

PREVENTION: MAKING A SHADOW COMPONENT A REAL GOAL IN SOCIAL WORK

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Abstract: *Although need, opportunity, and funding for prevention programs are currently increasing, social workers do not appear to be leaders in this area of practice. Their lack of initiative in prevention will not likely change until social work education incorporates concepts from prevention science into the curriculum. This article: identifies and explains major prevention concepts and principles; discusses their congruence with social work's historical roots and current curriculum policy; and offers thoughts on integrating prevention values and content into both generalist and advanced courses. An appendix of resources is included to encourage faculties to consider how prevention could fit in the overall design of their programs.*

Key words: *Prevention; Social Work Education; Prevention Science; Public Health; Curriculum*

INTRODUCTION

In the wake of the 1960s and 1970s community mental health movement, a few voices called for social work to get involved in prevention (Rapoport, 1961, as cited in Levine, Allen-Meares, and Easton, 1987; Meyer, 1974). By the 1980s, interest in teaching the theory of primary prevention surfaced (Bloom, 1981; Bowker, 1983), along with discussion of its importance in the schools (Levine, Allen-Meares, & Easton, 1987). Schools of social work apparently did not act on this interest and did not incorporate basic preventive concepts (Black, 1985, as cited in Siefert, Jayaratne, & Martin, 1992). Therefore, it is not surprising that prevention is not currently an obvious priority in practice areas dominated by social work. For example, of the 76 presentations listed for a recent conference on child sexual abuse, not one mentioned prevention or any related concept in the title (Midwest Conference on Child Sexual Abuse, 2003). Similarly, prevention is still not a priority in social work education. A recent survey found that of 70 MSW programs (71% response), almost 45 percent offered no formal training in primary prevention, although 42 percent claimed that they incorporated the content into the curriculum (Diaz & Kelly, 1991).

While many of the practices and programs of the profession can and do encompass preventive efforts, social workers often do not conceptualize them as such. This situation is likely due to what is missing in social work education; namely, most programs have not incorporated principles that derive from prevention science. The social work knowledge base implies preventive goals but may not label them as such. For example, students may learn about interventions such as parent-training and family support,

but probably in the context of treatment options for specific clients. And in learning about and implementing well-established government programs, students may not realize that these programs were initially developed to achieve the preventive goal of promoting child health and social competence (e.g., Head Start; Medicaid; Women, Infants, Children's Program).

It appears that the profession has largely forgotten its early advocacy of prevention measures and commitment to change social environments and government policies--social work concepts that are clearly congruent with current preventive science models. For example, in reviewing the history of social work, Reynolds (1963) cites the profession's concern with the public regulation of life and health, advocacy of occupational standards, development of settlement houses as a means of raising the health level through organized neighborhoods, and provision of hospital services to assist unmarried pregnant teens and address venereal disease. In addition, early social work theorists saw the preventive potential of policies; for example, Gil (1973) argued that mothers' wages could bring improvement in child development and reduce the "incidence and prevalence of physical and mental illness, mental retardation, and various forms of deviance in social and psychological functioning" (p. 82). Historically, social work values and philosophy have long been aligned with prevention. It is now time to teach prevention theory as a valued component, rather than an unnamed shadow in the social work curriculum.

Recently, social work educators who have discussed roles for practitioners in promoting social and public health and prevention advise university faculties to emphasize the knowledge and skills needed for community practice and social workers to retool their practice skills to become effective in new community partnerships that are pursuing prevention goals (Poole, 1997; Poole & Van Hook, 1997). In the health care field, Berkman (1996) wants social workers to be part of a team that addresses "the needs of patients for preventive, curative, and rehabilitative services." She recommends that MSW programs teach a specific theoretical framework for health care practice that focuses not on psychopathology but on adaptive capacities "with the goals of preventing maladaptive behavior and enhancing recovery" (p. 547).

Without more knowledge about prevention, social workers may not be attuned to new perspectives of their clients and communities. Today, prevention is much more a part of the public consciousness than in the past, primarily because of the mass media coverage of health issues and public health initiatives. The daily news often includes information about lifestyle choices and/or environmental risks associated with such public health problems as automobile accidents, heart disease, stroke, lung cancer, depression, unwanted pregnancy, and sexually transmitted infections.

It is time to give prevention a well defined place in the social work curriculum for both masters' and baccalaureate programs. This addition is essential if we expect students to allot time in their future practice for the goal of primary prevention and if the profession is to play a role in the many initiatives that are underway to address health and mental health prevention (e.g., National Technical Assistance Center for Children's Mental Health). This article discusses basic prevention theory, concepts, and practice principles and comments on their application to existing social work

curricula. Although it offers general thoughts about making selected prevention concepts explicit in the social work curriculum, faculties should explore this issue in depth and determine how prevention could fit into the overall design of their programs.

BASIC PREVENTION THEORY AND CONCEPTS

Prevention science draws heavily from the public health model that posits multiple contributors to disease and different levels of prevention/interventions. This model emphasizes disease control, prevention of disease states, and the promotion of health for the whole society; it stands in contrast to the medical model that typically emphasizes diagnosis and treatment of the individual with disease symptoms. Health promotion centers not simply on reduction of symptoms but also on promotion of positive health. For example, a prevention program for children at risk of mental health problems would pursue not only the prevention of or reduction in such symptoms as depression or anxiety but also the promotion of positive functioning in all areas of the child's life.

Prevention is compatible with the educational policy of the Council on Work Education (CSWE), which states that one of the many purposes of social work is "preventing and alleviating distress" (CSWE, 2001, 1.0) as a way of enhancing social functioning; the policy further indicates that the various purposes should encourage "curricula and teaching practices at the forefront of new and changing knowledge bases of social work and related disciplines" (CSWE, 2001, 1.2). The practical issue is to determine which prevention concepts are appropriate for social work students.

An early project to infuse prevention into the graduate social work curriculum at the University of Michigan developed three specialized prevention courses (Siefert et al., 1992); however, not all programs can offer this degree of specialization. Drawing on the philosophy and principles of this project, the following section briefly explains selected basic prevention concepts that could be integrated in the social work curriculum: (1) models of preventive services; (2) epidemiology, causation, and risk; and (3) the multidisciplinary framework and theory base for multiple levels of intervention. The discussion includes comments on how these concepts can fit into existing social work curriculum areas. As will be evident, incorporating relevant prevention concepts will require an added focus not a large change in the content of courses.

MODELS OF PREVENTIVE SERVICES

Discussion

Social work students typically learn that the medical model focuses on the individual and the progression and treatment of disease in contrast to the broader systems framework that focuses on the interaction between persons and systems. With this background, students are poised to understand two important models of prevention: the public health model, which is seen as more applicable to physical disease in populations, and the continuum of care model, which is seen as more applicable to behavioral and mental health disorders in clinical settings. Figure 1 aims to show the interface

between both models, and is an adaptation of the continuum of care model, which comes from a report of the Institute of Medicine (IOM). (Nitzkin & Smith, 2004).

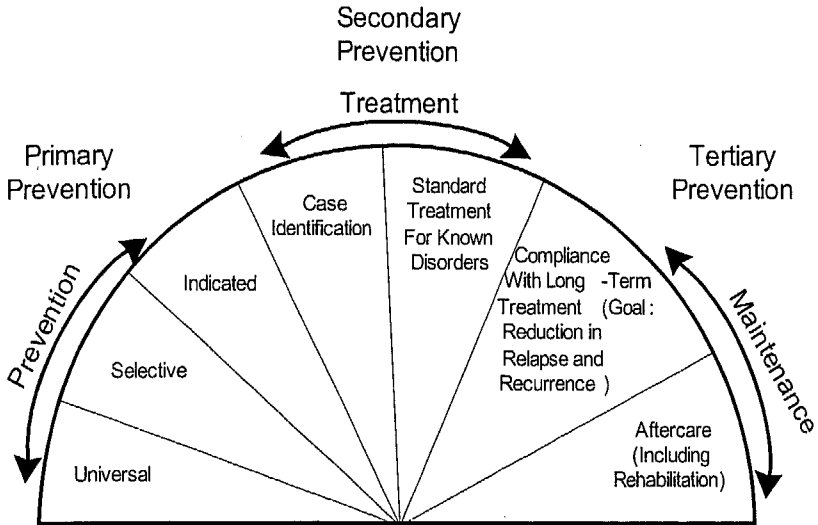


Figure 1. Continuum of Care Model

The public health model posits three levels of prevention—primary, secondary, and tertiary—that are linked to the course of the disease process in populations (Bloom, 1981); more recently, the opinion is that the boundaries between these three levels are not entirely clear (Blair, 1992). The continuum of care model covers the full range of health care services—prevention, treatment, and maintenance; for behavioral disorders in clinical settings, this model is considered more practical than the public health level of prevention since patient interviews during treatment are the source of “identifying risk factors and detecting early-stage disease” (Nitzkin & Smith, 2004, p. 5).

Figure 1 offers an adaptation that links the public health levels of prevention to the continuum of care. Primary prevention, which takes place before any biologic onset of disease, is equivalent to prevention on the continuum of care; the focus is on protective measures to prevent or forestall disease and on health promotion; definitional differences are often based on whether the author focuses on social versus medical dimensions (Blair, 1992). Within the continuum of care primary, prevention services can be “universal” or useful or applicable to everyone in a given population (e.g., childhood immunization or pre-natal care for all pregnant women). “Selective” measures target persons/subgroups at above-average risk (e.g., smoking cessation programs for all smokers). “Indicated” measures target persons/subgroups that are at extremely high risk or have symptoms/abnormalities not yet meeting diagnostic criteria (e.g., case management/counseling for young children with school behavior problems). Note that all of the targets for primary preventive measures consists of groups not yet diagnosed with a disease or behavioral/mental health disorder (Nitzkin & Smith, 2004).

Secondary prevention (encompassing Treatment in Figure 1), which takes place when underlying risks or incipient symptoms appear, aims for early detection and treatment to arrest or eliminate the disease. This goal often translates to reducing the duration of the disorder; and, as shown on Figure 1, some theorists have argued for re-labeling secondary prevention as "treatment activities" (Blair, 1992). Tertiary prevention (encompassing Maintenance in Figure 1), which takes place when symptoms are such that disease is diagnosed, aims to prevent complications and limit disability; and, as shown on Figure 1, others have described this level of intervention as "rehabilitation" (Blair, 1992; Nitzkin & Smith, 2004).

With the growing incidence and cost of chronic illnesses that are determined by multiple factors, the continuum of care centers on their predictability, prevention, and management. (Berkman, 1996). Pro-active screening, assessment, and case finding, whether in clinical settings or population groups, are essential to early intervention. And ongoing case management and secondary and tertiary population-based interventions are essential to promote compliance with treatment, screen for additional complicating factors (e.g., psychological or family issues), and connect people with needed community resources that can prevent relapse, and promote rehabilitation and health.

It is important to note that measures to promote health, not just efforts to eliminate disease or mental health problems, can also fit into the integrated public health-continuum of care framework. Health includes "life satisfaction, appropriate achievement of developmental milestones (such as developing social skills, completing school) and attainment of normative adult social functioning (establishment of a family, community engagement, career attainment, financial security)" (University of Michigan, 2006, p. 1).

As noted above, a final issue within prevention science is whether programs should emphasize clinical or population-focused interventions. Clinical prevention is more focused on illness and services for individuals, such as developing clinics for impoverished persons or home-care services for the elderly. Some believe that population-based practice is once again becoming important in public health (Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002); an example would include media advertisements or system policies designed to prevent child abuse, family violence, substance use, etc. A practical position is that both types of interventions are important for effective preventive efforts (Blair, 1992).

Application to the Curriculum

The blended perspective of prevention as shown in Figure 1 would readily fit in the generalist level of the social work curriculum. This framework would apply to various courses and is compatible with the social work value of promoting effective functioning for individuals, families, and the larger social systems. Social work educators could use the content in Figure 1 to encourage discussion of the need for prevention programs, as well as for services that treat symptomatic individuals and families, and to remind students that well-established social services and policies were originally part

of preventive efforts (e.g., crisis hot lines, information about domestic violence posted in women's public restrooms, mandated parent training for divorcing couples, etc).

Learning about prevention models can expand students' understanding of alternative models of service that go beyond community or clinic-based treatment, which too often become a "wait and watch" system (wait for severely troubled clients to appear and watch the no-shows, cancellations, and early terminations). A 50 per cent no-show rate has been reported for child psychotherapy (Kazdin, 1996). Most of the helping professions, including social work, emphasize essential clinical services; yet, this focus renders primary prevention an afterthought not a goal to consider in all program planning. For example, the funds allocated for mental health services in the schools are often used to contract for treatment of individual disruptive students by local agencies or practitioners whose methods may lack proven effectiveness (Pelham & Massetti, 2003). In contrast, recent model programs have demonstrated that school-based preventive services can effectively promote urban children's mental health (Atkins, Graczyk, Frazier, & Abdul-Adil (2003).

Discussion of prevention in generalist courses is compatible with social work's philosophy of the need for multi-system intervention and change to promote social functioning. As students learn about the traditional methods of social work (casework, group work, and community practice), they realize that these are applicable to all social system targets—from the individual to the total society. When the goals of prevention and health promotion become part of the curriculum, students can readily see a new application of practice methods that target potentially all social systems. Once basic prevention models are clearly delineated as a part of generalist human behavior and practice courses, students can understand how social work practice skills would fit in the design and delivery of programs that promote prevention goals. As Bloom (1983) says, an added benefit of including this content is the optimism that it embodies.

EPIDEMIOLOGY, CAUSATION, AND RISK

Discussion

According to public health theory, the state of health/mental health is a product of the interaction of the host, environment, and agent, although this model is most appropriate for infectious disease for which there is a single agent of transmission such as a virus (McLeroy, Bibeau, Steckler, & Glanz, 1988). In the classic early public health approach to infectious diseases, such as typhoid, the target of intervention was the environment and the intervention was sanitation engineering that reduced the toxic environmental conditions. Data about the host, environment, and agent are revealed through epidemiological research.

Epidemiology, broadly defined, is "the basic science for public health"; it describes and analyzes "causes of social and psychological health and illness," including patterns and interpretations that can suggest hypotheses for intervention and prevention (Bloom, 1981, p. 170). Epidemiological research uncovers facts about prevalence rates, morbidity, mortality, and the distribution of disease or other negative outcomes in the population, thus identifying both risk and protective factors. For example, public health specialists have often reported research showing

that "the very poor are at highest risk for many pathological conditions, including mental disorders" (Albee & Ryan, 1998, p. 445). The research also has established multiple interacting contributors for many diseases and behavioral disorders.

Epidemiological findings are typically available in "existing data sources (such as vital statistics, state and national health surveys, medical and administrative records)" (Gielen & McDonald, 2002, p. 415). Indicators of prevalence and impact on health in a population and high-risk subgroups help identify which problems are most important for which groups and suggest what factors could be used to determine measurable program objectives. Policy documents can help identify problems to address and targets for change; for example the United States Public Health Services publication *Healthy People 2010* gives data on major national health problems and some high risk subgroups (United States Department of Health and Human Services [USDHHS], 2000). Additional theory and research literature can shed light on further behavioral and environmental factors that contribute to a given problem.

Application to the Curriculum

Epidemiological analysis that encompasses the interaction of host, environment, and agent is compatible with various theoretical frameworks taught in social work programs: social systems, the social ecology model, and/or the biopsychosocial model, all of which serve as the basis for understanding human behavior in the social environment; social work curricula often refer to these multiple levels as micro, meso, and macrosystem influences (Poole, 1997). At the generalist level social work courses could cover the multi-factorial public health explanation of causality as a metatheory that is compatible with other theoretical frameworks taught in human behavior courses. An introduction to epidemiological research can expand students' knowledge of research methods and provide a basis for additional prevention concepts in advanced courses. An assignment might be for student groups to search for epidemiological data around a particular health/mental health problem, e.g., diabetes, depression, etc.

MULTIDISCIPLINARY FRAMEWORK AND THEORY BASE FOR MULTIPLE LEVELS OF INTERVENTION

Discussion

Prevention science draws extensively on the disciplines of public health (investigators and environmental specialists), physicians, nurses, social workers, health educators, and psychologists, with additional contributions coming from community and organizational representatives. The multidisciplinary approach is essential for accessing relevant theories to explain the etiology and epidemiology of health and illness and practice principles appropriate for the design, delivery, and evaluation of effective prevention programs (Smith & Bazini-Barakat, 2002). Social workers are highly involved in the interdisciplinary process, but mostly in the context of case management teams that assess, plan, and provide treatment services. The profession, however, has much to contribute to multidisciplinary prevention activities.

With the interdisciplinary approach already embedded in the practice of social work, Poole (1997) believes that social work education, with its ecological and social systems theory base, is in a good position to transmit additional theory that will better train social workers to address community health problems and design appropriate interventions. This task calls for an multidisciplinary framework that allows for a "comprehensive theory" of the problem based on the interactive effects of intrapersonal, interpersonal, organizational, community, cultural, and public policy factors and a comprehensive 'theory of intervention' with potential points of intervention and appropriate strategies" (Poole, 1997, p. 166).

Table 1, reprinted from Poole (1998, p. 373), offers a social ecology framework for health promotion/education.

The overview shows that preventive programs can draw on multiple theories that explain human and systems behavior in terms of certain change processes, specify targets of change, and posit strategies to achieve change. Any one or more of the ecological levels may contribute to a problem and consequently be a target for change.

The summary format of Table 1 makes it easy to see that various disciplines have contributed to the theories and change strategies. The content summarized here can serve as a review of theories and strategies covered in the social work curriculum, introduce new theoretical concepts, and highlight the contributions of other disciplines, some of which may be unfamiliar to students. Note the intrapsychic and interpersonal theories that draw from developmental and social psychology and from sociology. Regarding the organizational, community, and public policy levels, the disciplines of sociology, social work, and political science all clearly contribute to these theories and strategies.

Although the content of Table 1 was designed to apply to health promotion efforts, it has broad application to all intervention levels of the combined public health and continuum of care models shown previously in Figure 1—primary prevention, treatment, and maintenance. For example, with the aftercare process that is part of maintenance for substance abusing clients, various ecological levels could be targeted to promote rehabilitation (e.g., intrapsychic cognitive/social learning-based relapse prevention, interpersonal social support groups, community-based incentive programs such as job training, etc.).

Application to the Curriculum

Close analysis shows that many of the theories and practice strategies listed in Table 1 are part of the social work curriculum. Nonetheless, seeing a comprehensive overview of many theories can help students further internalize theoretical concepts and hone practice skills in general as well as see their application to prevention. To achieve this goal, students need educational activities that apply the range of strategies to prevention projects.

Advanced level human behavior and clinical and macro practice courses would be appropriate for introducing the broad ecological framework of Table 1. A learning objective could be to give students practice in applying multiple theories to a public

health problem already identified through epidemiological analysis as appropriate for prevention. An assignment could ask students to use Table 1 as the basis to "brainstorm" ideas (not evaluate their feasibility) for planning a prevention initiative. The instructor could illustrate the assignment by offering a brainstorming example relevant to the course.

Table 1. A Social Ecology Framework for Theories Related to Health Promotion and Health Education* Part One

Ecological Level	Change Processes	Theories or Models	Targets of Change	Strategies and Skills
Intrapersonal	Psychological	Value expectancy Attitude change Social learning theory Control theories Personality theories Attribution theories	Developmental processes Knowledge Attitudes Values Skills Behaviors Self-concept, self efficacy Self-esteem	Tests and measurements Program planning Educational approaches Mass media Social marketing Skills development Resistance to peer pressure
Interpersonal	Psychosocial	Network theory Social support theories Role theory Social influence models Social comparisons	Social networks Social support Families Work groups Peers Neighbors	Enhancing social networks Changing group norms Enhancing families Social support groups Increasing access to normative groups Peer influence
Organizational	Organizational	Diffusion of innovations Stage theories Leadership theories Organizational climate Organizational culture Leadership	Norms Incentives Organization culture Management styles Organization structure Communication networks	Organizational development Incentive programs Process consultation Coalition development Linking agents

Table 1A Social Ecology Framework for Theories Related to Health Promotion and Health Education Part Two*

Community	Cultural and social	Cultural change theories Social change theories Community development Diffusion of innovation Community power Community decision making	Area economics Community resources Neighborhood organizations Community competencies Social and health services Organizational relationships Folk practices Governmental structures Formal leadership Informal leadership Legislation	Change agents Community development Community coalitions Empowerment Conflict strategies Mass media
Public Policy	Political	Policy development theories Political change theories Political parties Citizen participation Bureaucracies	Policy Taxes Regulatory agencies	Mass media Policy analysis Political change Lobbying Political organizing Conflict strategies

Note. From *Community building: Renewal, well-being, and shared responsibility* (p. 373) by P. L. Ewalt, E. M. Freeman, & D. L. Poole (Eds.). Washington, DC: National Association of Social Workers. Copyright 1998, by National Association of Social Workers. Reprinted with permission

For example, the following ideas are for a community-wide initiative to address, at all ecological levels, the problem of high rates of adolescent sexually transmitted infections (STIs).

One program component at the intrapsychic level could develop media messages directed to the entire adolescent population in the community (universal target) to influence attitudes and values about intercourse and use of protection. Another intrapsychic level intervention could offer high-risk females (selective target) a psycho-educational group to develop assertiveness/skills. At the interpersonal level; a preventive program might provide all parents in the community school system (universal target) information on how to talk effectively with their children about sexual risks. At the organizational level, a preventive initiative might aim to implement a school-based health clinic that will offer sexual health services to students in a neighborhood with high rates of STIs (indicated target). At the community level, a preventive initiative might aim to develop a transitional neighborhood's economic resources so as to help high-risk youth (selective target) see opportunities to achieve positive personal life goals. Finally, an initiative at the public policy level could lobby for a governmental policy to mandate that public school sex education programs (universal target) include information about protection during sexual intercourse.

This discussion has briefly explained three basic prevention concepts and commented on applying these to required generalist and advanced level courses. The goal is not

to turn students in to prevention or public health specialists; rather, they should learn early on how the philosophy and practice of prevention fit and have a place in their chosen profession.

PRINCIPLES AND PRACTICE OF PREVENTION

The next set of selected principles is relevant to prevention practice as well as to other social work roles. Again, these are congruent with many concepts and strategies taught in both generalist and advanced social work practice courses. Some may already be mentioned in various courses; however, these principles merit explanation in regard to prevention and health promotion. They would readily fit into courses that deal with populations at risk or specialized practice settings (e.g., health, mental health, substance abuse, child welfare, family violence, sexual issues, minority populations, school social work, etc.). CSWE educational policy specifies that curricula should "integrate content on populations-at-risk" and . . . "present content on the dynamics of such risk factors and responsive and productive strategies to redress them" (CSWE, 2001, 4.2). Faculties should review their program and courses to decide how best to integrate selected prevention principles. To promote this dialogue, ten principles are briefly discussed here.

1. Outreach, access, and engagement designate processes necessary to bring prevention services to a large segment of the population or to identified at-risk or symptomatic individuals. These principles emphasize that prevention is pro-active as opposed to reactive. The idea is to anticipate and address the barriers to obtaining services that vulnerable, underserved groups experience, rather than wait for patients or clients to present themselves.

Several strategies are used to enhance outreach, access, and engagement. Given that stigma is still associated with mental illness and many physical illnesses, use of low-stigma settings is the choice for prevention programs. Access is expanded and stigma reduced when prevention programs are offered in settings such as schools, primary healthcare facilities, community centers, the workplace, recreation programs, places of worship, etc. Another strategy, use of indigenous natural helpers, has the added benefit of helping with the management of resources, as prevention programs need to reserve highly trained professionals for the most complex services. Indigenous helpers are those who have regular contact with large numbers of persons, ranging from those who could benefit from health promotion to those who are symptomatic. Teachers, parents, daycare workers, and church members are examples of indigenous helpers who have been part of recent prevention programs; for example, a camp-based health program in Michigan enlisted "migrant farm workers to provide culturally appropriate health education, advocacy, outreach, referral, and follow-up services" (Poole & Van Hook, 1997, p. 2).

2. As with all social work practice, sensitivity to local/cultural norms/practices is an important principle in the planning, delivery, and evaluation of all types of prevention programs. This principle applies to the methods used for outreach, access, engagement, stigma reduction, and appropriate adaptations in intervention methods and aims to increase the likelihood that services will be meaningful and successful

with the targeted groups. For example, an asthma education program was adapted to make it culturally relevant for African American adults and was located in a church setting, which research has identified as a context central to many African Americans (Ford & Edwards, 1996).

3. Education and consultation are practice methods that have wide application in prevention programs. Educational efforts can aim to: inform a general population group (such as a mass media campaign on the risks of smoking, alcohol, and drug use in pregnancy); inform an adolescent population or teachers about mental health; teach symptomatic individuals, such as heart attack survivors, about follow-up health practices; or train indigenous or professional workers for their role in prevention programs. Consultation is the process whereby a highly trained professional provides expertise and support to enable front-line indigenous or professional helpers to better carry out their role in a prevention program.

4. Identification of both risk and protective factors is central to prevention programming. Epidemiological, psychological, and sociological research contributes to this identification process. Prevention specialists draw from research findings on a particular problem area to gain knowledge of risks and protective factors. For example, research has identified children who are early starters of aggressive behaviors at high risk for delinquency or drug abuse, whereas a protective factor is a positive family environment that includes supervision, consistent discipline, and communication of family values (Kumpfer & Alvarado, 2003).

5. Risk screening is an important part of prevention that aims for early identification of persons within a larger population who display risk behaviors; once identified, these individuals can receive selective or indicated prevention efforts. Many types of screening methods are possible. For example, prevention programs have taught primary health care personnel in clinics and emergency rooms, classroom teachers, daycare workers, and other natural helpers to screen children for signs of physical abuse, behavioral/emotional symptoms, or other risk characteristics. Screening tools might include brief behavioral, emotional, or symptoms checklists that could be routinely administered in certain settings or as a part of a media health campaign or a health fair.

6. Risk reduction is a principle that aims to reduce risk, either for a large population group, a known risk group, or a group with specific problem behaviors/symptoms. Programs can help reduce risk by: promoting health behaviors that keep people out of high risk category (smoking education campaigns to prevent teens from starting to smoke); lowering existing risk (campaigns to decrease the risk of second-hand smoke for adults and children); and reducing actual problem behaviors or disease risk (e.g., smoking cessation programs that arrest disease symptoms that may be in progress and lower the risk of serious disease).

7. Community capacity building is the process of fostering "conditions that strengthen communities that enable them to plan, develop, implement, and maintain effective community programs," such as identifying and addressing "social and public health problems" (Poole, 1997, p. 163). This process contrasts with programming that is driven, developed, and administered by professionals, a "top-down" approach that critics

say can weaken community potential. A goal is to create or revitalize community action structures—councils, commissions, committees, and task forces. These channels allow for citizen participation, decision-making, and social action. Professionals are needed to build, support, and provide internal maintenance for the functions of these structures.

An important strategy for community capacity building is to foster development of community team building/partnerships; these are advocated for establishing effective comprehensive and primary health care programs. Partnerships are coordinated networks that include community members, health care providers, and various social service professionals. These partnerships can serve many functions: involve community members in program design and delivery, increase access and outreach, encourage community ownership of health issues and solutions, export training and skills beyond traditional professional boundaries, and create new structures that can integrate and sustain new systems of care. Social work's repertoire of skills in community practice is applicable to this goal. But to become relevant to prevention programs, skills may need to be honed or expanded to include grassroots organization and constituency building, budgeting and resource packaging, training and consultation, outcome evaluation and cost analysis, marketing, and skills in facilitating task groups (Poole & Van Hook, 1997).

8. Evidence-based interventions have become important in the practice of all of the helping professions and are a central feature of health promotion and prevention programs. Government agencies are mandating that public funds be spent only on "effective programs as found on their lists of scientific programs" (Kumpfer & Alvarado, 2003, p. 459). Data are available that identify the most effective interventions for various problems, most often based on rigorous, randomized controlled trials. "Intervention frameworks that are based on epidemiological and developmental research documenting risk and protective factors, recognize the common concurrence of multiple problems, and involve family-, peer-, school-, and community-focused components appear more effective, in general, than single-problem, single-component designs" (Bierman, 2003, p. 526). Prevention science emphasizes the use of such research to specify a desired outcome that reduces risk or promotes protective factors. This focus allows selection, implementation, and evaluation of whether an evidence-based strategy is effective in achieving the program's proposed outcomes. Because of government mandates and competition for funds, prevention programs must give strong emphasis to evidence-based interventions. Their use can also help cut costs because they offer a manualized protocol for assessment and outcome measures, delivery of the intervention, training workers, etc. Besides evidence about specific interventions, researchers have also identified general principles of effective prevention programs (Nation, et al., 2003).

9. Evaluation research, while recommended for all types of service programs, is a hallmark of health promotion and prevention programs. With funding sources demanding accountability, all aspects of a program must be evaluated, including the processes of outreach, screening, training and consultation, record-keeping, and overall integrity and fidelity of the selected evidence-based intervention. Cost-analysis and

indicators of sustainability are also part of the evaluation needed. The evaluation research should document which program components were effective (including the size of behavioral change or effects), which were modified, and which proved ineffective.

10. Sustainability of programs refers to the goal of maintaining and continuing the operation of prevention programs. Sustainability is linked to the capacity of “locally existing structures that enable organizations to maintain, enhance, and expand their use of effective practices and systems” (Sugai, 2003, p. 533), rather than depend on temporary external supports such as grants and external consultants. Resources for sustaining programs include: guiding policies, specialized knowledge and skills, competent management, fiscal supports, and ongoing process and program evaluation. For example, one school mental health prevention program included functions that would be ongoing with existing resources: trained teachers for mental health roles, developed the capacity of families to sustain positive change, and initiated an effective school procedure for dealing with disruptive behavior (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003).

This brief discussion is only a starting point for how important prevention practice principles can fit into existing social work courses. It is likely that the curriculum already covers some of these principles and strategies, such as in relation to clinical, administrative, and community practice. One of the best teaching tools for any advanced course is to have one assignment that requires students to review and analyze an effective or model health or mental health prevention program. Many such programs are available that deal with depression, HIV-AIDS, substance abuse, adolescent pregnancy, school drop-out, and other child/adult health and mental health risks (for examples, see Appendix: Resources). The analysis required in the assignment should reflect prevention concepts that are relevant to the particular course, for example, clinical practice, planning, research, etc. Other prevention assignments as suggested in the discussion above can bring concepts and principles to life, show students how the roles and strategies that they are learning are relevant to prevention, and inspire them to include prevention in their future practice.

CONCLUSION

The philosophy, knowledge base, and practice skills taught in social work education programs are compatible with prevention and health promotion. Unfortunately, the models and practice principles that derive from prevention science are not explicit in many social work programs. On just one aspect, skills for building and participating in community partnerships, “there appears to be a great divide between what faculty are teaching students in academia and what practitioners are doing in the field” (Poole, 1997, p. 163). Social work educators must do a better job of preparing students for prevention practice. Integrating prevention content into courses will provide students with an added lens for viewing the content of all courses.

When courses articulate prevention as a value and goal for social work practice, students will be better prepared for the complex professional roles awaiting them in the community. They can be knowledgeable collaborators with agencies and programs that pursue prevention. They can participate in efforts to build

community partnerships and action structures to support community prevention goals. They can serve as clinical and consultation/education specialists for specific programs. They can examine their employing agency's mission and foster dialogue about whether prevention is or should be part of that mission. They can assume major roles in the design, delivery, and evaluation of proposed and funded health promotion/prevention programs.

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Appendix: Resources

Registries and Web Sites

- Center for Substance Abuse Prevention's National Registry of Effective Prevention Programs ([www.samhsa.gov/csap/model programs](http://www.samhsa.gov/csap/model_programs)).
- Center for Substance Abuse Prevention's Decision Support System (www.preventiondss.org).
- Centers for Disease Control and Prevention's Guide to Community Preventive Services (www.thecommunityguide.org).
- National Alliance for the Mentally Ill (NAMI). A grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of children and adults living with severe mental illnesses (www.nami.org).
- National Technical Assistance Center for Children's Mental Health. Georgetown University Center for Child and Human Development (www.gucchd.georgetown.edu).
- Society for Prevention Research's International Registry of Prevention Trials (Brown, H. Mrazek, P. & Hosman, C. (1998, December). *International classification of prevention trials*. Paper presented at the Workgroup Meeting on the International Classification of Prevention Trials, Washington, DC.
- Western Center for the Application of Prevention Technology (www.westcapt.org).

Recent Publications on Prevention Theory and Programs

- Atkins, M. S., Graczyk, P. A., Frazier, S. L., & Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services. *School Psychology Review, 32*, 503-514.
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