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INTRODUCTION

“No major disorder in a population has ever been eliminated by providing one-to-one treatment,” stated the report of the Task Panel on Prevention (1978, p. 214) of the President’s Commission on Mental Health. Does this mean that treatment of major disorders is of no use? Not at all! One must remember that prevention is a future oriented process while treatment is a more immediate procedure. Treatment and rehabilitation are essential methods of working with patients. They are, however, not the only effective tools of human services. What this statement does mean is that other approaches are needed if society hopes to successfully cope with the increasing number of individuals who are dysfunctional. One such approach is preventing disorders from developing in the first place.

Although prevention in the human services is not a new idea, it is rarely addressed in introductory human services texts. When it is discussed in such texts, it is most often covered only briefly. We applaud the recent growth of prevention programs in the human services and are convinced of the great potential of these programs. For this reason, we feel that it is essential to introduce the subject of prevention to those planning to enter human services. It should be clear to you that human services are not limited to the repairing or patching up of dysfunctional persons through treatment and rehabilitation. Furthermore, by introducing the concept of prevention in an introductory text, we hope that human services training programs will be encouraged to begin covering prevention with the same thoroughness now given to treatment and rehabilitation. Adequate information on prevention programs also offers the human services student another option regarding career choice.

The first part of the chapter focuses on what prevention is and what it is one seeks to prevent. A brief history of prevention efforts follows. The remainder of the chapter includes a discussion of the different levels of prevention and the rationale for the importance of prevention efforts. The chapter ends with an examination of current prevention programs and obstacles or barriers to the development of prevention programs.

DEFINING PREVENTION AND ITS TARGETS

To prevent means to keep something from happening. In the field of medicine, it is quite clear what one attempts to prevent. Illness, injury, and premature or unnecessary death are the three major targets of prevention programs in medicine. In the human services—not including medicine—the major targets are not so clearly defined or identified. The Task Panel on Prevention (1978) of the President’s Commission on Mental Health felt strongly that efforts should focus on the prevention of “persistent, destructive, maladaptive behaviors” (p. 219). These behaviors include child abuse, drug abuse, criminal activities, and desertion of family, among many others.
The panel also stated that disorders should be the target of prevention programs. It is clear that there are many stressful situations, such as puberty, illness, and death, that cannot be kept from occurring, particularly by those faced with the problems. The goal, then, would be to prevent the situation from causing the kind of psychological and social disorders that have been mentioned. Situations such as the recession of the early Bush administration with the increase in unemployment, the loss of investments, pensions and retirement funds create a great deal of uncertainty and stress. The additional loss of homes and medical benefits that followed, further increased stress and added to the need to help individuals and families to cope with these misfortunes. How to keep these losses from becoming overwhelming and causing disorders such as alcoholism, family disintegration, and depression, as well as other maladaptive behaviors, is the focus of prevention efforts of the human services. President Bush formed the President’s New Freedom Commission on Mental Health on April 29, 2002 because of his desire to help people deal with the stresses and fears brought on about via the kinds of problems mentioned above. The commission’s focus is on how to reform the mental health delivery service system, which includes treatment and prevention programs, so that it is more efficient and effective. More details about the work of the commission are given later in the chapter.

PREVENTION IN THE PAST

In this section, we focus on the history of prevention efforts in the human services. Because it is impossible to separate the history of prevention programs from the history of human services, some of the material discussed here will necessarily overlap material in Chapter 3.

Preliterate and Ancient Civilizations

People have always tried to find ways to prevent hunger, injury, illness, and death. In preliterate civilizations, rituals, prayer, and sacrifices were used in the hope of preventing such catastrophes. These preventive rituals focused not only on hostile animals, environments, and people but also on the weather and other natural phenomena that influenced the supply of food and shelter.

Ancient civilizations also used many of the “preventive” methods of preliterate groups such as prayer and ritual. However, a movement away from the priest, shaman, or religious healer slowly developed. There was an increasing awareness that in many cases illness and death were due to natural rather than supernatural phenomena. In fact, some early efforts at prevention were successful, even though the actual causes of the disease were not known. In ancient Greece, for example, Hippocrates noted that a particular disease, now thought to be malaria, developed and spread near swamps. When people avoided these areas or when the swamps were filled in, the disease abated
(Bloom, 1981). Ancient Rome also contributed to the prevention of disease, even though the Romans might not have been aware of doing so. Their sewers and aqueducts were built to overcome unpleasant living conditions brought on by waste products and poor-tasting water. In effect, they prevented illness caused by poor sanitation and contaminated water.

The Dark Ages and the Renaissance

With the coming of the Dark Ages, medical practices reverted to an emphasis on prayer and rituals. According to Catalano (1979), medicine in Europe at that time became more of a combination of pagan myth and Christian prayer, then considered the best protection against illnesses of any kind. (This change is described in more detail in Chapter 3.) Prevention efforts related to illness, hunger, and poverty made little headway during the Middle Ages. The Church did, however, provide care and food to many in need, which prevented hunger and the accompanying stress-related problems.

The Renaissance and the Age of Reason saw a return to acceptance of more scientific medical practices. Quarantines were used to prevent the spread of disease. Inoculation against smallpox was developed. This was a powerful preventive measure, for it kept a specific disease from occurring. New drugs were found to be useful in treating and preventing diseases. During the 17th and 18th centuries, other practices and discoveries prevented some diseases. Improvement of sanitation projects, promotion of general cleanliness, and a beginning understanding of contagion all helped in prevention of diseases. The lack of knowledge of causes of specific illnesses was not always an obstacle. Scurvy, for example, was practically eliminated without an understanding of vitamin deficiency or of how a diet that included fresh fruits and vegetables prevented it from occurring. Most prevention efforts were made in relation to physical illness. Mental illness was perceived in a different way by most medical doctors and the public at large. The treatment of the mentally ill was influenced by religious beliefs. During this time, the prevention of mental illness was, therefore, based on a belief in prayer, ritual, and living a life free of sin.

The 19th and 20th Centuries

The 19th and 20th centuries saw even greater advances in medicine. Pasteur introduced the germ theory of disease. Ehrlich introduced the idea of a chemical “magic bullet” against specific diseases, the idea that a single medication could cure or prevent a particular disease. Clinical laboratory diagnosis and specialization became the trend. In the field of mental illness, advances were also being made but at a slower rate. Haindorf, in the early 19th century, introduced the concept that emotional conflicts that disturb the normal functioning of the body result in mental illness. Groos, before Freud, believed that humans are affected by physical forces they are not aware of and that these forces determine their behavior (Alexander & Selesnick, 1966).
Some significant, though rudimentary, efforts to prevent mental illness were made in the latter part of the 19th century and the early 20th century. For example, the settlement house movement represented a major attempt to help people deal with the perils and pressures of poverty, hunger, crime, poor education, sweatshops, and filthy living conditions. The primary focus was not on the prevention of mental illness but rather on helping the millions of immigrants coming to America establish themselves in their new homeland. Exploitation of these people, many of whom did not even know the language, was the rule. Human services workers of that era were convinced that this exploitation and its attendant hardships contributed to high rates of juvenile delinquency, crime, alcoholism, and poor health. Efforts to prevent these conditions from occurring were a major focus of the settlement house movement. Settlement house workers attempted to help the exploited overcome their poverty through education. Some progressive politicians also tried to alleviate the plight of the poor, and their attempts continued over many years. However, the settlement house movement and cooperating politicians did not have the political power to make significant changes in the distribution of resources to reduce or eliminate the stress brought on by poverty. They did, however, help sensitize the general public to the plight of poor immigrants.

The movement that probably attained the greatest success in preventing the exploitation of the poor was the union movement. Unions were formed and supported by exploited workers. Their efforts were supported by the settlement houses, other institutions, and liberal political leaders. The unions not only prevented exploitation of their members through the collective bargaining process but also actively promoted legislation that increased opportunities for the poor to break the cycle of poverty and its accompanying disorders. The minimum wage laws and unemployment insurance are examples of such legislation. The unions, in effect, brought about a significant increase of resources for their members and millions of others entering or already in the workforce. Although the workers did not suddenly become rich, they were much better off financially than before the advent of unions. Economic pressures, one of the avowed causes of emotional stress, were significantly reduced for many. Unions today are very often seen as the cause of economic problems such as high prices and inflation. Whether or not such a view is accurate or justified, there is no question that the union movement was—and still is, according to some—a powerful force in enhancing the lives of union members and working people in general.

The latter part of the 19th century and early part of the 20th century also saw movement in determining the relationship between some physical and behavioral problems. There was a recognition that syphilis in its later stages caused many behavioral problems such as impulsive and bizarre actions. During the first 20 years of the 20th century, the mental hygiene movement, one of the most significant reform movements, was initiated by Clifford Beers and his associates. The main impetus for this movement was the autobiography of Beers, a former institutionalized mental patient. His book *A Mind That*
Found Itself helped establish the National Committee for Mental Hygiene. One of the stated aims of the committee was the prevention of mental disorders. An article in the first issue of the committee’s journal, Mental Hygiene, stated that “a healthy life-style could save people from insanity, hence the importance of educating the public as a means of preventing mental illness” (Dain, 1980, p. 103).

Most prevention programs in this country prior to the 1960s were aimed at physical diseases and were carried out largely by the Public Health Service. It was not until the 1960s that prevention efforts related to disabling behaviors were again seriously considered. Federal laws were passed that had an impact on prevention efforts in mental health and behavioral disorders. Some of the more familiar pieces of legislation were the following:

- The Community Mental Health Centers Act of 1963
- The Economic Opportunities Act of 1964—the War on Poverty
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970
- The Child Abuse Prevention and Treatment Act of 1974
- The Juvenile Justice and Delinquency Prevention Act of 1974
- The establishment of an Office of Prevention within the National Institute of Mental Health in 1982

It should be noted that four of the acts listed specifically include “prevention” in their titles. The other two, although not specifying prevention in their titles, most certainly had prevention efforts as an integral part of their programs. In addition, Congress began to earmark funds for research in prevention activities.

The development and growth of community psychology since its conceptualization in 1965, was most significant to the field of prevention. The recognition on the part of many psychologists that traditional forms of helping people (such as therapy in the office) were not very effective in the struggle to eliminate, or even stem the tide of problems that are frequently the cause of maladaptive behaviors. The attempt of community psychologists is to connect the individual to the forces in the community and the individual’s quality of life. Community research to determine the needs of the individual and community is an essential tool of community psychologists. The research also helps identify current as well as possible or anticipated problems in the community. According to Dalton, Elias, and Wandersman (2001), there are four current trends in the field of community psychology:

- Prevention and competence promotion
- Community building, citizen participation, and empowerment
- Understanding human and cultural diversity
- Developing “adventuresome” research methods to match the complexity of community phenomenon (pg 49)

Another important development in the field of prevention was the convening of the first national colloquium on Professional Education in Prevention in
1988. The focus of the conference was on training prevention professionals. There was also discussion of credentialing, evaluating, and testing various prevention models and programs. Sponsors of the conference included the National Prevention Network, the Illinois Department of Alcoholism and Drug Abuse, the Illinois Certification Boards, Inc., and the National College of Education. Although the sponsors are for the most part involved with alcohol and drug abuse causes and programs, the concept of prevention professionals is one that is most welcome and long overdue.

A program recently developed appears to be a major primary prevention effort, although it does not use the word prevention in its descriptive material. It is called the Family Development and Credentialing Program (FDC) and was initiated by the New York State Department of State, Division of Community Services. The response, in part, to the question raised in their material—why is the FDC necessary—is as follows: For too long, services have been available only when a family is in crisis or about to disintegrate. Public interventions have focused on “rescuing and fixing” families rather than helping families develop their capacity to solve problems and achieve long-lasting self-reliance. Now on both the state and national levels, families, service providers, and policymakers are joining together to reorient the way services are delivered toward a more family-focused and strengths-based approach (New York State, 1995). We would hope that other institutions and jurisdictions become involved in similar projects.

**Levels of Prevention**

The various state and federal prevention programs that have been mentioned focus their efforts on different levels of prevention. The concept of levels originated with the Public Health Service and includes primary, secondary, and tertiary levels of prevention. Before discussing these levels, it must be made clear that there are controversies within the field of human services regarding the definition of each level. These differences will be described after a definition and example of each of the three levels of prevention.

**Primary Prevention**

Primary prevention in the human services is designed to prevent a disorder, disability, or dysfunction from occurring in the first place. An example of primary prevention might be a program to help the unemployed learn new skills and use support networks. Such a program might help prevent depression, alcoholism, and other psychological disorders. In the medical field, the shots given to prevent polio, the flu, or tetanus are examples of primary prevention at work.

Primary prevention is seen by Price, Bader, and Ketterer (1980), Cowen (1980), and the Task Panel on Prevention (1978) as being principally concerned with the reduction of new cases of disorders in a community. If, for
example, families with severely retarded children were helped to learn new ways of dealing with their children and how to use all the resources provided for such problems, it might well prevent the onset of family strife or any other disorder that would further keep the retarded individual (or members of the family) from functioning at their potential. Stemming the ever-increasing number of disorders that develop among families facing difficult and different problems is one of the goals of primary prevention. Another example is one involving child abuse. Studies have indicated that people who were abused as children are more likely to become child abusers, delinquents, and prone to various kinds of societal violence. If such individuals are identified, they can be helped to learn other ways of dealing with their children prior to becoming parents. This approach might well prevent that type of destructive and maladaptive behavior from occurring at all.

The Task Panel on Prevention (1978) claims that “primary prevention involves building the strengths, resources, and competence in individuals, families, and communities that can reduce the flow of a variety of unfortunate outcomes—each characterized by enormous human and societal costs”
When one looks at the “flow of unfortunate outcomes,” such as divorce, desertion, delinquency, and depression, brought on by these or other problems, one can clearly imagine “the enormous human and societal costs” and thus the need for primary prevention programs. Such programs involve providing education and training to help individuals and families to cope successfully with difficult problems.

An additional but critical aspect of primary prevention efforts, according to Cowen (1982), is that they must be group or mass oriented. This does not mean that primary prevention programs may not deal with individuals but rather that the major focus must be on large and/or specific populations. These populations are referred to as target populations, high-risk groups, or the general population. Although these groups may not be demonstrating any disorders, their circumstances, as described earlier, are such that many of them are probably vulnerable or open to such disorders. These groups function, live in the community, and show no signs of disorder.

Secondary Prevention

Secondary prevention can be defined as the early detection and treatment of dysfunction. If, for example, parents noticed that their teenage child was beginning to use alcohol and do poorly in school, and if they sought and obtained help for their child, that would be secondary prevention. In such an instance, the aim would be to help the youngster refrain from using alcohol and improve in schoolwork. Secondary prevention in medicine is similar. An individual, for example, goes to the doctor with the complaints of headache and slight fever and is diagnosed as having a touch of the flu. The treatment is then focused on eliminating the symptoms and helping the patient get well.

Secondary prevention, according to Goodstein and Calhoun (1982), “involves early diagnosis and treatment of a disorder at a stage when problems may be nipped in the bud” (p. 499). Price et al. (1980) see the goal of secondary prevention somewhat differently, as an attempt “to shorten the duration of the disorder by early and prompt treatment” (p. 10). If, for example, a young child of an alcoholic parent began to show signs of withdrawal and the nonalcoholic parent took the youngster for help, many would consider this to be secondary prevention. It would include diagnosis and treatment in an attempt to “nip the problem in the bud,” or at least to shorten the duration of the problem.

There are those, however, who would claim that this is treatment of an existing disorder. The maladaptive behavior (that is, withdrawal) has already begun; it has not been prevented or kept from occurring. What, then, if anything, has been prevented? Those who claim that early and prompt treatment is secondary prevention assert that if the intervention or treatment is successful, the signs of withdrawal are reduced or eliminated. In effect, intervention has prevented increased or continued withdrawal and therefore should be considered to be a significant prevention effort. One could argue either way as to whether one should call this example treatment or prevention.
In our view, the very existence of a disorder takes the effort out of the realm of prevention and places it in the category of treatment. Although it is true that prevention efforts could focus on an individual, the major thrust of prevention is toward reaching groups at risk, target populations, or the general population. This may be a technical point, but it does have significance as an obstacle to the development of primary prevention programs. This point is discussed more fully later in the chapter.

Tertiary Prevention

Tertiary prevention is generally defined in terms of efforts to rehabilitate and return to the community those afflicted with severe mental disorders. For example, some mental patients suffer from delusions; that is, they believe they are someone else, such as Napoleon, God, or Superman. They even try to behave as such figures, and it is this behavior that keeps them from functioning successfully in society. In many cases, these people are placed in institutions. They remain there until they are able to regain enough of a hold on reality to return to the community. A medical example might be an individual who lost a leg, was fitted with an artificial one, and was taught to walk with the new leg. Tertiary prevention, according to Price et al. (1980), is an attempt “to reduce the severity and disability associated with a particular disorder” (p. 10). Goodstein and Calhoun (1982) describe tertiary prevention in more detail. From their point of view, “tertiary prevention includes efforts to reduce the overall damaging effect of a disorder, to shorten its duration, and to rehabilitate those afflicted for reentry into the community” (p. 499).

If those delusional individuals referred to earlier were treated in an institution and were again able to live and function in the community, this would be considered tertiary prevention by many in the human services. Here again, one might ask what is being prevented. From one point of view, permanent disability or continued institutionalization is the prevention target. Another point of view—one to which we subscribe—states that the tertiary prevention is actually rehabilitation. That is, it restores the individual(s) to better health. It should be noted that most tertiary prevention programs are focused not on a mass of people or on large groups of people but rather on individuals and/or small groups.

Why an Emphasis on Primary Prevention Is Crucial

Community psychology is one of the few but growing number of human service professions that recognize and believe in the critical importance and efficacy of primary prevention, as well as the promotion of wellness and social competence. What is so important about the idea of primary prevention in the human services? Four major reasons have been put forward to support pri-
mary prevention as a top priority. One reason was provided at the very begin-
nning of this chapter: According to the Task Panel on Prevention (1978) and
others in the Public Health Service and in private practice, there has never been
a major disease or disorder eliminated through treatment alone. If this is so, it
becomes clear that treatment and rehabilitation efforts cannot hope to com-
pletely eliminate serious disorders. Furthermore, treatment and rehabilitation
have been practiced for years, and it is clear that both processes have not been
able to stem the tide of disorders in our society.

The second reason is that there are not enough human services personnel
to treat or rehabilitate all those in need. Although it is true that human ser-
vices is a rapidly growing field, human services educators recognize that the
training of personnel cannot keep up with the increasing numbers of people in
need of treatment. This is true in spite of the fact that the primary focus of
training has been, and still is, on treatment and rehabilitation. To make things
more difficult, the economic policies of the early 1990s, caused a reduction in
support of the human services in general. This decrease in support occurred in
spite of the increase in the number of people in need of help due to problems
of unemployment, people living longer and becoming more dependent, more
families breaking up, and continuing child abuse.

Other problems, such as battering of women—the leading cause of injury
to women (Faludi, 1991)—suicides, school dropouts, crime, and AIDS, are not
getting the attention they need. To add to the problem, the National Institute of Mental Health (NIMH) estimates that over 22% (or over 44 million) Americans over 18 years of age suffer from a mental disorder (NIMH, 2001). Furthermore, the National Alliance for Mental Illness (NAMI) claims that 9 to 13% of children between the ages of 9 and 17 (or approximately 5 million children) have a serious emotional disturbance (NAMI, 2000). As if that were not enough, the 2001 National Household Survey on Drug Abuse finds that an estimated 109 million people over 12 years of age drink alcohol. Over 20% (about 21 million) participated in binge drinking. Almost 13 million were considered heavy drinkers. Underage drinkers, 12 to 20 years of age, totaled about 10 million youngsters (Substance Abuse and Mental Health Services Administration, 2001). Still another problem is indicated in a news release of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It reports that about 19 million children from birth to 17 years of age is exposed to family alcoholism, alcohol abuse, or both (NIAAA, 1999).

This situation reminds one of the story of a man fishing off the bank of a wide and fast-flowing stream. While fishing, he sees a person being swept along with the current. He quickly throws the person a line and pulls him to safety. Before he can do anything more, he spots another person being swept downstream and he pulls him out also. Just as he does this, he sees a few more people struggling in the current. He calls for help as he pulls someone else out of the surging water. Others come to help as still more people are caught in the current. However, it soon becomes impossible to pull everyone out of danger. There are too many victims and not enough helpers. As more and more people float downstream, more and more are lost. It finally dawns on someone to head upstream and try to keep people from falling into the stream in the first place. Many feel that human services workers had best head upstream before they too become less and less effective.

The third reason that primary prevention should be a priority is that society pays a huge cost for disorders that are not prevented. The Task Panel on Prevention (1978), for example, puts its emphasis on the prevention of disorders, each of which is “characterized by enormous human and society costs” (p. 213). According to the Seventh Special Report to the U.S. Congress on Alcohol and Health, the estimated cost of alcoholism and alcohol abuse was more than $136 billion in 1990 and about $150 billion in 1995 (Secretary of Health and Human Services, 1990). The National Institute of Mental Health (NIMH) estimates that mental illness alone costs our nation over $129 billion a year.

The fourth reason for the promotion of primary prevention is that emotional and behavioral disorders exact an enormous human cost. Human costs have to do with personal pain and suffering. Perhaps the only way to truly realize these costs is for us to try to personalize them. Everyone has had to face, at some time or another, a painful or terrible experience. Some remember the fear of being left behind when parents separated. Some remember the shame of having a “drunkard” in the family. Others who have had a mentally ill person living in the same house can still feel the anxiety, fear, and frustration in that situation. The guilt, shame, and apprehension of having a retarded
child still affect many others. The anger and fear of living with a drug addict are still with many. The terror after being abused, mugged, or raped does not leave victims or their loved ones.

How many can recall the gut-wrenching pain and sense of helplessness of watching a loved one suffer and die due to illness? How many remember the rage and bitterness they felt when their disabled child or they themselves were made fun of or denied an opportunity to go to school? There is also the feeling of desperation, frustration, and rage known by African Americans, Latinos, and other minority group members when they or their children are abused and denied the opportunity to grow and prosper. The enormous human costs are the tremendous assaults on the emotions and strength of those affected directly and indirectly. Some of the effects radically change the lives of those who, without help, cannot cope successfully with such traumas and too often become alcoholics, abusers, addicts, or mentally ill or develop some other disorder, thus increasing the number of people needing treatment and rehabilitation.

A brief description of what happens when the type of stress just described leads, for example, to alcoholism will bring the issue into sharp focus.

- Alcohol contributes to 100,000 deaths yearly (McGinnis & Foege, 1993).
- Approximately 10,000 murders a year are alcohol related.
- Victims report each year 183,000 rapes and sexual assaults involving alcohol, as well as 197,000 robberies, 661,000 aggravated assaults, and nearly 1.7 million simple assaults (U.S. Department of Justice, 1998).
- A third of all suicides each year involve alcohol.
- A third of all arrests each year are alcohol related.

On the college level alone: 1400 students between 18 and 24 years of age die each year from alcohol related injuries; 500,000 are injured while under the influence of alcohol each year; 600,000 are assaulted by another student who was drinking; 70,000 were victims of alcohol related sexual assault or date rape. In addition many thousands are involved in unsafe sex, have academic and health problems, and have attempted suicide. (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2002).

Remember, this listing is only a sample of the data on the effects of alcoholism. It does not include data on preteen and teenage alcohol abuse described earlier, death and injuries in the house or workplace, or injuries in auto accidents. Left out are the data on physical and mental illness and disabilities, forcible rape, family disintegration, and many other problems related to alcoholism and alcohol abuse. Still, a significant sustained federal alcohol abuse prevention program is not in place. A nationwide federal alcohol abuse prevention program might include approaches such as these:

- Mandating the listing of health hazards of alcohol on all alcohol containers (the government has mandated a very limited warning regarding the health hazards of alcohol to be placed on all forms of liquor containers).
- Mandating a very clear presentation of health hazards of alcohol in advertising in the print, television, and radio media.
• Considering a ban on advertising alcohol altogether. Nations banning the advertising of alcohol have approximately 16% less consumption, and those that prohibit beer and wine ads have 11% lower use. Fatality rates are lower by 10% and 23%, respectively (National Institute for Alcohol Abuse [NIAA], 1993).
• Raising the federal excise tax on alcohol and particularly on beer, as was done with cigarettes.
• Increasing prices on alcoholic beverages, which may be especially effective at reducing addictive consumption by younger, poorer, and less educated consumers (NIAA, 1993).
• Enforcing the 21-year-old drinking age on college campuses, where three-quarters of the students are under the legal drinking age and the massive marketing of alcohol still continues (Sessel, 1988).

Many state and local alcohol prevention programs are in progress. They include, among others, raising the drinking age to 21, significantly raising the tax on liquor products, limiting the availability of alcohol purchases to specific outlets, strict enforcement of DWI (driving while intoxicated) and similar laws, and initiating education programs in schools and communities.

The Feb. 8, 2003 interim report of President’s New Freedom Commission on Mental Health provides other reasons and impetus for the development of primary prevention programs. As indicated in Chapter 2 the prevalence figures translate into millions of adults and children disabled by mental illness. Furthermore the report points out that about half of those who need treatment do not get it. The quality of care for those who get treatment may be less than adequate. For racial and minorities the rate of treatment and the quality of care is poorer than that for the general population. The report emphasizes that the system needs “dramatic reform.” The report, however, is not totally negative, as it also depicts model prevention and treatment programs that are ongoing. A prevention program included in the report is described below.

Primary prevention programs are geared to help people learn how to deal positively and successfully with their problems and stress. If such programs prevent people from developing any of the disorders that have been described, the human cost will have been reduced. We believe that a greater number of prevention programs make possible a greater reduction in human and societal costs.

The acknowledged inability of treatment and rehabilitation programs alone to stem the tide of people in need of human services makes increased primary prevention efforts almost mandatory. A brief look at the two types of strategies used in primary prevention programs will provide a clearer picture of how these programs are developed and how they work.

**Primary Prevention Strategies**

Both active and passive prevention strategies are used in the development of prevention programs (Gilchrist & Schinke, 1985). Passive strategies refer to broad informational-type approaches, such as warnings on cigarette packages or television programs discussing and describing ways to prevent AIDS. Active
strategies involve working directly with the target populations in developing skills that enable individuals to deal successfully with pressures and problems that might lead to dysfunction. This is referred to as the life skills model. Such skills include problem solving, making thoughtful and helpful decisions, and recognizing consequences of behavior (Gilchrist & Schinke, 1985). Other skills include identifying behavior options, examining the advantages and disadvantages of the various options, and communication and listening skills (Snow, 1985). The various skills of active strategies are best described by Briar (1985) when he points out that they essentially contain “cognitive and behavioral elements that are aimed not only to help people prevent social and health problems but also to help people promote personal competence and adaptive functioning” (p. 8). A brief look at a sample of primary prevention programs and a listing of major areas in desperate need of primary prevention programs will be helpful at this point.

A Sample of Primary Prevention Programs

A brief look at different kinds of primary prevention programs will give you a sense of the scope of such efforts and a clear idea of the goals of primary prevention programs. Primary prevention programs have been growing in number since the mid-1970s. Many of them have been short-term, research, experimental, or demonstration programs limited in terms of time and funding. Much of the data derived from these programs indicates positive results in improving individuals’ abilities to cope with stress. These data and results can be and have been used to develop additional theories and programs focused on long-term results. There are programs, although too few from the point of view of proponents of primary prevention, that are ongoing. In any case, it should be noted that the final results of these long-term programs are not yet available, for it is impossible to tell whether the targeted disorders have been prevented for the entire life span of those in the various programs.

One program aimed at reducing teenage pregnancies by Girls Inc. included 750 girls 12 to 17 years of age. They were all at high risk of becoming pregnant. The program consisted of a mother-daughter workshop, an assertiveness training workshop, an educational and career planning workshop, and sessions on sexuality that also provided contraceptive services.

It was reported that the number of pregnancies was reduced by 50% among the girls 15 to 17 years of age. The number of girls aged 12 to 14 years who subsequently began having sexual intercourse was also reduced by 50% (Brody, 1991). The results showed that the high-risk characteristics (for example, being welfare-dependent; from a single-parent, female-headed household; living in an urban environment; having peers and relatives who were pregnant teenagers) were not insurmountable obstacles to a well-planned prevention program. The director of the program pointed out that the cost of the program per year per girl was $116. The director estimated that delaying a single pregnancy until after teenage years could save society $8,500 (Brody, 1991); one assumes these savings would be made in a range of welfare benefits.
Tableman, Marceniak, Johnson, and Rodgers (1982) describe a pilot program of stress management training involving women on public assistance who were generally isolated and subjected to more than average stress in their lives. None of the women were in crisis, nor did they display maladaptive behaviors that required treatment. The women took part in 10 sessions during which they learned skills and methods of reducing stress that helped them change their perceptions of their situations. The program resulted in significant change in the participants’ lives. They were no longer isolated and were able to function more effectively with less stress, thus preventing the kinds of behavioral disorders discussed earlier. The program has been further tested and used with different populations living under stressful conditions.

Another primary prevention program was developed by the Catholic Church because of the increase in the number of divorces. Couples wishing to be married in the Church now go through a series of group meetings, led by a member of the clergy, to discuss the responsibilities, joys, and strains of marriage. Childbirth, child rearing, sex, and other aspects of marriage are among the many topics discussed. The goal is to prevent many of the problems occurring in marriages from becoming serious enough to cause behavioral disorders, family disintegration, and divorce.

The last primary prevention program to be described here centers on promoting mental health in rural areas through informal helping (D’Augelli & Vallance, 1981). Provision of human services in rural areas is more difficult than in urban areas. For example, because of the smaller populations in rural areas, isolation is usually greater and transportation is not readily available. Many rural residents have close family and community ties, and asking for help from “outsiders” is not looked upon with much favor. Some rural communities have an informal system of helpers. The project under discussion was designed not only to encourage such a system but also to teach members of the community to train those residents who make up this informal system. The focus is to build on the existing strengths of the community by training the local helpers to become more efficient in helping residents deal with personal problems, job loss, sudden illness or injury, and other problems in living. This approach permits local residents to teach other local residents skills in the helping process, and thus they do not have to share problems with or ask for help from outsiders. This method also increases the number of helpers and provides increased sources of support to those who are faced with problems in living before maladaptive behaviors are developed. This particular prevention program is an ongoing one staffed by local volunteers.

Presidents New Freedom Commission on Mental Health is an example of an early intervention to prevent mental health problems.

Program: Nurse—Family Partnership

Goal: To improve pregnancy outcomes by helping mothers to adopt healthy behavior, to improve child health and development, to reduce child abuse and neglect, and to improve families’ economics self-sufficiency.
Method: A trained nurse is sent to the home of a high-risk woman during her first pregnancy and extending through the first year of her child’s life. The nurse helps young, typically unmarried, women learn how to parent and to avoid risky behavior. The nurse follows a visit by visit approach to help women adopt healthy behaviors and responsibly care for their child.

Results: For mothers: 80% reduction in abuse of their children, 25% reduction in maternal substance abuse, and 83% increase in employment. For children (15 years later): 54–69% reduction in arrests and convictions, less risky behavior, and fewer school suspensions and destructive behaviors.

This program has been considered so successful it is now being used in 230 cities in 23 states.

We could continue to describe primary prevention programs, but we believe that it will be more enlightening at this point to list just a few areas in which primary prevention programs can make a significant difference. They need no description or further comment.

- Mental illness
- Crime
- Alcoholism
- Child abuse
- Teenage pregnancies
- Rising juvenile crime
- Violence
- Battered women
- AIDS
- Increased teenage drug abuse
- Physical illness
- Immunization of children
- Lack of pre- and postnatal care for poor women

Community mental health centers develop prevention programs as well as provide treatment services. One such center, the Center for Preventive Psychiatry in White Plains, New York, states as its mission “to promote positive mental health attitudes and prevent the onset of mental illness, or reduce its impact, through programs of early identification and treatment, community education, professional training, consultation and research.” Unfortunately, there are not sufficient community mental health centers to provide the needed services that we have described.

**OBSTACLES TO THE DEVELOPMENT OF PRIMARY PREVENTION PROGRAMS**

Although a growing number of primary prevention programs are operating throughout the country, funding for such programs is quite limited in comparison to the funds available for treatment and/or rehabilitation programs. What is frightening is that this is true even in life-and-death situations such as
the AIDS epidemic. That no one would object to the elimination or significant reduction of the disorders described earlier seems certain. Why, then, the persistent resistance to funding and development of primary prevention programs in the human services field? As indicated in Chapter 5, the community psychologists’ focus is on both prevention and wellness promotion. It should be noted that even among community psychologists there is a . . . continuing debate about where the emphasis of time and resources for prevention efforts is best placed (Dalton, Elias, Wandersman, 2001). Should efforts emphasize prevention of disorders or the promotion of wellness and social competence? We choose not to enter the debate but rather describe the greater difficulty in overcoming the obstacles to developing prevention programs and obtaining resources for them. There seem to be three major categories of obstacles to funding and development: professional, political, and economic. An examination of just a sampling of these obstacles will give you a greater understanding of the problems surrounding the introduction of primary prevention programs. Note that these problems are very closely interrelated.

Professional Issues

Professional issues that create problems regarding the growth of primary prevention programs include the training, practice, philosophy, and ethics of human services workers and human services professions. Very few 2- or 4-year training programs for human services workers discuss, much less focus on, primary prevention theory or skills. Few, if any at all, train workers for careers in the field of primary prevention. Graduate school training is equally limited in terms of primary prevention. For the most part, the training of human services workers is focused on treatment and/or rehabilitation theories and skills. This training leads, naturally, to practice concentrated on treatment and rehabilitation. These services are, in addition, the major services of most agencies in which human services workers are employed.

From a theoretical or philosophical perspective, the fact that primary prevention is not seen the same way by all human services workers creates an additional obstacle to the growth of primary prevention programs. There is no one definition of primary prevention acceptable among human services workers. Furthermore, a group of mental health professionals in a report to the New York State Commission of Mental Health (Prevost, 1982) states that “the distinctions among primary, secondary, and tertiary prevention do not provide meaningful guidance for the formulation of programs and policies” (p. 3). The group adds that the concepts have triggered more arguments than action. For example, when a particular disorder, such as drug abuse, is treated successfully, some might claim that the successful treatment actually prevented a potential crime and thus is really primary prevention. This perception does not include the element of intent, considered to be an essential aspect of primary prevention in mental health (Cowen, 1980). The intent in the example is to stop the drug abuse and not to stop a crime.
Another issue that causes hesitation and confusion centers around whether primary prevention efforts should concentrate on the causes of disorders or the “trigger” or “spark” that sets off a disorder. To add to the dilemma, the question of whether to approach disorders with a biological, psychological, or sociological emphasis is raised. In a biological approach, disorders are thought to be caused by physical problems such as brain damage, chemical imbalances, pollution, physical disability, or other similar difficulties. In a psychological approach, disorders are thought to be caused by a lack of knowledge or an inability to cope with emotional stress. In a sociological approach, disorders are thought to be caused by institutions or systems that do little to eliminate racism, unemployment, crime, poverty, hunger, poor housing, and similar societal ills.

Ethical questions regarding primary prevention programs also arise from the point of view of some human services workers. Some workers claim that if primary prevention programs were aimed at high-risk groups, unforeseen and unfortunate consequences could occur. High-risk groups, for example, could include children from broken homes or children with alcoholic parents. The children would have to be identified as such, which could lead to additional problems and violations of privacy. The children would have little or no voice in this matter, yet they might be adversely affected. Another ethical issue raised by some is that if primary prevention programs are aimed at entire communities or populations, what responsibility do providers have to those in the community who feel no need or want no part of the programs?

Another issue, as Califano (1994) describes it, is that “[d]octors are not trained or paid to seek or counsel patients about disease prevention or health prevention, and among those that do, instruction comes to only a few hours” (p. 145). Sadly, this is also true in the training of most human services workers.

These and other professional problems cause many to be hesitant and reluctant to expend their resources and efforts on primary prevention to any degree similar to those given for treatment and rehabilitation programs.

Political Issues

Political issues are also obstacles to the development of primary prevention programs. For example, ours is a crisis-oriented society. That is, our society does not usually act on or react to problems unless they become great enough to affect and bad enough to frighten large numbers of people. It is at those times that the storm of protest or concern becomes large enough to move legislators and legislatures to initiate attempts to deal with the problem. This is usually done through the rapid passage of legislation and funding.

The early outcry regarding the AIDS epidemic is a clear example of how a crisis affects the political system. Initially, there was a great deal of resistance to doing much about the issue because AIDS was considered a “gay” problem. The political reversal was abrupt and powerful when politicians realized that the epidemic was spreading to the heterosexual community. The lack of a
sense of crisis in the view of the public and many human services workers in addition to the lack of unanimity among politicians and professionals regarding the efficacy of primary prevention programs provides little impetus for the political system to press for the development and funding of such programs. Furthermore, how can one justify the use of limited resources to prevent disorders that only might occur?

Califano (1994) points out, “As long as big bucks are in treatment and the projects are in sick care, that’s where members of Congress and influential lobbyists will center their efforts; there are precious few political contributions to be found in health promotion and disease prevention” (p. 245). Unfortunately, here, too, the same holds true for the human services field.

**Economic Obstacles**

Economic obstacles to primary prevention efforts pointed out by the Task Panel on Prevention (1978) include limited resources and funding practices. Limited funding of human services also limits the development of new and uncertain or unproven programs. To take increasingly scarce resources away from treatment and rehabilitation programs and from people who are in immediate need of assistance to fund new and, in the eyes of many, questionable primary prevention programs is not acceptable to many in the human services field. According to Califano (1994), “Perhaps the biggest deterrent to health promotion and disease prevention efforts is the fact that the big bucks are in promoting unhealthy habits and treating poor health” (p. 145). He points out that prevention costs money up front and saves money later, which is an obstacle that lawmakers seem unable to overcome. Once again, these factors hold true in the human services field as well as in the medical professions. Furthermore, the cost of primary prevention programs serving large populations is very high, even though the cost per person is much less than the cost of treatment and rehabilitation of one person. In addition, most hospitals and other human services institutions are not prepared or geared for primary prevention programs but are certainly dependent on the income derived from their treatment and rehabilitation services. Primary prevention programs might well affect that income adversely. The same threat to income faces those human services workers in private practice. Recipients of third-party payments through their clients’ medical insurance could also be affected financially.

**CONCLUSION**

We believe that these and other obstacles to primary prevention can be overcome. Our strong bias in favor of primary prevention programs has been made obvious purposely. We just do not believe that the human services profession needs to, or can afford to, stand still regarding the development of primary prevention programs until critics are satisfied and all questions are answered. We do believe that sufficient research has been done to warrant significant
increases in funding of primary prevention programs and continued research in this area. The old cliché “an ounce of prevention is worth a pound of cure” is particularly appropriate here. From an economic, social, professional, and moral perspective, it is clear to us that the human services must become more than a “repair shop” for individuals and society.

We are heartened by the increasing awareness that human services educators and professionals have of the vital importance of prevention. This is evidenced by the inclusion of prevention courses in schools of social work and by programs of preventive psychology. In the field of psychology, there are programs to train psychologists in prevention practices (Price, 1983). Primary prevention programs are essential in the fight against dysfunctions, disorders, and disabilities.

Additional Reading


References


