Chapter 15
Preventative Services for Children and Adolescents

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Introduction

The years surrounding the turn of the century have been years in which our country has focused greatly on the well-being of young children and mental health of the youth. Policy makers, practitioners, and scientists have been working together to find interventions to promote the health of our country's young people. The contemporary concept of prevention gained ground in the nineteenth and twentieth century to combat mental illnesses, but in the past two decades, new scientifically based approaches have moved to the forefront (Weisz et al. 2005).

The prevention approach to intervention has implications for the traditional role of the social worker and for the timing of the interventions. Social workers attempt to help clients learn how to exert control over their own behaviors and over the environments in which they live. Practitioners do not take a passive role in the intervention process. Instead they use their professional knowledge, expertise, and understanding of human behavior theory and personality development in the conceptualization and implementation of intervention strategies. Since their training equips them to evaluate scientifically any treatment procedure they have instituted, there is continual assessment of the treatment process (Steinberg 2010).

Prevention is especially appropriate for dealing with the problems of the adolescent. It provides early developmental focus for intervention, which may forestall development of future problems. These problems usually intensify later and become harder to alter. Prevention provides a view of the person that is optimistic. The approach is mass-oriented rather than individual-oriented, and it seeks to build health from the start rather than to repair.

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Problem behaviors of the young and their undesirable consequences are extensive and well documented. Teenagers' experimentation with drugs and alcohol can lead to overindulgence and abuse. Serious short- and long-term effects include risk-taking and daredevil behavior that increases risks to mental and physical health, including accidents, a leading cause of death among adolescents. Likewise, they may increase the incidence of irresponsible sexual activity, which eventuates in venereal disease, unwanted pregnancy, and premature parenthood (Ozer et al. 2011). In 2006, research was conducted to determine the connection between delinquency, drug use, sexual activity, and pregnancy of urban adolescents. The results of this study showed that in adolescents the above are co-occurring problem behaviors (Smith and Thornberry 2006). Prevention during childhood and the adolescent developmental period would reduce these serious physical and social problems.

There is confusion in the field as to what prevention approaches are effective in prevention with children and adolescents. Research in the area of prevention of adolescent substance abuse shows that the programs which focus on factual information, self-esteem, or decision making are less effective than prevention programs that follow a social (or peer) influence model (Skiba et al. 2004). Resilience should also be taken into account when seeking proper interventions. Resilience protects adolescents against psychological risks that are associated with negative environmental factors. Resilience has some advantages for adolescents. Good intellectual functioning, close supportive families, and positive role models outside the family are all factors that help increase resilience which aids the child in overcoming negative environmental factors (Santrock 2003). Research conducted on resilience finds that most young children from resource-deprived communities who have high amounts of resilience do become successful and develop their own strengths regardless of their harsh childhoods (Benard 2006).

This chapter will define prevention and review the three approaches to prevention: primary, secondary, and tertiary. From a life span developmental approach, skills an adolescent must master such as social, cognitive, and academic, should provide the focus for the intervention. The life skills approach is proposed as the treatment of choice. This approach has rational elements in common with other prevention programs that are based on public health orientation. These consist of three essential components: health education, skills training, and practice applying skills. The teams-games-tournaments (TGT) model consists of the same components except that in addition it uses peers as parallel teachers (Wodarski and Feit 2011).

Prevention Defined

Prevention is defined as the act of discouraging a problematic behavior or illness before it actually happens or before it becomes a problem. As there is a gradual shift away from the band-aid, after-the-fact approach to mental health, programs designed to prevent more serious consequences of present and/or future mental health problems or to prevent the recurrence of mental dysfunction are beginning to

emerge in rural as well as in urban areas. Since it is more cost-effective to prevent or reduce social problems, these programs proposed during a period of tight funds are sure to continue gaining appeal.

Social problems are the by-product of undesirable or ineffective behaviors. For adolescents, these behaviors, such as the abuse of drugs and alcohol, may be the result of poor coping mechanisms, peer pressure, and lack of self-esteem (Wodarski and Feit 2011). Furthermore, research shows that there are several factors that place youth at risk for drug use including school climate, peer influence, and lack of parental monitoring. Protective factors against drug use in youth have also been identified, such as intellectual and social skills (Hanlon et al. 2002). Frequent communication between parents and teenagers about the dangers of alcohol use can also serve as a protective factor against adolescent alcohol use (Abar et al. 2011). Similarly, the frequency of eating meals together as a family is related to decreased alcohol and tobacco use in teenagers, particularly in girls (White and Halliwell 2011).

Approaches to Prevention

Preventative programs should focus on those adolescents who will require services in the future if no ameliorating activities occur. Preventative programs must teach alternate ways of dealing with environmental conditions. Prevention programs should not only focus on information or attitude change, but should have multiple components to address many aspects of the individual and community (Skiba et al. 2004). This type of substance abuse prevention strategy is part of a new generation of primary prevention programs that have proven effective in reducing the initiation of one or more forms of substance use.

Primary prevention is concerned with methods of reducing the overall incidence of social problems. These preventions can also be referred to as universal interventions which are targeted at the general public, not selected because of individual risk factors (Wodarski and Feit 2011). Primary prevention has a group focus, targets at-risk adolescents, has a solid knowledge base, and can be used to prevent school, learning, and behavioral problems (Baker 2001). An example of primary prevention of physical need deficits could be testing newborns for phenylketonuria (PKU) to prevent mental retardation and providing adolescent parents with information regarding child rearing. Primary prevention of psychosocial need deficits could focus on acquisition of studying skills (Fisak et al. 2011).

Secondary prevention takes on a different approach to the issue of social problems. This approach uses organizational and community supports to select candidates for intervention. These interventions are generally targeted at groups and individuals who are at risk (Durlak et al. 2011). Examples of secondary prevention programs include school-based programs, family therapy, and interventions (Elliot et al. 2005). Secondary prevention strategies should focus on communities and youth who are exposed to greater risk factors. Community-level secondary prevention intervention has shown a decrease in the gang problem among adolescents

who reside in impoverished communities (Esbensen 2000). Adolescents who are children of alcoholics might be an appropriate group for a secondary prevention program, as they have been identified as being at a high risk for developing alcoholic tendencies (Belles et al. 2011). Another at-risk group that might benefit from secondary prevention programs are adolescents in the child welfare system, who have been found to be more likely to experiment with and become addicted to drugs (Casanueva et al. 2011).

Tertiary Prevention deals with adolescents who have had previous social problems. The goal is to maintain the individual in the community and to prevent problems from recurring. The effort here is to reduce the recidivism rate for adolescents who have been institutionalized. Such efforts might include helping a student reintegrate back into a school setting following a treatment program as well as giving relapse prevention support (Lewis et al. 2010).

Adolescent Developmental Tasks

The adolescent is preoccupied with rapid physical and intellectual maturation, heightened emotional sensitivity, and acceptance by social groups. Abstract thinking is possible and the adolescent is capable of conceptualizing changes that may occur in the future. The adolescent can anticipate the consequences of behavior and is especially sensitive to consistent and inconsistent parental behavior. Membership in peer groups that are more structured and organized than they were in earlier stages are extremely important. Group membership is most frequently based on physical attractiveness. The adolescent also begins engaging in heterosexual relationships. Forming relationships with boys at this age has specifically been found to increase the likelihood of cigarette smoking in adolescent girls (Mrug et al. 2011). Parents and significant adults influence the child's identity and self-esteem less than the all-important peers.

The psychological crisis at this stage is "group identity versus alienation." The adolescent receives pressure from parents, peers, and school to identify with a group. A positive resolution of the crisis results in the individual allying with a group that is perceived as meeting social needs and providing a sense of belonging. A negative resolution results in the adolescent experiencing a sense of isolation and continually feeling uneasy in the presence of peers. The central process in adolescence is peer pressure (Harrell et al. 2009).

Peer Influence

The peer group serves as a transitional world for the adolescent. Data suggests that participation in extracurricular activities is the most important determination of the adolescent's status with peers (Wodarski and Feit 2011). The self-concept of the

adolescent is very susceptible to status fluctuations that occur with family transience and high school transitions. The worker should encourage the adolescent undergoing such transitions to become involved in extracurricular activities because they can provide support (Crean 2012).

For teenagers, detrimental behaviors frequently occur in situations involving peers. The influence of peer groups on adolescent behavior is well known and for many adolescents, strong social pressure provokes participation in peer-sanctioned behaviors such as smoking, drinking, and sexual intercourse. Although teenagers may understand the health risks involved in these activities, this understanding is insufficient to counter the social significance of indulging (Ozer et al. 2011).

A recent study found that popularity at school is related to a teenager's willingness to conform to the drinking behaviors of peers. For boys, popularity is further increased when they drink alcohol excessively to the point of intoxication (Balsa et al. 2011). However, peer influence can also have positive consequences. Research has shown that contraceptive use among adolescents increases when they are aware that peers are also using contraceptives (Ali et al. 2011). In other words, peer pressure tends to cause adolescents to conform to whatever behavior is the norm for their peer group, whether that behavior is positive or negative.

When taking parental and peer influence into account in substance abuse cases, research shows that the adolescent reacted more negatively when parents monitored drug use than when their peers did so. The more active their peers were in using substances, the more the adolescent was to participate in substance abuse. However, the study shows that the less an adolescent's drug use was monitored by parents or peers, the more likely they were to increase their substance use. It is very important for peers and parents to work together to steer the adolescent on the right path (Brown and Bakken 2011)

Specific cognitive and behavioral skills are needed to resist external pressures and to successfully negotiate interpersonal encounters where pressure occurs. Adolescents often lack these skills not because of individual pathology but for developmental reasons. Age brings increased opportunity to engage in previously unknown or prohibited activities. Lack of experience and prior learning opportunities hampers youths' ability to deal with a new situation and behavioral requirements (Romer 2010)

There is confusion among the helping professionals about whether or not prevention programs have been effective. It is clear that prevention intervention should not focus on one aspect of an individual, but should focus on the person in the environment (Skiba et al. 2004; Weisz et al. 2005). A recent program that utilized this prevention approach successfully was the Health Wise program in South Africa. This program used education and enhancement of social skills to prevent substance abuse and the spread of HIV in adolescents (Tibbits et al. 2011). In addition, because prevention educational intervention is frequently poorly designed, with vague goals compounding difficulties, prevention program effects are hard to evaluate, further diminishing the likelihood of public and legislative support. A new conceptualization is required if prevention and health promotion services are to become effective components of service systems (Cameron and Keenan 2010)

There is an accurate database to provide rational and empirical support for development prevention and health education programs for children and adolescents. This is based on the Skills Training Intervention Model and the use of TGT, a teaching method with successful empirical history (Wodarski and Feit 2011)

The social development prevention model focuses on "effects of empirical predictors ("risk factors" and "protective factors") for antisocial behavior and attempts to synthesize the most strongly supported propositions of control theory, social learning theory, and differential association theory" (Gavazzi 2011). This model has also been used to predict drug use in adolescents. The social development model is much like the TGT prevention plan. The social development model states that positive socialization is achieved when youth interact and are rewarded by peers for positive behaviors. This theoretical model creates bounds that can prevent delinquent behavior (Hawkins and Weis 2005).

Skills Training Intervention Model

The skills model described here has rationale and elements in common with other preventative approaches. The interventive goal is skill building to strengthen adolescents' resistance to harmful influence in advance of their impact. Three components comprise this preventative model: health education, skill training, and practice applying information and skills in troublesome situations (Aarons et al. 2011).

Health Education That adolescents need accurate information to make informed choices is clear. Equally clear is the inadequacy of simply exposing teenagers to facts about unhealthy consequences of certain behavior. One fault with past health education programs is their assumption that exposure to training materials guarantees learning. Information-only programs have few lasting effects (Skiba et al. 2004). Particularly among younger adolescents, perceptual errors such as selectively ignoring, misreading, or mishearing certain facts or selectively forgetting information can create discrepancies between facts presented and facts received and remembered. The model proposed here addressed this potential problem by asking teenagers to periodically summarize presented content in written and verbal quizzes. Correct responses are then reinforced and errors are detected and clarified. Also, peers are used as teachers, which enhances their commitment to healthy behaviors.

Skills Training Even personalized information is of little value if adolescents lack the skills to use it. Translating health information into everyday decision-making and behavior involves cognitive and behavioral skills. Therefore, this model emphasizes skills for making effective short- and long-term decisions and assertive and communications skills needed to implement decisions (Kazdin 2011).

Training also focuses on behavior skills necessary to transform decisions into action. Based on established assertive and communication skills-training procedures, training presents verbal and nonverbal aspects of good communication to help adolescents learn to initiate difficult interactions, to practice self-disclosure and positive and negative feelings, to refuse unreasonable demands, to request changes

in another's behavior, to ask others for relevant information and feedback, and to negotiate mutually acceptable solutions (Rakovshik and McManus 2010).

Practice Applying Skills In the final and most important phase of the model, adolescents practice applying skills in a variety of potentially risky interpersonal situations. Extended role-played interactions provide adolescents with opportunities to recall and make use of health information, decision-making techniques, and communication skills. The following is an example of a vignette that might be used in this phase: You are at a party with someone you've been dating for about 6 months. The party is at someone's house; their parents are gone for the weekend. There is a lot of beer and dope and couples are going into upstairs bedrooms to make out. Your date says, "Hey, Lisa and Rom have gone upstairs. It's real nice up there—let's go, come on."

Role playing is an important tool that can be used to help adolescents develop confidence needed to foster refusal skills and to provide assistance in developing communication skills (Hamby et al. 2011).

In role-playing, teenagers practice responding to increasingly insistent demands and receive feedback, instructions, and praise to enhance performance. Practice applying skills also takes the form of "homework" assignments involving written contracts to perform certain tasks outside the training environment such as meeting with a family planning counselor and initiating discussion of birth control with a dating partner.

Teams-Games-Tournament (TGT) Model

The most important socialization agent in an adolescent's life is his/her peer, and schools provide a natural environment for peer influence. Virtually all attempts to educate teenagers about health topics have taken an education lecture model approach aimed at general education of all teenagers. Nearly all instruction in educational techniques is aimed at the individual pupil, ignoring the potential usefulness of the peer group in motivating students to learn and to acquire new skills or behaviors. Research has shown that students participating in learning teams in the classroom have uniformly positive effects (Wodarski and Feit 2011).

TGT is an innovative, small group teaching technique. The method is grounded in current theory, applies to diverse problems and settings, and provides clear criteria for evaluating program effects. The technique alters the traditional classroom structure and gives each student an equal opportunity to achieve and to receive positive reinforcement from peers by capitalizing on team cooperation, the popularity of games, and the spirit of the competitive tournaments. Group reward structures set up a learning situation wherein the performance of each group member furthers the overall group goals. This has been shown to increase individual members' support for group performance, to increase performance itself under a variety of similar circumstances, and to further increase the group's goals. This program has been found to be successful in helping students acquire and retain knowledge in such areas as nutrition, alcohol, and drug abuse (Wodarski and Feit 2011).

Peer relationships play a significant role in the adolescent's socialization and health behavior. Therefore, the information is provided in a group context to help students practice necessary social skills to develop adequate health behavior. Moreover, it capitalizes on the power of peers to influence the acquisition and subsequent maintenance of behavior, which data indicate, is the most potent influencing faction in an adolescent's life. It capitalizes on peers as teachers and this changes the normative peer structure to support healthy behavior (Wodarski and Feit 2011).

Components of Teams-Games-Tournament (TGT) Model The components of the program are as follow:

1. Drug education. This aspect includes biological, psychological, and sociocultural determinates of drug abuse. Basic knowledge about drug consumption and usage is in the next section. The final area is the ten-session curriculum. These are thought group discussion and participatory activities.
2. Self-Management and Maintenance. The comprehensive educational program provides instruction in self-management.

This component is based on social learning theory concepts. Adolescents also need training in terms of coping with daily problems of living. They are taught a problem-solving approach based on the work of Robin and Foster (Siu and Shek 2010). The general components emphasized are:

1. Problem definition
2. How to generate possible solutions
3. Decision making
4. How to choose and implement strategies through the following procedures:
    a. General introduction as to how the provision of certain consequences and stimuli can control problem-solving behavior.
    b. Isolation and definition of a behavior to be changed
    c. Use of stimulus control techniques to influence rates of problem solving behavior
    d. Use of appropriate consequence to either increase or decrease a behavior
5. Verification of the outcome and renegotiation

Cognitive Foci

Cognitive theories propose, in their stage development, that a child is at a concrete operations stage early in school and moves into more abstract, formal operational thought during adolescence. By utilizing cognitive-behavioral methods the worker is able to adjust the service mode according to the child's cognitive developmental stage. The ultimate goal of most cognitive intervention methods is to control his/her

own outcomes, through techniques such as desensitization, self-observation, and in-vivo exposure, all of which are geared toward showing that the individual has a large amount of control over the situation (Chen et al. 2010). For adolescents, the achievement of adequate self-concept and self-esteem can foster relationship building and strengthen resiliency (Myers et al. 2011).

Various cognitive theories originated from Bandura's 1950s social learning theory. Bandura demonstrated that modeling, imitation, or observational learning is an important basis for children's behavior (Berk 2003; Pratt et al. 2009). Cognitive theorists have proposed several major approaches, many of which overlap. These approaches focus both on particular sets of cognitive deficits or ways in which thinking may deviate from the logical, and on the methods by which these errors or deficits may be corrected. The ultimate aim in cognitive intervention is to produce change in the negative attitudes an adolescent has, thus reducing cognitive blocks to appropriate behavior (Gibbons et al. 2012).

Cognitive theorists' investigation of the client's thinking is based on two premises. First, clients think in an idiosyncratic way (that is, they have a systematic negative bias in the way they regard themselves, their world, and their future). Second, the way clients interpret events maintains their cognitive distortions (Tolin 2010).

Cognitive therapists continue to view cognition in the treatment process as the behavior that needs to be modified or as an area that is indirectly changed when the overt behavior is treated, which is what many studies continue to show (Dobson and Dozios 2001). The cognitive therapist attempts to alter what the adolescent thinks in order to effect a change in behavior. The belief is that the therapy should aim at reducing the maladaptive behavior through the carefully guided lead of the therapist using cognitive-behavioral techniques. The focus is on the cognitive beliefs that the client has created, and these faulty beliefs are viewed as a pattern of thinking that needs to be changed in order to alter the maladaptive behavior (McGowan et al. 2005).

Formerly there were believed to be only four types of cognitive distortions (arbitrary interference, overgeneralization, magnification, and cognitive deficiency). However, recent studies by Leahy (2003), and Najavits and colleagues, modified Beck's (1976) scale to make 20 total cognitive distortions. These distortions include: (1) instant satisfaction, (2) mind reading, (3) shoulds, (4) fooling yourself, (5) overreacting, (6) arbitrary interferences, (7) fortune-telling, (8) confusing needs and wants, (9) focusing on the negatives, (10) all or none thinking, (11) catastrophizing, (12) discounting positives, (13) over generalizing, (14) personalizing, (15) regret orientation, (16) short-term thinking, (17) emotional reasoning, (18) negative filtering, (19) labeling, and (20) blaming (Najavits et al. 2004).

To address these distortions, the worker may have the client utilize problem-solving skills that are used throughout his/her life (Gitterman and Heller 2011). In addition, a number of behavioral therapy procedures can be adapted to modify cognitive statements (Tolin 2010). For example, cognitive theorists have emphasized the following cognitive aspects of depression. Beck assigned a primary position to a cognitive triad consisting of a very negative view of the self, of the outside world, and of the future (Gitterman and Heller 2011). This triad is seen as the key to the

consequences of depression, such as the lack of motivation, the affective state, and other ideational and behavioral manifestations. The depressed person's cognitions lead to misinterpretations of experience; hence many of the secondary responses are logical sequences of such misinterpretations. The depressed person is locked in an unsolvable situation, the result of which is further despair which has been shown to be treated significantly well by cognitive-behavioral therapy, especially when followed up by a continuation phase to prevent relapse (Jarret et al. 2001). Research has shown that cognitive behavioral therapy is particularly effective with adolescents suffering from comorbid major depressive disorder and alcoholism (Cornelius et al. 2011). Thus, cognitive responses that can be altered by the therapist are: (1) sense of hopelessness, (2) self-condemnation and self-defeating thoughts, (3) low self-esteem, (4) tension, (5) death wishes, and (6) sense of helplessness.

Successful interventions have been found to have to address the client, the family, school, work, community, the media, as well as other system factors that affect the client's ability to overcome the situation (Skiba et al. 2004). The individual's expectations and assumptions will play a significant role in the success he/she will experience in therapy (Goldfried 2012). In relation to success in therapy, Pratt and colleagues (2009) noted that regardless of the methods used, treatments implemented through the individual's actual performance achieve consistently superior results to those based on symbolic forms of the same approach.

Social Networks

Data suggests that adolescents are at less social risk to develop mental distress if they are socially connected to other peers and family, i.e., these supports can buffer stress, help with stressful events, generally help promote good physical health, provide emotional support, material support, informational support, and several other beneficial effects (Cohen 2004). Alarmingly, however, recent research has also found that best friend dyads tend to report similar levels of depression, so it is critical for adolescents to be socially connected to a variety of people and networks (Giletta et al. 2011).

One of the most perplexing yet critical problems confronting social work professionals interested in prevention is the use of networking for adolescents at risk (Gibbons et al. 2012). Questions that need to be resolved include the following: How can adolescents be tied to the networks available in the community? What peer characteristics may be matched with adolescent attributes to facilitate networking and enhancement of an individual's functioning? What support systems such as the church, extended family, and friends are available to enhance the adolescent networks?

This aspect of prevention would involve developmental programs to utilize efficacious and cost effective assessment procedures to isolate physical, psychological, and social factors that lead to networking. Possible procedures include

(1) assessment of adolescent's attributes; (2) enlistment of social networks and support groups such as family, peers, ministers, and significant adult models to provide necessary support; (3) preparation of the adolescent in terms of emphasizing appropriate social behaviors that will be rewarded and will facilitate integration into the social structure of their peer community; (4) educating the adolescent about support services available and whom to contact and gradually introducing the individual to appropriate and available support systems; and (5) developing appropriate preventative intervention (Goldfried 2012).

Family Prevention

One empirically supported theoretical perspective is anchored within a broad base of a social learning framework (Crittendan 2005). From this viewpoint, the adolescent learns appropriate and inappropriate behavior from the context (that is, parents and peers) in which he/she functions by modeling and reinforcement (Grusec 2011). That is, by observing the behaviors demonstrated by parents who receive or do not receive reinforcement/punishment for engaging in such behaviors, adolescents acquire certain behavior patterns. Furthermore, and of particular importance, if an adolescent functions within a context in which good communications and/or adequate cognitive skills are lacking (e.g. he/she has inadequate knowledge and unrealistic beliefs, expectations or attributions) he/she is more likely to engage in maladaptive behavior patterns through modeling and reinforcement (Grusec 2011).

One of the critical variables that influence an adolescent's development is the family. The particular types of parenting behavior (lack of positive reinforcement, communication skills, and problem-solving skills) can serve as predictors of adolescent problems, and can discriminate between adolescents at high risk who are or developing subsequent interpersonal difficulties (Oliver et al. 2009).

Basically, problem solving involves four steps: problem identification, generation of alternative solutions, decision making, and planning solution implementation (Siu and Shek 2010). Communication involves skills which can be used during problem solving discussions and at other times. Siu and Shek (2010) have identified 20 behaviors that may interfere with effective communication. These include accusing, putting down, interrupting, getting off topic, dwelling on the past, and threatening. Siu and Shek have conducted three well-controlled studies which support the effectiveness of a problem solving communication skills training program for parents. Relative to waiting list control groups and a family therapy approach, problem solving communication skills increase communication and decrease conflicts (Siu and Shek 2010). Furthermore, at follow-ups, improvements achieved with problem solving skills were maintained. Therefore, it would appear that teaching parents to provide appropriate models and improving parents' problem solving and communication skills would be critical ingredients of an adolescent prevention program.

Research Foci

Few would deny the controversy surrounding the efficacy of current social work preventive services aimed at changing adolescent behavior. Issues pertain to where services should be provided and by whom, what is the proper duration of services, and what are appropriate criteria for evaluation. The legal emphasis on providing effective services to clients and the expressed desire to provide social services on an empirical and rational basis are motivating factors in the development of a sound theoretical base (Wodarski and Feit 2011).

Critical questions center on the following issues: What are the relevant human behavior variables that can provide a solid base for structuring prevention services to adolescents? What guidelines can be furnished for structuring services for an organizational perspective? What criteria can be utilized in the evaluation services? How can one delineate the level of intervention of the micro-macro level continuum? Results and products culminating from a number of research projects over the last decade indicate rationale for a more elaborate comprehensive theory of prevention.

It is evident that more elaborate theories of human behavior are needed to provide the rationale for complex therapeutic intervention systems that are based on principles derived from empirical knowledge, with the goal being to prevent adolescent dysfunction. These theories must consider biological, sociological, economic, political, and psychological factors as they interact in the human matrix to cause behavior (Wodarski and Feit 2011). It is a definite challenge for any theory of human behavior to isolate those components that lead to prevention, such as the specific aspects of an intervention package in terms of expectations for change, role of cognitive processes, particular client and social work characteristics, interventions, context of intervention, and so forth. Once this knowledge is developed, the choice of prevention techniques can be made on such criteria as client and worker characteristics, context of intervention, and type of intervention.

Recent evidence suggests that in order for prevention to be successful, macro-level intervention variables have to be considered. An adequate theory of prevention will isolate the social system variables (i.e., legal, political, health, financial, social services, educational, housing, unemployment, etc.) and their effects on human behavior. Moreover, these variables have to be addressed in a manner that focuses on the attainment of prevention and maintenance of behavior. Current theories fall far short of this goal.

Summary

A major challenge to the community mental health approach is the question of timing of the intervention. Prevention places great emphasis on the teaching of components of the interceptive process with social workers attempting to help clients

learn how to exert control over their own behaviors and the environment in which they live. In recognition of the critical role of prevention in improving the mental health of all citizens, it has been suggested that a special staff be set up in each mental health center for prevention programs (Haggerty and Shapiro 2013). The setup of such a branch of programs in mental health centers has been implemented, and while costly, it will surely have been shown, relative to the cost of remedial programs, to have been a bargain to the mental health field.

Additional Resources

Raising Teens
http://hrweb.mit.edu/worklife/raising-teens/ten-tasks.html
Developmental Tasks facing adolescents
http://www.education.com/reference/article/Ref_Adolescence/
Preventative Services for Children
http://www.hhs.gov/healthcare/prevention/children/
Guidelines for Adolescent Children Services
http://www.uptodate.com/contents/guidelines-for-adolescent-preventive-services
Framework for Prevention of Child Maltreatment
https://www.childwelfare.gov/preventing/overview/framework.cfm
Preventive Services
http://www2.monroecounty.gov/hs-preventative.php

References

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4–23.

Abar, C. C., Fernandez, A. C., & Wood, M. D. (2011). Parent-teen communication and pre college alcohol involvement: A latent class analysis. *Addictive Behaviors, 36,* 1357–1360.

Ali, M. M., Amialchuk, A., & Dwyer, D. S. (2011). Social network effects incontraceptive behavior among adolescents. *Journal of Developmental and Behavioral Pediatrics, 32*(8), 563–571.

Baker, S. B. (2001). Coping-skills training for adolescents: Applying cognitive behavioral principles to psychoeducational groups. *The Journal for Specialists in Group Work, 26*(3), 219–227.

Balsa, A. I., Homer, J. F., French, M. T., & Norton, E. C. (2011). Alcohol use and popularity: Social payoffs from conforming to peers' behavior. *Journal of Research on Adolescence, 21*(3), 559–568.

Belles, S., Budde, A., Moesgen, D., & Klein, M. (2011). Parental problem drinking predicts implicit alcohol expectancy in adolescents and young adults. *Addictive Behaviors, 36,* 1091–1094.

Benard, B. (2006). Using the strengths based practice to tap the resilience of families. Boston

Berk, L. E. (2003). Child Development. Boston: Illinois State University.

Brown, B. B., & Bakken, J. P. (2011). Parenting and peer relationships: Reinvigorating research on family-peer linkages in adolescence. *Journal of Research on Adolescence, 21*(1), 153–165.

Cameron, M., & Keenan, E. K. (2010). The common factors model: Implications for transtheoretical clinical social work practice. *Social Work, 55*(1), 63–73.
Casanueva, C., Stambaugh, L., Urato, M., Fraser, J. G., & Williams, J. (2011). Lost in transition: Illicit substance use and services receipt among at-risk youth in the child welfare system. *Children and Youth Services Review, 33,* 1939–1949.
Chen, A. C., Thompson, E. A., & Morrison-Beedy, D. (2010). Multi-system influences on adolescent risky sexual behavior. *Research in Nursing and Health, 33*(6), 512–527.
Cohen, S. (2004). Social relationships and health. *American Psychologist, 11,* 676–684.
Cornelius, J. R., Douaihy, A., Bukstein, O. G., Daley, D. C., Wood, S. D., Kelly, T. M., & Salloum, I. M. (2011). Evaluation of cognitive behavioral therapy/motivational enhancement therapy (CBT/MET) in a treatment trial of comorbid MDD/AUD adolescents. *Addictive Behaviors, 36,* 843–848.
Crean, H. F. (2012). Youth activity involvement, neighborhood adult support, individual decision making skills, and early adolescent delinquent behaviors: Testing a conceptual model. *Psychology, 33*(4), 175–188.
Crittenden, W. F. (2005). A social learning theory of cross-functional case education. *Journal of Business Research, 58*(7), 960-–966
Dobson, K. S., & Dozois, D. J. (2001). Historical and philosophical bases of the cognitive-based behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive behavioral therapies* (2nd ed.). New York: Guilford.
Durlak, J. A., Weissberg, R. P., Dymicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school- based universal interventions. *Child Development, 82*(1), 405–432.
Elliot, L., Orr, L., & Watson, L. (2005). Secondary prevention interventions for young drug users: A systematic review of the evidence. *Adolescence, 40,* 1–22.
Esbensen, F. (2000). Preventing adolescents gang involvement. Office of juvenile justice and delinquency prevention.
Fisak, B. R., Richard, D., & Mann, A. (2011). The prevention of child and adolescent anxiety: A meta-analytic review. *Prevention Science, 12*(3), 255–268.
Gavazzi, S. M. (2011). *Families with adolescents: Bridging the gaps between theory. Research and practice*. New York: Springer.
Gibbons, F. X., Kingsbury, J. H., & Gerrard, M. (2012). Social-psychological theories and adolescent health risk behavior. *Social and Personality Psychology Compass, 6*(2), 170–183.
Giletta, M., Scholte, R. H. J., Burk, W. J., Engels, R. C. M. E., Larsen, J. K., Prinstein, M. J., & Ciairano, S. (2011). Similarity in depressive symptoms inadolescents' friendship dyads: Selection or socialization? *Developmental Psychology, 47*(6), 1804–1814.
Gitterman, A., & Heller, N. R. (2011). Integrating social work perspectives and models with concepts, methods and skills with other professions' specialized approaches. *Clinical Social Work Journal, 39*(2), 204–211.
Goldfried, M. R. (2012). On entering and remaining in psychotherapy. *Clinical Psychology and Practice, 19*(2), 125–128.
Grusec, J. E. (2011). Socialization processes in the family: Social and emotional development. *Annual Review of Psychology, 62,* 243–269.
Haggerty, K. P., & Shapiro, V. B. (2013). Science-based prevention through communities that care: A model of social work practice for public health. *Social Work in Public Health, 28*(3–4), 349–365.
Hamby, A., Pierce, M., Daniloski, K., & Brinberg, D. (2011). The use of participatory action research to create a positive youth development program. *Social Marketing Quarterly, 17*(3), 2–17.
Hanlon, T. E., Bateman, R. W., Simon, B. D., O'Grady, K. E., & Carswell, S. R. (2002). An early community based intervention for the prevention of substance abuse and other delinquent behavior. *Journal of Youth and Adolescence, 31*(6), 459–472.
Harrell, A. W., Mercer, S. H., & DeRosier, M. E. (2009). Improving the social-behavioral adjustment of adolescents: The effectiveness of a social skills group intervention. *Journal of Child and Family Studies, 18*(4), 378–387.

Hawkins, J. D., & Weis, J. G. (2005). The social development model: An integrated approach to delinquency prevention. *The Journal of Primary Prevention, 6*(2), 73–97.

Jarret, R. B., Kraft, D., Doyle, J., Foster, B. M., Eaves, G. G., & Silver, P. C. (2001). Preventing recurrent depression using cognitive therapy with and without a continuation phase. *Arch Gen Psychiatry, 58,* 381–388 (Journal of Business Research, 58, 960–966).

Kazdin, A. E. (2011). Evidence-based treatment research: advances, limitations, and next steps. *American Psychologist, 66*(8), 685–698.

Leahy, R. L. (2003). Cognitive therapy techniques: A practioner's guide. New York: Guilford.

Lewis, T. J., Jones, S. E. L., Horner, R. H., & Sugai, G. (2010). School-wide positive behavior support and students with emotional/behavioral disorders: Implication for prevention, identification and intervention. *Exceptionality: A Special Education Journal, 18*(2), 82–93.

McGowan, J. F., Lavender, T., & Garety, P. A. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinician's views. *The British psychological society journal, 78,* 513–529.

Mrug, S., Borch, C., & Cillessen, A. H. N. (2011). Other-sex friendships in late adolescence: Risky associations for substance use and sexual debut? *Journal of Youth and Adolescence, 40,* 875–888.

Myers, J. E., Willse, J. T., & Villalba, J. A. (2011). Promoting self-esteem in adolescents: The influence of wellness factors. *Journal of Counseling and Development, 89*(1), 28–36.

Najavits, L. M., Gotthardt, S., Weiss, R. D., & Epstein, M. (2004). Cognitive distortions in the dual diagnosis of PTSD and substance use disorder. *Cognitive Therapy and Research, 28,* 159–172.

Oliver, P. H., Guerin, D. W., & Coffman, J. K. (2009). Big five parental personality traits, parenting behaviors, and adolescent behavior problems: A mediation model. *Personality and Individual Differences, 47*(6), 631–636.

Ozer, E. M., Adams, S. H., Orrell-Valente, J. K., Wibbelsman, C., Lustig, J. L., Millstein, S. G., Garber, A. K., & Irwin, C. E. (2011). Does delivering preventive services in primary care reduce adolescent risky behavior? *Journal of Adolescent Health, 49*(5), 476–482.

Pratt, T. C., Cullen, F. T., Sellers, C. S., Winfree, L. T., Madensen, T. D., Daigle, L. E., Fearn, N. E., & Gau, J. M. (2009). The empirical status of social learning theory: A meta-analysis. *Justice Quarterly, 27*(6), 765–802.

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review, 30*(5), 496–516.

Santrock, J. W. (2003). Psychology 7ed. New York: McGraw Hill

Siu, A. M. J., & Shek, D. T. L. (2010). Social problem solving as a predictor of well-being in adolescents and young adults. *Social Indicators Research, 95*(3), 393–406.

Skiba, D., Monroe, J., & Wodarski, J. (2004). Adolescent substance use: Reviewing the effectiveness of prevention strategies. *Social Work, 49*(3), 343–353.

Smith, C. & Thornberry, T. P. (2006). The relationship between childhood maltreatment and adolescent involvement in delinquency. *Criminology, 33*(4), 451–481.

Steinberg, D. M. (2010). Mutual aid: A contribution to best-practice social work. *Social Work with Groups, 33*(1), 53–68. (Strengths Perspective in Social Work Practice. Boston: Pearson Press).

Tibbits, M. K., Smith, E. A., Caldwell, L. L., & Flisher, A. J. (2011). Impact of Health Wise South Africa on polydrug use and high-risk sexual behavior. *Health Education Research, 26*(4), 653–663.

Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clinical Psychology Review, 30*(6), 710–720.

Weisz, J. R., Sandler, I. N., Durlak, B. S., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*(6), 628–648.

White, J., & Halliwell, E. (2011). Family meal frequency and alcohol and tobacco use in adolescence: Testing reciprocal effects. *The Journal of Early Adolescence, 31,* 735–749.

Wodarski, J. S., & Feit, M. D. (2011). Adolescent preventive health and Team-Game- Tournament: Five decades of evidence for empirically based paradigm. *Social Work in Public Health, 26*(5), 482–512.