DATA TRENDS: April, 2002 #50

Summaries of research on mental health services for children and adolescents and their families

An Evidence-Based, Family-Focused, Early Intervention for Preventing Aggressive Behavior

Source: Strain, P.S., & Timm, M.A. (2001). Remediation and prevention of aggression: An evaluation of the Regional Intervention Program over a quarter century. *Behavioral Disorders, 26*(4), 297-313.

With increasing evidence of successful systemic changes in service systems for children with emotional and behavioral disorders, researchers have begun to focus on factors responsible for improvement at the level of individual children and families. Evidence-based treatment modalities such as multisystemic therapy (MST; see for example Data Trends 15 and Data Trends 11) have gained widespread support for demonstrating effectiveness. Unlike previous empirically based therapeutic interventions, which have not always been successfully transported from laboratory to community settings, therapies such as MST provide clear treatment protocols that are designed to ensure therapist adherence and to readily allow measurement of effectiveness. One such intervention is the Regional Intervention Program (RIP) originating from Vanderbilt University in Tennessee. Since its inception in 1969, RIP has been offering comprehensive training to families whose young children are on a trajectory toward enduring emotional and behavioral difficulties. The program provides parents with instruction (from other parents who have participated in the program) on methods for interacting with children that will maximize positive, developmentally appropriate behavior, while minimizing noncompliant and negative behaviors. RIP has clear objectives and procedures for outcome evaluation and has been successfully replicated nationally and internationally. This article describes RIP and the longitudinal studies that have been conducted to examine its effectiveness.

Research documenting the longitudinal stability of aggression and other behavioral problems in young children "clearly speaks to the compelling need for effective and sustainable early intervention tactics" (p. 298). RIP was designed to fill this need, using empirically derived techniques to teach parents how to increase positive interactions and reduce "coercive cycles of exchanges [that seem] to fulfill a child's goal of gaining any form of parental attention" (p. 298). Although RIP services are free to families, parents who have made substantial progress through the program, and those who have graduated, are expected to assume teaching duties equal in length to the amount of time they receive services. RIP is composed of a variety of modules, nearly all coordinated by parent staff members. The *Behavioral Skills Training* (BST) module "assists parents in the use of shaping, differential reinforcement, extinction, and timeout procedures in a variety of structured adult-child interaction sessions" (p. 300). The *Social Skills Training* (SST) module helps to improve peer interactions, while the *Preschool Classroom* module provides an opportunity for parents to work with each other's children in a classroom while "children acquire or refine skills necessary to function effectively in educational placements outside RIP" (p. 300). Agencies can analyze their success in meeting RIP objectives with a three-tiered evaluation protocol, started in 1972, in which outcomes are measured at the level of (1) individual child behavior, (2) family objectives, and (3) 6-month and annual evaluations of the modules.

An initial study of RIP (Phase I), reported in 1982, measured outcomes on 40 families who had completed RIP between 1969 and 1978. Phase II, a replication of Phase I, involved 23 additional families who had participated in and completed RIP between 1986 and 1995. Phase II represented an important test of RIP outcomes due to the 100% turnover in professional and family staff since Phase I. All children from participating families had entered RIP with oppositional difficulties. Behavioral observations of children's interactions with teachers and peers at school and with parents at home were conducted 3 to 9 years after completion of RIP. Although the primary focus of the school observation was to evaluate the behavior of former RIP clients, an additional sample of students from the same classrooms was also observed in order to compare functioning between these two groups. In addition, parents and teachers completed the *Walker Problem Checklist*, a scale on which raters assess the validity of 50 problem statements as they relate to a child. Observations in school (Phase I only) revealed that on average, 89% of former clients complied with teacher commands, demands, or respects, similar to 87% of classroom peers who had not participated in RIP. Results of both multiple linear regression and Pearson correlations revealed only one significant finding: an association between earlier treatment in RIP and more favorable current behavior. Observations in the home revealed that "with few exceptions, parents engaged in patterns of interaction with their child that resembled the management

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skills taught 3 to 9 years previously" (p. 307). Compliance of former RIP clients to parents' commands, demands, and requests occurred on average 82% of the time in Phase I and 85% of the time in Phase II, while inappropriate social activities were recorded in less than one half of 1% of observations. Interactions were classified as positive over 97% of the time in Phase I and 95% in Phase II. Multiple linear regression (Phase I) revealed that earlier age of enrollment in RIP predicted current levels of compliance and social interaction and that intact families predicted improved compliance. Pearson correlations at both Phase I and Phase II revealed significant associations between age at which treatment began and compliance ($r = .63$, $p < .05$), and age at which treatment began and positive interaction ($r = .63$, $p < .05$). Results from the problem checklist (Phase I) revealed no significant differences between children who had and had not been enrolled in RIP, indicating high levels of functioning among former RIP clients. Problem checklist results also indicated that no former clients had been referred for specialized testing or services due to behavior problems.

Phase II also involved follow-up interviews of the original cohort of former RIP clients from Phase I. At the time of observation, former clients ranged in age from 25 to 32 years. These results revealed that:

- All but one former client was either employed or in graduate school.
- All but one former client had graduated from high school and 50% had completed college.
- There were no reported instances of aggression or antisocial behavior throughout adolescence (with the exception of one incidence of shoplifting).

Additional ratings of RIP by former clients and parents revealed very positive attitudes toward RIP and specific examples of program elements that had been helpful over the years.

Although this study does not contain a control group, the authors note the lack of "evidence to suggest that this population [i.e., children with oppositional difficulties] experiences anything but a negative developmental course in the absence of effective intervention" (p. 310). The overwhelmingly positive outcomes of this study suggest the success of the Regional Intervention Program for young children with oppositional difficulties and provide evidence of the effectiveness of early interventions. Given the need for evidence-based treatments in systems of care, RIP offers one well-established option for preventing the continuation of early childhood aggressive and oppositional behavior.

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