago HIV Prevention and Adolescent Mental Health Project (CHAMP). CHAMP interventions are family-based prevention interventions designed to prevent HIV infections in young adolescents (youth in fourth and fifth grade) by engaging caregivers and their youth in 10–12 manualized, multiple-family group sessions. The sessions are designed to provide education and skill-building practice to increase knowledge about HIV, risky sexual behaviors and contexts, and essential caregiver skills (e.g., parental connectedness with youth, parenting styles, parental monitoring, and caregiver support from the community and peers) designed to protect youth from engaging in high-risk behaviors. The sessions also actively seek to strengthen caregiver comfort and frequency in talking about difficult topics, caregiver and youth connectedness, and caregiver skills in monitoring and disciplining their youth. The program also helps youth practice social and emotional skills of resisting sexual and drug use, peer pressure, and problem solving about how to avoid risky sexual situations (Bell et al. 2008; Baptiste et al. 2006; McBride et al. 2007; McKay et al. 2004; McKay and Paikoff 2007). Because a CHAMP research staff member and a member of the indigenous community deliver CHAMP family-based interventions in multiple-family groups held in the community and co-led, all of the CHAMP family-based interventions are adapted to the population and setting (McKay et al. 2007a). In addition, serious community partnership is a centerpiece of all CHAMP family-based interventions (McKay et al. 2007b).

In the original CHAMP that began in Chicago in 1993 (Madison et al. 2000; McCormick et al. 2000), 324 families were randomly assigned to the experimental condition and 315 families were assigned to the control condition (McBride et al. 2007). Nearly three-fourths of the families in the experimental condition completed the

entire program. Compared to the control families, these families showed increased family decision making, improved caregiver monitoring, greater comfort in discussing sensitive topics, more neighborhood supports, and fewer disruptive difficulties with children, such as externalizing (aggressive and rule-breaking behavior) behaviors and social problems (McBride et al. 2007; Bannon and McKay 2007; McKay et al. 2004, 2007a). However, the youth in the experimental condition also reported significantly more family conflict than the control group presumably because they were having more serious conversations with their caregivers (McBride et al. 2007). More importantly, the youth in the experimental condition reported that they chose to be in fewer situations in which risky sexual behavior could ensue (McBride et al. 2007). Finally, the CHAMP Chicago research also indicated that caregivers benefited from the intervention, as their anxiety and depression measures showed a significant decrease from the pre-test to the post-test (Paikoff 1997).

The original CHAMP that began in Chicago morphed into the CHAMPNYC (Collaborative HIV Adolescent Mental Health Project – New York City), CHAMPWS-C (Collaborative HIV Adolescent Mental Health Project – West Side/Chicago), CHAMPSA (Collaborative HIV Adolescent Mental Health Project – South Africa), and CHAMPTandT (Collaborative HIV Adolescent Mental Health Project – Trinidad and Tobago) (McKay and Paikoff 2007). This metamorphosis did not change the core family-based HIV prevention principles of this evidence-based intervention. The basic goals of increasing family connectedness, family communication (i.e., frequency of communication about difficult topics), social skills training and practice of youth and caregivers, HIV transmission knowledge, etc. were preserved in each iteration of the CHAMP intervention. Differences in CHAMP multiple-family group manuals were based on language (e.g., the New York CHAMP manual was translated into Spanish) and cultural contexts (e.g., the CHAMPSA manual was adapted to fit Zulu culture). In addition, based on ethnographic assessments of the Zulu community, there were other adaptations in lessons in the manual. These modifications did not compromise the core principles necessary for family-based HIV prevention work, e.g., we added a lesson on bereavement owing to the large number of HIV deaths in South Africa.

The first international adaptation of the original CHAMP model (Paruk et al. 2005) was done in the semi-rural area of Durban, South Africa (Bell et al. 2007, 2008; Bhana et al. 2004). Due to the high rates of illiteracy of the target population, the intervention manual had to be illustrated (Petersen et al. 2006). The objective of the manual was to illustrate Bell's seven field principles of health behavior change:

- Rebuilding the village/constructing social fabric
- Providing access to modern and ancient technology
- Improving bonding, attachment, and connectedness dynamics
- Improving self-esteem – a sense of power, a sense of models, a sense of uniqueness, a sense
- Increasing social and emotional skills of target recipients

- Reestablishing the adult protective shield and monitoring
- Minimizing the residual effects of trauma (Bell et al. 2007, 2008)

Accordingly, a goal of the intervention was to “rebuild the village.” Encouraging families to cultivate community/social fabric or “collective efficacy” (Sampson et al. 1997) accomplished this task. For example, family duties such as child rearing were supported by the social support CHAMPSA. Modern psychosocial technology (e.g., multiple-family group contexts) was used to deliver the intervention. The CHAMP intervention facilitated connectedness within the family (Bell 2001), i.e., positive parent–child interactions, and developed social and emotional skills related to parenting practices. Caregivers and youth were given models, such as how to communicate with “I messages,” so that families could ensure good outcomes for their children. This enabled caregivers to develop a sense of power or self-efficacy in the rearing of their children. The CHAMPSA manual also encouraged families to provide an “adult protective shield” for their children by setting family rules, monitoring their whereabouts, and joining with neighbors to watch out for their children. Finally, the manual sought to relieve the participants’ sense of “learned helplessness” from the HIV/AIDS epidemic in Durban, South Africa by teaching family members the “learned helpfulness” of being a major part of the solution to the epidemic. Subjects in the experimental condition had more knowledge about HIV/AIDS transmission and had less stigmatizing attitudes toward individuals with HIV/AIDS. Caregivers in the CHAMPSA prevention intervention significantly increased their monitoring of youth’s activities and developed more family rules than those in the control group. The outcomes in experimental families illustrated increased frequency of care giving and comfort in communicating with youth about HIV/AIDS and other difficult subjects. Caregivers in the experimental condition reported less neighborhood disorganization and more social control and cohesion in their communities. Youth in the experimental CHAMPSA condition, who were 9–12 years old, had more knowledge about HIV/AIDS and had less stigmatizing attitudes toward individuals with HIV/AIDS than the control youth. Engaging indigenous community residents to recruit and retain experimental and control families and deliver the intervention resulted in a high retention rate. Similar to Chicago CHAMP, a significant number of families (94%) completed the entire CHAMPSA program. As the intervention began with young adolescents who had not made their sexual debut, CHAMPSA only has proximal outcomes. We have to wait for a longitudinal study to determine the long-term impact on sexual behavior and potential HIV infections.

2.6 Family-Based Teen Pregnancy Prevention Interventions

Another example of how family-based prevention interventions can change health behavior is in the area of teen pregnancy. As mentioned earlier, because different parts of the brain develop at different rates, teens are at risk for a variety of unhealthy

sexual behaviors, such as early sexual debut and unsafe sex. Young pregnant teens are at risk for numerous health problems for their infants (e.g., preterm birth, intra-uterine growth retardation, and perinatal complications) (National Research Council and Institute of Medicine 2009). In addition, experience with teen pregnancy illustrates that pregnant teens are often “kicked out” of their family and society and shunned. Thus, they are often deprived of resources necessary to protect and nurture them and their infants. Although teenagers are heavily influenced by peers, their families continue to have influence on their behavior (Rai et al. 2003). Accordingly, family-based interventions have tried to decrease teenage pregnancy and the multiple, potential untoward consequences of having a child as a teen (see Guttmacher 2006). Furthermore, Bowlby (1969, 1973) and Ainsworth (1973) theorized that failure to form a secure attachment with caregivers during infancy has a strong influence on ability to form trusting relationships later in life. Thus, common sense dictates, if a teenage pregnancy is unavoidable, family-based interventions might help the teenage parents provide their infant with the attachment and connectedness necessary to form trusting relationships.

Teen pregnancies have been decreasing since 1991 (Guttmacher 2006). The National Research Council and Institute of Medicine (2009) notes that efficacious and effective family-based methods to prevent teenage pregnancy “remain elusive;” thus, the quality of this research needs strengthening. On the other hand, family-based interventions to increase maternal sensitivity and infant attachment are shown to be effective. A meta-analysis of 51 studies illustrates that interventions to increase maternal sensitivity were significantly and moderately effective ($p < 0.001$; effect size = 0.38) (Bakermans-Kranenburg et al. 2003). The meta-analysis by Bakermans-Kranenburg et al. (2003) of 23 studies illustrated that interventions to increase secure infant attachment had small effect sizes, but still important ($p < 0.05$; effect size = 0.20).

2.7 Family-Based Prevention Interventions Designed to Increase Connectedness and Attachment

As societies’ understanding of the need for maternal sensitivity and fostering secure infant attachments has increased, more societal emphasis has been placed on this aspect of family life. Accordingly, there have been various widespread initiatives designed to increase maternal sensitivity and secure infant attachment. Nurse home visitation (Olds 2002), which teaches the social skill of parenting (i.e., understanding maternal sensitivity, attachment and connectedness, child development, etc.), has been repeatedly shown to foster pregnancies that have good outcomes. In addition to the parenting guidance designed to help children have nurturing early childhood environments, nurse home visitation programs also provide a number of other valuable family-based supports. Nurse home visitation programs provide social support, promotion of positive caregiver–child interactions, and direct social and health services (e.g., referrals to agencies for various services, including health and developmental

screening) (Olds 2002). Sweet and Appelbaum (2004) conducted a meta-analysis of experimental and quasi-experimental evaluations of 60 home visiting programs. While it is clear that professional nurse home visitation has the best outcomes and effect size (compared to other mother/infant attachment approaches), programs to improve maternal sensitivity and secure infant attachment are still needed. (Zero to Three 2011). For example, “Zero To Three” offers a web-based, educational format to parents (Zero to Three 2011), and, although education, while essential, is not enough to significantly change behavior.

Early Head Start is designed to promote healthy prenatal outcomes by improving family functioning (Gray and Francis 2007). Early Head Start centers provide an excellent setting to implement family-based prevention interventions designed to increase connectedness and attachment between teen caregivers and infants (Stormshak et al. 2002). Started in 1994 and aimed at children 0–3, a major evaluation of “Early Head Start” by Love et al. (2005) found children in the program had significant improvements in cognitive and language development and social and emotional development. Compared to control children, “Early Head Start” children displayed higher parental emotional engagement, sustained attention with play objects, and were less aggressive. Compared to control parents, “Early Head Start” parents were more emotionally supportive, provided more language and learning, read to their children more and spanked less.

Finally, “Cradles to Classroom” (based on the philosophy of nurse home visitation) is a program that Paul Vallas, Chief Executive Officer, Chicago Public Schools, Philadelphia, and now New Orleans, has been implementing around the country with success (Bell et al. 2001; Lamberg 2003). This long-range prevention strategy teaches teenage mothers parenting skills needed to bond with and parent their babies and how to access community resources. Assuming a practical and resource-oriented philosophy, “Cradles to Classroom” provides counseling about domestic violence and access to prenatal, nutritional, medical, social, and childcare services. In 2002, of 495 seniors with babies, 100% graduated and 78% enrolled in a 2- or 4-year college and only five had a repeat pregnancy (Lamberg 2003).

Despite this success, when leadership changes, new programs are often initiated. Accordingly, the 2004 change in Chicago Public Schools leadership resulted in the initiation of the “Chicago KidStart Program” (a nurse home visitation program delivered by the Chicago Department of Public Health). This program services 17,000 young, at-risk mothers (Chicago KidStart 2008). As a subsystem of the “Chicago KidStart Program,” “Cradle to Classroom,” which serves more than 4,000 teen mothers, and the Ounce of Prevention Fund expanded pre-natal and post-natal services to asterisk teen mothers. One-on-one coaching (i.e., parent training on how to attach to their infants and guidance to understand child development) was provided to these mothers at three new sites in Chicago and will reach more than 300 mothers in the first year (Chicago KidStart 2008).

Clearly, the early theoretical propositions of Bowlby (1969, 1973) and Ainsworth (1973) (e.g., theories of attachment/separation) have been actualized in the academic study of Nurse Home Visitation by Olds (2002), and have been put into real world practice by “Zero to Three,” “Early Head Start,” and “Cradle to Classroom” programs.

2.8 Family-Based Child Abuse and Neglect Prevention Interventions

In 1999, the executive leadership team of Community Mental Health Council, Inc. got an opportunity to test the seven field principles through a large, naturalistic community-based demonstration project. Late that year, the Director of the Illinois Department of Children and Family Services (DCFS) informed us of a problem in McLean County. Early reports from McLean's DCFS office noted African-American children being removed from their families for abuse and neglect due to hotline calls was 35/1,000 (the statewide average was 4.3/1,000). Using a business model, CMHC's Executive Team strategically planned to apply Bell's seven field principles of health behavior change to this population-based problem (Redd et al. 2005). Two-year follow-up reports revealed that the number of African-American children being placed in foster care in McLean County had decreased to 11/1,000, while the hotline calls for abuse and neglect did not decrease. Furthermore, the rates of subsequent removal of children from families with unsubstantiated hotline calls were lower than the statewide average. Such efforts are important as they illustrate that theoretical paradigms, if implemented properly, have the potential to change individual outcomes in large population interventions. This project also spurred the development of innovative statistical methodology. This methodology gave some credence that the naturalistic prevention intervention that was implemented in McLean County was associated with few African-American children being removed from their families (Gibbons et al. 2007).

The McLean county intervention had the same core elements of community-based interventions found to be successful in a meta-analysis of 56 programs designed to promote family wellness and prevent child maltreatment (MacLeod and Nelson 2000). For instance, a "Family Advocates Program" achieved "rebuilding the village" by providing social support, parent training, childcare, community development, and in-home support programs for families that had been the focus of a DCFS hotline call (Redd et al. 2005). From their meta-analysis, MacLeod and Nelson (2000) concluded that most interventions that aim to promote family wellness and prevent child maltreatment are successful with an effect size of approximately 0.41.

2.9 Family-Based Aggression and Antisocial Behavior Prevention Interventions

There is extensive evidence that training interventions that emphasize behavioral parenting skills help families develop social and emotional skills. These skills are a potent preemptive tool in preventing youth from developing aggressive and antisocial behaviors (Mihalic et al. 2004; US DHHS 2001). Patterson's team has repeatedly shown that lack of parental monitoring, represented at its extreme by neglect and

poor discipline methods and conflict about discipline, has been related to participation in delinquent and violent behavior for a range of populations (Patterson et al. 1989; Patterson and Stouthamer-Loeber 1984). Conversely, parenting with high levels of positive involvement with children and positive reinforcement of desirable behavior cultivates pro-social behavior. Similar to how the attachment theories of Bowlby (1969, 1973) and Ainsworth (1973) spawned interventions to improve attachment and bonding, Patterson et al.'s work (1989) has spawned numerous evidence-based interventions targeted at children in varying levels of development, e.g., the "Incredible Years" for young children (Webster-Stratton et al. 2001), "Strengthening Families Program" for early adolescence (Spoth et al. 2001), and "Multidimensional Treatment Foster Care" for adolescence (Chamberlain 1990; Chamberlain and Mihalic 1998). These programs teach and train parents to engage in behaviors that will reinforce positive connectedness between themselves and their children. The evidence is clear that parenting skills training to develop child management skills are efficacious (de Graaf et al. 2008; Kaminski et al. 2008).

2.10 Family-Based Substance Abuse Prevention Interventions

Ackard et al. (2006) note that adolescent perceptions of low parental caring, difficulty talking to their parents about problems, and overly valuing their friends' opinions for serious decisions were significantly associated with compromised behavioral and emotional health. Interventions aimed at improving the parent-child relationship may provide an avenue toward preventing health risk behaviors in youth. Brody et al. (2004, 2006a, b) have convincingly shown that their Strong African-American Families (SAAF) program increases protective factors preventing African-American adolescents from using drugs. SAAF, a family-based intervention positing "regulated, communicative parenting," causes changes in factors protecting youth from early alcohol use. Brody et al. (2004) proposed that parental variables (involvement-vigilance with children and their activities, racial socialization, communication about sex, and clear expectations for alcohol use) and youth variables (negative attitudes about early alcohol use and sexual activity, negative images of youth who drink, resistance efficacy, a goal-directed future orientation, and acceptance of parental influence) protect African-American youth from substance use/abuse. Brody et al. (2004) illustrate parents in the intervention group increases parental protective factors over a 7-month period. Brody's team performed a randomized prevention trial that included 667 African-American 11-year-old students and their caregivers (Brody et al. 2004, 2006a; Murry et al. 2005). According to adolescent reports, the 332 families who participated in SAAF, experienced increases over time in "regulated, communicative parenting." There were also increases in targeted parenting behaviors and lower rates of high-risk behavior initiation among youths (Brody et al. 2006a). In another study, Wills et al. (2007) tested a theoretical model of how ethnic pride and self-control are related to risk and protective factors. In this study the researchers interviewed a community sample of 670 African-American

youth (mean age = 11.2 years) and measured cigarette smoking and alcohol use (lifetime to past month). The results of this study indicated that parenting was related to self-control and self-esteem, and racial socialization was related to ethnic pride. Self-control and self-esteem variables were related to levels of deviance-prone attitudes and to perceptions of those who engage or abstain from substance use. Thus, self-esteem and self-control are related to parenting approaches and have pathways to attitudes and social perceptions that are significant factors for predisposing to, or protecting against, early involvement in substance use. Further, in addition to preventing problems of substance abuse, SAAF has also been shown helpful in reducing conduct problems. Among youth who had more affiliations with deviance-prone peers, SAAF reduced the chances of engaging in conduct problems by 62% ($p < 0.01$) (Brody et al. 2008).

Family-based prevention interventions have also been shown to prevent substance abuse in Hispanic adolescents. In addition to emphasizing improving family relationships (i.e., addressing family issues of conflict, inconsistent or inappropriate parenting, and parent-adolescent communication) which have been shown to prevent drug abuse in adolescents (Szapocznik and Murtines 1989), Structural Ecosystems Therapy (SET) also tackles familial interfaces with external systems (Szapocznik et al. 2004). SET emphasizes parental monitoring and supervision of peer activities and includes parental involvement in school. Thus, SET has demonstrated that the mere focus on family relationships is sufficient for reducing Hispanic adolescent drug use. Prevention interventions should also attend to exo-level structures (e.g., school) (Robbins et al. 2008).

2.11 Efforts to Move Research into Practice

Unfortunately, despite an increase in funding for children's mental health research, the US children's mental health infrastructure is not flourishing (Bell and McKay 2004; US DHHS 2000). While there have been several efforts at infusing modern technology into children's mental health systems (National Advisory Mental Health 1999; NECON 2005; President's New Freedom Commission on Mental Health 2003), these efforts have been stalled. In part, they have been stalled by a very strong anti-psychiatry push back (Bell 1996; Issac and Armat 1990) as well as an anti-government push back that did not want to see prevention programs from the government enter private lives (Paul 2008). Another reason such efforts are languishing is due to gaps in understanding how to transport, disseminate, and implement programs in various cultural and contextual settings while preserving sufficient program fidelity (National Research Council and Institute of Medicine 2009; Fixsen et al. 2005; Glasgow et al. 2003).

Bell (2008) points out that for an intervention to be culturally sensitive, it must have content that is welcoming to the target culture, contain issues of relevance to the culture, not be offensive, and be familiar to and endorsed by the target culture. However, if a given intervention has generic principles of health behavior change,

such as aspects that create social fabric, generate connectedness, help develop social skills, build self-esteem, facilitate some social monitoring, and help minimize trauma (Bell et al. 2002), that intervention can usually be adapted to have an appropriate level of cultural sensitivity (Paruk et al. 2005; Bhana et al. 2004; Petersen et al. 2006; LaFromboise and Lewis 2008). In addition to the lack of knowledge of how to fit evidence-based interventions into culture and context, there are organizational dynamics (e.g., organizational culture that make it difficult to create change toward evidence-based practices in many service organizations) (Hoagwood et al. 2001; Kondrat et al. 2002; Redd et al. 2005; Rosenheck 2001).

There are several methods to help infuse science into service: (1) researcher-driven implementation, (2) adaptation of existing programs to the community done by researchers and community leaders, and (3) community-driven implementation. Unfortunately, very little braided state and Federal governmental support for focused family-based prevention infrastructure efforts (as opposed to scattered family-based prevention efforts) (e.g., occurring within education, juvenile justice, health and human services, foster care, law enforcement, mental health) are available (National Research Council and Institute of Medicine 2009).

2.11.1 Challenges for the Future

One of the National Institute of Mental Health's revised mission statement goals is to "Strengthen the Public Health Impact of NIMH-Supported Research" (US DHHS 2008). Accordingly, one of the major challenges for the future is to set up a monitoring system for NIMH grant funding awards that takes this goal seriously. One major method of accomplishing this goal is to ensure that adequate evaluation is done on family-based prevention interventions. In addition, there should be further development of the knowledge base that will support dissemination, adaptation, and implementation of evidence-based prevention interventions in various contexts and cultures. Many suggest that the cost effectiveness of family-based prevention interventions should be emphasized. This understanding will be an impetus to infuse research strategies designed to prevent mental and physical problems into practice. Time and experience have taught us to be less enamored by this strategy. Everyone knows it is cheaper to prevent a child from entering the criminal justice system by paying for the child's decent education. Despite the solidity of this cost-effective argument, the society continues to send more funds to juvenile justice systems than schools. One ostensible reason for this shortsighted behavior is that staff in juvenile justice systems and criminal justice facilities would rather be paid than send their revenues to schools. Accordingly, it is our view that until the science of prevention becomes so irrefutable that it becomes unethical not to spend money on youth's education, the criminal justice system will continue to profit from the nation's lack of prevention. After all, despite the cost-effective arguments of giving or not giving polio shots, it would be unethical not to prevent polio – using vaccines.

Finally, North America is in a “health care crisis” because we have an “illness care system,” thus, our “illness care crisis.” The only way to relieve ourselves of this challenge is to strengthen our mental health prevention and promotion practices. We need to use business models and technology to sell mental health prevention and promotion practices as we sell soap. We need to support more researcher-driven implementation, adaptation of existing programs to the community done by researchers and community leaders, and community-driven implementation. We can shorten the health disparities gap and resolve the “illness care crisis” by implementing the new NRC and IOM prevention report’s recommendations (National Research Council and Institute of Medicine 2009). We are hopeful the new Obama White House will understand this necessity and move forward on this initiative with the same “Yes, we can” spirit of the most recent election.

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