Promoting Child and Family Wellness: Priorities for Psychological and Social Interventions

ISAAC PRILLELTENSKY* and GEOFFREY NELSON
Department of Psychology, Wilfrid Laurier University, Waterloo, Ontario, Canada

ABSTRACT

In order to foster the well-being of children and families we propose a shift in the priorities of psychological and social interventions. Following a brief discussion of the concept of wellness, we present a framework for interventions to promote child and family wellness. Psychological and social intervention strategies to promote child and family wellness are then reviewed and interpreted in terms of the framework. Recommendations for changing priorities for programmes and policies are based on the framework and a review of the effectiveness of existing interventions. Copyright © 2000 John Wiley & Sons, Ltd.

Key words: prevention; children; mental health; values; social justice; ecological interventions; social change

INTRODUCTION

There is a well known adage that prevention is better than cure, but departments and ministries of health in Canada and the US devote less than 1% of their budgets to the prevention of mental health problems. Most of the money goes toward treatment (Goldston, 1991, Nelson *et al.*, 1996). Brain malleability is greatest during the first years of life, but governments spend very little on early intervention (Keating and Mustard, 1996; McCain and Mustard, 1999; Ramey and Ramey, 1998; Steinhauer, 1998).

Mental health professionals want teenagers unprepared for parenthood to delay having children, but there is insufficient investment in family panning, educational and preventive services (Harris, 1996; Rickel and Becker, 1997). The result: statistics from 1990 in the US report that '1,040,000 adolescents under the age of 20 became pregnant, approximately 530,000 (51%) of whom gave birth' (Levine Coley and Chase-Lansdale, 1998, p. 152). In Canada, teenage pregnancy has steadily risen in recent years from 39,340 in 1987 to 45,771 in 1995 (Mitchell, 1998).

* Correspondence to: Isaac Prilleltensky, Department of Psychology, Wilfrid Laurier University, Waterloo, Ontario, Canada, N2L 3C5.

About 26% of children experience behavioural, learning, emotional, or social problems (Offord *et al.*, 1987). Of those, at the very least 12% 'have clinically important mental disorders, and at least half of them are deemed severely disordered or handicapped by their mental illness' (Offord, 1995, p. 285). Similarly, the Institute of Medicine (IOM) (1994) reported that at least 12% of children in the US 'suffer from one or more mental disorders—including autism, attention deficit hyperactivity disorder, severe conduct disorder, depression, and alcohol and psychoactive substance abuse and dependence' (p. 487). Using this figure of prevalence rate of 12% for mental, behavioural, and developmental disorders in children around the world, Kramer (1992) argued that 'the total number of cases of mental disorders in children under 18 years of age would increase from 237.8 million in 1990 to 261.5 in the year 2000, an increase of 10%. In the more developed regions the number of cases would increase from 37.8 million to 38.2 million' (Kramer, 1992, p. 15). Despite the fact that these are alarming figures, no major health or social policies are being launched to curb these problems.

Newspapers report that the economy in North America is doing very well, but the number of children growing up in poverty in Canada and the US continues to be much higher than in all other industrialized countries. Close to a million and a half, or 21% of Canada's children live in poverty, half a million more than in 1989, when the entire House of Commons voted to end child poverty by the year 2000 (Campaign 2000, 1996; Canadian Council of Social Development [CCSD], 1997). The Standing Committee on Health of the House of Commons (1997) stated that 'poverty among children in Canada is especially troublesome when compared with the rate in other industrialized countries. The rate of child poverty in Canada after government redistribution is four times the rate in Sweden, twice as high as in France and German, and 1.4 times the rate in Great Britain. Only in the United States is the rate higher than in Canada' (p. 7). 'As of 1994, 22% of American children lived in families with cash incomes below the poverty threshold. In addition to being more economically disadvantaged than their counterparts in other Western industrialized countries, American children today are faring less well than their American counterparts three decades ago' (McLoyd, 1998, p. 185).

It is well known that health is determined by multiple factors, but interventions often focus on single solutions and take place after the health problem has developed. Population health frameworks show that health outcomes depend of five key determinants: social and economic environment, physical environment, personal health practices, individual capacity and coping skills, and services needed for health (Canadian Public Health Association, 1996; Hamilton and Bhatti, 1996; National Forum on Health, 1996). Yet despite our sophisticated ecological notions of health, interventions typically focus on the person and his/her family and fail to change pernicious environments (e.g. Albee and Gullotta, 1997; IOM, 1994; Weissberg *et al.*, 1997).

These contradictions pose a great concern to psychologists interested in advancing child and family wellness. Unless there is a shift in social priorities, it is unlikely that wellness will be promoted and that child maltreatment will be averted. In order to foster the well-being of children and families, we propose a shift in the priorities of psychological and social interventions. Following a brief discussion of the concept of wellness, we present a framework for interventions to promote child and family wellness.

CHILD AND FAMILY WELLNESS

Child wellness is predicated on the satisfaction of material, physical, affective, and psychological needs. Wellness is an ecological concept; a child's well-being is determined by the level of parental, familial, communal, and social wellness. Parents who enjoy physical and psychological health, and who have access to adequate financial resources, will be in a good position to provide a wellness-enhancing environment for their children. Parental wellness, in turn, is based on the opportunities afforded them by the community in which they reside (Rickel and Becker, 1997; Trickett *et al*., 1998).

Family wellness can be considered a state of affairs in which everyone's needs in the family are met. This requires that people reach a balance between pursuing personal aspirations, such as careers and studies, and contributing to the well-being of other family members. Family wellness is more than the absence of discord; it is the presence of supportive, affectionate and gratifying relationships that serve to promote the personal development of family members and the collective well-being of the family as a whole.

Family wellness comes about through the creative satisfaction of personal and family wishes at the same time. When this creative and delicate balance is attained, parents find energy in themselves and support in their partners or others to devote attention to their children (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996; Standing Committee on Health, 1997; Stinnett and DeFrain, 1985). While parents do most of the giving during the children's early years, children gradually develop the ability to reciprocate and contribute to family well-being in many ways.

Cowen (1991, 1994, 1996) has done much to advance the notion of wellness enhancement. According to him, wellness is

> the positive end of a hypothetical adjustment continuum—an ideal we should strive continually to approach ... Key pathways to wellness, for all of us, start with the crucial needs to form wholesome attachments and acquire age-appropriate competencies in early childhood. Those steps, vital in their own right, also lay down a base for the good, or not so good, outcomes that follow. Other cornerstones of a wellness approach include engineering settings and environments that facilitate adaptation, fostering autonomy, support and empowerment, and promoting skills needed to cope effectively with stress. (Cowen, 1996, p. 246)

A similar definition has been proposed by Muñoz *et al*. (1996). In *Mental Health for Canadians: Striking a Balance*, however, a somewhat different definition of wellness is proposed.

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and rational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. (Epp, 1988, p. 7)

This definition of wellness is predicated on the presence of a healthy and just society that affords citizens opportunities for growth and development (Albee, 1986; Canadian Public Health Association, 1996). This definition goes beyond the individual to address the importance of social conditions for wellness.

Recently there has been considerable research into the measurement of child and family wellness. At the individual level, it has been recognized that wellness entails positive social, cognitive, and emotional functioning (Peters, 1988). Social functioning entails occupational and academic performance, as well as problem-solving skills and the ability to deal with stress. Positive emotional adjustment pertains to subjective feelings of well-being and personal satisfaction; whereas cognitive adaptation relates to a sense of mastery, self-efficacy, and control (Cowen, 1991; Dunst *et al.*, 1990; Peters, 1988).

Nelson *et al.* (1999b) have conceptualized the measurement of family wellness as ranging on a continuum from child maltreatment to family wellness. At one end of the continuum are measures of verified reports of child physical abuse, neglect, or sexual abuse, and records of out-of-home placement of the child. Somewhat less direct are various 'proxy' indicators of abuse, which include hospital admissions, use of emergency room services, and incidents of accidents, ingestions, or poisonings. Moving further down the continuum, there are observations of parenting and self-report measures of parents' attitudes about child-rearing. These latter measures do not just tap maltreatment, but often assess positive parental behaviours and attitudes towards their children. Hence, such measures may be indicators of family wellness.

A FRAMEWORK FOR INTERVENTIONS TO PROMOTE CHILD AND FAMILY WELLNESS

In our view, it is important to have a framework that includes values and concepts. Values represent the moral foundations of our interventions. They address the issue of the ideal state of affairs towards which we are striving, and, as such, they are prescriptive. Concepts, however, are analytical tools or ways of thinking about how to achieve our values. They are used to describe, explain, and predict ways of promoting child and family wellness. Values and concepts are interdependent.

Values
Values can be plotted along a continuum that ranges from individualist to collectivist principles (Avineri and De-Shalit, 1992; Sandel, 1996; Schwartz, 1994). The idea of a continuum is not meant to reflect a rigid taxonomy but rather the varied emphases of different values (see Table 1). Whereas some values promote personal wellness, others focus on collective wellness. Individualist values are those concerned primarily with the well-being of the person. Self-determination and personal growth are examples of values that seek to achieve what the person desires. These two are highly valued tenets in North American and Western societies. Collectivist values, however, are those that strive to enhance the well-being of the community at large. They are premised on the notion that a strong community benefits everyone. Social justice is a collectivist value because it seeks a fair allocation of resources in the community. Distributing the wealth more equally among members of various classes and groups is a collectivist measure (Prilleltensky, 1994a, 1994b, 1997).

Some values may be conceptualized as belonging in the middle of the range (Schwartz, 1994). Human diversity, for instance, is a value that preserves the identity of individuals and groups in order to respect their integrity and in order for people to co-exist peacefully. Collaboration can also be placed somewhere in the middle of the

Table 1. Values for the promotion of child and family wellness

	Range of individualist and collectivist values					
	Individualist values ←					→ Collectivist values
	Self-determination and personal growth	Caring and protection of health	Respect for human diversity	Collaboration and democratic participation	Support for community structures	Social justice
Definition	Promotion of ability of children and adults to pursue chosen goals in life	Expression of care, empathy, and concern for the physical and emotional health of children	Promotion of respect and appreciation for diverse social identities and for people's ability to define themselves	Promotion of fair processes whereby children and adults can have meaningful input into decisions affecting their lives	Promotion of vital community structures that facilitate the pursuit of personal and communal goals	Promotion of fair and equitable allocation of bargaining powers, obligations, and resources in society
Needs addressed	Mastery, control, self-efficacy, voice, choice, skills, growth and autonomy	Empathy, nurturance, emotional and physical well-being	Identity, dignity, self-respect, self-esteem, acceptance	Participation, involvement, and mutual responsibility	Sense of community, cohesion, formal support	Economic security, shelter, clothing, nutrition, access to vital health and social services

continuum, for it seeks to attend to diverse voices in the hope that personal and collective interests will be met. We cooperate and negotiate with groups so that our needs and the needs of the collective will be advanced at the same time. This requires a give and take that is characteristic of values in the middle range between individualism and collectivism.

Today, most interventions cater to individual goals. We seek to promote autonomy and to enhance personal wellness. We endeavour to foster healthy life styles. These are worthy and moral causes. The problem is not investing in individuals, but neglecting the social dimension of caring. Balancing individualist with collectivist values is crucial because strong communities are vital in supporting private citizens to achieve their goals. A poor medical system blocks the attainment of health, a prerequisite for autonomous functioning. A stagnant educational system prevents us from reaching scholastic excellence (O'Neill, 1994; Prilleltensky, 1997). Collectivist values support the equalization of access to valued societal resources and foster a sense of community that is missing from today's society (Etzioni, 1993; Sandel, 1996).

Our current priorities in social interventions are skewed toward individualism (Cowen, 1985). Many community-based and prevention programmes are designed to enhance the level of skills and knowledge of individuals on a particular topic, such as parenting, drug-abuse, social skills, and assertiveness. In fact, it has been argued that most prevention programmes tend to be person-centred (Albee, 1996; Albee and Perry, 1995; Cowen, 1985). These are important interventions but tend to neglect the need for social justice and a fair distribution of societal resources. We define, analyse, research, and treat human problems as if they were all within the individual or the micro-system (Ratcliffe and Wallack, 1985/1986). At best we think also about the meso-system. Rarely do we think about the macro-system (Prilleltensky, 1994b). Future priorities should reflect a more balanced approach between individualistic and collectivist values; for they respond to different needs (see Table 1).

Concepts
There are two main concepts that are useful for the promotion of child and family wellness: (a) the prevention–intervention continuum and (b) ecological levels of analysis.

The prevention–intervention continuum. 'A stitch in time saves nine', 'pay now or pay later', 'an ounce of prevention is worth a pound of cure'. We all know the logic of prevention, but, as we indicated earlier, most resources in human and medical services go toward treatment, not prevention. Like the calls to strengthen families and promote wellness, the request to be proactive is echoed in many quarters. To understand the shift in orientation we propose we should familiarize ourselves with the language of prevention.

> *Universal* preventive interventions are targeted to the general public or a whole population group that has not been identified on the basis of individual risk. An example of a universal preventive intervention for physical health is childhood immunization. *Selective* preventive interventions are targeted to individuals or subgroups of the population whose risk of developing problems is significantly higher than average. A Head Start or other early childhood programmes for all children living in a socio-economically depressed neighbourhood is an example of a selective prevention intervention. *Indicated* preventive interventions are targeted to high risk individuals who are

identified as already having minimal, but detectable signs or symptoms, or biological markers, indicating predisposition for the mental disorder, but who do not meet diagnostic criteria. An intervention to prevent depression in children with one or both clinically depressed parents is an example of an indicated preventive intervention. (NIMH Committee on Prevention Research, 1995, pp. 6–7)

This terminology, widely promoted by the Institute of Medicine (IOM, 1994; Muñoz *et al.*, 1996), is helpful in clarifying what we mean when we talk about various preventive interventions.

These three types of prevention can be conceptualized as a continuum for the promotion of family wellness and the prevention of child maltreatment. Interventions can range along a continuum from universal to indicated approaches (Nelson *et al.*, 1999a; Prilleltensky *et al.*, 1999). At one end of the continuum are universal programmes which are provided to all members of a community or setting. Moving further down the continuum are selective programmes that are targeted to people who are at-risk for child maltreatment ('high-risk' programmes). At the other end of the continuum are indicated programmes, which seek to prevent maltreatment from re-occurring, to prevent other family problems (e.g. out-of-home placement of the child), to prevent long-term problems for the child (e.g. emotional and behavioural problems), to prevent the maltreatment of younger siblings, or to prevent the maltreatment of the next generation of children born to those parents who have been maltreated themselves. As one moves across the intervention continuum, the size of the population receiving the interventions becomes smaller (from everyone to those with specific problems) and the degree of psychological problems becomes more severe (from no problems to specific problems).

Ecological levels of analysis. 'Child maltreatment is now widely recognized to be multiply determined by a variety of factors operating through transactional processes at various levels of analysis (i.e. life-course history through immediate-situational to historical evolutionary) in the broad ecology of parent–child relations' (Belsky, 1993, p. 413). So varied are the sources of influence on children and families that we require an ecological perspective to understand their lives and to devise useful programmes. An ecological and contextual approach considers multiple levels of analysis. Thus, mental health problems are viewed in the context of characteristics of the individual (e.g. coping skills, personality traits); the micro-system (i.e. the family and social network); the exosystem, which mediates between the individual and his/her family and the larger society (i.e. work settings, schools, religious settings, neighbourhoods); and the macro-system (i.e. economic policies, social safety net, social norms, social class). Each of the smaller levels is nested within the larger levels (e.g. person in the family in the community in the society). Thus, for example, the problem of child maltreatment is viewed as being influenced by characteristics of the individual (e.g. whether or not the person committing the abuse was abused himself of herself as a child, lack of practice in the parenting role), micro-system (e.g. marital conflict, coercive family interactions), meso-system (e.g. involuntary job loss, work-related stress, neighbourhood isolation), and macro-system (e.g. the level of violence in society, social norms that sanction corporal punishment for disciplining children) (Belsky, 1993; Garbarino, 1992). As Belsky put it:

Although most child maltreatment takes place in the family and thus 'behind closed doors', this immediate and even development context of maltreatment itself needs to be

contextualized. Cultural attitudes, values, and practices, as well as the economic circumstances of a society and its cultural history, play an important role in the etiology of child maltreatment. (1993, p. 423)

The example of child maltreatment illustrates the presence of risk factors at different levels of analysis. At the same time, there are protective factors at the individual (e.g. coping skills), the micro-system (e.g. a supportive relationship with one parent), meso-system (e.g. neighbourhood cohesion, a supportive employer), and the macro-system (e.g. social norms against corporal punishment, economic safety net).

'Optimal development of wellness ... requires integrated sets of operations involving individuals, families, settings, community contexts, and macro-level societal structures and policies' (Cowen, 1996, p. 246). Despite what we know about the impact of various systems and levels on families, most preventive and reactive interventions in child welfare and mental health deal with individuals, dyads (e.g. parent–child or marital relationships), or families. Our actions seriously lag behind our understanding of wellness. An enormous corpus of evidence points to the powerful impact of socio-economic, cultural, and contextual factors in shaping the lives of children and families (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996; Bronfenbrenner and Neville, 1994; Garbarino, 1992; McCain and Mustard, 1999; McLoyd, 1998; National Forum on Health, 1996; Ramey and Ramey, 1998), yet in apparent disregard for this knowledge, workers continue to focus on counselling, therapy, or person-centred prevention as the main vehicles for the promotion of wellness (Albee, 1996; Cowen, 1985; Febbraro, 1994).

The causes for maintaining an individualistic and intrapsychic orientation in child welfare and mental health are many and have been reviewed elsewhere (Fox and Prilleltensky, 1997; Prilleltensky, 1989, 1994b, 1997; Wharf, 1993). A culture that emphasizes individualism and blames victims for their misfortune is bound to want to fix people and not structures. So ingrained in our society is the individualistic mentality that professionals rarely question the narrow focus for psychological and social interventions. In a sense, changing individuals in light of ominous social forces is like searching for the penny where there is more light, never mind the penny got dropped in the dark.

Values, the prevention continuum, and ecological levels of analysis form the main organizing dimensions of our framework for interventions to promote child and family wellness (see Table 2). In the next section, we ground this framework in practical programmes and policies and research findings. Interventions can be categorized as those that promote individualist values (psychological interventions) and those that promote collectivist values (social interventions). Psychological interventions focus on smaller ecological levels of analysis (individual and micro), while social interventions tend to focus on larger ecological levels of analysis (meso and macro). Both psychological and social interventions can vary along the prevention–intervention continuum. Some of the programmes that we describe are noted in the cells as exemplars of the different intervention approaches. While not all interventions fit neatly into this framework, there are general differences between the interventions that make this broad framework a useful tool for understanding a large number of diverse approaches to the promotion of child and family wellness.

Table 2. Framework for interventions to promote child and family wellness

Level on the prevention–intervention continuum	Values and ecological levels of analysis emphasized			
	Individualist values (Psychological interventions)		Collectivist values (Social interventions)	
	Child (Individual)	Family/parents (Micro)	Community (Meso)	Society (Macro)
Universal	• Education programmes for children regarding sexual abuse	• Universally accessible group-based parent training	• Better Beginnings, Better Futures	• Universal and sufficient family benefits • Universally accessible child care
Selective	• Pre-school intervention programmes (e.g. Perry Preschool)	• Old's Prenatal/Early Infancy Project	• Self-help/mutual aid and support groups for high-risk families • Syracuse Family Development Project	• Child support for children of divorce • Flexible parental leave • Flexible work arrangements for families with young children
Indicated	• Group treatment programmes for abused children	• Social learning parent training for families involved with child welfare agencies • Family preservation programmes (e.g. Homebuilders)	• Parents Anonymous • Project 12-Ways	• Child welfare legislation

INTERVENTIONS FOR THE PROMOTION OF CHILD AND FAMILY WELLNESS

In this section, we provide a brief overview of psychological and social interventions aimed at promoting child and family wellness. We also report research findings regarding the effectiveness of these interventions. Viewed within our framework, this review of interventions is used to prescribe priorities for intervention.

Psychological interventions

Child-focused interventions. Universal programmes which focus primarily on the child and which tend to ignore important aspects of the child's social context are those dealing with child sexual abuse. Universal, educational programmes for pre-school or elementary school-aged children have been developed to teach children what constitutes sexual abuse, to help children distinguish between 'good' and 'bad' touching, to teach resistance skills, and to encourage children to report instances of abuse or attempted abuse. There is now a considerable body of research evaluating such programmes and recent reviews have concluded that children do learn the information and skills imparted by the programmes (MacMillan *et al.*, 1994b; Rispens *et al.*, 1997) However, there is no evidence that such child-focused programmes can prevent child sexual abuse.

Selective interventions that are child-focused include pre-school education programmes for children who are at high-risk, typically because they come from economically deprived families. One example of such an intervention is the Perry Preschool Programme (Schweinhart and Weikhart, 1989). A high-quality pre-school programme was provided to three and four year-old children from families living in poverty for either 30 or 60 weeks. These children and a control group of children were followed until age 28. Compared to the control group, the pre-school intervention group had higher rates of employment, higher educational attainment, lower welfare rates, and lower arrest rates. Moreover, the 30-week programme returned $6 in cost savings for every dollar invested, while the 60-week programme yielded a return rate of $3 in cost savings for every dollar invested. Recent reviews of the literature on pre-school education interventions for high-risk children have reported positive long-term impacts on child wellness (Karoly *et al.*, 1998; Ramey and Ramey, 1998; Yoshikawa, 1994).

Indicated group interventions for pre-schoolers (e.g. Oates *et al.*, 1995) and elementary school-aged children (e.g. Silovsky and Hembree-Kigin, 1994) who have been abused address children's feelings of guilt, responsibility, fear, and anger. Such group interventions provide a safe place for children to discuss abuse-related issues. Controlled evaluations for elementary school-aged girls who have been sexually abused have found significant improvement for girls participating in group interventions relative to girls in control groups on measures of problem behaviour (Burke, 1988; McGain and McKinzey, 1995).

Family and parent-focused interventions. Parent education and training and in-home support programmes constitute the two main approaches that have been used to address the ecological level of family and parent. Universal parent education and training programmes are designed to enhance parents' knowledge of child

development, improve attitudes about parent–child relationships, and develop skills in parenting behaviour. Group-based parent training, based on humanistic (e.g. Parent Effectiveness Training), social learning, and Adlerian (e.g. Systematic Training for Effective Parenting) approaches have been used on a universal basis to promote these goals. In a review, Todres and Bunston (1993) found that studies of the social learning and Adlerian approaches reported more positive outcomes on indicators of child and family wellness than studies of Parent Effectiveness Training.

One popular type of selective prevention programme for families is home visitation. Exemplars of this approach include Olds' Prenatal/Early Infancy Project (Olds *et al.*, 1986) and Hawaii's Healthy Start Programme (Breaky and Pratt, 1991). While these programmes vary greatly in terms of the type of home visitor used (e.g. nurses, non-professionals), the length of the intervention, and the number of home visits, most begin prenatally or at birth and focus on the needs of the parent and the parent–child relationship. There is a great deal of research evaluating home visitation and positive impacts have been reported on measures of child, family, and parental wellness (for reviews, see MacMillan *et al.*, 1994a; Nelson *et al.*, 1999b; Olds and Kitzman, 1993). Furthermore, cost-effectiveness research has shown that these programmes save government spending by the time the child reaches 4 years of age (Hardy and Streett, 1989; Olds *et al.*, 1993).

Indicated family support programmes have also been implemented with families who are at imminent risk of having a child placed out of the home. In intensive family preservation programmes (e.g. Homebuilders), support workers provide such families with a variety of services, in the home, on a short-term but intensive basis (more than a day per week of face-to-face contact and crisis support is available around the clock) (Pecora *et al.*, 1991). There is some evidence that these programmes can improve family wellness and reduce out-of-home placements both immediately and over the course of one year after the intervention (for reviews see Dagenais *et al.*, 1999; Nelson *et al.*, 1999b). Parent training has also been used on an indicated basis with parents who are involved with child welfare agencies. Several controlled evaluations have demonstrated significant positive impacts on indicators of child and family wellness in families in which the children have been physically abused or neglected (for a review, see Wolfe, 1994).

Critique and priorities for psychological interventions. Individual and family-centred prevention programmes have been criticized for their emphasis on changing individuals to the neglect of the need to change social environments. For example, it has been argued that universal education programmes regarding child sexual abuse place the onus for prevention on potential victims and that these programmes may lull us into a false state of security that we have done all that is needed to prevent child sexual abuse (Bagley and Thurston, 1998; Reppucci and Haugaard, 1989). One future priority is the need for more efforts to intervene with the potential perpetrators of abuse (Tutty, 1991).

Similar criticism can be weighed against universal parent education programmes. Such programmes can also be criticized for following a pre-set agenda conceived by professionals, rather than emphasizing the values of collaboration and participation. Parenting programmes also need to examine gender roles and power differences in families, to engage fathers more in parenting responsibilities, and to be more culturally sensitive reaching out to parents from different cultures. Thus another

priority is for micro-centred programmes to attend more to the values of diversity and social justice.

Many of the same criticisms can apply to selective preventive interventions that are child or family-focused. Febbraro (1994) has noted the conceptual limitations of home visitation programmes for high-risk mothers. Such programmes which focus on family wellness, she argues, ignore larger social and political forces. In so doing, such interventions may inadvertently blame the victims (poor, single mothers) for their problems. Also, the goal of integrating mothers into low-wage, low-power positions in society perpetuates a system that is socially and economically unequal for women, the very conditions that threaten violence towards women and children. Febbraro (1994) argues that such micro-level interventions should be accompanied by macro-level community development and advocacy interventions that are designed to change social policies to promote social, economic, and gender equality. Such a shift would provide more of a focus on the values of diversity and social justice.

Indicated or reactive programmes at the individual and family levels of analysis currently constitute the majority of interventions to promote child and family wellness. These programmes share many of the same criticisms that universal and selective programmes at the individual and family levels, such as their failure to change social conditions which cause problems in the first place. However, a recent meta-analysis of programmes to promote child and family wellness has uncovered another significant limitation of such programmes (MacLeod, 1999). While universal, selective, and indicated interventions have found positive impacts at the end of the intervention, they differ in terms of effectiveness at follow-up intervals. The size of the programme effect is larger at follow-up than at post-intervention for the universal and selective programmes, while the opposite is true for indicated interventions. Thus, indicated programmes may be too little, too late to have a positive long-term effect on child and family wellness. These findings suggest the need for a shift in priorities from indicated to universal and selective programmes.

Social interventions

Community-focused programmes. Interventions aimed at involving the community in supporting families and children include self-help/mutual aid and social support programmes and multi-component programmes which emphasize community development. Self-help/mutual aid and social support groups have been implemented on a universal (Boger *et al.*, 1983), selective (Slaughter, 1983), and indicated (Cameron *et al.*, 1992; Lieber and Baker, 1977) basis. Such support groups address the meso-level of analysis in aiming to increase the social networks, social support, and community integration of families. Controlled studies of such interventions have found improvement on a variety of measures reflecting child and family wellness (Boger *et al.*, 1983; Cameron *et al.*, 1992; Henninger and Nelson, 1984; Minde *et al.*, 1980; Slaughter, 1983; Telleen *et al.*, 1989).

Multi-component, community-based interventions provide programme components which target several ecological levels of analysis ranging from the individual child to the community. Examples of such programmes which are implemented on a universal basis (albeit with high-risk communities) are the Better Beginnings, Better Futures projects in Ontario (Peters, 1994) and 1, 2, 3 Go! in Montréal (Bouchard, 1997). These programmes provide child-focused, family/parent-focused, and

community-focused interventions. Affholter *et al.* (1983) have conducted an evaluation of a universal, community-based programme in six sites which focuses on child development, emphasizes family strengths, provides individualized services to families, and extends the age range for intervention from the prenatal period to age 8. They found significantly more teaching interaction and parent–child activity for families in the intervention group compared with the control group.

Multi-component programmes that have been implemented on a selective basis included Avancé (Rodriguez and Cortez, 1988), the Houston Parent–Child Development Center (Andrews *et al.*, 1982; Johnson and Breckenridge, 1982; Johnson and Walker, 1987), the Yale Child Welfare Programme (Seitz *et al.*, 1985; Seitz and Apfel, 1994), and the Syracuse Family Development Programme (Lally *et al.*, 1988). All of these programmes begin at birth and provide a combination of home visitation support, parenting education and training, health services for the children, English as a second language classes for parents, connection with community resources, support groups, family resource centres, community development, and pre-school education.

Controlled follow-up studies have reported positive impacts on indicators of child and family wellness. There is also some cost-effectiveness data on such programmes. Compared with families who participated in the intervention, Seitz *et al.* (1985) found that welfare and education costs were $40,000 US higher for families in the control group, and Seitz and Apfel (1994) estimated that the costs of supplemental school services were $26,000 US higher for the younger siblings of children in the control group.

Multi-component programmes have also been implemented on an indicated basis with families at risk for out-of-home placement of a child. For example, Project 12-Ways uses an 'eco behavioural' approach which includes parenting skills training, stress management, social support, assertiveness training, health promotion and nutrition, job placement, money management, marital counselling, etc. (Lutzker and Rice, 1984). Evaluations of multi-component interventions for families in crisis have found positive impacts on indicators of child and family wellness (Halper and Jones, 1981; Jones, 1985; Jones *et al.*, 1976; Lutzker and Rice, 1984, 1987; Wesch and Lutzker, 1991).

Societal-focused interventions. Social policies can operate at the universal, selective, and indicated levels of analysis. At the universal level, governments can enhance child wellness by providing universal and sufficient child and family benefits. Family benefits refer to the economic support governments provide to families to help them raise their children (Baker, 1995). This economic support can be in the form of either cash benefits of tax concessions. While the principle of universality in family benefits was eliminated in Canada, other countries which have retained it claim that it has many advantages that outweigh its costs. Two advantages of the universal system are that (a) no needy children requiring help are missed by the system, and (b) there is no social stigma attached to receiving government support. The most notable benefit of the universal benefit system embraced by some European countries (e.g. like Holland, Sweden and Denmark) is that child poverty has been nearly eliminated (Peters *et al.*, 1999). In contrast, in Canada and the US, as noted earlier, the rate of child poverty in the population is over 20%.

Another universal policy that some European countries have enacted concern the availability and accessibility of child care for all who need it. Several authors have

documented the potential benefits of having access to universal high quality child care, including advanced cognitive development, acquisition of life skills, savings to governments and parental option to return to the work force (Cleveland and Krashinsky, 1998; McCain and Mustard, 1999; Peters *et al.*, 1999; Ripple *et al.*, 1999).

At the selective level governments can help children of divorce by putting in place effective child support legislation. In addition, governments can help families with young children by implementing flexible parental leave policies and work arrangements. As was the case with family benefits and child care policies, European members of the Organization for Economic Cooperation and Development have more generous family policies than Canada and the US. Research provides evidence that those European countries do more than their North American counterparts in promoting child wellness (Peters *et al.*, 1999).

An example of an indicated intervention at the social level concerns child welfare policies. We can imagine a continuum in the field of child welfare. The continuum ranges from interventions dedicated to strengthen families on one end, to actions to minimize maltreatment on the opposite end. Numerous calls have been made to allocate more resources to strengthen families, as the current and dominant focus of child welfare is the protection of children at risk. This is the situation in Canada (Armitage, 1993; Wharf, 1993), the US (Emery and Laumann-Billings, 1998; Melton and Barry, 1994; Schorr, 1997), and the UK (Burton, 1997; Hearn, 1995). Many reasons account for this imbalance, not the least of which is the lack of resources to do preventive work.

Critique and priorities for social interventions. Community-focused interventions have several advantages over the individual and family-centred interventions reviewed earlier. First, the self-help/mutual aid and multi-component interventions place a strong emphasis on community participation and collaboration. Whereas individual and family interventions tend to be professionally prescribed and controlled, such community interventions are, to a large extent, controlled by citizens. Citizen participation helps to build community ownership for the programmes and to ensure that the programmes are individualized to meet the needs of families. MacLeod's (1999) meta-analysis found consumer participation to be a significant moderator of the effectiveness of family support programmes. The greater the participation and the greater the emphasis on consumers' strengths, the more effective the programmes.

Second, such programmes also emphasize informal peer and community support, rather than relying exclusively on professionals. Social support has been shown to be very important for child and family wellness (Belsky, 1993). Third, in providing several programme components, the multi-component programmes overcome the limitations of single-component interventions, such as the individual and family-centred programmes reviewed in the previous section. Finally, research has shown that such programmes are effective, both in the short-term and in the long-term. In the meta-analytic review mentioned earlier, MacLeod (1999) found that the multi-component programmes implemented on a universal or selective basis had the highest effect sizes both at post-intervention and at follow-up compared with other types of programmes.

While community-focused programmes offer more promise than individual or family-centred programmes, in and of themselves they still have significant limitations. The researchers for the Syracuse Family Development Programme (Lally *et al.*,

1988) noted that in spite of several positive impacts on child and family wellness that most of the families continued to live in poverty. In MacLeod's (1999) meta-analysis, she found that the socio-economic status of research participants was a significant moderator of programme success. Interventions that were exclusively with low-income participants were less effective than those with participants of mixed socio-economic backgrounds. These findings point to the vital need to address the issue of poverty, which is a major focus of some societal-focused interventions. For governments to eradicate child poverty, a major risk-factor, they need to adopt a social responsibility model and avoid victim-blaming ideologies. Societal values of individualism, self-interest and survival of the fittest lead to victim-blaming and to a philosophy of individual responsibility. Child maltreatment is viewed as an individual or family problem, disconnected from societal forces and power dynamics. In contrast, societal values of justice, collectivism and cooperation lead to solidarity and philosophy of social responsibility. Social responsibility posits that family wellness and child maltreatment are universal concerns in which everyone has a stake, including the government. Such a view, adopted by some European countries, has facilitated the near complete eradication of child poverty (Eichler, 1997; Peters *et al.*, 1999).

CONCLUSIONS

We have claimed that most programmes to promote child and family wellness have individualist values in the foreground and that they attend primarily to the individual and family ecological levels of analysis. If we seek a more balanced approach to the promotion of child and family wellness, we need to place greater emphasis on social interventions. To reach that end, we need to adopt a model of social responsibility to replace the dominant paradigm of individual responsibility. Individual responsibility models lead to programmes that are only for families at-risk. Such programmes do not address social and economic determinants of maltreatment and wellness, but instead emphasize adjusting people to unjust social conditions. Social responsibility models lead to social policies that support all families. Such policies, which are prominent in some European countries, address some of the social and economic determinants of child maltreatment and emphasize family support. We need to resist the pressure to pathologize families and individualize social problems and, instead, we need to reformulate solutions in terms of parental, communal, and government responsibility (Evans and Wekerle, 1997; Griffin Cohen, 1997; Kitchen, 1995).

ACKNOWLEDGEMENT

REFERENCES

Affholter, D. P., Connell, D. and Nauta, M. J. (1983) 'Evaluation of the Child and Family Resource Program: early evidence of parent–child interaction effects', *Evaluation Review*, **7**, 65–79.

Albee, G. W. (1986) 'Toward a just society: lessons from the observations on the primary prevention of psychopathology', *American Psychologist*, **41**, 891–898.

Albee, G. W. (1996) 'Revolutions and counterrevolutions in prevention', *American Psychologist*, **51**, 1130–1133.

Albee, G. W. and Gullotta, T. P. (1997) *Primary Prevention Works*, Sage, London.

Albee, G. W. and Perry, M. J. (1995) 'Change course without rocking the boat' [Review of the book *Reducing Risks for Mental Disorders: Frontiers for Preventative Intervention Research*] *Contemporary Psychology*, **40**, 843–846.

Andrews, S. R., Blumenthal, J. B., Johnson, D. L., Kahn, A. J., Ferguson, C. J., Lasater, T. M., Malone, P. and Wallace, D. B. (1982) 'The skills of mothering: a study of the Parent–Child Development Centers', *Monographs of the Society for Research in Child Development*, **47**(6, Serial No. 198).

Armitage, A. (1993) 'The policy and legislative context', in B. Wharf (ed.), *Rethinking Child Welfare in Canada*, McClelland and Stewart, Toronto.

Avineri, S. and De-Shalit, A. (1992) 'Introduction', in S. Avineri and A. De-Shalit (eds), *Communitarianism and Individualism*, Oxford University Press, New York.

Bagley, C. and Thurston, W. E. (1998) 'Decreasing child sexual abuse', In *Canada Health Action: Building on the Legacy—Determinants of health, Vol. I—Children and youth*, Éditions Multimondes Inc., Ste. Foy, Québec.

Baker, M. (1995) *Canadian Family Policies: Cross National Comparison*, University of Toronto Press, Toronto.

Basic Behavioral Science Task Force of the National Advisory Mental Health Council (1996) 'Basic behavioral science research for mental health: family processes and social networks', *American Psychologist*, **51**, 622–630.

Belsky, J. (1993) 'Etiology of child maltreatment: a development-ecological analysis', *Psychological Bulletin*, **114**, 413–434.

Boger, R., Richter, R. and Weatherston, D. (1983) 'Perinatal positive parenting: a program of primary prevention through support of first-time parents', *Infant Mental Health Journal*, **4**, 297–308.

Bouchard, C. (1997) *The community as a participative learning environment: The case of Centraide of Greater Montréal 1, 2, 3 Go! project*, Conférence prononcée devant l'Institut canadien de recherches avancées (Human Development Program) lors de la 14ième biennale de l'International Society for the Study of Behavioural Development, Québec.

Breaky, G. and Pratt, B. (1991) Healthy growth for Hawaii's 'Healthy Start': toward a systematic statewide approach to the prevention of child abuse and neglect, *Zero to Three* 16–22 April.

Bronfenbrenner, U. and Neville, P. R. (1994) 'America's children and families: an international perspective', in S. L. Kagan and B. Weissbourd (eds), *Putting Families First*, Jossey-Bass, San Francisco, CA.

Burke, M. (1988) 'Short-term therapy for sexually abused girls: a learning theory based treatment for negative affect', *Dissertation Abstracts International*, **49**(5-B), 1935(University Microfilms No. 88-12052).

Burton, S. (1997) *When there's a will there's a way: Reinforcing child care practice*, National Children's Bureau, London.

Cameron, G., Hayward, K. and Mamatis, D. (1992) *Mutual Aid and Child Welfare: The Parent Mutual Aid Organizations in Child Welfare Demonstration Project*, Centre for Social Welfare Studies, Wilfrid Laurier University, Waterloo, ON.

Campaign 2000 (1996) November *Crossroads for Canada: A time to invest in children and families*, (Available from Campaign 2000, c/o Family Service Association, 355 Church Street, Toronto, ON, Canada, M5B 1Z8), Campaign 2000, Toronto.

Canadian Council on Social Development (CCSD) (1997) *The Progress of Canada's Children 1997*, Canadian Council on Social Development, Ottawa, ON.

Canadian Public Health Association (1996) *Action Statement for Health Promotion in Canada*, Canadian Public Health Association, Ottawa, ON.

Cleveland, G. and Krashinsky, M. (1998) *The Benefits and Cost of Good Child Care: The Economic Rationale for Public Investment in Young Children*, Centre for Urban and Community Studies, University of Toronto, Toronto.

Cowen, E. L. (1985) 'Person-centred approaches to primary prevention: situation-focused and competence enhancement', *American Journal of Community Psychology*, **13**, 31–48.

Cowen, E. L. (1991) 'In pursuit of wellness', *American Psychologist*, **46**, 404–408.

Cowen, E. L. (1994) 'The enhancement of psychological wellness: challenges and opportunities', *American Journal of Community Psychology*, **22**, 149–179.

Cowen, E. L. (1996) 'The ontogenesis of primary prevention: lengthy strides and stubbed toes', *American Journal of Community Psychology*, **24**, 235–249.

Dagenais, C., Bégin, J. and Fortin, D. (1999) 'L'impact des programmes de soutien intensifs offerts à des familles en crise: une synthèse des résultats de la recherche évaluative', *Les Cahiers d'analyse du GRAVE*, **6**(1), 62 pp. (Laboratoire de recherche en écologie humaine et sociale (LARES), Université du Québec à Montrèal).

Dunst, C. J., Trivette, C. M. and Thompson, R. B. (1990) 'Supporting and strengthening family functioning: toward a congruence between principles and practice', *Prevention in Human Services*, **9**, 19–43.

Eichler, M. (1997) *Family Shifts: Families, Policies, and Gender Equality*, Oxford University Press, Toronto.

Emery, R. E. and Laumann-Billings, L. (1998) 'An overview of the nature, causes, and consequences of abusive family relationships', *American Psychologist*, **53**, 121–135.

Epp, J. (1988) *Mental Health for Canadians: Striking a Balance*, Minister of Supplies and Services, Ottawa, ON.

Etzioni, A. (1993) *The Spirit of Community*, Touchstone, New York.

Evans, P. M. and Wekerle, G. R. (1997) 'The shifting terrain of women's welfare: Theory, discourse, and activism', in P. M. Evans and G. R. Wekerle (eds), *Women and the Canadian Welfare State*, University of Toronto Press, Toronto.

Febbraro, A. (1994) 'Single mothers "at risk" for child maltreatment: an appraisal of person-centred interventions and a call for emancipatory action', *Canadian Journal of Community Mental Health*, **13**(2), 47–60.

Fox, D. and Prilleltensky, I. (1997) *Critical Psychology: An Introduction*, Sage, London.

Garbarino, J. (1992) *Children and Families in the Social Environment*, 2nd edn, Aldine de Gruyter, New York.

Goldston, S. E. (1991) 'A survey of prevention activities in state mental health authorities', *Professional Psychology: Research and Practice*, **22**, 315–321.

Griffin Cohen, M. (1997) 'From the welfare state to vampire capitalism', in P. M. Evans and G. R. Wekerle (eds), *Women and the Canadian Welfare State*, University of Toronto Press, Toronto.

Halper, G. and Jones, M. A. (1981) *Serving Families at Risk of Dissolution: Public Preventive Services in New York City*, Children's Bureau of the Administration of Children, Youth, and Families, Department of Health and Human Services, New York.

Hamilton, N. and Bhatti, T. (1996) *Population Health Promotion: An Integrated Model of Population Health and Health Promotion*, Health Canada, Health Promotion Development Division, Ottawa, ON.

Hardy, J. B. and Streett, R. (1989) 'Family support and parenting education in the home: An effective extension of clinic-based preventive health care services for poor children', *Journal of Pediatrics*, **115**, 927–931.

Harris, I. (1996) *Children in Jeopardy: Can we break the cycle of poverty?*, Yale University Press, New Haven, CT.

Hearn, B. (1995) *Child and Family Support and Protection: A Practical Approach*, National Children's Bureau, London.

Henninger, C. and Nelson, G. (1984) 'Evaluation of a social support program for young unwed mothers', *Journal of Primary Prevention*, **5**, 3–16.

Institute of Medicine (IOM) (1994) *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, National Academy Press, Washington, DC.

Johnson, D. L. and Breckenridge, J. N. (1982) 'The Houston Parent–Child Development Center and the primary prevention of behavior problems in young children', *American Journal of Community Psychology*, **10**, 305–316.

Johnson, D. L. and Walker, T. (1987) 'Primary prevention of behavior problems in Mexican–American children', *American Journal of Community Psychology*, **15**, 375–385.

Jones, M. A. (1985) *A Second Chance for Families: Five Years Later Follow-up of a Program to Prevent Foster Care*, Child Welfare League of America, New York.

Jones, M. A., Neuman, R. and Shyne, A. W. (1976) *A Second Chance for Families: Evaluation of a Program to Reduce Foster Care*, Child Welfare League of America, New York.

Karoly, L. A., Greenwood, P. W., Everingham, S. S., Houbé, J., Kilburn, M. R., Rydell, C. P., Sanders, M. and Chiesa, J. (1998) *Investing in our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, Rand, Santa Monica, CA.

Keating, D. P. and Mustard, J. F. (1996) 'The national longitudinal survey of children and youth: an essential element for building a learning society in Canada', In *Growing up in Canada: National Longitudinal Survey of Children and Youth* (Statistics Canada, Cat. No. 89-550-MPE, no. 1). Human Resources Development Canada and Statistics Canada, Ottawa, ON.

Kitchen, B. (1995) 'Children and the case for distributive justice between generations in Canada', *Child Welfare*, **LXXIV**, 430–458.

Kramer, M. (1992) 'Barriers to the primary prevention of mental, neurological, and psychosocial disorders of children: a global perspective', in G. W. Albee, L. A. Bond and T. V. Cook Monsey (eds), *Improving Children's Lives: Global Perspectives on Prevention*, Sage, London.

Lally, J. R., Mangione, P. L. and Honig, A. S. (1988) 'The Syracuse University Family Development Research Program: long-range impact on an early intervention with low-income children and their families', in D. R. Powell (ed.), *Parent Education as Early Childhood Intervention: Emerging Directions in Theory, Research, and Practice*, Ablex Publishing Corporation, Norwood, NJ.

Levine Coley, R. and Chase-Lansdale, L. (1998) 'Adolescent pregnancy and parenthood: recent evidence and future directions', *American Psychologist*, **53**, 152–166.

Lieber, L. L. and Baker, J. M. (1977) 'Parents Anonymous—self-help treatment for child abusing parents: a review and evaluation', *Child Abuse and Neglect*, **1**, 133–148.

Lutzker, J. R. and Rice, J. M. (1984) 'Project 12-Ways: measuring outcome of a large in-home service for treatment and prevention of child abuse and neglect', *Child Abuse and Neglect*, **8**, 519–524.

Lutzker, J. R. and Rice, J. M. (1987) 'Using recidivism data to evaluate Project 12-Ways: an ecobehavioral approach to the treatment and prevention of child abuse and neglect', *Journal of Family Violence*, **2**, 283–290.

MacLeod, J. (1999) *A Meta-Analytic Review of Programs to Promote Family Wellness And Prevent Child Maltreatment*, Unpublished Master's Thesis, Wilfrid Laurier University, Waterloo, ON.

MacMillan, H. L., MacMillan, J. H., Offord, D. R., Griffith, L. and MacMillan, A. (1994a) 'Primary prevention of child physical abuse and neglect: a critical review. Part I', *Journal of Child Psychology and Psychiatry*, **35**, 835–856.

MacMillan, H. L., MacMillan, J. H., Offord, D. R., Griffith, L. and MacMillan, A. (1994b) 'Primary prevention of child sexual abuse: a critical review. Part II', *Journal of Child Psychology and Psychiatry*, **35**, 857–876.

McCain, M. and Mustard, F. (1999) *Reversing the Real Brain Drain: Final Report of the Early Year Study*, Canadian Institute for Advanced Research, Toronto.

McGain, B. and McKinzey, R. K. (1995) 'The efficacy of group treatment in sexually abused girls', *Child Abuse and Neglect*, **19**, 1157–1169.

McLoyd, V. C. (1998) 'Socioeconomic disadvantage and child development', *American Psychologist*, **53**, 185–204.

Melton, G. B. and Barry, F. D. (1994) 'Neighbors helping neighbors: the vision of the US Advisory Board on Child Abuse and Neglect', in G. B. Melton and F. D. Barry (eds),

Protecting Children from Abuse and Neglect: Foundations for a New National Strategy, Guilford, New York.

Minde, K., Shosenberg, N., Marton, P., Thompson, J., Ripley, J. and Burns, S. (1980) 'Self-help groups in a premature nursery', *Journal of Pediatrics*, **96**, 933–940.

Mitchell, A. (1998) 'Teen-age pregnancy on rise again', *The Globe and Mail*, **A1**, A7.

Muñoz, R., Mrazek, P. J. and Haggerty, R. J. (1996) 'Institute of Medicine Report on Prevention of Mental Disorders: summary and commentary', *American Psychologist*, **51**, 1116–1122.

National Forum on Health (1996) *What determines health?*, National Forum on Health, Ottawa, ON, (Ministry of Public Works and Government Services of Canada, Cat No. H21-126/3-1996E).

Nelson, G., Prilleltensky, I. and Peters, R DeV (1999a) 'Prevention and mental health promotion in the community', in W. Marshall and P. Firestone (eds), *Abnormal Psychology Perspectives*, Prentice Hall, Scarborough, ON.

Nelson, G., Laurendeau, M.-C., Chamberland, C. and Peirson, L. (1999b) 'A review and analysis of programs to promote family wellness and prevent the maltreatment of pre-school and elementary school-aged children', in I. Prilleltensky, G. Nelson and L. Peirson (eds), *Promoting Family Wellness and Preventing Child Maltreatment: Fundamentals for Thinking and Action*, Final report to Social Development Partnerships, Human Resources Development Canada, Waterloo, ON.

Nelson, G., Prilleltensky, I., Laurendeau, M.-C. and Powell, B. (1996) 'A survey of prevention activities in mental health in the Canadian provinces and territories', *Canadian Psychology*, **37**, 161–172.

NIMH Committee on Prevention Research (1995) *A plan for prevention research for the National Institute of Mental Health (A report to the National Advisory Mental Health Council)*, Washington, DC: NIMH Committee on Prevention Research.

Oates, R. K., Gray, J., Schweitzer, L., Kempe, R. S. and Harmon, R. J. (1995) 'A therapeutic preschool for abused children: the Keepsafe project', *Child Abuse and Neglect*, **19**, 1379–1386.

Offord, D. R. (1995) 'Child psychiatric epidemiology: current status and future prospects', *Canadian Journal of Psychiatry*, **40**, 284–288.

Offord, D. R., Boyle, M. H. and Szatmari, P. (1987) 'Ontario Child Health Study, II: six month prevalence of disorder and rates of service utilization', *Archives of General Psychiatry*, **44**, 832–836.

Olds, D. L. and Kitzman, H. (1993) 'Review of research on home visiting for pregnant women and parents of young children', *The Future of Children*, **3**, 53–92.

Olds, D. L., Henderson, C. R., Chamberlin, R. and Tatelbaum, R. (1986) 'Preventing child abuse and neglect: A randomized trail of nurse home visitation', *Pediatrics*, **78**, 65–78.

Olds, D. L., Henderson, C. R., Phelps, C., Kitzman, H. and Hanks, C. (1993) 'Effects of prenatal and infancy nurse home visitation on government spending', *Medical Care*, **31**, 155–174.

O'Neill, J. (1994) *The Missing Child in Liberal Theory*, University of Toronto Press, Toronto.

Pecora, P. J., Fraser, M. W. and Haapala, D. A. (1991) 'Client outcomes and issues for program design', in D. E. Biegel and K. Wells (eds), *Family Preservation Services: Research and Evaluation*, Sage, Newbury Park, CA.

Peters, R. DeV. (1988) 'Mental health promotion in children and adolescents: an emerging role for psychology', *Canadian Journal of Behavioural Science*, **20**, 389–401.

Peters, R. DeV. (1994) 'Better Beginnings, Better Futures: a community-based approach to primary prevention', *Canadian Journal of Community Mental Health*, **13**(2), 183–188.

Peters, R. DeV., Peters, J. E., Laurendeau, M. C., Chamberland, C. and Peirson, L. (1999) 'Social policies for promoting the well-being of Canadian children and families', in I. Prilleltensky, G. Nelson and L. Peirson (eds), *Promoting Family Wellness and Preventing Child Maltreatment: Fundamentals for Thinking and Action*, Final report to Social Development Partnerships, Human Resources Development Canada, Waterloo, ON.

Prilleltensky, I. (1989) 'Psychology and the status quo', *American Psychologist*, **44**, 795–802.

Prilleltensky, I. (1994a) 'The United Nations Convention on the Rights of the Child: impli-cations for Children's Mental Health', *Canadian Journal of Community Mental Health*, **13**(2), 77–93.

Prilleltensky, I. (1994b) *The Morals and Politics of Psychology: Psychological Discourse and the Status Quo*, State University of New York Press, Albany, NY.

Prilleltensky, I. (1997) 'Values, assumptions, and practices: assessing the moral implications of psychological discourse and action', *American Psychologist*, **52**, 517–535.

Prilleltensky, I., Peirson, L. and Nelson, G. (1999) 'Mapping the terrain: framework for thinking and action in the promotion of family wellness and the prevention of child mal-treatment', in I. Prilleltensky, G. Nelson and L. Peirson (eds), *Promoting Family Wellness and Preventing Child Maltreatment: Fundamentals for Thinking and Action*, Final report to Social Development Partnerships, Human Resources Development Canada, Waterloo, ON.

Ramey, C. T. and Ramey, S. L. (1998) 'Early intervention and early experience', *American Psychologist*, **53**, 109–120.

Ratcliffe, J. and Wallack, L. (1985/1986) 'Primary prevention in public health: an analysis of some basic assumptions', *International Quarterly of Community Health Education*, **6**, 216–239.

Reppucci, N. D. and Haugaard, J. J. (1989) 'Prevention of child sexual abuse: myth or reality', *American Psychologist*, **44**, 1266–1275.

Rickel, A. and Becker, E. (1997) *Keeping Children from Harm's Way*, American Psychological Association, Washington, DC.

Ripple, C. H., Gilliam, W. S., Chanana, N. and Zigler, E. (1999) 'Will fifty cooks spoil the broth? The debate over entrusting Head Start to the states', *American Psychologist*, **54**, 327–343.

Rispens, J., Aleman, A. and Goudena, P. P. (1997) 'Prevention of child sexual abuse victimization: a meta-analysis', *Child Abuse and Neglect*, **21**, 975–987.

Rodriguez, G. G. and Cortez, C. P. (1988) 'The evaluation of the *Avancé* parent–child education program', in H. B. Weiss and F. H. Jacobs (eds), *Evaluating Family Programs*, Aldine de Gruyter, New York.

Sandel, M. (1996) *Democracy's Discontent*, Harvard University Press, Cambridge, MA.

Schorr, L. (1997) *Common Purpose: Strengthening Families and Neighborhoods to Rebuild America*, Doubleday, New York.

Schwartz, S. (1994) 'Are there universal aspects in the structure and contents of human values?', *Journal of Social Issues*, **50**(4), 19–46.

Schweinhart, L. J. and Weikhart, D. P. (1989) 'The High/Scope Perry Preschool study: implications for early childhood care and education', *Prevention in Human Services*, **6**, 109–132.

Seitz, V. and Apfel, N. H. (1994) 'Parent-focused intervention: diffusion effects on siblings', *Child Development*, **65**, 677–683.

Seitz, V., Rosenbaum, L. K. and Apfel, N. H. (1985) 'Effects of family support intervention: a ten-year follow-up', *Child Development*, **56**, 376–391.

Silovsky, J. F. and Hembree-Kigin, T. L. (1994) 'Family and group treatment for sexually abused children: a review', *Journal of Child Sexual Abuse*, **3**(3), 1–20.

Slaughter, D. (1983) 'Early intervention and its effects on maternal and child development', *Monographs of the Society for Research in Child Development*, **48**(4).

Standing Committee on Health (1997) *Towards well-being: strategies for healthy children—Report of the Standing Committee on Health respecting consideration of a study on preventa-tive strategies for healthy children. House of Commons*, Canada Communication Group—Publishing, Public Works and Government Services Canada, Ottawa, ON.

Steinhauer, P. D. (1998) 'Developing resiliency in children from disadvantaged populations', in *Canada Health Action: Building on the Legacy—Determinants of Health, Vol. I—Children and Youth*, Éditions Multimondes, Ste. Foy, Québec.

Stinnett, N. and DeFrain, J. (1985) *Secrets of Strong Families*, Little, Brown, and Company, Toronto.

Telleen, S., Herzog, A. and Kilbane, T. L. (1989) 'Impact of a family support program on mothers' social support and parenting stress', *American Journal of Orthopsychiatry*, **59**, 410–419.

Todres, R. and Bunston, T. (1993) 'Parent education program evaluation: A review of the literature', *Canadian Journal of Community Mental Health*, **12**(1), 225–257.

Trickett, P. K., Allen, L., Schellenbach, C. J. and Zigler, E. (1998) 'Integrating and advancing the knowledge base about violence against children: implications for intervention and prevention', in P. J. Trickett and C. J. Schellenbach (eds), *Violence Against Children in the Family and the Community*, American Psychological Association, Washington, DC.

Tutty, L. M. (1991) Child sexual abuse: a range of program options, In B Thomlison and C Bagley (eds), Child sexual abuse: Expanding the research base on program and treatment outcomes [Special issue]. *Journal of Child and Youth Care*, 23–41.

Weissberg, R. P., Gullotta, T. P., Hampton, R. L., Ryan, B. A. and Adams, G. R. (1997) *Enhancing Children's Wellness*, Sage, London.

Wesch, D. and Lutzker, J. R. (1991) 'A comprehensive 5-year evaluation of Project 12-Ways: an ecobehavioral program for treating and preventing child abuse and neglect', *Journal of Family Violence*, **6**, 17–35.

Wharf, B. (1993) 'Rethinking child welfare', in B. Wharf (ed.), *Rethinking Child Welfare in Canada*, McClelland and Stewart, Toronto.

Wolfe, D. A. (1994) 'The role of intervention and treatment services in the prevention of child abuse and neglect', in G. B. Melton and F. D. Barry (eds), *Protecting Children from Abuse and Neglect: Foundations for a New National Strategy*, Guilford Press, New York.

Yoshikawa, H. (1994) 'Prevention as cumulative protection: effects of early family support and education on chronic delinquency and its risks', *Psychological Bulletin*, **115**, 28–54.