1 The Practice and Science of Prevention: Introduction and Overview

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> An ounce of prevention is worth a pound of cure.
> —Benjamin Franklin, *Pennsylvania Gazette*, February 4, 1735

> If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.
> —Lilla Watson, 1985 United Nations Decade for Women Conference, Nairobi

1.1 Focus of This Book

This book fills an important gap in the growing field of prevention, that is, to provide training, resources, and exemplary illustrations of evidenced-based prevention programs for students, practitioners, researchers, educators, and policy makers to utilize in developing and implementing their own prevention initiatives. The specific aims of this book are twofold:

1. to provide training for students, educators, and practitioners in psychology, social work, human services, medicine, and public health in designing and implementing prevention, and
2. to highlight established and promising model programs in health promotion and prevention that may reduce the negative effects for people and communities struggling with psychological disorders, trauma, or mental distress.

1.2 Chapter Authors' Perspectives

One of my (Sally) favorite tasks as founding editor of the *Journal of Prevention and Health Promotion* (https://us.sagepub.com/en-us/nam/journal-of-prevention-and-health-promotion/journal203644, *JPHP*, Sage) is presenting the annual *JPHP* Best Paper Award to an author or set of authors whose work stands above the rest. In 2022, I presented this award to Dr. Richard Lee who, with his colleagues Xiaug Zhou and Judy Ohm, wrote an outstanding

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paper about the Incredible Years Attentive Parenting program (Zhou et al., 2021). When Dr. Lee accepted the award, he remarked that as mental health professionals, "prevention is in our bones, but it is not in our training" (R. Lee, personal communication, August 6, 2022). Long after hearing this remark, I pondered the meaning of these words and the larger context in which they were uttered. The majority of mental health professionals believe wholeheartedly in the importance of prevention, yet few of us engage in or purport to have the skills and knowledge to actually carry it out. This discrepancy – between our beliefs and our actions related to prevention– not only creates ethical dissonance but likely contributes to burnout among mental health professionals, many of whom indicate they feel overwhelmed by being unable to meet current demand for mental health services. Nearly half of psychologists report feeling burned out during the past year (APA, 2022).

As a practicing mental health professional, I (Mary) have been fortunate to work in fast-paced, acute settings providing care to a wide variety of presentations, demographics, and levels of need. It has been a privilege to be schooled in evidence-based practice in order to provide the most effective treatment possible to the people I serve. Throughout my training and practice, it has been astoundingly apparent that the need for prevention in the mental health setting is essential. While such a need is evident, what is less evident is the manner in which mental health professionals can actually implement preventative measures with clients, students, and communities. It is for this reason that this volume is of extreme interest to me as a provider. In an era in which we are seeing more attention given to the research–practice gap, this book is a welcome resource for taking the current research and offering practical, empirically supported recommendations for prevention in clinical practice.

1.3 How Clinical Experience Informs This Chapter

Well-intentioned clinicians are taught to look toward symptoms and diagnoses to guide treatment. In an era of increasing importance placed on evidence-based practice, such an approach allows practitioners to match a client's presentation with empirically supported treatments that literature tells us have the best chances of offering improvement. There is nothing inherently "wrong" with this approach; it is indeed the therapist's responsibility to provide care to a client using interventions grounded in scientific evidence. While not inherently "wrong," it is nonetheless an approach of omission. It omits an orientation toward prevention.

Post-pandemic times have revealed both an increase in demand for psychotherapeutic intervention and a shortage of available mental health professionals. Given substantial waiting lists and populations that remain chronically

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underserved, prevention allows practitioners the opportunity to intervene before the wait-list of need exceeds who the clinician can serve and before burnout impedes their work. The guidelines, recommendations, and interventions detailed in this book provide the practitioner with specific, culturally informed strategies for prevention-oriented practice. As trainees, mental health providers are presented with intensive theoretical knowledge intended to be implemented in field placements and entry-level positions. Novice practitioners develop applied skills under the supervision of more experienced professionals guiding their interventions. The normative process is to be handed a new client, conceptualize the case for presentation to the treatment team, and develop a treatment plan in response to "chief complaints" and "presenting problems." It is thus my (Mary's) fortune as an early career practitioner to be emerging in a time in which prevention is of increasing focus. I will provide anecdotes from my clinical practice in support of just how relevant preventive efforts are to the current field of health service psychology.

After several years providing care for individuals with eating disorders, the utility of prevention is evident. I have seen devastating consequences from these illnesses, ranging from severe medical complications to impaired mental health to families torn apart in the wake of a loved one's struggle to be nourished. The tragic state of eating disorder life, one cultivated in trauma and adversity, family and relational conflict, genetic vulnerability, and sociocultural pressures, is one pouring out a need for prevention. The National Eating Disorders Association (NEDA) recognizes the need for eating disorder prevention programs while describing modest benefits of existing programs (NEDA, n.d.). Many existing prevention efforts target sociocultural pressures (Ciao et al., 2014), including the Body Project (Stice et al., 2012). A widely implemented dissonance-based prevention initiative for adolescents and college students, the Body Project has been found to be moderately to highly effective in preventing eating disorder development among participants (Becker & Stice, 2017; Stice et al., 2012, 2017). Positive outcomes have also been observed when the Body Project has been implemented among diverse racial and ethnic groups (Stice et al., 2021).

Crucial research efforts, both recently completed and currently in progress, have targeted genetic vulnerability to better understand the biological susceptibility to eating disorders (e.g., ANGI study [Watson et al., 2019]; EDGI study [Bulik et al., 2021]). Within the growing field of eating disorder research, food insecurity is a risk factor of increasing awareness. Individuals who experience inconsistent access to nutritional intake are at elevated risk of developing eating disorder symptoms (Christensen et al., 2021; Hazzard et al., 2020). While the literature continues to unfold more evidence that food insecurity is a risk factor for eating pathology, an absence of prevention initiatives exists that are targeted directly at the relationship between food insecurity

and eating disorders. The emerging literature on factors contributing to eating disorder development contains exciting implications for prevention; with enhanced understanding regarding disordered eating etiology, we can generate better-informed preventive efforts targeting vulnerable populations. Such efforts must involve community participation, address both eating disorder symptom severity *and* the very onset of these disorders, and receive more research attention to better understand their efficacy (Stice et al., 2013).

In addition to appreciating the role of prevention in eating disorder care, I am also reminded of the journeys of clients with whom I have worked in medical settings, pawns in the game of health-care chess; they are shuffled from one provider to the next in times of crisis. Consider the cardiac patient recovering from a myocardial infarction, pumped with new medications, adjusting to lifestyle and dietary changes, and living in the aftermath of a near-death experience. Consider the motor vehicle accident survivor who obtained a traumatic brain injury, plagued now with memory and concentration problems, left scrambling to recreate life as they navigate their injuries. They may receive state-of-the-art medical care, yet they remain left in a period of adjustment to new health-care regimens, new physiological processes, and new identities and health statuses.

I am optimistic upon consideration of emerging prevention trends in the field of health psychology. Going back to the example of the cardiac patient, it is imperative to consider the association between cardiovascular disease and mental health problems (Centers for Disease Control and Prevention, 2020; Chaddha et al., 2016; De Hert et al., 2018). While many bidirectional factors may be at play in the relationship between heart disease and mental health problems, the need for prevention is apparent. Cardiac rehabilitation programs offer a secondary prevention intervention for cardiovascular patients that includes psychological intervention as a component tantamount to other components such as regulating blood pressure, optimizing physical activity, and enhancing nutrition (Winnige et al., 2021). Research even suggests that cardiac rehabilitation participation is more common among people who experience mental health problems such as depression and posttraumatic stress disorder (Krishnamurthi et al., 2019). It is encouraging to see positive outcomes across health domains reported in studies on such cardiac rehabilitation programs (e.g., Listerman et al., 2011; Martin et al., 2012; Pintor Reverte et al., 2021; Taylor et al., 2022).

Ultimately, in this book, practitioners across settings are provided with a multitude of empirically supported, culturally informed, practical techniques for meaningful prevention. As a clinician, it is exciting and refreshing to see detailed discussion on prevention for individuals with psychosis in this book. Sadly, I have observed fatalistic, complacent, symptom-focused attitudes toward this population; I know I am far from unique with this observation. It

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is refreshing to read positive outcomes from a program designed to prevent increased problems in individuals with first-episode psychosis. The practitioner is offered prevention recommendations tailored for unique developmental, clinical, and other demographic populations. From individual therapy to system-oriented change, this book gives mental health practitioners valuable prevention strategies for applied practice. In Section 1.4, we offer strategies for applied practice to better face the mental health crisis we find ourselves in at that time.

1.4 The Mental Health Crisis in the United States

A recent snapshot of the state of mental health in the United States (Reinert et al., 2021) details an alarming array of statistics. In 2022 (pre-COVID), approximately 50 million or one in five adults had a mental illness. A 2023 report by Mental Health American (MHA) indicated that the prevalence of adults with mental illness ranged from 17.49% in Florida to 29.68% in Utah. More than half of adults with a mental illness (i.e., 27 million people) did not receive any treatment (Mental Health America, 2023). Further, over 60% of youth with major depression did not receive any treatment, and more than 11% of Americans with mental illness were uninsured (Reinert et al., 2021). These numbers point to the overwhelming inadequacy of our public mental health system as well as the critical need for mental health professionals to engage in prevention.

In comparison with other public health systems around the world, the United States ranks at the bottom in terms of universal health-care coverage, lagging far behind similarly wealthy nations that censure equitable access to medical services, reduce administrative inefficiencies, and invest in social programs. Limited access to health care and increases in poverty amid the COVID-19 pandemic have also exacerbated the problem, especially for marginalized groups, such as communities of color, people who identify as sexual and gender minorities, and people who are low income (Schneider et al., 2021).

Moreover, since 2020, the COVID-19 pandemic has presented a growing and unremitting threat to people's lives, their physical welfare, and their psychological and social well-being (Galea et al., 2020). Furthermore, killing of Black Americans, such as George Floyd and Tyre Nichols, and the Black Lives Matter movement have illuminated the persistent and tenacious health, social, and economic disparities that undermine the lives of entire communities and, in particular, marginalized communities in the United States. Finally, the advent of climate change and extreme weather events are causing extreme hardship in this country and throughout the world. In the context of these stress-inducing events, mental health has plummeted, with one in three Americans (32%) and nearly half of millennials (48%) indicating that

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they are sometimes so stressed that they struggle to make even basic decisions, such as what to wear and what to eat (APA, 2021).

Those of us working as health-care professionals discover, time and time again, when working with clients and communities that the mental health issues presented to us as individual "problems" began long before we ever see the client. The seeds of psychopathology and mental distress are often planted in the systemic challenges that people face – poverty, racism, sexism, homophobia, interpersonal abuse or family violence, discrimination, and lack of community or connectedness. A subtle but deep awareness of underlying reasons for mental health concerns truly is in our "bones," and it is our hope that the wisdom and practical training related to how to engage in prevention practice and research found in this book will fuel a passion in mental health professionals to create lasting mental health in our clients and communities. This introductory chapter will lay the groundwork for the chapters that follow. In this chapter, we provide a definition of prevention, a rationale for expanding prevention activities in mental health service and training, and an overview of the model prevention programs that will be presented in this book.

1.5 What Is Prevention?

The definition of prevention employed in this book is a broad-based framework to guide prevention activities, and it is taken from a seminal article I [Sally] co-authored more than 20 years ago (Romano & Hage, 2000). Prevention includes one or more of the following elements. First, it is targeted at stopping (preventing) a problem behavior from ever occurring, which historically has been called primary or universal prevention (Caplan, 1964; Gordon, 1983). Examples of primary prevention include a school-based bullying prevention or social and emotional learning program that is routinely presented to all students in a school. A second type of prevention, often called secondary or selective prevention (Caplan, 1964; Gordon, 1983), is aimed at early identification of symptoms of a mental health problem or disorder, so as to delay the onset or duration of a problem behavior. Examples of secondary prevention include screening days for depression on a college campus so as to prevent severe depression or suicidal risk or a dating violence prevention program for youth with a history of violence in their family.

A third type of prevention is called tertiary or indicated prevention (Caplan, 1964; Gordon, 1983) and is focused on reducing the impact of an existing mental health problem or behavior. An example of indicated or tertiary prevention includes a harm-reduction prevention program for college students who drink alcohol heavily or use drugs and have experienced or who are at risk for alcohol or substance-use-related problems. In sum, these first

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three types of prevention – primary, secondary, and tertiary – often apply to individual, group, or community interventions with individual clients. Working with individuals is the cornerstone of what mental health professionals, quite literally, the bread and butter of what we do. However, if we are *truly* going to make a difference in changing the widespread mental health problems in the United States, namely, the fact that at least 21% or 50 million adults and more than 15% of youth struggle with a mental illness (Reinert et al., 2021), then we need to broaden the focus of our professional efforts to add community-based, institutional, and policy-based health-promoting preventative interventions, which describe the final two types of prevention.

The next two types of prevention include environmental or systemic intervention that aims to create social and health equity. The goal of the first of these systemic interventions is to strengthen knowledge, attitudes, and behaviors that promote emotional, psychological, and physical well-being (Hage et al., 2007; Romano & Hage, 2000). Activities include those focused on health promotion, building strengths, and attending to wellness and resources in communities in which we work. One example of this type of prevention is the Fun for Wellness (FFW) Program, which is a global, online behavioral intervention that encourages growth in well-being by providing capability-enhancing learning opportunities to the participants. The FFW program utilizes self-efficacy theory to promote physical activity, and evaluations of FFW demonstrate that participation in the program produces significantly higher subjective well-being scores, as compared to a wait-list control group (Myers et al., 2019).

The final type of prevention is aimed at systemic policy change that promotes institutional, community, and government policies that further physical, social, psychological, and emotional well-being (Hage et al., 2007). One example of a governmental policy that promotes emotional and physical well-being and equity is New York State Education Law on bullying prevention (*The Dignity for All Students Act*, 2010). The goal of this act is to ensure a safe and supportive environment free from discrimination, intimidation, taunting, harassment, and bullying on school property, a school bus, and/or at a school event. In addition, this bullying prevention act also requires prevention education aimed at positively impacting school culture and climate, in order to reduce harassment and discriminatory behaviors. Further, a level of accountability exists as the act also requires school administrators to collect and report data regarding incidents of discrimination and harassment.

1.6 The Critical Need for Training in Prevention

The failure to incorporate prevention practice and research in the training of mental health professionals has been widely documented (Albee, 2000; Lichtenberg et al., 2018; Romano & Hage, 2000). For example, Matthews

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(2003) surveyed training directors from APA-accredited counseling psychology programs and found that close to 75% of counseling psychology programs did not offer any prevention-specific courses. This void in prevention courses was in spite of the fact that 80 of respondents reported viewing prevention as important to the field of psychology, and 70% reported believing that prevention should receive increased attention in training. In a more recent national study, Lichtenberg et al. (2018) surveyed 799 psychologists about their professional activities, and the authors compared the results to an earlier survey completed in 2000. They found that the mean percentage of time mental health professionals devoted to prevention had actually declined over time, from spending about 10.5% to 9.2% of their time on prevention activities. This means that mental health professionals likely spend about 90% of their time in direct service, coined remedial work or research. In this same survey, prevention was identified as eighth in importance in terms of core values of these practitioners (only career and research were less valued). Further, mid- and late-career professionals placed higher value on preventative interventions that did early career professionals. A commitment to prevention work seems to be falling, despite the current mental health crisis, which follows the "unfathomable" stress of COVID-19 (APA, 2021; Office of the Surgeon General [OSG], 2021).

While the previous findings suggest a decline in prevention, they stand in stark contrast to recent advances in psychology-related policy initiatives on prevention. For example, APA endorsed a set of practice guidelines on prevention (APA, 2014), and Division 17 of APA started a new journal on prevention, namely, the *Journal of Prevention and Health Promotion* (Sage Publications). The *APA monitor* also recently released their top eleven trends of 2023, with four of these trends specifically targeted at prevention activities, including suicide prevention (Clay, 2023), social connectedness in schools to address "record high levels of anxiety and depression" (Abrams, 2023, p. 63), a focus on worker well-being (Stringer, 2023), and a call to "rebrand the field" of psychology to "take a more preventive approach" (Weir, 2023, p. 88). This inconsistency – between actual prevention happenings and a growing awareness of the critical need for prevention – points to the imperative of implementing training to prepare mental health professionals to do prevention work.

1.7 Why Current Approaches to Training Are Limited

One of the most significant arguments for a prevention focus is that it would address existing disparities in mental health care, which have been exacerbated by the recent mental health epidemic. Traditional psychological treatments are not only in short supply, but they are limited by their tendency to be reactionary and overly focused on symptoms, while ignoring systems such

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as oppression and institutional barriers. Racial/ethnic, gender, and sexual minorities often suffer from poorer mental health outcomes due to several factors, most notably, inaccessibility of high-quality mental health-care services, stigma surrounding mental health care, discrimination, and lack of awareness about mental health.

For example, American Indians and Alaska Natives males, aged 18–24, experienced the highest suicide rate in the United States during the pandemic. The higher rates have been associated with COVID-19, including negative social (e.g., community gatherings postponed), cultural (e.g., inability to gather for ceremonies), and economic (e.g., loss of tribal revenue to fund local services) consequences. Additional cited factors include lack of clinician cultural responsiveness, stigma, under resourced mental health care, and structural barriers to accessing services, which are related to mental health inequities (Bridget et al., 2023).

1.8 Why Mental Health Professionals Are Uniquely Poised to Include Prevention in Our Work

Despite a dearth of training opportunities in prevention, mental health professionals may be in the very best position to engage in prevention work. One major reason for this assertion is that accreditation requirements for mental health professions include knowledge and skill competency domains important in preparing mental health professionals to engage in prevention work (Conyne, 1997; Hage et al., 2007; O'Neil & Britner, 2009). These domains include: (a) understanding distinctions between preventive and remedial approaches; (b) designing and implementing educational programs; (c) assessing community needs; (d) understanding systemic approaches that incorporate cultural and contextual factors into preventive interventions; (e) collaborating with interdisciplinary teams that include professionals and community leaders; (f) promoting positive development across the lifespan; (g) empowering individuals and communities to work on their own behalf; (h) developing strength-based approaches that reduce risk and enhance resilience in individuals and communities; (i) influencing policy decisions and their impact on prevention efforts; and (j) evaluating prevention interventions. In sum, mental health professionals may be in the very best position, due to their training and credibility with community leaders, to engage in preventative work in their communities.

Similarly, a CDC report released in February 2023 indicates that nearly 3 in 5 (57%) teen girls in the United States in 2021 felt persistently sad or hopeless, and nearly 1 in 3 (30%) seriously considered attempting suicide – both statistics were double that of boys, representing a nearly 60% increase and the highest level reported over the past decade. Similarly, Hispanic and

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Latina girls in grades 9–12 report almost twice as many suicide attempts as their non-Latinx White peers; yet both these groups have less access, quality, and overall mental health care (Center for Disease Control and Prevention, 2022; Schnitzer et al., 2023). It is clear that racial/ethnic health inequities exist and are tied to several factors, such as supply and demand related to mental health treatment services, stigma, and discrimination, as well as institutional barriers related to lack of access, systemic inequities, and deficits in cultural responsiveness among providers. These factors can only be addressed by reducing incident rates and instituting policy changes through prevention and health promotion interventions, including structural changes to expand access to health care and wellness-related practices.

In addition, while a dearth of prevention training exists in mental health training programs, a new focus on addressing social and contextual factors in mental health has emerged. Many of the prevention approaches described in this book may be conceptualized as largely synonymous with social justice (Coard et al., this volume; Liang et al., this volume; Tucker et al., this volume; Vera et al., this volume). These interventions align with emerging trends in critical and liberation psychology that calls upon mental health professionals to address environmental factors (not just individual or person-focused dimension) (Hage & Kenny, 2009; Kenny & Hage, 2009), "name oppressive structures and systems within our society," and "to communicate their commitment to countering injustices and how they wish to work alongside their client(s)" (Singh, 2020, p. 219).

Further, prevention efforts with marginalized communities are a positive step both in addressing health inequities while reducing the overall cost of health care (Maciosek et al., 2010; Tolan & Dodge, 2005). For example, the Washington State Institute for Public Policy's analysis of an elementary-school-based preventative intervention called the Good Behavior Game saved taxpayers $25.92 for each dollar invested. Similarly, an analysis of the Communities That Care prevention system, which helps communities utilize their resources most effectively to address identified risk factors for substance use, aggression, and other problems in youth, showed that an approximately $602 investment in each child yielded an estimated $7754 in savings by the time participants were aged 23 – a $12.88 return for each dollar invested (Volkow, 2022). In other cases, prevention programs may be deemed cost effective, meaning that they may not save money but rather they improve health at a price that is considered good value for the funds that are spent (Baid et al., 2021).

The positive impact of prevention interventions on increasing healthy functioning and decreasing psychological distress has been demonstrated across several studies (Catalano et al., 2002; Durlak et al., 2007; Evidence-Based Practices Resource Center, 2023; Greenberg et al., 2001; O'Connell

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et al., 2009). The integral components of successful prevention interventions include social and cultural relevance, a strong theoretical base, comprehensiveness (multicomponent interventions that address multiple ecological levels, such as individual, family, school, community, and of sufficient dosage), developmental appropriateness, and a focus on person- and environment-centered change (Nation et al., 2003; Walsh et al., 2009). Effective programs also have well-trained staff and support positive relationships with adults and peers (Durlak, 2003, Nation et al., 2003; Rotheram-Borus & Duan, 2003).

1.9 Theoretical Framework for This Book

This *Ounce of Prevention* book does not promote one particular theory, discipline, or research methodology. That said, this book includes an intentional integration of multicultural and social justice content throughout, recognizing the importance of addressing the social and cultural context and systems when engaging in prevention work (Hage et al., 2020). The prevention and health promotion programs highlighted in this book are evidenced-based and mirror recent developments in the field of prevention and health promotion related to optimizing the efficacy of preventative programming.

These developments include the critical importance of focusing on societal change (i.e., going beyond individual change), as long-term success requires also engaging in social and policy change efforts in systems and institutions (Banyard & Hamby, 2022; Prilleltensky, 2008). In addition, the highlighted programs are theory-based (Nation et al., 2003), and they address the importance of ongoing evaluation to improve outcomes (Maxwell et al., 2015), along with tailoring prevention interventions to be culturally responsive to the specific communities in which they are implemented (Jones & Neblett, 2016; Reese & Vera, 2007). This cultural responsiveness means direct collaboration with a target community in designing, implementing, and evaluating the program (Anyon et al., 2018; Gittelsohn et al., 2020). Further, the innovative prevention programs in this book reflect an approach that is strength-based (not just admonishment programs or those that focus on negative behaviors) and aim to measure concrete changes in behavior and/or behavioral intention, not just changes in knowledge or attitudes (Banyard & Hamby, 2022). Finally, the book has an explicit emphasis on tailoring prevention to developmental level of the target community in which it is implemented, and illustrations of model programs are presented across the lifespan.

A feature of this book is the strong integration of the practice and science of prevention, utilizing a multidisciplinary perspective, appealing to students, educators, practitioners, researchers, and policymakers from a diverse number of specialty areas in the mental health fields. The book is comprehensive, and topics address psychological practices and model interventions

across the lifespan and include detailed discussion of program development and implementation, which is not typically taught in counseling and psychotherapy theory courses and other applied areas. Students and practicing psychologists often have interest in prevention, and they may be asked to engage in prevention activities during their career. However, until recently psychologists and counselors generally received little, if any, training during their academic programs in how to plan and implement prevention programming. The book fills a gap in providing training and exemplary prevention interventions and effective research strategies, aimed at addressing emerging trends in psychology, which include a focus on systems and social justice. Finally, the book reflects the application of the aspirational principles and guidelines APA's Professional Practice *Guidelines for Prevention in Psychology* (APA, 2014).

1.10 Organization of This Book

Each chapter illustrates the design and evaluation of an evidence-based program focused on a particular period in the lifespan. These developmental periods are broken up into (a) prevention with children and youth,(b) prevention with emerging adults, and (d) prevention with adults, including older adults, and families. The overall goal of each chapter is to provide readers with illustrations of model prevention programs, concrete tools, resources, and strategies to design and evaluate culturally specific prevention programs in their own communities.

The first section of the book lays for the foundational knowledge and skills for the remainder of the book. In the first chapter, a definition of prevention is presented along with a compelling rationale for the need for an expanded focus on prevention training, practice, and research. In addition, a theoretical framework for the book is presented along with an in-depth focus on clinical training and how mental health professionals are uniquely poised to engage in prevention work.

The second section of the book presents four evidenced-based, model prevention programs that address racial health disparities, discrimination, and the structural inequalities with children and youth. These interventions include the Black Parenting Strengths and Strategies (BPSS; Coard [this book]) program that promotes positive and culturally relevant parenting practices for fostering cultural, social, and behavioral competence in African American children. A second intervention, City Connects, has a 20-year track record of providing an evidence-based intervention that helps teachers and schools provide integrated supports to address the unique needs of students in schools serving underresourced neighborhoods and families. In their chapter, Walsh et al. detail how City Connects utilizes a public health/clinical model to intervene at individual,

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group, and school levels to ensure that each student is provided with a support plan tailored to their unique needs and strengths. The third chapter in this section provides impactful illustrations of school-based systems-centered interventions that focus on improving school climate and educational resources, particularly for BIPOC, immigrant, and refugee children and families. These interventions adopt Mahoney et al.'s (2021) systemic social-emotional learning framework and uniquely draw on the strengths of students' family systems and the broader community to promote well-being in BIPOC youth. The final chapter in this section presents a race-centered, trauma-responsive, transformative school approach that is responsive to family- and community-based trauma. This framework provides tools to reduce negative outcomes of child of the global majority (i.e., Black, Indigenous, Asian, Latinx, the Global South) and to interrupt the current prevailing school-to-prison pipeline (Liang et al., this volume).

The third section of the book centers on emerging adults, defined as people in the developmental period from the late teens through the 20s, with a particular focus on ages 18–25 years (Arnett, 2000). Arnett's research suggests that emerging adulthood is a distinct period demographically, subjectively, and finally, in terms of identity explorations. The first paper in this section, by Vaughan and colleagues, presents several examples of evidence-based prevention interventions to address problematic substance use and substance use disorders among emerging adults. The authors utilize an ecodevelopmental and multicultural framework to target risk and protective factors of substance use, with a focus on Latinx emerging adults. The next chapter is written by the founder of the Bandana Project (www.thebandanaproj.org), Conlin Bass, a nation-wide campaign to raise awareness of the importance of mental health and to reduce the risk of suicide by engaging supportive peers in facilitating the help-seeking behavior of those at risk. Bass (this volume), who was an undergraduate when he developed the Bandana Project, went on to earn a public health degree from Yale and aptly describes the context for this movement and how to start your own chapter. The third chapter details key strategies and evidence in developing an effective and comprehensive campus-based sexual violence prevention program (Cook-Craig, this volume). Cook-Craig adopts a public health model to effectually describe how to choose a prevention strategy and how to implement and evaluate a campus-based program.

The final chapter in this section details the development of an experiential learning curriculum, Changing Minds, Changing Lives, that aims at buffering stress, boosting adaptive resilience by fostering connections, and promoting healthy growth in college students, particularly in college athletes and first generation and BIPOC students and students from underresourced public schools. Outcomes of the program include social–emotional skill development and personal growth and transformation. The final section of the book

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aims at model prevention evidenced-based interventions with adults and families. The first of these programs, the Kid's Club and Mom's Empowerment Program that has been adopted both nationally and internationally, targets mothers and their children who have been exposed to intimate partner violence. The ten-week programs (one for children and one for moms) foster resilience, parenting emotional regulation, safety planning, stress management, and problem-solving skills (Graham, this volume). The next chapter describes two variations of an evidence-informed, culturally sensitive health promotion program for Black adults, the Health-Smart Holistic Health Program (for seniors) and the Health-Smart for Weight Loss (for Black women). What makes these grant-funded interventions especially noteworthy is that they were developed using a community-based participatory action research approach that works in partnership with community members/leaders who were involved in all aspects of the planning, implementation, and evaluation of the interventions.

The next chapter details a unique, innovative Psychosis Identification and Early Referral (PIER) program (McFarlane et al., this volume). This nationwide evidence-based, family- and community-aided program targets early intervention with youth at risk of psychosis, significantly minimizing the impact of mental illness (e.g., schizophrenia) in adolescents and young adults so they can live healthy, rewarding, and productive lives. The program incorporates best practices in adapting the program to fit a client's cultural background and urging cultural humility and competence of facilitators. The final chapter in this section focuses on older adults and in particular, aims at reducing the negative impact of the transition to retirement. In this chapter, Conyne (this volume) presents a five-phase Charting Your Personal Future intervention that draws on a person-centered enhancement approach, aimed at promoting well-being and resilience and aimed at buffering the losses and negative impact of the transition. The final chapter in the book synthesizes the lessons learned across the chapters and charts a course for future directions in the field of prevention and health promotion. We offer a blueprint for training, interdisciplinary community collaborations, evaluation and dissemination of evidence, and future practice. Each chapter also includes a detailed list of resources for readers who wish to delve further into the topic of the chapter. These resources provide further reading and sources of knowledge, skills, and strategies for the reader who is ready to further their learning beyond this book.

1.11 Conclusion

In our work as counselors, mental health professionals, psychologists, educators, and researchers, we often feel powerless to prevent human suffering, and yet, we

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may yearn, deep in our hearts, for a way to intervene earlier so as to prevent or reduce the pain and distress in our communities, intuitively aware that a way to make our clients' lives easier and our work more impactful exists. This book is about giving mental health professionals the knowledge, resources, and tools to engage in "before the fact" intervention, to apply an ounce of prevention to the work we do, knowing that, ultimately, it will be worth a "pound of cure," while also better aligning our deepest hearts with our work and significantly expanding the depth and breadth of our impact. The model programs in this book illustrate strength-based, culturally informed efforts to work with families and communities instead of around public health problems. This approach, as noted in the quote by Lila Watson at the beginning of this chapter, is by necessity collaborative and ties the liberation of an individual with that of the entire community.

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