The Promise of Prevention: Does It Deliver?

A Discussion Paper Prepared for
Edmonton Community Services Advisory Board

February 2005

COMMUNITY SERVICES CONSULTING LTD.
9357 – 98A STREET
Edmonton, Alberta T6E 3N3

Phone (780) 439 5764
Fax (780) 439 3124
commserv@shaw.ca

The Promise of Prevention: Does It Deliver?

A Discussion Paper Prepared for
Edmonton Community Services Advisory Board
February 2005

During a planning session members of the Edmonton Community Services Advisory Board (CSAB) identified a central question: "What do we mean by the term 'primary prevention' and what would be the characteristics of an effective primary prevention program?"

CSAB's uncertainty about the meaning of prevention and its promises is no real surprise. It reflects the ambivalence that continues to exist within the human service field. At one level there seems to be little reason to question its value. There is broad agreement that 'an ounce of prevention is worth a pound of cure'. There is the moral argument that what ever can be done to reduce human suffering or make people's lives better is the right thing to do. The economic argument for prevention, that intervening early will likely be less expensive and save the cost of additional services later, has considerable appeal. There is also the common sense argument for prevention: it is preferable to be 'proactive' rather than to wait until a social problem has appeared, after which it is only possible to be 'reactive' (Mangham 2003).

At another level nothing has hampered an understanding of prevention more than the confusion that continues to exist about what the term means. As the search for clarity has continued it has been common to re-use the well-worn definitions from the past, with the forlorn hope that if they are repeated frequently enough they will eventually be proven to be true. Some definitions have overtime become so broad that almost any human service program could, with some imagination, be considered preventive. At its most cynical a preventive program might be simply seen as one that has the support of a funder as opposed to a program that does not.

Even if a commonly accepted definition of prevention could be reached, the problem remains understanding the complexity of the circumstances that prevention is expected to address and the myriad of human service systems that need to be involved to be effective. Whether a program is intended to meet the needs of children, youth, parents or families, untangling the various influences frequently makes it very difficult to demonstrate reliably that it was the prevention activities or interventions that made the critical difference. As well, prevention has continually struggled against the traditional commitment in the human services to focusing on symptoms and taking remedial actions. Added to this is the burden of exaggerated expectations that improvements in the condition of those who are benefiting from a preventive program will become evident in a very short period of time.

Prevention, then, has always held considerable promise, but it has had problems with the delivery, as well as convincing many in the field of human services that it has something significant to offer. This discussion paper is intended to refresh and update the definitional debate, to reflect upon emerging conceptual thinking about prevention and to assess the findings of recent evaluations of preventive programs. The underlying purpose is to strengthen CSAB's understanding of prevention and to offer a possible

template for assessing the preventive nature of the programs it currently supports as part of the Board's obligations to 'due diligence' in conducting its funding reviews.

Origins of Preventive Social Services

Leslie Bella, in her study, *The Origins of Alberta's Preventive Social Services Program*, (1978) indicated that the introduction of the Preventive Social Services legislation in 1966 occurred at the same time as responsibility for social assistance and child welfare was being transferred from the municipalities to the province. There was therefore a desire on the part of the Social Credit government "to cut future costs by removing and preventing social conditions which encourage welfare cases." The Act proposed a 80/20 split in funding between the province and the municipalities, a commitment to municipal leadership and the importance of local planning and decision-making – all of which remain central elements of the FCSS program. At the same time as the proposed approach to prevention was being debated in the legislature, discussions between municipal leaders and department officials identified the new legislation as being important for strengthening family life in order to avoid family breakdown and of promoting general social and physical well-being. It has since been acknowledged that the introduction of the PSS Act in 1966 made it possible for municipalities to provide support to a number of programs, such as family counseling and childcare, that otherwise would never have received support directly from the provincial government.

Prevention and the FCSS context

Despite the occasional challenge to the program, the Alberta government has retained the arrangement with municipalities and Metis settlements to fund preventive social services for almost 40 years. Over this period, various provincial departments have been responsible for the program; but in 1999 the newly created Children's Services assumed responsibility for the current Family and Community Support Services Program, including setting the policies that guide it.

The City of Edmonton was one of the original partners in the program. Being a partner today involves a municipality entering into a joint funding agreement with Children's Services and complying with the requirements set out in the *Family and Community Support Services Act* and its Conditional Agreement Regulation. As a partner, the City of Edmonton makes various commitments under the terms of the agreement. It commits to providing **preventive** social programs. It also commits to promoting "citizen participation in planning, delivery and the governance of the [FCSS] program and of services provided under the program."

Children's Services describes the FCSS approach as a "people helping people to help themselves." The philosophy is that self-help contributes to a sense of integrity, self-worth and independence. Programs funded under FCSS are intended to help individuals and families to adopt healthy lifestyles, thereby improving their quality of life and building their capacity to prevent and deal with crises.

Within the context of FCSS, **prevention** refers to *trying to reduce or eliminate some risk or problem for members of a particular group, while at the same time taking steps to strengthen their ability to cope*. A related term, **primary prevention,** rests on the premise that corrective action is more effective when it occurs before a problem can become firmly established. **Community development** is described as a process or

approach that helps people in a community to organize themselves, identify and respond to local issues, develop relationships, mobilize local leadership and resources, build commitment for shared action, and develop and execute plans – while relying as much as possible on shared or community resources.

The Conditional Agreement Regulation lays out the responsibilities and obligations associated with administering FCSS programs locally and provincially. Services provided under a program must be of a preventive nature that enhances the social well-being of individuals and families through promotion or intervention strategies provided at the earliest opportunity; and do one or more of the following:

- help people to develop independence, strengthen coping skills and become more resistant to crisis;
- help people to develop an awareness of social needs;
- help people and communities to assume responsibility for decisions and actions that affect them
- provide supports that help sustain people as active participants in the community;
- help people to develop interpersonal and group skills which enhance constructive relationships among people.

Children's Services provides examples of the types of projects and services that may be funded as an FCSS program. These include services that promote the social development of children and their families, such as parent-child development opportunities, as well as those that enrich and strengthen family life by developing skills so people can function more effectively within their own environment. These might include programs for single adults or single parents, youth development opportunities or courses intended to enhance self-awareness and personal growth. A third category makes reference to services that enhance the quality of life for the retired and semi-retired, while a fourth and fifth encourage services that promote or support volunteer work or provide information to the public about the services available.

A question of importance to this discussion paper is: How consistent is the FCSS definition of prevention programs and its related policies to that developed by other jurisdictions or organizations? What follows is a selection of definitions of prevention drawn from a range of documents available on the Internet.

Medical Model and Focus on Problems

The World Health Organization initially provided the seminal definition of prevention in 1948. It had a medical focus on reducing the risk of disease, premature death, illness or disability or any undesirable health event. The definition identified three successive stages of prevention**:**

- **Primary prevention** seeks to prevent the onset of a disease by altering some factor in the environment, bringing about a change in the status of the host, or changing behaviour so that disease is prevented from developing.

- **Secondary prevention** aims to halt the progression of a disease once it is established. The focus here is on early detection or diagnosis, followed by prompt, effective treatment.

- **Tertiary prevention** is concerned with rehabilitating people with an established disease to minimize residual disabilities and complications. Action taken at this stage aims at improving the quality of life, even if the disease itself cannot be cured.

These medically based distinctions have been carried over into the broader field of prevention, despite general dissatisfaction with the terms. They have been described as confusing and distracting and as being so broad that anything from 'lollypops to lobotomies' would qualify as a preventive strategy (Lofquist, 1983). The WHO medical model of prevention has also perpetuated the three interrelated elements of the "agent," the "host" and the "environment." Unfortunately the analogy does not translate much beyond health care and as a result contributes very little to the more general field of prevention.

In 1994 the American Institute of Medicine reserved the use of prevention for those *interventions that occur before the initial onset of a disorder or disease*. Although another medical model, one key component of the IOM definition has allowed it to be applied in a wider context: its reference to three levels of interventions.

Universal prevention is intended to delay or prevent the onset of a problem; targets the entire population, assuming all share the same general risk; and does not assess individual risk.
Example: a life skills training curriculum for all junior high students.

Selective prevention is also intended to delay or prevent the onset of a problem; however, it does so by targeting a subgroup identified as having a number of characteristics that will significantly increase the subgroup's risk of problems. So, selective prevention programs address specific subgroup risk factors.
Example: a mentoring program for youth from low-income families.

Indicated prevention slows or stops the progression of problems and related disorders by targeting high-risk individuals who are identified as having minimal but detectable signs or symptoms, but who do not meet diagnostic levels at the present time.
Example: a skills group for specific individuals at high risk of dropping out of school.

Taking Constructive Action

As useful as this new medical classification might be, it continues to emphasize 'prevention' as being about "stopping something from happening." A number of writers on prevention have complained that this is much too narrow an interpretation (Lofquist, 1983; Pransky, 2001, 2003). While prevention indeed "comes before," it must incorporate the idea of taking positive, constructive action that will mean that the

destructive outcomes or behaviours never materialize. It is this focus on the positive that is central to the definition of prevention provided by William Lofquist (1983):

> an active, assertive process of creating conditions and/or personal attributes that promote the well-being of people

In keeping with this definition, several jurisdictions or prevention initiatives have chosen to highlight the positive approach to well-being in their current definitions of prevention.

> We are defining prevention as an active, assertive process of creating conditions that promote well-being. Our focus will be on "universal prevention", or the practice of taking positive actions that support children and families right from the start – and all along the cycle of a child's life.
>
> *Communities for Children, Maine State*

> Prevention is an active, assertive process of creating conditions and/or personal attributes that promote the well-being of people. It is a positive approach to planned social change toward a vision of health for individuals and social systems at all levels.
>
> *Southwest Regional Center for Drug-Free Schools and Communities, University of Oklahoma*

> Prevention is a proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviours and lifestyles.
>
> *Wicomico Behavioral Health, Drug Prevention, Maryland*

> Prevention represents both an effort to foster competence and to prevent problems. Intervention is a protective process by which one deliberately attempts to steer development in a more favourable direction.
>
> *National Resilience Resource Centre, University of Minnesota, Minneapolis and the Center for the Application of Prevention Technologies*

> Prevention is a proactive approach of providing support and services to families before a problem or crisis occurs. Prevention is an approach that emphasizes health and wellness versus after-the-fact problem driven services. Prevention is about giving parents and other caretakers of our children the skills they need to be successful.
>
> *Arkansas Children's Trust*

> Prevention is a proactive process which focuses on capacity-building for individuals, families, institutions and organizations – including specifically identified high-risk individuals or groups within the population. Prevention is an

active process of creating conditions and personal attributes that promote the well-being of people.

Alcohol and Other Drug Abuse Prevention Program (AOD), University of Santa Cruz

Prevention is a proactive process which empowers individuals and systems to deal constructively with potentially difficult life situations, to keep healthy people healthy and to bolster the strength of those at risk. It requires that a measurable, risk-based series of collaborative, culturally relevant strategies be employed within the areas of information dissemination, education, alternative activities, problem identification and referral, community-based process and environmental prevention.

Commonwealth of Pennsylvania

Prevention: Activities that enhance and maintain protective factors and decrease the presence and effect of risk factors for children, families and communities.

A paper prepared by the Director, Prevention Source, BC for the BC Ministry of Children and Families, 2001

Some Consistent Themes

In reflecting upon these definitions of prevention and that provided by the FCSS documentation there is significant consistency. Being proactive and taking action early before a problem can become established is a common theme. There are similar references to strengthening the abilities of individuals or families to cope with crises or providing opportunities to develop inter-personal or group skills. Acknowledging the contribution of community processes and development to prevention is referenced by FCSS as well as a number of the other definitions. If there is a difference, it is one of emphasis. The basic FCSS definition of prevention begins with a reference to risks and problems, whereas many of the other definitions either do not refer to the negative or, instead, begin with a positive focus on well-being through building capacities in order to overcome the potential risks or problems.

Previous efforts by the City of Edmonton to define prevention have drawn upon the WHO classification of primary, secondary, tertiary, sometimes with the addition of two further categories, “crises” and “rehabilitation.” Traditionally, the city has declared that its FCSS program should focus its attention on primary and secondary prevention. Primary prevention was defined as “measures taken to reduce the incidence of social breakdown and to support the individual, family and community”, while secondary prevention was considered “the intervention with individuals who are displaying initial signs of a social disorder but for whom it is not yet ingrained.” It is long overdue that the terms secondary and tertiary prevention be dropped from the discussion, or at best renamed for what they are: “remediation” and “rehabilitation.” The term “primary prevention” should also be changed to simply “prevention.”

So what is prevention? A useful definition would include the following elements:

- it starts early before a crisis occurs
- it is “pro-active”, intentional and assertive
- it focuses on strengthening the positive conditions that are known to contribute to the well-being of children, families and communities
- it builds upon the personal attributes and skills that are required to ensure healthy lifestyles, especially for those who are at risk
- it is community-based, empowering and engaging for those who are involved

Building on these elements, prevention might be defined as:

> a pro-active, intentional process focused on strengthening the positive conditions that contribute to the well-being of children, families and communities and building upon the personal attributes and skills that are required to ensure healthy lifestyles, especially for those who are at risk.

As suggested earlier, having a definition of prevention in place is insufficient to really gaining an understanding of the processes of prevention and what they can achieve.

Values Underpinning Prevention

First, it is important to acknowledge what values underpin prevention. Linked to his contribution of the positive, action oriented definition of prevention, Lofquist (1983) suggested that all prevention activities rest upon a number of fundamental values – regardless of whether the activities focus on individuals and their personal growth and development; the circumstances within a family, a school classroom, or a peer group; or on broader social conditions in the community. The values include:

- People can become responsible, within reasonable limits, for shaping the conditions under which they live, work, learn, use their leisure and otherwise spend their time.
- People are their own best resources for bringing about the change which is important to them.
- Participation by people in shaping the conditions that affect them promotes ownership and vested interest in the change being sought and increases commitment to seeing that the change is achieved and maintained.

Lofquist acknowledged that, while everyone is restrained by various realities, there is still some latitude for responsible individual action that may influence the conditions that surround them. He also emphasized that individuals working together can eventually shape the conditions that are important to them. As active and effective participants in a process of planned change, those involved must be acknowledged as resource people rather than as problems that need to be fixed or the targets for the change process.

Change as Essence of Prevention

A second requirement to understanding prevention is to appreciate that change is its central essence. There are numerous theories as to how change occurs, but most agree it is unlikely to happen as the result of a single intervention or action, unless the readiness to change is high, as may occur, for example, because of a personal crisis or because the benefits of change are highly compelling. Change is seldom linear and the positive impact of the change may take years to appear.

Colin Mangham (2001, 2003) suggests that change begins with the process of becoming more aware of an issue, or the benefits associated with change for an individual, family or community, through conversations with others. As similar messages are received and interpreted over time, through education activities or awareness campaigns, attitudes begin to shift and the learning of new skills is contemplated. If others in the community, especially those who are viewed as role models, promote the change in behaviour, then often a critical threshold is reached and the new way of thinking and acting catches on. It is therefore a collective process where individual changes are gradually reinforced by changes in the accepted norms of the community.

A Conceptual Framework

In his recent examination of prevention, Jack Pransky (2003) also highlights this important interplay between personal and community change. He suggests as well that there is a vertical dimension to prevention. Pransky postulates that those who work in prevention operate at different "depths," depending on what they consider to be important. The "deeper the prevention depth the more impact it appears to have in changing people's lives towards well-being and away from problems." Pransky does not necessarily propose abandoning any of the levels; rather he suggests that there needs to be a "push" to incorporate other considerations and approaches. Each level may be necessary, but not in itself sufficient. Table1draws on Pransky's thinking and offers a conceptual framework useful to understanding the processes of prevention.

Traditional Approaches to Prevention

The first four levels reflect what have traditionally been considered prevention activities, where there is recognition that a problem exists that should be addressed in some way, but uncertainty about what actions should be taken. Providing some information on the nature of the problem seems like a positive first step and, if the problem is already quite serious, then a treatment or a new service may seem an appropriate response, although it is unlikely to reduce the number of people impacted by the problem. In Level 3, intervening early in a problematic situation is a significant advancement in preventive thinking; but often programs that sound as if they might be effective are quickly introduced, with the best of intentions, in order to be seen as doing something in response. What is frequently missing is any evidence that the new service or program actually prevents the problem it is trying to address.

Influence of Environmental Factors

Levels 5 and 6 reflect the developing appreciation that by changing societal, community or environmental conditions a program can contribute much to effective prevention. Linked to this important shift in thinking is the recognition that preventive actions need to

be based on solid research into risks or causal factors. Only by identifying the risk factors, can prevention efforts be directed towards reducing them. For example, research points to a number of underlying causes – poor housing or social isolation – as associated with risk. These root causes need to be addressed if progress is to be achieved, and a community development approach is often used towards this objective. When the causes are thought to be economic injustice and the gap between rich and poor, advocacy and demands for social change may be the only logical option. However, before undertaking action, individuals and agencies must be mindful of the sheer complexity involved in making fundamental changes, as well as the demands.

Healthy Communities and Healthy Self Perceptions

Level 7 emphasizes the importance of community wide responses in responding to risk factors that impact children and families. Encouraging members of a community to work together in addressing a common concern or root cause can have important implications for building self confidence and responding to challenges in a way that individuals did not ever think was possible. Once one small hurdle is overcome, then other challenges no longer seem so daunting. Working to create health environments within a family, school, or peer group can build healthy self-perceptions that are the beginnings of effective change.

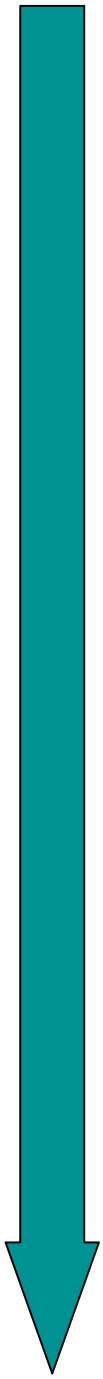
Resiliency and Assets

An important shift in thinking about prevention is illustrated in levels 8 and 9, where the focus moves more emphatically from the negative (risks) to the positive (resiliency, assets or strengths). Resiliency has been defined as the capacity of individuals, families or communities to cope successfully in the face of significant adversity (Mangham, 2001). Asset building likewise adopts a positive approach by starting with what individuals, families or communities already have (their assets) and working to strengthen those protective factors that can make a difference in responding to crises or risks. The protective factors in both resiliency and asset building considered most important are optimism, self confidence, problem-solving skills, mentoring by adults outside of the family, autonomy, and caring and support from siblings and other caregivers.

Factors that contribute to family resiliency are strong family traditions and the transmission of values; relative stability; cohesiveness; shared responsibilities; and clear, reasonable rules and expectations. Within communities, the contributing factors include clear and positive social norms, clear and fair rules, inter-generational communication and involvement, competent adult role models, and strong external support systems for individuals and families.

In his research into resiliency, Mangham (2001) suggests that of all these attributes the most important are opportunity, ties and support, which he describes as “opportunities to experience success, ties that mean belonging and acceptance and emotional and social support from family members of other significant people in the community.” These reinforce Pransky’s work on the basis of prevention as healthy self perception: the capability of appreciating self-worth and competence, feeling that one is an important contributing part of something greater than oneself, and believing that one has some power and control over what happens in one’s life (Pransky, 2001).

Table 1 – Levels of Prevention

Levels	Program Approach	Program activity
	1. Recognizes a problem exists but provides generalized solutions	Provide information pamphlet
	2. Provides services only after the problem has materialized and become quite serious	Group counselling session for drug addicts
	3. Acknowledges the importance of intervening at the earliest possible time to stop the problem from escalating	Workshop on school bullying
	4. Proposes a strategy to reduce the incidence of a problem without any evidence of its effectiveness	Developing a youth centre
	5. Identifies risk factors in the environment and works to reduce their impact	Matching child with mentor
	6. Determines the root causes behind the risks and proposes to change the related social conditions	Employment training for people with barriers
	7. Applies broad community interventions rather than focusing on a group of individuals	Community-run collective kitchen
	8. Focuses on building strengths and assets	Program to strengthen parent-family connected-ness
	9. Appreciates that resiliency and healthy self-perception are fundamental to achieving the changes required	Leadership and decision-making training
	10. Recognizes that positive well-being is achieved through an innate sense of self-efficacy and optimism	School program based on concepts of learned optimism

A related theme, pursued in a recent study concerning prevention and youth, suggests that while preventing problems from occurring is admirable it is limiting, if by doing so, people are defined on the basis of their problems and not their potentials (Pittman and Irby, 2001). According to these researchers, being "problem free" is insufficient without a commitment to effective growth and development for all young people. Being "fully prepared" is also inadequate, if there are limited opportunities for real engagement for young people in their own development, in the operation of organizations, or in the activities and decision-making within their communities.

Prevention from 'Inside-out'

Level 10 is still emerging as a possible contribution to an understanding of prevention. John McKnight's work (1997) promotes an "inside-out", preventive, community development approach that begins by connecting people to their own internal resources and to those available within the community. Pransky (2003) proposes a further "inside-out" approach to prevention, suggesting that if a person's thinking does not change, their feelings and behaviour will remain unchanged. He postulates that there must be an additional mediating influence at work, one that strengthens a person's resiliency and self-perception towards a positive outcome. What is that influence? He identifies it as thought, consciousness and the innate sense of self-efficacy and optimism that is inherent in all people. To Pransky, people are not simply subjected to the ravages of their environment. Instead as thinkers they shape their experiences of it and what they can become in the future.

Available to Grades 3-5 students in Arizona, *Positive Paths to Personal Power*, is an example of a program based on the concept of learned optimism. The program fosters resiliency by teaching students how to be optimistic and hopeful. It encourages social competence and autonomy and directly addresses problem-solving skills. The end results have been a decrease in depression, suicidal behaviour, hopelessness, substance abuse and behavior problems (www: empact-spc.com/training.html).

The prevailing "outside-in" model of prevention suggests that within an environment filled with risks, efforts can be made to reduce their impact by building resiliency with people, so as to encourage healthy self-perceptions and give them the internal health and strengths they need. Pransky (2003) suggests that the "inside-out" approach reverses the direction. Unveiling the innate health and inner strength automatically creates healthy self-perceptions, which in turn provides the resilience required to maintain healthy relationships. He does not, however, suggest forgoing prevention from the outside-in, but that appreciating the source of change will bring an important dimension to understanding the meaning of prevention.

Evidence of Effectiveness

Over the past decade, there has been growing interest in finding clear evidence of the effectiveness of prevention. As well as meeting the increasing demands of funders for accountability and reliable outcome measures, findings based on sound research could reveal ways of strengthening prevention programs. Knowing the characteristics of effective prevention programs may offer funders a template by which to more accurately assess the likelihood of programs achieving the changes proposed.

In the early 1980s, the American Psychological Association established a taskforce to investigate research based prevention programs. Three hundred such programs were examined in detail, but only 14 were identified as offering evidence of effectiveness. Fortunately the amount of prevention research conducted since the taskforce reported has grown considerably. As well, the definition of prevention has expanded from an earlier focus on preventing problems to a broader commitment of strengthening competencies, connections and contributions. A new taskforce recently established by the APA was asked to systematically review prevention research from the past decade. The taskforce examined 35 journal articles, books or book chapters that reviewed the efficacy of prevention programs in four content areas: substance abuse, risky sexual behaviours, school failure, juvenile delinquency and violence. A total of 252 characteristics were initially identified and then coded independently by the researchers. There was agreement that just nine characteristics were generalizable. These were (Nation et al, 2003):

Comprehensive
The program needs to be comprehensive, involving multiple approaches in a number of different settings, such as with peers, within schools, within the family and within the community.

Varied learning approaches
Effective prevention programs involve interactive learning opportunities that provide information as well as hands-on experience and useful skills.

Program intensity
The programs provide sufficient interventions to bring about the desired effects as well as opportunities for 'booster' follow-ups.

Theoretical underpinnings
The program has a sound theoretical justification, it is based on accurate information and it is supported by research findings.

Positive relationships
The program provides opportunities for the development of strong, positive relationships with adults, including parents or with peers.

Appropriately timed
The interventions of the program are initiated early enough to maximize their impact and as well they are sensitive to the developmental needs of the participants.

Socioculturally relevant
The program is effectively tailored to the needs and the cultural norms of the participants and where it is possible the participants are included in the design and implementation of the program

Well-trained staff
Staff delivering the program is competent, sensitive, well trained, supported and supervised.

Outcome evaluations
The program has clear goals and objectives and makes a sound effort to systematically document its results.

A further review of programs for younger children and their families conducted by The Birth to Five Project identified rather similar characteristics for effective preventive programs. This list also highlighted the importance of providing services of sufficient intensity and comprehensiveness to be effective. It included the need for flexibility and individualized programming that would best meet the learning styles of children and family members. Another similar characteristic was the importance of enhancing supportive relationships while building on the strengths of families and supporting them as the primary nurturers and educators. The list included culturally responsive, community-based and accessible as three further characteristics of effective preventive programs (www.ounceofprevention.org).

In his book, *Prevention: The Critical Need*, Pransky (2001) cautions that even if it is possible to identify the characteristics of effective programs, it is often difficult to replicate success in a different setting or another community. Nevertheless, he does list a number of characteristics. To be effective, programs must use multiple strategies at many different levels affecting a number of systems, such as families, schools, peers, work and community. The prevention efforts should affect all people at all developmental levels and across the life span. The earlier a sound prevention foundation can be established the better. Prevention programs must be of sufficient quality and quantity to be effective, because there is a clear cumulative effect and one-shot programs are rarely useful. Prevention programs should always be guided by sound research and evaluation. The program content must be culturally sensitive and relevant, address different modes and styles of learning and be developmentally appropriate. Effective prevention programs should, as much as possible, emerge from a community development process that enables those in the community to come together to develop the necessary plans and carry them out. Finally, the most important ingredient for success for all prevention programs is the opportunity to build healthy self-perceptions.

Table 2 – Assessing Effectiveness in Prevention

Characteristic	Examples of Questions about the Program	Evidence	Red Flag
Comprehensive and Intense	• Does it offer multiple interventions (information, workshop, etc.)? • Does it address multiple prevention settings (school, home, community)? • Is it long enough to reflect depth of issue (number/ frequency of contacts, length of session, scheduling)? • Are there follow-up or booster sessions?	Description of program and components Surveys/reports from participants	Program is not linked in any consistent way to other activities or initiatives The program is of short duration
Varied Learning Approaches	• Are active and interactive opportunities provided? • Is there a focus on skill development? • Are different learning styles accommodated? • Are the materials/approaches suited to the needs of the audience in terms of age, ability, maturity or depth of issue?	Description of program and components Description of target audience Rationale for approach Training materials	There is just one learning approach used
Theoretical Underpinning	• Is it based on sound research and accurate information?	Rationale for approach Citation of research/best practice	No awareness of related research findings or best practices
Positive Relationships	• Are there opportunities to develop strong, positive relationships, e.g., with mentors, peers, parents and family members?	Description of program processes	Relationship development is not a feature of program
Appropriately Timed	• Do the interventions take place when they are expected to have maximum impact? • Do they coincide with the developmental stage of participants?	Rationale for approach Training materials	No appreciation of developmental phases
Socially and Culturally Relevant	• Is the language and approach culturally appropriate? • Does the program address individual needs? • Is it accessible to the target audience? • Is the target audience involved in the program design?	References to cultural sensitivity Make-up of board, staff Description of site, location, timing Surveys/reports from participants	No recent survey of participant observations and comments on the program No commitment to cultural sensitivity
Well-trained Staff	• Are staff competent, sensitive and trained to program requirements? • Are support and supervisory mechanisms in place?	References to staff qualifications and training Description of program	Staff development opportunities not available
Evaluation	• Is there a clear link between goals/objectives and activities? • Is there a follow-up with participants? • Does the data collected by the agency demonstrate effectiveness?	Description of goals, objectives Rationale for approach References to evaluation and quality assurance	Program has never been evaluated

Applying Research to Practice

How can CSAB benefit from this research? One way is to incorporate it into the funding allocation process, for example by asking agencies to provide information on prevention programs and activities. Currently, to assess funding eligibility, CSAB requires agencies to submit information relating to the organization's financial stability, history and longevity, management, operations and so on. The application form could be revised to focus on prevention. A new list of questions could be added, to serve as a kind of "prevention lens" through which CSAB could examine the agency's rationale, plans and objectives for a prevention program.

Building on the prevention lens concept, Table 2, Assessing Effectiveness In Prevention, takes eight of the characteristics most frequently mentioned in the research cited earlier and presents them as a template. It shows potential questions to be asked of agencies, evidence that could be gathered to support the answers, and possible "red flags" – all of which would assist CSAB in making funding allocation decisions.

Here is how the process could work. Agencies complete the application form and provide the required information about their programs. Working in pairs or small groups, CSAB members review the forms to determine whether sufficient information has been provided to answer the questions. If not, they draw up a more specific list of questions and request the agency to provide the answers in writing or an interview.

Ideally, an application rating system and independent peer review process would be developed. This would allow CSAB members to work in pairs, assess an application and then compare the assessment with another pair and rationalize any differences. Eventually, it may be possible to computerize the rating process.

Benefits to Agencies

It would be necessary to involve agencies, and possibly other funders, in drawing up the list of questions and designing the new application form. Developing the criteria collaboratively this way would keep it "grounded" and ensure that all needs were met. Tying the questions to prevention would ensure they were meaningful, purposeful and focused. There are additional benefits to this process. With multiple input, there is more likely to be consistency and a fit between the questions, and a lower likelihood of duplication. The application form will be practical and easy to use if it incorporates the needs of both CSAB and agencies. Agencies will see the process as transparent. Finally, working together this way will also help to identify any issues or needs for additional information.

Need for Technical Support

Since the concepts and approaches proposed in this paper are new, agencies cannot be expected to know how to implement them. In addition, they may need to find stronger or more recent evidence to support existing programs. They may find that, given the newness of the approach and the complexity of prevention, traditional ways of defining outcomes or evaluation measures do not apply. Consequently, agencies are expected to need technical support – for example, in the form of guidance to develop programs or expertise to determine the validity of research or design an evaluation framework. Or they may simply need more information.

Research into prevention outcomes and evaluation is ongoing. However, stakeholders need a local forum to explore ideas and discuss emerging best practices. They need somewhere to go for help and information. An effective way to meet these needs is through a centre for research into prevention. The Community University Partnership for the Study of Children and Families receives funding for research and evaluation. It may be interested in adding the domain of prevention, providing funding becomes available. Historically, funders have not contributed to research or innovations in prevention as proposed in this paper. However, they did respond when collaboration became popular. As a result, local agencies have built a considerable knowledge base on collaboration as well as having honed their experience. A similar view will be required of funders if prevention programs are to be effective in strengthening the social well-being of Edmonton's children and families.

Conclusions

The concept of prevention is a complicated one, particularly where it applies to social issues; however, increasingly, the medical model does not appear to meet the needs of social programs, and researchers and policy developers are looking for alternatives. While prevention in the FCSS context can refer to the attempt to stop something from happening or escalating, thereby being aligned with the medical model, what is needed in addition is to incorporate the value of taking positive, constructive action – on an individual, family or community level. Language consistent with the philosophy of community development can contribute to a new understanding of prevention by adding concepts related to asset building, strengthening interpersonal relationships, and increasing optimism, self-confidence and self-worth. Indeed, prevention is more likely to be successful where programs acknowledge the need to meaningfully engage participants in a timely manner and respond to the individual's emerging awareness of optimism and the fact that he or she has the capability to bring about change.

Questions for Discussion

1. What should our definition of prevention be, given the nature of our funding?

2. How will the characteristics provided in Table 2 lend themselves to making good decisions on funding allocations?

3. How could we promote a centre of excellence in prevention and who might be willing to get involved to take the debate province-wide?

4. What is the next level of discussion and who should be invited to the table?

Bibliography

Bella, L. (1978). *The Origins of Alberta's Preventive Social Services Program.* A unpublished paper prepared with funding from Health Canada.

Kretzmann, J. & McKnight, J. L. (1997). *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing A Community's Assets*. Evanston, Illinois: Center for Urban Affairs and Policy Research at Northwestern University.

Lofquist, W. (1983). *Discovering the Meaning of Prevention: A Positive Approach to Positive Change.* Tucson, AZ AYD Publications.

Mangham, C. (2001). *Best Practices in Prevention, Promotion and Early Support for Children and Families*. BC Ministry for Children and Families.

Mangham, C. (2003). Inside the Black Box of Health Promotion: What Do We Know? Presentation to Prevention of Problem Gambling Conference. Lethbridge, AB.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K., Seybolt, D., Morrissey-Kane, E., and Davino, K. (2003). What Works in Prevention: Principles of Effective Prevention Programs. *American Psychologist*, 58 (6-7), 449-456.

Pransky, J. (2001). *Prevention: The Critical Need*. First Books.

Pransky, J. (2003). *Prevention from the Inside-Out*. First Books.

Pittman, K. & Irby, M. (2001). Preventing Problems, Promoting Development, Encouraging Engagement: Competing Priorities or Inseparable Goals? A working draft prepared for The Forum for Youth Investment. Tacoma Park, Maryland.