



Minnesota Youth “ACE” Intervention Program

By Carrie McVicker



EMERGING PRACTICE

Quasi-experimental study, a correlational or ex post facto study, posttest only, single group pre- and posttest, comparison group.*

All Children Excel

According to research in England, New Zealand, and the United States, most chronic juvenile offending can be attributed to just a few youth. Many of these young people show signs of trouble before they reach puberty.

Alarmed at the growing number of children under age 10 committing delinquent acts, the Ramsey County (St. Paul), Minnesota, Board of Commissioners developed the All Children Excel (ACE) program in 1998. The program is bolstered by cost-effective, researched strategies that target children under 12 predicted to become chronic serious delinquent offenders.

In St. Paul, some 702 children under age 10 had police reports for delinquent acts between 1995 and 1998. The combined effort of county government, schools, police, parents, health and social services agencies, and community volunteers, ACE was designed to reduce risk factors in the lives of identified children and build resiliency in them, their families, and their communities.



SHELLY LOSEE

When ACE identified one of her children as being at high risk for serious, violent, and chronic delinquency, the program helped this single mother and her family get the help they needed.

Rigorous Selection, Personal Intervention

Children are accepted into the ACE program through a rigorous referral and acceptance process. The school or police department sends the child’s police report to the Ramsey County Attorney’s office. This process provides the program with the legal authority to bring a Child in Need of Protection or Services (CHIPS) petition if the parents fail to cooperate.

Although a last resort, this is a very important option the county can bring to bear on resistant families. Programs without this leverage, such as voluntary services, usually aren’t successful with these children.

A thorough background check is performed on the child’s family, examining where the family has lived, for how long, and how often they have moved; involvement in the criminal justice system; and use of county and community services. A multidisciplinary screening team of seven people—including a mental health professional, a corrections representative, a social worker, and others—reviews the police report to further assess the child’s risk for serious, violent delinquency.

After the child is accepted into the program, ACE sends community agency social workers to visit the family and create a strength-based action plan that involves the entire family. With support from a six-person county multidisciplinary team, including a senior protection worker, a public health representative, the county attorney, and others, ACE community workers focus on the needs of the child—in such areas as school attendance, academic skills, and impulse control—and the family, helping parents obtain counseling, parenting skills training, substance abuse treatment, job training, employment opportunities, and housing.

Praising their ACE worker, one family said, “We know we can call you about anything. We like that you meet with us face to face—the close contact. You are there for us like a real person. You are not like other workers, you really know our family, and we really know you. We trust you. We know that you really support us. This program is helping our family a lot, especially our son.”

*Each program highlighted by the Research to Practice Initiative (R2P) is supported by research. For more information on the levels of research, visit the R2P website at www.cwla.org/programs/r2p, or e-mail R2P at R2P@cwla.org.

Assessing Risk, Evaluating Outcomes

An important contribution to ACE's success was the development of a risk assessment tool that would immediately show risk levels for children referred to the program. The tool needed to be short, easy to use, and able to accommodate missing data. ACE officials developed a Risk Factor Profile that takes about 15 minutes to complete on a computer. Scores estimate a child's overall risk for chronic and serious juvenile delinquency.

The Risk Factor Profile examines the child's referring offense, behavior history, risk factors, and temperament, as well as parent, sibling, peer, and community risk factors. Scores range from 0 (no risk) to 7 (extreme risk for offending). Children who score 3 or higher are considered high-risk and enter the long-term ACE program. Children who score below 3 are considered low-risk and referred to short-term interventions within the community.

Although the profile's validity in predicting risk has yet to be determined, ACE officials have found a high concurrence between profile scores and global risk assessments conducted by the screening team. Further, the percentage of referred children whom the profile identifies as high risk approximates the number of children whom other research suggests will be serious juvenile offenders in the absence of effective intervention. These factors suggest the Risk Factor Profile is a valid measure of risk.

ACE costs about \$5,000 per child in long-term intervention, which can last 6–24 months. A cost-benefit analysis concluded that early intervention could save between \$1.7 million and \$3.5 million over the course of a child's life, including costs to state and county governments, businesses, and victims; insurance costs; and lost wages for all involved.

ACE also tracks cost-effectiveness to guide quality improvement and enhance accountability. County and community service providers furnish ACE with monthly data on the type, frequency, duration, and cost of services per child. Comparing these data to the child and family's progress in their action plan, team members can adjust their strategies.

In January 2002, ACE released preliminary outcome data for children in the long-term program. The study examined 40 high-risk young offenders who had received services for 6–24 months. Children were then divided, based on their scores, into moderate high risk, high risk, and very high risk.

Aggressive and delinquent behavior had declined for all three groups. All children in the moderate high-risk category showed improvement in behavior, as well as half of the high-risk children and more than one-third of the very high-risk children. Children managed to avoid being disruptive, defiant, aggressive, and delinquent.

Frequency of police contact declined for all three groups—100% of the moderate high-risk group and 62%–65% of the high- and very high-risk groups had no further contact with police. This was a significant improvement, considering every child in the program had some level of police contact beforehand. Court charges for delinquency declined by 81% for all three groups, and there was little evidence of substance use by the children after participating in the program.

Before participating in ACE, approximately 90% of the children were not working at grade level, 75% were truant,

and 50% were chronically truant and subsequently referred to truancy programs. After ACE, school failure declined for all groups—88% of the moderate high-risk group, 55% of the high-risk group, and 43% of the very high-risk group were attending school regularly, behaving appropriately, and earning passing grades.

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Jeremy's Story

The Smith family was having a difficult year. Their 9-year-old son Jeremy was acting out violently. Yesterday, his mother Lisa had received a phone call from the school informing her that Jeremy had thrown a chair at a teacher.

This wasn't the first time. Jeremy already had a police record for violent behavior and property damage. His mother did her best, but with three other young children, she could not pay as much attention to Jeremy as she should. To make matters worse, Lisa suffered from depression and addiction to pain medication.

Jeremy was in danger of becoming a chronic juvenile offender. The school recommended that he be assessed for ACE, a multidisciplinary program for very young juvenile offenders. The police department sent Jeremy's records to the county attorney's office, where a team examined his file. Jeremy underwent an assessment to determine his level of risk for becoming a chronic offender. He scored a 5 out of a possible 7 and was immediately accepted into the program.

An ACE community worker met with Jeremy's family weekly and, with the help of experts, developed a case plan for the entire family. Lisa received parenting education to develop skills for dealing with Jeremy's behavior, drug dependency counseling, and job training. Jeremy and the ACE community worker slowly built a relationship of trust, and Jeremy responded positively to the additional attention. He learned how to control his angry impulses and began to reintegrate into his usual class at school.

One year later, Lisa had a job and was not dependent on pain medication, and Jeremy was attending school regularly and improving his grades. ACE workers will continue to monitor the family and provide assistance until Jeremy is 18.

25–February 4, 2004. A delegation of Indian child welfare professionals will visit the United States in late February or early March.

The project will be carried out in collaboration with Deepalaya, a child advocacy agency in Delhi, India, as well as several other U.S. and Indian organizations. Deepalaya works to improve the condition of children living in India's slums, reaching more than 16,000 children in 2001. With ties to other Indian organizations, such as Don Bosco Ashalayam and the Indian Council for Child Welfare, Deepalaya's activities include counseling and assessment of children, as well as advocacy campaigns.

U.S. agencies involved in the exchange include CWLA members Children's Home Society of Florida, the Florida Children's Campaign, and For Love of Children in Washington, DC, as well as the National Collaboration for Youth and the Washington (DC) Council of Agencies.

The State Department grant will support a number of activities before, during, and after the exchanges, including planning and follow up, and expenses for U.S. participants while in India.


For more information—and to express interest in being part of the team to visit India—contact Martin Scherr, Director, CWLA International Office at 202/638-2952, or e-mail global@cwla.org.

For more information on these items or other issues affecting children, youth, and families worldwide, contact Martin Scherr, Director, CWLA International Office, at 202/638-2952, or e-mail global@cwla.org.

The ACE program psychologist and social worker also complete quarterly assessments of functioning for each child in the program. At intake, all ACE children showed measurable impairment. The 2002 evaluation showed improvement for each of the three groups—50% of moderate high-risk children, 54% of high-risk children, and 29% of very high-risk children were showing little or no functional impairment at home, at school, or in the community.

A CPS worker cited a possible reason for these results: "The ACE worker is a terrific advocate for the child and family in the community, school setting, and other settings. The ACE program gives the families the one-to-one weekly contact they are not likely to get from the child protection workers."

ACE would like to develop more tracking tools for children in the program. The ultimate goal is to link assessments across children's developmental stages and across systems, such as mental health, education, and corrections, so that they complement each other and better predict and track changes in risk.

ACE has received both a 2000 Minnesota state award for innovation in county government and a semifinalist award in 2002 in the Harvard University Innovations in American Government competition. It was also a top 10 finalist in the 2003 W.T. Grant Foundation's national competition for promoting healthy youth development. 

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