Moving Toward Effective Community Prevention Practices:
Opportunities for Social Work Education

J. David Hawkins Ph.D.
Social Development Research Group
University of Washington
9725 3rd Ave. NE, Suite 401,
Seattle, WA 98115

Valerie B. Shapiro M.S.W.
Social Development Research Group
University of Washington
9725 3rd Ave. NE, Suite 401,
Seattle, WA 98115

Abigail A. Fagan
Department of Criminology and Criminal Justice,
University of South Carolina
Columbia, South Carolina 29208

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Abstract

In the United States about 17% of youth between the ages of 12 and 17 meet diagnostic criteria for mental, emotional, and behavioral disorders. Six million young people receive treatment services annually for mental, emotional, or behavioral problems. These problems affect one in five families in the United States and cost $247 million annually (O’Connell, Boat, & Warner, 2009). Effective strategies for preventing mental, emotional, and behavioral disorders in young people are needed. In recent years, prevention scientists have developed and tested policies, programs, and practices that have been found to be effective in preventing the onset, persistence, and severity of psychological disorder, drug abuse, and delinquency in children and youth. Unfortunately, tested and effective prevention policies, programs, and practices are not widely used (O’Connell, et al., 2009).

Finding ways to translate effective prevention policies, programs, and practices into widespread application is a current challenge facing prevention scientists. This paper highlights recent advances in prevention science and describes the opportunities and challenges in seeking to develop systems for advancing the use of science based prevention in communities. The chapter concludes with a discussion of the potential role of social work education in advancing the dissemination of science based prevention approaches and developing a workforce ready to advance science based prevention in communities.

Advances in The Science of Prevention and the Need for Infrastructure to Support Prevention
Much progress has been made over the past thirty years in the development and testing of prevention policies, programs, and practices. Effective policies, programs, and practices for preventing mental, emotional, and behavioral problems of young people have been identified through controlled studies using rigorous designs (O’Connell et al., 2009). A variety of effective prevention programs has been found to produce benefits to individuals and society that far exceed costs (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004). Lists of these programs are available on the internet (www.colorado.edu/cspv/blueprints/; ncadi.samhsa.gov/features/ctc/resources.aspx).

Yet in the allocation of resources, when the pain of manifest problems is so evident, effective prevention strategies are often overlooked in favor of strategies to cope with the “downstream consequences” of disorder (Woolf, 2006). Systems for treating mental, emotional, and behavioral disorders are sustained through an infrastructure that provides funding, access, and workforce training. The translation of effective preventive approaches to widespread practice now requires the development of a sufficient infrastructure for prevention (O’Connell et al, 2009; Woolf, 2006; Cullen & Jonson, 2009.)

Balas and Boren, (2000) speculated on reasons that advances made through research might fail to be successfully institutionalized in widespread practice. They suggested that (a) scientific research is often intentionally isolated from the complicated realities of individuals, service providers, and communities to maintain the integrity of the scientific process, (b) scientific theories tested with mainstream populations may fail when generalized to understudied populations and settings, (c) tested and effective practices may be difficult for potential users to access, (d) tested policies, programs or
practices may be too poorly articulated, cumbersome, or costly for widespread replication with fidelity, (e) attention is not given to the needs, values, and priorities of the individuals and communities that might use the new programs or practices, and (f) lack of attention to understanding mechanisms for sustainable systems change and community infrastructure development needed to support effective policies, programs and practices.

Some of the problems identified by Balas and Boren have been addressed by prevention scientists. Prevention scientists have developed standards for efficacy, effectiveness, and dissemination research trials (Society for Prevention Research, 2004). The standards for effectiveness and dissemination trials of the Society for Prevention Research require that everyday practitioners implement the policy, program, or practice being tested in real world settings. Those who conduct effectiveness and dissemination trials following these standards cannot work in isolation from the individuals and organizations that must implement the program in wider applications. Policies, programs and practices subjected to effectiveness and dissemination trials that meet the standards of the Society for Prevention Research should be useable in real world settings. Further, as noted above, there are now available lists of tested and effective prevention policies and programs, and these lists often define the populations with which they have been tested. Thus, it is possible to determine the sociodemographic characteristics of those groups with which a specific program has been tested as well as those groups for which the preventive intervention has not yet been tested. The best of these lists also require manualized instructions for implementers in order to include a program on the list. For example, the Center for the Study and Prevention of Violence at the University of
Colorado that publishes the Blueprints for Violence Prevention list, develops a guide for implementing each of the preventive interventions listed as model programs on that list. This development addresses the concern that tested programs may be too poorly articulated or cumbersome for widespread replication with fidelity.

Nevertheless, a challenge to widespread adoption of tested and effective preventive interventions remains. Community infrastructures are needed that can support the installation of tested and effective prevention policies, programs and practices while attending to the needs, values, and priorities of the individuals and communities that could use these new preventive interventions.

Why is a new infrastructure needed for installing tested and effective preventive interventions in communities? This is due in part to the nature of prevention work as distinct from the treatment of already identified disorders or problems. True prevention, as distinct from treatment, seeks to keep mental, emotional, or behavioral problems from happening in the first place. Universal preventive interventions seek to prevent the emergence of mental, emotional, and behavioral problems in the whole population. Selective preventive interventions seek to prevent the emergence of mental, emotional, and behavioral problems in individuals or groups at high risk for later disorders or problems who have not yet experienced a mental health or drug problem or committed a crime, but who are at risk because of exposure to high levels of specific or multiple risk factors. Indicated preventive interventions target those who have shown early signs or symptoms of emotional or behavior problems likely to become mental health disorders or criminal behavior with development: for example extreme shyness, attention deficits, oppositional behavior, defiant behavior, or aggressive behavior. Indicated prevention
does not include responses to those who have already manifested or been diagnosed with a mental or substance use disorder or who have committed or been apprehended for criminal offenses. Interventions initiated in response to mental disorders, drug abuse or dependence, or delinquent or criminal behavior, including treatment, punishment, and incapacitation, often seek to prevent future mental or substance use disorders or crimes by those who already have manifested mental or drug use disorders or are already delinquents or criminals. However, these interventions are not truly preventive, as discussed here, because they require identification and treatment of those who have already manifested mental health problems or have already committed crimes (Mrazek & Haggerty, 1994: O’Connell et al., 2009).

Prevention science is based on the premise that to prevent mental health problems, substance abuse disorders or crime, before these problems are manifested, it is necessary to identify and reduce factors that predict these future problems, called risk factors, and to identify and strengthen factors that predict the future absence of these problems (Coie et al., 2003). These latter factors are sometimes called promotive factors because they promote mental, emotional, and behavioral health or protective factors because they inhibit mental health problems, substance use disorders and criminal behavior even in the presence of risk or risk exposure. Longitudinal studies in the United Kingdom, New Zealand, and the U.S. have identified malleable predictors—risk factors, protective factors, and promotive factors—of a wide range of youth mental, emotional and behavior problems. These studies have found that factors in neighborhoods and communities, families, schools, and peer groups, as well as characteristics of individuals themselves, increase the probability of these problems. They have also revealed that
many of the same factors predict depression, substance abuse, teenage pregnancy, dropping out of school, and other behavior problems in adolescence and young adulthood (O’Connell et al.; Howell, 2009). These studies also have identified protective and promotive factors that inhibit the development of mental health disorders, criminal behavior, the misuse of drugs, and other risky behaviors of young people (Catalano, Kosterman, Hawkins, Newcomb, & Abbott, 1996; Catalano et al., 2005; Huang, Kosterman, Catalano, Hawkins, & Abbott, 2001; Lonczak et al., 2001; O’Connell, et al., 2009).

To summarize, effective prevention requires altering empirically identified risk, promotive, and protective factors that predict future mental, emotional, and behavioral problems or their absence, rather than treating mental, emotional, or behavioral problems after they have emerged. Because many risk factors are common predictors of diverse problems of young people, systems for addressing these shared risk factors community wide, across settings where they may appear, are needed for effective population level prevention. The salient risk factors that need to be addressed to prevent problems before they arise are often not under the province of the agencies that treat mental, emotional, and behavioral disorders. For example, a low commitment to education and academic failure are both risk factors for later delinquency and drug abuse, but juvenile courts and drug treatment agencies often have little influence on the methods of classroom management and instruction used in the schools in the communities they serve. Yet methods of classroom management and instruction can, in fact, prevent future drug use and delinquent behavior (Wilson, Gottfredson, & Najaka, 2001). Schools must be involved in prevention efforts if the risk factors of low commitment to education and
academic failure are to be addressed. This is just one example. New prevention infrastructures are needed to ensure that all the relevant stakeholders who represent the entire range of institutions and organizations that affect the risk, promotive and protective factors that may need to be addressed to prevent mental, emotional, and behavioral problems of young people are involved in planning preventive interventions.

Localized infrastructures for prevention are likely to be needed to promote effective prevention in each community because risk, promotive, and protective factors vary in intensity and prevalence in different communities. Not only do overall levels of risk exposure vary by community (Hawkins, Van Horn, & Arthur, 2004; Van Horn, Hawkins, Arthur, & Catalano, 2007), but the specific risk factors that are elevated and the specific promotive and protective factors that are weak are different in different communities (Fagan, Hawkins, & Catalano, 2008). Community wide efforts to prevent mental, emotional, and behavioral problems before they arise need to address those specific risk factors that are elevated and those specific promotive and protective factors that are low in each community. This means that each community needs its own structure for planning, promoting and implementing prevention community wide. Further, the resources available for prevention, the values and priorities of community members and the perceived fit and acceptability of various preventive interventions are likely to differ across communities. Local prevention infrastructures are needed that empower community stakeholders to choose those tested and effective preventive interventions that match community needs while taking into account local community resources, values and priorities. In short, community prevention infrastructures are needed that foster local
ownership and self-determination while still using the advances of prevention science (Hawkins, Catalano & Arthur, 2002).

Community Coalitions as Prevention Infrastructures

Coalitions of diverse stakeholders representing a variety of agencies and organizations concerned with the healthy development of young people have been advocated as infrastructures for advancing prevention in communities. Coalitions have been a popular mechanism for community-wide change in substance use prevention and other areas (Roussos & Fawcett, 2000). A community-driven, community-wide effort to reduce health risking behaviors, coordinated across health, education, and human service sectors, should significantly reduce health risking behaviors community wide (Woolf, 2008).

However, a number of prior efforts to activate coalitions of community stakeholders to prevent problems have been unsuccessful. Several well intentioned community-based coalition efforts have failed to make any significant difference in the lives of young people. Scientific evaluations of coalitions focused on preventing problems ranging from drug abuse to teen pregnancy have found no positive effects (Yin, Kaftarian, Yu, & Jansen, 1997; Roussos & Fawcett, 2000; Hallfors, Cho, Livert, & Kadushin, 2002; Wandersman & Florin, 2003; Flewelling et al., 2005; Zakocs & Edwards, 2006; Collins, Johnson, & Becker, 2007). Even well-funded initiatives such as the Robert Wood Johnson Foundation’s Fighting Back project and the federal government’s Center for Substance Abuse Prevention’s State Incentive Grants (SIG) have failed to produce significant effects on young people’s health or behaviors (Hallfors et al. 2002; Collins et al., 2007).
Evaluations of these failed coalition initiatives have concluded that to produce a significant impact on intended outcomes, coalitions should follow some basic guidelines (Hallfors et al. 2002; Flewelling et al., 2005; Collins et al., 2007; Feinberg, Greenberg, Osgood, Sartorius, & Bontempo, 2007; David-Ferdon & Hammond, 2008):

• Set clearly defined, focused, and manageable goals;
• Ensure that efforts allow for adequate planning time;
• Base prevention decisions on empirical data about what needs to change in the community and on evidence from scientifically valid studies of what has worked to address those needs
• Implement prevention policies, practices, and programs that have been tested and shown to be effective;
• Carefully monitor prevention activities to ensure implementation quality

A dual focus on both community mobilization and the use of scientific evidence is essential for the success of community-based prevention. When community stakeholders from diverse organizations and backgrounds come together to achieve clear and common goals, using scientific advances regarding what works to prevent problem behaviors, and monitor their activities for quality assurance, positive outcomes can be achieved. By pooling information and resources and selecting tested and effective policies and programs that address local needs, community coalitions can ensure the adoption of tested and effective prevention activities, enhance community buy-in for these initiatives, and increase the likelihood of their sustainability.
There is now clear evidence that coalition-based efforts that meet these conditions can increase the likelihood of positive and widespread benefits for community youth. Recent evaluations of two community based coalition-driven models have demonstrated effectiveness in reducing children’s involvement in problem behaviors. Although their specific implementation processes differ, both the PROmoting School-community-university Partnerships to Enhance Resilience (PROSPER) project (Spoth, Greenberg, Bierman, & Redmond, 2004) and the Communities That Care (CTC) operating system (Hawkins & Catalano, 1992; Hawkins, et al., 2002) rely on broad-based coalitions of community stakeholders who work together to carefully implement and monitor prevention strategies that have scientific evidence of effectiveness. The PROSPER model is initiated by local university Cooperative Extension Service agents, who partner with school district personnel to advocate for the use of tested and effective family- and school-based programs. Prevention activities are overseen by a coalition of stakeholders that typically includes representatives from substance use and mental health agencies, parents, youth, and other local leaders (Spoth et al., 2004).

In the Communities That Care system (Hawkins & Catalano, 1992), the community coalition is comprised of key leaders and stakeholders from all sectors of the community, including schools, law enforcement, health and human service agencies, youth serving agencies, local government, business, religious groups, youth, and parents. The coalition identifies local prevention needs by reviewing existing archival data about the community from schools, law enforcement agencies, the census and other sources, and by conducting a school-based survey of the community’s youth and a comprehensive review of on-going community prevention services. The coalition then selects prevention...
activities from a menu of tested and effective preventive interventions to fill gaps in prevention services, implements and tracks these activities and their outcomes, and makes implementation changes as needed to ensure results.

PROSPER and the CTC system have both been tested in well designed randomized experiments and found to reduce adolescent problem behaviors. The evaluation of the PROSPER model was conducted in 28 communities in Iowa and Pennsylvania in which communities were randomly assigned either to receive PROSPER or not. Information about the effectiveness of the project was collected from 6th and 7th grade students, most of whom participated in a tested and effective school-based prevention curriculum and some of whom attended a tested and effective parent training program with their families. Eighteen months after the study began, fewer students in the 14 communities that used the PROSPER model, compared to students in the 14 control communities who did not use PROSPER, reported having used for the first time one to three gateway drugs (i.e., alcohol, cigarettes, or marijuana) and one to five illicit drugs (methamphetamines, ecstasy, marijuana, drugs prescribed for another person, and Vicodin, Percocet, or Oxycontin). Students in the PROSPER communities also reported less marijuana and inhalant use in the past year compared to students in the control communities (Spoth et al., 2007).

The Communities That Care system has been evaluated in two studies, one conducted by the Prevention Research Center at The Pennsylvania State University (Feinberg et al., 2007) and one conducted by the Social Development Research Group at the University of Washington (Hawkins et al., 2008). The Penn State project involved 120 communities in Pennsylvania that were provided funding to create CTC coalitions
and enact tested and effective prevention programs, and a group of comparison communities in which CTC was not enacted. The evaluation then compared self-reports from students in Grades 6, 8, 10, and 12 in all communities. The results showed that 6th and 12th grade students in CTC communities reported less alcohol use in the past month, 6th graders reported less cigarette use in the past month, and 6th and 8th graders reported fewer delinquent behaviors in the past year (e.g., trying to seriously hurt someone, getting arrested, carrying a gun) versus those in the comparison communities (Feinberg et al., 2007; Feinberg et al., in press).

The second CTC evaluation, the Community Youth Development Study (CYDS), involved a rigorous implementation and evaluation of the CTC system in which 24 communities across seven states were randomly assigned to either implement the CTC system (12 communities) or to serve as control communities (12 communities) in which prevention services were conducted as usual. The CTC sites then received training and technical assistance to implement the CTC model and funding to implement prevention programs that addressed the local community needs identified through the CTC process. The evaluation of this study was based, in part, on self-reported information from students in all 24 communities who were in Grade 5 in the 2003-2004 school year and who were assessed annually through Grade 8 (Brown et al., 2009; Hawkins, et al., 2008).

At the end of Grade 8, four years after the CTC process was begun, students in the CTC communities were significantly less likely to have initiated tobacco use, alcohol use or delinquent behaviors than students living in the control communities (Hawkins et al., 2009). When students who had never used drugs prior to grade 5 in CTC and control communities were compared, the evaluation showed that significantly fewer students in
the CTC communities had begun to use smokeless tobacco, smoke, or drink alcohol by the spring of grade 8. Specifically, students in the CTC communities were 59% less likely to have tried smokeless tobacco, 45% less likely to have initiated tobacco use, and 38% less likely to have initiated alcohol use by spring of 8\textsuperscript{th} grade compared to students in control communities. In addition, significantly fewer students in the CTC communities than in control communities had started delinquent behaviors such as stealing, destroying property, shoplifting, or seriously harming someone. Students from CTC communities were 29% less likely than those in control communities to initiate delinquent behavior between Grade 5 and Grade 8.

The occurrence of recent alcohol use among 8\textsuperscript{th} grade students was also reduced in CTC communities. In the CTC communities, 16.4% of students reported alcohol use in the past month compared to 21.4% of children in control communities and 5.7% reported binge drinking (i.e., having 5 or more drinks in one sitting) in the past two weeks, compared to 9%, of students in control communities. Smokeless tobacco use was significantly reduced in CTC communities, as 2.3% of CTC students reported past month use compared to 4.3% of students in control communities. In addition, 8\textsuperscript{th} grade students in CTC communities reported significantly fewer delinquent behaviors in the past year than did 8\textsuperscript{th} grade students in control communities.

Both PROSPER and the CTC system have produced significant, community wide reductions in health risking behaviors among young people while many other coalitions initiatives have not. Nevertheless, it can be challenging to faithfully implement these coalition-based approaches, because they involve multiple components enacted over several years by groups of diverse individuals (Wandersman & Florin, 2003). Given the
positive outcomes found when evaluating these coalition-driven systems, it is important to understand what is required to implement them.

If coalition based prevention systems like PROSPER and Communities That Care are to be effective in promoting the public health nationwide, they will have to be widely implemented in communities across the country. Both these prevention systems require a community coordinator in each participating community to facilitate the work of the prevention coalition. The skills of these coalition coordinators will be important determinants of the success of efforts to replicate these systems nationwide (Allen, 2005; Kelger, Norton, & Aronson, 2007; Watson-Thompson, Fawcett, & Schulz, 2008; Riggs, Morgan, & Pentz, 2008). What skills are needed? In our work with communities implementing Communities That Care, we have identified the following skills and capacities that community coordinators should have.

- An understanding of the basic premises and the advances of prevention science.
- Community mobilizing skills for activating and organizing coalitions of diverse community stakeholders.
- Ability to collect, analyze, interpret and present epidemiologic data on levels of youth mental, emotional, and behavioral problems in the community and on levels of empirically identified risk and protective factors in the community.
- Knowledge of the risk factors shown in longitudinal studies to predict youth mental, emotional, and behavioral problems and the promotive and protective factors that predict prosocial behaviors.
• Ability to manage and conduct surveys of young people and stakeholders in communities.

• Group process facilitation skills needed to build stakeholder consensus around priorities and actions.

• Ability to read, comprehend, and critique research reports on the effects of preventive interventions.

• Knowledge of universal, selective, and indicated prevention policies, programs and practices shown to be effective in preventing mental, emotional, and behavioral problems of young people in well controlled studies.

• Ability to link preventive interventions and the risk and protective factors they address.

• Knowledge of the various systems, agencies and organizations that affect youths that could be activated for prevention programming.

• Skills to facilitate implementation and integration of prevention strategies into existing systems, agencies and organizations.

• Ability to manage systems for monitoring fidelity of implementation of new policies, programs, and practices chosen by the community coalition.

• Process and outcome evaluation skills.

• Ability to communicate the economic benefits of tested and effective preventive interventions shown to have benefits to individuals and society that exceed their costs.
• Ability to identify and secure resources to support and sustain coalition and prevention work.

This is an extensive, though probably not exhaustive, list of skills and capacities needed to successfully coordinate the work of community prevention coalitions. It is difficult to find workers who have them all. The 2009 IOM report identified workforce development as one of three infrastructure challenges to the effective widespread dissemination and implementation of the advances of prevention science (O’Connell, et al., 2009). The Annapolis Coalition on Behavioral Health Workforce Education (Hoge & Morris, 2003) complained that “the public health perspective on the value of prevention, early identification and early intervention (is) honored in training programs more in word than deed.” (p.2) The Annapolis Coalition recommended that clinical training programs be expanded to include specific competencies in prevention (Hoge, Huey, & O’Connell, 2004). There is a need for rigorous training programs for prevention practitioners.

Social Work’s Advantageous Position for Providing Prevention Training

Social work has a long history of leadership in prevention work (Siefert, 1983). Social work originally emerged as a distinct profession through primary prevention efforts in the settlement house movement (Van Pelt, 2009). The Sheppard-Towner Act of 1921 established governmental responsibility for the health of children, and was passed based in large part on an advocacy campaign led by social workers. This legislation established national and local infrastructures to carry out data collection activities and to mount preventive interventions. Yet in 1981, Bloom decried the lack of emphasis on prevention training in social work education programs. Subsequently, the Council on
Social Work Education was awarded a three year NIMH grant to “promote the development of curriculum and teaching materials on primary prevention in mental health. The ultimate object of the project was to increase the supply of manpower equipped to plan and deliver preventive mental health services.” (Nobel, 1981, p. v). Unfortunately, reimbursement structures for services, the lure of private practice, and emphasis on “casework” in the 1980’s inhibited the widespread inclusion of curricula focused on prevention in social work training programs at that time (Roskin, 1980). Advances of prevention science in the last two decades have created a demand for new practice roles in prevention that require multiple skills. The Council for Social Work Education has responded to this need for a trained prevention workforce by making the “Advanced Social Work Practice in the Prevention of Substance Use Disorders” (2009) the first concentration area for which it has developed advanced practice training competencies to layer upon the Educational Policy and Accreditation Standards of 2008.

Social work is a natural home for prevention training. Social work has a tradition of preparing students to consider structural and environmental predictors of health and problems as potential targets for preventive solutions (Roskin, 1980). Social workers use an ecological model to consider multiple contextual factors in assessment, intervention, and evaluation, as well as the role of power and resources in understanding policy, institutions, and interpersonal dynamics (Russell, Champika, Wagoner, & Dawson, 2008). Social work training already provides significant content in policy development and agency administration (Moore, Davis, & Mellon, 1985). Social workers are exposed to the great variety of service systems and agencies that are included in prevention coalitions. At any given time, 58% of social work students are in field placements
learning applied skills. Social workers provide services with immediate practical utility (Moore et al., 1985). Furthermore, the behavior change, solution-focused, and strength-based methods that social work trains students to use in their casework and community organizing activities are appropriate in the work of prevention (Roskin, 1980). Social work is poised to respond to the 2009 IOM report’s call for the social work profession to develop a workforce to advance the prevention of mental, emotional, and behavior disorders (O’Connell, et al., 2009). However, this will require a change in social work training programs.

Opportunities for Development of the Prevention Workforce

We see three strategic opportunities through which social work schools and departments can contribute to the advancement of evidence based prevention policies, programs and practices at scale. These are through undergraduate liberal arts education, pre-service training in social work at the bachelors, masters, and doctoral levels, and continuing education training for social workers already in practice.

Liberal Arts Education - The federal Substance Abuse and Mental Health Services Administration (SAMHSA) broadly defined their workforce to include professionals, paraprofessionals, and community members and families who work to promote resilience and recovery (Hoge, et al., 2007). Given the importance of consumer advocacy in system transformation, and the expanding role of paraprofessionals in service delivery (Brennen 1967; Clark, Power, LeFauve, & Lopez, 2008; Lincourt, 2005), it is important to empower students earning associate and bachelor degrees with knowledge of the advances of prevention science and skills needed to become informed consumers of prevention services, committed front-line paraprofessionals, engaged
community members, citizen advocates, and contributors to the advancement of prevention through their chosen professions.

Teaching undergraduates to use scientific principles to inform opinions and decisions (Gambrill, 2006) helping them to develop content knowledge and critical thinking skills (Nickerson, 1986) in regard to the effective prevention of social problems, and developing an ideal of social justice fostered through the universal promotion of well-being (Kenny, Horne, Orpinas, & Reese, 2008) should increase public support and advocacy for prevention, encourage enrollment and retention in preventive interventions, and facilitate recruitment into the social work profession (Wittman, 1965). Social work faculty should reach across disciplines and institutional boundaries to teach non-social work undergraduate students. In a course we offer at the University of Washington, titled “Advances in Prevention Science: Bridging the Gap from Science to Service”, undergraduate students from diverse schools, departments and disciplines learn, often for the first time, that many significant social problems can, in fact, be prevented before these problems occur. The students learn to ask “what is the scientific evidence that this policy, program or practice works” in formulating an opinion as to how to ameliorate social problems. They learn how to evaluate evidence to determine an answer to that question. To do this, undergraduate students need to be able to read scientific reports. They also need to understand their power as engaged citizens and allied professionals to shape debate and advocate for the implementation of tested and effective prevention strategies in their communities.

Pre-service Training - Pre-service training provides an opportunity for future social workers to learn the skills needed for effective prevention practice. Prevention can
be incorporated into social work education through integration into the core curriculum,  
through elective courses and/or specialty tracks, and through interdisciplinary  
collaborations.

Core Curriculum – Adding prevention content to required coursework is the most  
direct way to broaden social workers’ perception of their roles (Roskin, 1980) and ensure  
that classroom training is aligned with prevention practice demands (Volland, Berkman,  
Stein, & Vaghy, 1999; Wilkinson, Rounds, & Copeland, 2002). Reframing students’  
expectations of a social worker as one who works to prevent problems in the first place  
(Conyne, Newmeyer, Kenny, Romano, & Matthews, 2008) will encourage students to  
learn skills for community outreach, social marketing, and the design, implementation,  
and evaluation of preventive interventions (Wilkinson et al., 2002). Skills needed for  
prevention work build upon skills developed in other courses, but the utility of these  
skills for prevention often goes unnoted (Conyne et al., 2008).

In introductory social work courses, students should be introduced to the  
historical and intellectual foundations of prevention in social work practice. In these  
courses, students should understand the philosophical orientation that underlies public  
intervention to promote community welfare. The should learn about the history of  
prevention in social work from the community transformation efforts of the Settlement  
Movement and the institutionalization of health promotion practices through the  
Children’s Bureau (Kemp, Almgren, Gilchrist, & Eisinger, 2001) to contemporary  
advances in prevention science and mandates for evidence-based practice These courses  
should introduce students to the array of organizations involved in the provision of social
services in the kindred systems of education, justice, and health to promote appreciation for the cross-sector collaborations necessary in effective prevention work.

In foundation policy classes, learning objectives should include 1) increasing awareness of the history of the role of prevention in social work policy (i.e., the establishment of the Children’s Bureau, Kemp et al., 2001), 2) understanding the potential of welfare policy as an investment in prevention (i.e, Esping-Andersen’s Child Centered Social Investment Strategy that calls for a re-orientation from welfare state “social spending” to “social investment” in order to meet the demands of the 21st century, 2002), 3) developing skills to analyze a policy for use as both a tool and target for social change, and 4) discovering exemplars of effective policies for the prevention of social problems (for example, the effect of policies changing the minimum drinking age from 18 to 21 on the reduction of drinking and driving accidents involving 18 to 21 year olds, Wagenaar & Toomey, 2002).

In the Human Behavior in the Social Environment (HBSE) sequence, students should be introduced to the fact that longitudinal and epidemiologic studies have identified risk, promotive, and protective factors that predict future outcomes in the course of human development (Siefert, Jayaratne, Martin, 1992, Mason & Nakkula, 2008). Content should include individual, interpersonal, and structural/systemic factors (micro, meso and macro level factors) that predict diverse mental, emotional, and behavioral outcomes. The interactions among these factors in the etiology of behaviors across development as well as the degree to which different factors are unique versus common or shared predictors of diverse outcomes from depression to violence should be covered. This sequence should include discussion of the epidemiologic constructs of
incidence and prevalence and attributable risk. Students should develop skills to collect, organize, interpret, and report epidemiologic data on risk, promotive and protective factors and on mental, emotional, and behavioral outcomes as a foundation for data-based planning for preventive intervention in communities.

In research courses, students should learn to assess empirical studies of preventive interventions to determine if design, measures and analyses are adequate to rule out threats to internal validity and to allow conclusions regarding the efficacy or effectiveness of the interventions tested. This means they will need to learn the rationales for and characteristics of true experimental designs as well as quasi-experimental designs including interrupted time series designs, regression discontinuity designs and comparison group designs. They will also need to learn the importance of matching the level of analysis to the level of intervention in multilevel studies, and they will need to learn basic and advanced analysis methods including regression, analysis of variance and covariance, structural equation modeling and growth modeling. They will need to understand and be able to conduct analyses of mediation and moderation in order to test the theoretical or logic models that link risk, promotive and protective factors to outcomes and guide preventive interventions. Students headed for prevention practice should learn skills to monitor the fidelity of preventive interventions in research courses. In teaching research courses to MSW students, we have found that about three fifths of students begin the course with the assumption that research is “extremely useful or relevant” to social work practice, but only about a third anticipate that research will be as useful or relevant to the role they will have when they complete their MSW. MSW
students who find work in prevention will need to be able to assess research reports and use research skills in their prevention practice.

In foundation practice classes, students need to understand the distinction between prevention and treatment and the assumptions and characteristics of universal, selective, and indicated prevention approaches. Students who will work in prevention need to develop the macro practice skills of engaging stakeholders and assessing resources, building consensus for social priorities, using social marketing strategies to conduct effective outreach and education campaigns, and integrating new tested and effective programs and practices into existing service systems. Students who will work in prevention need to develop the micro practice skills of communicating across difference with diverse stakeholder groups, using screening protocols to select individuals for indicated preventive interventions, and appraising strategies for appropriateness with diverse populations in specific contexts. Students should be trained to use data to guide practice decision-making at all levels, from macro level community activation focused on choosing new preventive policies, programs or practices to address identified community needs to micro level preventive intervention with individuals manifesting early symptoms of mental, emotional, or behavioral problems. Advanced practice courses should teach students how to bring diverse coalitions together to assess epidemiologic data on risk, promotive, and protective factors and outcomes, to set explicit goals for change in these predictors and outcomes, and to plan and implement preventive interventions that address community priorities and achieve coalition goals. Students should learn how to secure or promote reallocation of resources to support and sustain prevention work. They will need to understand organizations and how to change them. They will need to understand the
research on the diffusion of innovations (Rogers, 1995) and how to apply it in practice. They will need to learn the basic principles of benefit-cost analysis and to communicate the impact of preventive interventions in economic terms.

Infusion into the core curriculum requires appropriate field education experiences (Zins, 2001; Conyne et al., 2008). Currently, prevention experiential placement opportunities appear most plentiful in school districts and school based clinics or with sovereign tribes. It is noteworthy that at our own university, prevention is not listed as an area of work on the checklists field sites use to communicate placement opportunities to prospective students prior to matching. Until a meaningful number of bachelor and masters level social workers have opportunities to engage in prevention work in their field placements, there will continue to be a paucity of social workers adequately trained in prevention.

Prevention Specialization –Institutions have created free-standing courses and programmatic tracks to prepare students specifically for prevention work. Examples include the University of Michigan where Siefert (1992) teaches “Preventive Intervention in Social Work” conveying the history of prevention in social work, the current knowledge base in prevention, ethical issues in the design and implementation of prevention strategies, and basic epidemiological methods. Courses such as these also are taught at the doctoral level. At the University of Michigan and the University of Washington institutional training grants support the development of prevention researchers through the National Institute of Mental Health Prevention Research Training Program. At the University of North Carolina, prevention coursework was designed for the Maternal and Child Health Leadership Program in order to connect the prevention
agenda with the mission and values of social work (Wilkinson et al., 2002). Other universities have established free-standing multidisciplinary prevention training programs outside schools of social work, such as the program at the University of Wisconsin (jointly affiliated with the schools of education, human development, nursing, and social work), or within Colleges of Education, such as Harvard University, the University of Pennsylvania, and the University of Virginia, which each grant a degree in some variant of Prevention Science (Britner & O’Neil, 2008; Mason, 2008) for graduate students. In partnership with the Southwest Prevention Center, the University of Oklahoma has developed an online masters degree program in prevention science awaiting final review from the graduate college that expects to enroll its first training cohort in 2010. This program will include required courses entitled Foundations in Prevention Science, Prevention across the Lifespan, Prevention Strategy Development, Implementation & Evaluation (http://swpc.ou.edu/services/masterdegree.htm). Electives include courses with clear links to coalition coordination, such as leadership, project management, grant writing, public budgeting, and social marketing.

Critics of these programs suggest that programs outside of social work schools and departments may be difficult or costly for social work students to access. It can be difficult to align the credits from these programs with accreditation standards for interdisciplinary graduation, certification, and licensing. Further, programs external to social work still should include in-house mentoring and coursework in order to integrate social work and prevention (Conyne et al., 2008). Such elective courses tend to be enrollment challenges for social work students if prevention content is absent from the
core curriculum in social work because students may not appreciate the prevention training program’s relevance or utility to their profession.

Public Health Social Work – Some universities have institutionalized relationships between schools of public health and schools of social work to cross-train cohorts of prevention workers (IASWR, 2003). Over the past thirty years, joint programs have expanded from an initial pilot in Minnesota (Hooyman, Schwanke, & Yesner, 1981) to the current 21 programs. Interdisciplinary trainers claim that the benefits are mutual in helping social workers learn applied epidemiology and public health students learn participatory, empowering, and culturally responsive techniques that aid in diffusion of macro practice preventive interventions (Ruth et al., 2006). Elizabeth Clark, the executive director of NASW, wrote that “public health social work might be the future of social work. Recent political changes are expected to affect the future delivery of healthcare, possibly leading to more emphasis on preventive healthcare and integrated healthcare and wellness services. The ability of public health social workers to bridge prevention and intervention, individual and community, and practice and policy will be increasingly valued in our changing society.” (Van Pelt, 2009, p.30). The IASWR (2003) reports several challenges to the implementation of this model, including that most social workers doing public health activity do not identify with the term “public health social worker” and that the 250 members of the Social Work section of the APHA are not entirely integrated into the professional public health organization. Students enrolled in the dual degree program experience tension between the social work commitment to the vulnerable and the public health commitment to the majority, which may be addressed by interdisciplinary mentoring and field placements. The only
published outcome study of graduates of these dual degree programs indicated that graduates were slightly underutilized for their skills sets, felt somewhat ‘homeless’, and had significant cost consequences of the dual degree training, though they reported that they would choose the same training again. Participants in the dual degree program saw social work as the ‘soft’, though valued, side of their training. They did not report that the dual degree program brought rigor to social work training (Ruth, Geron, Wyatt, Bachman, & Chiasson, 2006). Critics of the integration of public health content into social work fear it will medicalize the profession (Siefert et al., 1992).

These pre-service models for prevention training will require modifications at all three levels of social work training –bachelors, masters, and doctoral levels. While those trained at the doctoral level are unlikely to have direct practice roles in prevention, they will need to be well-trained in prevention science in order to train bachelors and masters level social workers to provide preventive services. The National Institute of Mental Health’s institutional training grants offer resources to prepare doctoral students for leadership in prevention science and, ultimately, to train social workers for careers in prevention.

In-Service Training / Technical Assistance –Workforce training for prevention should also reach professionals already in the field practicing social work through in-service training and technical assistance. In fact, most clinicians develop their prevention skills on the job post graduation (Conyne et al., 2008). Technical assistance can be very responsive and relevant to practice demands, but has been found to be more successful when built upon a training foundation that allows practitioners to take advantage of it (Chinman et al., 2005). Therefore, training and technical assistance programs should be
integrated. Social work departments have an opportunity to provide training to professionals through certificate and continuing education programs. Nearly every jurisdiction that issues social work licenses requires continuing education courses for license renewal. Social work continuing education requirements are rigorous across all fifty states (Daniels & Walter, 2002). Social work is in a unique position to contribute to the prevention workforce through in-service learning programs for prevention practice. However, many of state licensure requirements do not apply to macro level practitioners, and, as a result, continuing education opportunities for individuals working with communities to advance the use of science based prevention systems may be lacking. It would be worthwhile to extend collaborations with APHA to provide continuing education credits for public health social workers.

Schools of social work should also provide training to frontline prevention practitioners who have not received graduate training. Schools of social work could expand upon an emerging infrastructure by partnering with the Association for Addiction Professionals to become approved providers of training for Certified Prevention Specialists, a designation offered by the International Certification and Reciprocity Consortium (IC&RC) to credential frontline prevention workers in 40 states and 10 countries (Hayden, 2005). Credentialing requires a minimum of 2000 hours of practice experience, 120 hours in supervision, and 100 hours of education, with a 40 hour continuing education requirement every two years. The coursework content and the credentialing exam include (1) planning and evaluation, (2) education and skill development, (3) community organization, (4) public policy and environmental change, and (5) professional growth and responsibility. To facilitate the transfer of research to
practice, academic schools of social work should become involved in training for Certified Prevention Specialists.

The Challenge Ahead

We are aware of the challenges to reorienting social work education toward prevention practice. A case study from the Risk and Prevention training program at the Harvard Graduate School of Education suggests that success is predicated on finding like-minded faculty, communicating the importance and uniqueness of the program to administration and recruits, ensuring eligibility for licensure, and translating the training to professional opportunities upon graduation (Mason & Nakkula, 2008). Others have suggested focusing first on bachelors and doctoral training, so as to more quickly build a quorum of agency staff ready to carry out prevention work, change agency norms, and simultaneously prepare the next generation of faculty with skills to teach prevention content in the masters training program (Siefert et al., 1992).

The advances in prevention science over the past two decades have created the need for a national workforce that is trained to move evidence based prevention from efficacy and effectiveness trials into widespread national application. Schools and departments in other professions and disciplines are stepping up to fill this need. We urge schools and departments of social work to broaden their missions to include the training of the prevention workforce of the 21st century.
References


