

# Partnerships for Implementing School and Community Prevention Programs

Geoffrey Nelson, Jeannette L. Amio, Isaac Prilleltensky,  
and Peggy Nickels

*Wilfrid Laurier University*

The planning and implementation of prevention programs for families and children has shifted towards community-based, multi-component approaches that are rooted in partnerships among diverse stakeholders. We argue that values and partnerships should be central to the planning and implementation of this new approach to prevention programs. Following from these concepts, we propose 6 steps that can guide educational and psychological consultants in the implementation of prevention programs in partnership with other stakeholders. For each step, we identify key tasks, processes, and challenges for consultants. To illustrate these steps, we include examples from our work in prevention initiatives for and with immigrant and refugee children and families.

Recently, there has been a shift away from single-focus, researcher-driven approaches to prevention, to more community-based, multi-component approaches involving many partners (Schorr, 1997). In the new approach, the implementation of the intervention is rooted in community development (Powell & Nelson, 1997), and the evaluation of the intervention uses participatory action research (Nelson, Ochocka, Griffin, & Lord, 1998). Values and partnerships are central to this new approach.

The main objective of this article is to assist educational and psychological consultants in developing value-based partnerships for the effective

implementation of prevention programs. To achieve this aim, we prescribe a series of six steps to guide consultation practice: (a) create partnerships, (b) clarify values and vision and derive working principles, (c) identify and merge the strengths of different approaches and partners, (d) define the problem collaboratively, (e) develop the prevention program collaboratively, and (f) research and evaluate the program collaboratively. For each step, we identify key tasks, processes, and challenges. Moreover, we illustrate each of the steps with examples from our experiences as partners in implementing prevention programs for and with immigrant and refugee children.

### VALUES AND PARTNERSHIPS

We believe that although values are of central importance to planning and implementing preventive interventions, there has been very little discussion of values in the prevention literature (for an exception, see Prilleltensky, Peirson, & Nelson, 1997). We define *values* as beliefs that guide our actions. Like Shalom Schwartz (1994), we believe that values are principles that illuminate our personal, professional, and civic behavior. We concur with psychologists Mayton, Ball-Rokeach, and Loges (1994), who stated that "values may be defined as enduring prescriptive or proscriptive beliefs that a specific mode of conduct (instrumental value) or end state of existence (terminal value) is preferred to another mode of conduct or end state" (p. 3). We also agree with philosopher John Kekes (1993), who defined values as "humanly caused benefits that human beings provide to others.... By way of illustration, we may say that love and justice are moral goods" (p. 44).

Elsewhere, we have defined five key values for community psychology and prevention: (a) caring and compassion, (b) human diversity, (c) self-determination and participation, (d) health, and (e) social justice (Prilleltensky & Nelson, 1997; Prilleltensky et al., 1997). As community psychologists and as concerned citizens, we endeavor to actualize the five values with the belief that a more just society can result. *Caring and compassion* refers to the genuine and moral concern one has for the well-being of others, whereas *human diversity* speaks to a respect and appreciation for the ability of persons to self-define their identity (Prilleltensky & Nelson, 1997). *Self-determination* and *participation* refer to individuals being able to direct and participate in decisions relevant to their lives, whereas community psychology's definition of *health* entails a preventive and health promoting view of physical and mental wellness (Prilleltensky et al., 1997).

Finally, the equitable allotment of power, resources, and burdens in society defines the term *social justice* (Prilleltensky & Nelson, 1997; Prilleltensky et al., 1997). In Table 1, we summarize the definitions of these values and outline implications for the implementation of prevention programs. In our experiences, an adherence to these community values is not only important for the effective implementation of prevention programs, but also for creating larger social change. Values do not exist in the abstract, but rather are manifested in our day-to-day relationships with other people. It is through our relationships that we “live the values.” It is for this reason that we believe that partnership is another essential concept for the implementation of prevention programs. Elsewhere, we have defined partnerships as

relationships between community psychologists and oppressed groups (and possibly other stakeholders); relationships that strive to advance the values of caring, compassion, community, health, self-determination, participation, power-sharing, human diversity, and social justice for oppressed groups. These values drive both in the processes and the outcomes of partnerships

TABLE 1

Community Psychology Values: Definition and Implications for Partnerships in Program Implementation

<i>Community Values</i>	<i>Definition</i>	<i>Implications for Partnerships in Program Implementation</i>
<i>Caring and compassion.</i>	Showing empathy and concern for the well-being of others.	Form responsive and responsible relationships with stakeholders based on mutual trust, where professionals begin with humility and ensure partners feel safe and valued.
<i>Human diversity.</i>	Appreciating the inherent worth of others and respecting each person's right to define her/his identity.	Build a stakeholder-based approach to implementation that accepts and incorporates their different realities in the process and program.
<i>Self-determination and participation.</i>	Directing and participating in decisions affecting one's own life.	Share power with partners by using open problem solving and shared decision making.
<i>Health.</i>	Preventing and promoting physical and emotional wellness for the individual and the community.	Address the health, personal, and social needs of our partners and build on the strengths of the setting and its members.
<i>Social Justice.</i>	Distributing bargaining power, resources, and burdens in society in an equitable manner.	Work for an equitable distribution of power and resources among partners.

that focus on services and supports, coalitions and social action, and research and evaluation. (Nelson, Prilleltensky, & MacGillivray, in press, p. 3)

Although the concept of partnership draws attention to values, relationships, and processes, partnership can also lead to a bridging of ideas and perspectives.

It is our belief that values and partnerships are central to the implementation of effective prevention programs, but that these concepts have been overlooked in the prevention literature. In the next section, we outline concrete steps for the implementation of prevention programs that place values and partnerships front and center in our conceptualization of the implementation process.

## VALUE-BASED PARTNERSHIPS FOR IMPLEMENTING PREVENTION PROGRAMS: SIX STEPS

The six steps that we have identified include key tasks, processes, and challenges for effective prevention program implementation (see Table 2). We illustrate each of these steps with examples from work we have done in community settings with immigrant and refugee families and children. We refer to ourselves in the examples by our first names.

### Step 1: Create Partnerships

As defined earlier, the concept of *partnership* that we endorse is grounded in community psychology values and endeavors to put into practice the values in the partnership relationship itself and in the prevention programs for which the partnership is formed. A growing body of research (e.g., MacGillivray & Nelson, 1998; Nelson et al., in press) has reported on relationship qualities that facilitate successful partnerships, including mutual respect, trust, clear communication, self-disclosure, and friendship. Through positive relationships, groups of diverse stakeholders create something larger than a specific prevention program: They build a sense of community, a positive social climate, and an ethos of change in the setting, which promotes the thrust of specific prevention activities (Schorr, 1997). This is not to say that tangible resources are not important for planning preventive interventions. Research indicates that release time for teachers, child care, food and fun activities, an informal working style, and transla-

TABLE 2  
Steps in the Implementation of Valued-Based Partnerships for Prevention Program Implementation:  
Tasks, Processes, and Challenges

<i>Steps</i>	<i>Value-Based Tasks and Processes</i>	<i>Challenges for Consultants</i>
Create partnerships.	<ul style="list-style-type: none"> <li>• Include community residents and service providers from the community where the intervention is to take place.</li> <li>• Create a welcoming and friendly climate for partners.</li> </ul>	<ul style="list-style-type: none"> <li>• Abandon the role of the expert and share power with partners.</li> <li>• Reduce barriers to participation for partners.</li> <li>• Learn to value and build relationships</li> </ul>
Clarify values and vision and derive working principles.	<ul style="list-style-type: none"> <li>• Collaboratively clarify values and vision to guide the project.</li> <li>• Derive working principles (ground rules) for how the group and program should work.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage in self-reflexive analysis of personal values.</li> <li>• Be open to being challenged by partners.</li> <li>• Be aware of value incongruence and strive to reduce it.</li> </ul>
Identify and merge the strengths of different partners and approaches.	<ul style="list-style-type: none"> <li>• Identify and build on strengths of different partners.</li> <li>• Merge deductive/nomothetic and inductive/experiential approaches to planning and implementation.</li> </ul>	<ul style="list-style-type: none"> <li>• Work to overcome self-doubts and mistrust of community members.</li> <li>• Value the experiential knowledge of community partners.</li> <li>• Find common ground and respect differences to bridge the worlds of community members and professionals.</li> </ul>
Define the problem collaboratively.	<ul style="list-style-type: none"> <li>• Collaboratively define and analyze the problem in terms of risk and protective factors at multiple ecological levels.</li> <li>• Focus on the strengths of the community.</li> </ul>	<ul style="list-style-type: none"> <li>• Reconcile differing views and build consensus regarding a prevention program model.</li> <li>• Build ownership and support for program model.</li> </ul>
Develop the prevention program collaboratively.	<ul style="list-style-type: none"> <li>• Collaboratively decide on what type of prevention program to implement.</li> <li>• Ensure that necessary hardware and software are available for program implementation.</li> </ul>	<ul style="list-style-type: none"> <li>• Educate and train partners in research and evaluation.</li> <li>• Be open to learning new perspectives and ways of working from partners.</li> <li>• Clarify roles.</li> </ul>
Research and evaluate collaboratively.	<ul style="list-style-type: none"> <li>• Use both deductive (quantitative) and inductive (qualitative) approaches in program evaluation.</li> <li>• Research and evaluate each of the steps.</li> </ul>	<ul style="list-style-type: none"> <li>• Educate and train partners in research and evaluation.</li> <li>• Learn to see community members as valuable partners in research and evaluation.</li> <li>• Clarify roles of partners.</li> </ul>

tion services (if needed) are some of the resources required to build partnership relationships (Nelson et al., in press; Peirson & Prilleltensky, 1994).

*Who should be a partner?* Partnerships for the implementation of prevention programs should combine the efforts of two main stakeholder groups: those traditionally regarded as “experts” sent in to “fix” the focal problem and those most vulnerable to the problem itself. These two groups have been referred to as *outsiders* and *insiders*, respectively (Dimock, 1992), or the *formal* and *informal* sectors, respectively (Narayan, 1999). In a school setting, the formal sector includes consultants, teachers, psychologists, human service providers, and administrators, whereas students and parents comprise the informal sector. Rarely are parents or students recruited to participate in planning prevention programs. We argue that both sectors need to be involved in prevention program planning and implementation.

*Why should we form partnerships?* As community psychologists, we believe that value-based partnerships should exist for the ultimate benefit of those living in disadvantaged conditions. In other words, we believe that working with people who are disadvantaged in partnerships for prevention is a moral imperative based on the values that we outlined in the previous section.

Our belief in the empowering possibilities of the partnership relationship is also supported by more practical reasons for pursuing partnership. A program’s implementation will likely fail when the views of stakeholders, especially those for whom the intervention is intended, are not incorporated into the design (Peirson & Prilleltensky, 1994). Both insiders and outsiders are needed to plan and implement a prevention program tailored to the context, one where the program is “built in” to the setting, rather than “laid on” (Juras, Mackin, Curtis, & Foster-Fishman, 1997; O’Neill & Trickett, 1982; Peirson & Prilleltensky, 1994). Although community members can bring insightful ideas about what might work in their particular context, professionals can bring information about evidence-based programs (Durlak & Wells, 1997) enabling community members to make informed decisions about different program options. These typical roles notwithstanding, professionals can contribute more than knowledge, and community members can offer more than experience.

Subsequent feelings of ownership (Altman, 1995; Cherniss, 1997; Durlak, 1998; Kress, Cimring, & Elias, 1997; Lynch, Geller, Hunt, Galano, & Dubas, 1998) and commitment about the program can result because

stakeholders will have invested a part of themselves in the process (Gager & Elias, 1997; Peirson & Prilleltensky, 1994). In contrast, a program that is imposed from the top down can trigger indifference and even contempt and resistance (Johnson, Malone, & Hightower, 1997; Juras et al., 1997; Peirson & Prilleltensky, 1994). School administrators, teachers, parents, and students have been found to react negatively to top down changes (Johnson et al., 1997; Peirson & Prilleltensky, 1994).

*How should the partnerships work?* Creating the types of value-based partnerships that we propose is not easy. The challenge begins at the outset of the partnership, that is, when recruiting potential partners, and continues on throughout the life of the relationship. How do we attract members of the community, encourage them to share personal stories that inform the intervention-building process, and maintain their involvement? Cameron, Peirson, and Pancer's (1994) review of resident involvement at the seven Ontario Better Beginnings, Better Futures prevention program sites sheds light on methods that can attract prospective community members to the planning table. Their findings suggest that consultants and others from the formal sector should pay particular attention to ways in which their professional roles overtly and covertly dominate interactions with community members. For example, the authors found that the formal manner in which professionals conduct meetings, make decisions, and dominate air time during meetings can stifle resident involvement, whereas avoiding the use of professional jargon and sharing leadership responsibilities, such as chairing meetings, can facilitate community participation (Cameron et al., 1994).

*Challenges for consultants.* We call for consultants to abandon the role of researcher as expert (Kloos et al., 1997) and to recognize the wealth of knowledge inherent in the informal sector. When designing prevention programs, it is important that consultants and others from the formal sector share power with community members who are disadvantaged. The latter group possesses wisdom and experience, which the former group traditionally lacks. Lord and Church (1998) presented a similar view in their acknowledgement that "non-disabled professionals cannot fully understand the social world of disability" (p. 11).

Part of the challenge for consultants and other professionals is to proactively ensure the equal status of community members with whom they work (Chavis, Stucky, & Wandersman, 1983). Invitations

to participate are not enough. Mandating a larger representation from the community than that of professionals has been found to facilitate the involvement of the informal sector (Cameron et al., 1994). In Ontario's Better Beginnings, Better Futures prevention program sites, there must be at least 51% community resident membership on each decision-making committee. We believe consultants should take significant strides toward building a responsive relationship with the informal sector. Researchers and professionals need to be more humble and better listeners.

Creating safe and friendly processes is vital for recruiting and maintaining the interest and participation of different stakeholders. Also, consultants and other service providers need to recognize issues of volunteer burnout and turnover over time (Pancer & Cameron, 1994). It is important not to overload or exploit parent volunteers who are not being paid for their participation, but rather to recognize and support their contributions. To address the turnover issue, which is natural and inevitable, there needs to be continuous recruitment of interested parents and students.

*Illustration.* A practical example of creating a partnership for prevention can be found in Peggy's work with refugee children and families in Kitchener-Waterloo, Ontario. In this community, there is a growing number of refugee families, but little attention has been paid to addressing the needs of refugee children. Refugee parents, English as a second language teachers, counselors, health professionals, settlement workers, and other concerned community members came together to form a Community Supports Group. From its members' combined perspectives, experiences, and skills, this group is learning how to plan and develop community supports for refugee children and families.

In building its membership, the Community Supports Group has worked hard, although not always successfully, to recruit as many members as possible from communities with refugee experience. Group members from the mainstream culture make a conscious effort not to dominate discussions and to make space for the voices of those whose language and cultural background is different. Meetings are held at times and in places that are most conducive to participation from community members. Providing interpretation, transportation, and refreshments are all ways in which the group works to encourage participation in its activities.



## Step 2: Clarify Values and Vision and Derive Working Principles

As we have suggested, there is a need to recognize the role of values in planning and implementing prevention programs. Whether conscious of them or not, each of us has values and beliefs that invariably affect our thoughts and actions (Prilleltensky, 1997). Our second step in value-based partnerships for effective prevention program implementation asks consultants to clarify the vision and values of the partners and to derive principles for how these partners should work together.

*What is values and vision clarification?* We propose that partners undergo a process of values and vision clarification. We recommend a participatory process whereby children, teachers, parents, professionals, and volunteers have a say about what values they wish to promote. All partners should bring an open mind to the process and come to a consensus about values underlying the work of the project. Shared values may be the most important factor for successful partnerships (Nelson et al., in press).

Common values serve as a reference to guide, motivate, and bond the group, thereby facilitating prevention program planning. In our experiences, we have found that the partnership values of collaboration, democratic participation, solidarity, trust, and reciprocity are vital in the creation of prevention programs, in particular, and in social cohesion, in general (Nelson et al., in press). When there is value congruence, there is potential for a good partnership and hence effective implementation (Nelson et al., in press). When there is value incongruence, partners should realize that the relationship and program implementation will be more of a struggle. Shared values can be created by devoting time and energy to extensive pre-negotiation work (Nelson et al., in press). Clarifying the *vision* entails a similar process to that of values clarification, whereby group members form a shared purpose for the partnership founded on the group's shared values (Nelson et al., in press).

*What are working principles?* Once an agreement on the values and vision of the partnership has been reached, the next task is to develop working principles, or the collective norms, that will govern the group. We recommend grounding those principles in the input of partners. As derivatives of the vision and values, the working principles should address how best to resolve conflict, elicit participation, and reach a consensus. We have

found that, unless people learn to negotiate differences, it is not realistic to expect social harmony, let alone effective program implementation. This is why we promote partnership values, values that uphold conflict resolution and collaboration (Putnam, 1996).

Establishing clear procedures for decision making and encouraging collaborative and trusting relationships are key ingredients for successful working conditions. Well-conceived prevention programs cannot work unless the people who are supposed to implement them get along. The process of clarifying values, vision, and working principles is ongoing and fosters a sense of ownership and partnership among the players (Nelson et al., in press; Peirson & Prilleltensky, 1994; Prilleltensky et al., 1997). When individual partners are committed to the same goals and norms, a successful partnership is likely to follow (Nelson et al., in press).

*Challenges for consultants.* To actualize this second step, there is a need for consultants to engage in a self-reflexive analysis of the values she or he brings to consultation practice. Dei (1996) argued that a self-reflective critique is necessary prior to engaging in transformative projects. He called for a heightened self-awareness of the ways in which we oppress and are the oppressors of others (Dei, 1996). Part of this consciousness raising should include resensitizing ourselves to the hardships experienced by people living in disadvantaged conditions (Nelson et al., in press). It is important to realize that we all have blind spots, of which we may not be aware, and assumptions about people who are disadvantaged. If such assumptions are not subjected to critical self-reflection, they might surface and interfere with our work as consultants.

On recognizing one's values, there must also be a willingness on the consultant's part to have those values challenged (Nelson et al., in press). On a personal level, when others question and criticize one's beliefs, it can lead to feelings of hurt, self-doubt, and anger. Beyond those feelings, consultants should expect to feel uncomfortable because the experience of partnering with people living in disadvantaged conditions can lead to questioning one's own privilege. Given the likelihood of discomfort, to truly engage in the partnership we propose there must be a "readiness to enter into an uncomfortable zone" (Nelson et al., in press, p. 28).

Another challenge for consultants is value incongruence between different stakeholders (Cherniss, 1993). Our experience is that this can take two different forms. One is the case in which one or more partners subscribe to values that are antithetical to those of other partners. For example, if a service provider believes that he or she is the "expert," this will undoubtedly cause problems if other partners are striving toward power

sharing. Another problem is when there is a gap between the “talk” and the “walk” of the values on the part of some partners. We have experienced individuals who state that they espouse the values of the project, but their behavior is inconsistent with their words.

Both types of value incongruence mentioned previously can be overcome through opportunities for being challenged, which can lead to mutual learning and self-reflection. If, over time, value incongruence persists, the group needs to consider the participation of individual members or the viability of the present group. Perhaps different players or a different forum is needed.

*Illustration.* To illustrate, a key feature of the Community Supports Group with which Peggy has been involved is the shared values that bind the group together. These include the caring and compassion that have motivated people to invest time, energy, and resources in the work; a health-oriented perspective and belief in children’s resilience and capacity to heal; a commitment to community-based approaches that nurture empowerment and participation; and a conviction that individuals and groups must work together and advocate at multiple levels for a more equitable distribution of resources and opportunities for all members of the community. This group collaboratively defined its values and vision and uses them to guide the work of the group and programs that are designed to support refugee families.

The Community Supports Group did experience a serious internal crisis among group members that caused members to invest a lot of time reflecting on shared values and principles related to mutual respect and trust. This process led to a resolution of the issues, created a safe environment for those who had felt threatened, and enhanced group members’ relationships and their capacity to work together.

### **Step 3: Identify and Merge the Strengths of Different Approaches and Partners**

*What are the different approaches?* The third step in the development of value-based partnerships is to identify the strengths of different approaches and partners and to creatively merge the different strengths. In the first step, we identified the different stakeholder groups who need to be involved in value-based partnerships for prevention. It is important for consultants to recognize that each partner has strengths and brings something valuable to the planning and implementation process. This strengths-based focus has long been a key concept of community psychology (Rappaport, 1977). As planning group members first meet and get to

know one another, they can engage in mapping the assets of group members and of the community (McKnight, 1995). Focusing on strengths can energize the group and community for action.

It is also important for consultants to recognize that different stakeholders often work from different approaches and different bases of knowledge. Prevention researchers typically work from a deductive and nomothetic approach that is associated with formal research knowledge. The deductive and nomothetic perspective is a rational, empirical approach to implementing programs based on traditional notions of the scientific method.

On the other hand, service providers and community members typically work from an inductive and experiential approach, which is associated with experiential knowledge. This approach focuses explicitly on the politics and interpersonal relationships that are inherent in social research and intervention. Moreover, this approach asserts that the voices of people for whom an intervention is developed should be at the forefront of the change process because citizens have essential information and experience to contribute to such interventions, as well as a democratic right to self-determination.

It is important for consultants to recognize that different approaches and types of knowledge are valuable and important for prevention program implementation. Recently, the dominance of the deductive and nomothetic approach has been challenged on the grounds that it ignores the value-laden and political nature of most human problems (Lincoln & Guba, 1985). This does not mean that this approach is not useful, but that it should be balanced with the inductive and experiential approach by including and listening to the voices of the community.

*Why should we merge different approaches?* Our belief is that the inductive and experiential and deductive and nomothetic approaches are complementary, rather than contradictory, and that they need to be bridged in prevention program implementation. It is not enough to have impeccable theoretical formulations for a problem or program if they are not accepted or understood by people and do not reflect the people's realities (Bowden, 1997; Chambliss, 1996).

Partnerships provide an ideal forum for melding these two perspectives, given that the values of conflict resolution and collaboration are fundamental to the relationship (Putnam, 1996). Our experiences as prevention program planners have taught us that disagreements about how to intervene are an inevitable part of the partnership. However, as members negotiate past differences and synthesize ideas about implementation, the bonds between partners can be reinforced. Moreover, individ-

ual commitment to the partnership relationship, and to the implementation project, can also be strengthened (Gager & Elias, 1997; Peirson & Prilleltensky, 1994).

*Challenges for consultants.* In practice, combining the deductive and nomothetic and inductive and experiential approaches to program implementation is challenging. For consultants, the challenge lies in their ability to facilitate the involvement of members from both the formal and informal sectors (Cameron et al., 1994). Community members are likely unaccustomed to sharing their stories to inform program implementation. Having traditionally been overlooked in the planning process, eliciting their participation can be difficult. Feelings of self-doubt about one's knowledge and skills, as well as a mistrust for the partnership process, are likely to hinder involvement (Cameron et al., 1994; Nelson et al., 1999). Moreover, Cameron et al. noted that most professionals are not trained in ways to effectively involve residents. This is likely due to the traditionally individualistic, expert role of consultants.

To begin to move past the discomfort, there is a need to develop a safe climate (Nelson et al., in press). Much attention must be spent on ensuring that all participants are comfortable, feeling accepted and valued (Kloos et al., 1997; Nelson et al., 1999; Prilleltensky et al., 1997). Consultants will need to have patience (Nelson et al., in press): As with any relationship, developing a level of trust takes time (Perkins & Wandersman, 1990). A consultant cannot overestimate the importance of time when developing the partnership (Juras et al., 1997; Kloos et al., 1997; Nelson et al., in press) because the rapport among the consultant, prospective service users, and other stakeholders is the foundation for dialogue.

Consultants need to value the experiential knowledge of community members and service providers from the setting. The approaches and knowledge bases of professionals and disadvantaged citizens are like different worlds. Bridging these two worlds or cultures is quite a formidable challenge. We have found that language can be a barrier to such bridging. Researchers and professionals need to be wary of research and professional jargon and learn to speak in more easily understood terms. Our experience is that in bridging this gap, it is important both to find common ground and to understand and respect differences (Lord & Church, 1998). One helpful factor in this process is the location and inclusion of *boundary spanners* (i.e., people who have experience in, and can understand, both worlds; Bond & Keys, 1993). Another helpful factor is to have partners skilled in conflict resolution (Nelson et al., in press).

**Illustration.** In the formative meetings of Peggy's involvement with different stakeholders concerned with refugee children, a capacity-oriented skills and resources inventory of group members was taken. A nominal group process was then used to identify and set priorities for the group's objectives in a participatory and democratic fashion. This process empowered the group by documenting its collective wealth of knowledge and experience. It also elicited and validated the various kinds of resources that each person could contribute and established an ethic of mutual respect that group members have worked hard to promote.

A valuable process of mutual learning occurred within the group as different members complemented each other's theoretical and practical knowledge. Several members with clinical and academic backgrounds shared their knowledge of the concepts of risk and protective factors as related to children and trauma. Settlement workers and refugee members enhanced and expanded on this with real life examples of what they had experienced or observed in refugee children. English as a second language teachers were identified as pivotal in building bridges within and among the school, refugee families, and the larger community. The group was extremely fortunate to have several boundary spanners, who combined refugee and psychology, teacher and refugee, and immigrant and community psychology experience. The work of the Community Supports Group illustrates the importance of both the deductive and nomothetic and inductive and experiential aspects of planning.

#### **Step 4: Define the Problem Collaboratively**

For the fourth step in developing value-based partnerships for effective prevention program implementation, we recommend that stakeholders from the formal and informal sectors define the focal problem together, combining deductive and nomothetic and inductive and experiential approaches. The deductive and nomothetic approach includes attention to risk and protective factors and how they operate in a multi-level, ecological context on the focal problem. Cowen (1980) referred to this as the *generative base of prevention*, and Reiss and Price (1996) spoke of *life span human development* to capture this idea. Bloom (1984) asserted that in establishing the generative base of a social problem, one first decides on the focus of the preventive intervention and then constructs a model of how the problem develops. This involves defining the problem and assessing how widespread the problem is in a community.

The most popular, current theoretical approach for understanding the problems of children and youth involves an examination of the risk and

protective factors that may influence the problem of concern (Bogenschneider, 1996; Rae-Grant, 1994). Risk factors are those that are associated with an increased likelihood of the problem, whereas protective factors are those that enhance an individual's ability to cope with risk factors, thus reducing the likelihood of the problem (Rutter, 1987).

Related to the risk and protective factors framework is the ecological perspective. Bronfenbrenner (1986) asserted that a child is embedded within a number of nested and interdependent systems, including the microsystem (e.g., the family), mesosystems (e.g., schools, neighborhoods), and macrosystems (e.g., culture, media). Several writers have examined a variety of child and youth problems, such as delinquency and substance abuse, in terms of risk and protective factors at the child, family, and community levels of analysis (Hawkins, Catalano, & Miller, 1992; Rae-Grant, 1994; Yoshikawa, 1994).

However, in framing the problem for a preventive intervention, it is not enough for researchers to have a conceptual analysis based on the best information in the research literature. The inductive and experiential perspective reminds us that there must also be an understanding of, and an active engagement with, the school and/or community in which the preventive intervention is to be implemented (Bogenschneider, 1996; Peirson & Prilleltensky, 1994; Reiss & Price, 1996). A local planning committee, consisting of different stakeholders, can formulate the problem for the intervention. This approach has been successfully used in the development of a mentoring program in a high school (Peirson & Prilleltensky, 1994) and in the formulation of proposals for multi-component, community-based prevention programs in Ontario, known as Better Beginnings, Better Futures (Pancer & Cameron, 1994).

It is important for the most disadvantaged stakeholder group to have a voice in defining the group's problems and strengths. In the Better Beginnings program sites, Pancer and Cameron (1994) found that parents with a low income both benefited from and contributed through their participation. Such a process builds ownership and the commitment of stakeholders and brings resources from the host setting to the planning and implementation process, factors that have been found to be associated with effective prevention program implementation (Gager & Elias, 1997; Peirson & Prilleltensky, 1994).

One of the benefits of involving community members in a community needs assessment is that they are very knowledgeable about their community's strengths, resources, and capacities on which any proposed intervention can build (McKnight, 1995). They are, in addition, quite rightly sensitive to having their communities labeled in terms of problems or deficits.



*Challenges for consultants.* Combining the two approaches achieves a more thorough understanding of the focal problem and strengths than does conventional consultation. Like the medical model, traditional consultants work alone to assess and diagnose the setting *for* its members. In contrast, our proposal involves working *with* community members for a problem definition that builds a comprehensive understanding of the problem. Our proposal is based on a collaborative process where lived experience informs research, just as research informs people's understanding of the issues. The main challenge for consultants trying to implement this step is for them to engage in a collaborative process.

Another challenge for consultants is to educate community members about the risk and protective factor framework at multiple ecological levels of analysis. This model needs to be described in plain language using examples that are relevant to community members. Community members can then understand its value as a tool and use it to educate consultants about the most salient risks and protective factors in their communities. Thus, the process is one of mutual learning between the consultant and the community.

*Illustration.* Isaac has collaborated with a group of Latin American refugee families in Kitchener-Waterloo, Ontario, to improve the educational and personal opportunities of their children. Having grown up in Argentina and having experienced migration twice in his life, Isaac felt close to the community and its challenges. The families lived in a cooperative housing with about 80 units, and Latin American families occupied about one fourth of them. Parents had been concerned about the schools' responsiveness to their children's needs and came together to form the Latin American Educational Group.

To determine the children's needs, Isaac and the group conducted a needs and resources assessment. With collaboration from community leaders, they constructed an interview guide inquiring about risk and protective factors facing the children and families in this refugee community. Isaac trained community members in interviewing and focus group facilitation. Several parents helped with the research, including the analysis and interpretation. The findings were conceptualized at various levels of analysis. Risk, protective factors, and recommendations were all discussed at the levels of child, family, school, and community (Prilleltensky, 1993).



Two of the central problems that were identified were the need to prevent smoking and the need to promote the Spanish language skills of children. The work of this group illustrates the type of collaborative approach to problem definition and needs and resources assessment that we are proposing.

### Step 5: Develop the Prevention Program Collaboratively

The fifth step maintains that the prevention program should be developed collaboratively. The appropriateness of a solution depends on participatory decision making with those most vulnerable to the focal problem. We again argue that the prevention program should be based on a synthesis of the deductive and nomothetic and inductive and experiential approaches.

The deductive and nomothetic approach encourages planners to review theoretical formulations about prevention models and the qualities of effective prevention programs. Three types of prevention have been delineated in the literature: (a) proactive universal prevention (which is for everyone), (b) proactive high-risk prevention (which is for groups that are high-risk for developing a problem), and (c) reactive interventions (which treat problems in their early stages; Nelson, Laurendeau, Chamberland, & Peirson, 1999, Nelson, Prilleltensky, & Peters, 1999). Some writers are against subsuming reactive efforts under the larger *prevention umbrella*, maintaining that such efforts are really treatment services (Durlak, 1997; Goldston, 1986). Nonetheless, research shows that early intervention to reduce the negative effects of an existing problem is worthwhile because the likelihood of long-term maladjustment is diminished if milder problems are prevented from getting worse (Durlak & Wells, 1998).

Recent frameworks of preventive intervention draw from the generative base of the focal problem to formulate strategies that reduce risks and reinforce the presence of protective factors. It is through multi-component interventions that address the risk and protective factors at the micro, meso, and macrosystems that a child's development is best protected and promoted (Rae-Grant, 1994). Consistent with an ecological perspective, this multiple-level understanding of preventive interventions also calls planners to identify resources in the focal and related systems that facilitate intervention implementation. Peirson (1993) outlined two such resources. The term *hardware* describes the tangible resources needed to properly implement and sustain changes to a setting. People, funding, material resources, staff training, and pilot programs are some of the

facilitative factors befitting the hardware classification (Durlak, 1998; Lynch et al., 1998; Peirson, 1993). *Software* refers to the intangible factors that ease implementation, such as a long-term approach to the change process. Although previous research serves as an informative foundation from which to build an intervention, an understanding of the present context is still necessary. The inductive and experiential perspective fulfills this need.

The inductive and experiential approach to intervention is rooted in the strengths and views of those who are disadvantaged and in cultivating a respectful collaboration with them. Exploring what residents believe to be helpful in their context in terms of prevention and promotion of wellness is central to forming relationships and benefitting from capacities. Using grounded theory (Peirson & Prilleltensky, 1994), planners should explore people's hopes for the intervention and how they feel their needs can be best met:

For programs and change to be considered successful, community members must come to see them as their changes. However, for stakeholders to take ownership and believe a program/change is theirs, they must be able to recognize in it some of themselves: their needs, their beliefs, their ideas. (Peirson & Prilleltensky, 1994, p. 137)

Community residents must be involved in planning. The greater the community involvement, the more likely the community will be to support the intervention. In turn, an enhanced sense of ownership over the school or community program can result, and institutionalization of the prevention program is likely (Altman, 1995; Cherniss, 1997; Durlak, 1998; Kress et al., 1997; Lynch et al., 1998).

Fullan (1992) asserted that implementation of school innovation is enhanced when stakeholders agree on the need for change and the relevance of the intervention for the school. We believe that reaching an agreement about a setting's needs, and an intervention's relevance, require both the inductive and experiential and deductive and nomothetic perspectives. Whereas the deductive and nomothetic probes the theoretical underpinnings that have informed past interventions about the focal problem, the inductive and experiential approach reveals the present concerns and hopes stakeholders have about dealing with the issue. In the end, a comprehensive understanding of the necessary supports can, ideally, be attained.

**Challenges for consultants.** The main challenge for consultants at the fifth step of our proposed implementation is to help the group reconcile dif-

ferences and build a consensus about a prevention program approach. Whereas deductively oriented partners are likely to purport replicating programs that have been evaluated and proven effective in other settings, inductively oriented partners are more inclined to implement innovative preventive supports. Moreover, there are often conflicting ideas about whether an intervention should strive for immediate or long-term benefits.

We have found that achieving short-term goals builds confidence among partners and trust in others affected by the intervention. While partners come to believe in the effectiveness of the partnership relationship, members of the setting can become more receptive to future changes having witnessed previous success (Peirson & Prilleltensky, 1994). Achieving short-term goals prepares partners and the setting to attain goals that require more intense planning, commitment, and time. These debates of replication versus innovation and short- versus long-term goals are issues that consultants will likely need to mediate with others in the partnership.

*Illustration.* Isaac's work with the Latin American community led to several different prevention and promotion programs. Multiple needs called for multiple interventions at various levels and with various players. At the level of the child, there was a need to maintain cultural heritage. This prompted the creation of a Spanish school run by parent volunteers. At the family level, there was a need for parenting courses, which were coordinated by local facilitators. At the school level, advocacy was needed to help educators understand the unique circumstances of refugee children from Latin America. This led to presentations and meetings with school board officials.

At the level of the community, smoking prevention was seen as a priority. With government funding, a local initiative was launched to prevent smoking in children and youth. This program was not limited to skills, but incorporated a community action component. Children made presentations at city hall concerning the ill effects of smoking and displayed antismoking art in a shopping center.

### **Step Six: Research and Evaluate Collaboratively**

The final step in developing value-based partnership for effective implementation asks consultants to partner with program participants, other professionals, and community members in researching and evaluating the implementation of the prevention program. Once again, we believe that research and evaluation should blend the deductive and nomothetic and in-

ductive and experiential perspectives. The deductive and nomothetic approach includes various process and outcome measures related to program implementation, whereas the inductive and experiential approach is used to gather qualitative data regarding the implementation process as perceived by different stakeholders.

We propose an evaluation of each of the six steps. A deductively oriented evaluation measures the extent to which each step is successfully completed, whereas an inductively oriented evaluation focuses more on the process behind fulfilling each task; that is, how do partners experience the partnership relationship? For example, a deductively oriented evaluation of step five (i.e., develop and implement a prevention program) investigates the extent to which the program is implemented as planned (Durlak, 1998). Quantitative measures of program fidelity can be used for this approach. An inductively oriented evaluation investigates how partners feel about the evaluation process. Issues of resident participation, personal empowerment, and social climate are addressed by using qualitative interviews and observations more in line with inductive and experiential data-gathering tools. An excellent example of how these two approaches can be combined in the study of prevention programs for children is that of *Better Beginnings, Better Futures* (Peters, 1994).

We believe it is important that both approaches be used in a collaborative, participatory manner. Having research steering committees composed of community members and service providers to guide each step of the research process is one way to promote collaborative research, using either quantitative or qualitative methods (Nelson et al., 1998).

*Challenges for consultants.* The final challenge for educational and psychological consultants is to facilitate the sharing of the evaluation process between formal and informal sectors. To do so, partnership resources need to be distributed in a manner that enables all stakeholders to take part in the evaluation (Nelson et al., 1998). Educating and training partners who are unfamiliar with research methods is one way of equalizing the participation between the two sectors. Hiring people who are economically disadvantaged from the host community as research assistants is another viable method.

*Illustration.* Isaac's work with the Latin American community illustrates the type of participatory research related to prevention program implementation that we are advocating. Throughout the 6 years the various projects were in operation, the group conducted formal and informal eval-

uations to see how people got along and how effective the programs were. Isaac and members of the steering committee hired and trained research assistants to gather data for the evaluations. For example, a quantitative, outcome evaluation with a comparison group of the smoking prevention program was conducted. As well, qualitative data were collected from children, parents, and project workers about the implementation of the smoking prevention program.

## CONCLUSION

In this article, we highlighted the importance of values and partnerships for effective prevention program implementation. Following from these concepts, we outlined six steps in the planning and implementation process that we believe are helpful guidelines for educational and psychological consultants who are interested in developing school and community prevention programs. For each step, we have identified some key tasks, processes, and challenges for consultants.

Based on our reading of the prevention literature, we found that seldom is there a mention of the first three steps (creating partnerships, clarifying values and vision and deriving working principles, and identifying and merging the strengths of different approaches and stakeholders). These steps are central to our conceptualization of effective implementation. We believe that effective prevention programs need to be grounded in consensually agreed on values and solid partnership relationships among consultants, human service providers, and people for whom the intervention is designed that acknowledge and build upon one another's strengths. This is the essence of the first three steps.

Again, based on our reading of the prevention literature, we found that most consultants ignore the first three steps, beginning instead with the last three (defining the focal problem, developing a prevention program, and researching and evaluating the program). That is, consultants immediately dive into the task of analyzing the problem, creating a solution, and evaluating the solution. Moreover, these steps are typically done by researchers and human service providers, with those who are to be the recipients of the intervention being ignored in this process. Our belief is that parents, students, and other community members should be integrally and meaningfully involved in these latter three steps.

We acknowledge that some researchers and consultants may follow the path that we have outlined in the previous paragraphs. However, if they are behaving in a more value-based, partnership-oriented, collaborative man-

ner, then they are not writing about it. For the reasons that we have outlined throughout this article, we urge consultants to follow the suggested guidelines and to report, in the prevention literature, their experiences.

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**Geoffrey Nelson** is Professor of Psychology and Director of the Master of Arts Program in Community Psychology at Wilfrid Laurier University. He has served as Senior Editor of the *Canadian Journal of Community Mental Health* and Chair of the Community Psychology Section of the Canadian Psychological Association. Some of his research and writing have focused on community- and school-based prevention programs for children and families.



**Jeannette L. Amio** completed her master of arts in the Community Psychology Program at Wilfrid Laurier University. She is currently a Doctor of Educational Psychology at the Ontario Institute for Studies in Education, University of Toronto. Her research interests include full-service schools and the development, implementation, and evaluation of preventive school supports for newcomer children and their families.

**Isaac Prilleltensky** was Associate Professor of Psychology at Wilfrid Laurier University, and is currently Professor of Psychology at Victoria University, Melbourne, Australia. He is the author of *The Morals and Politics of Psychology: Psychological Discourse and the Status Quo* (1994, State University of New York Press) and Co-Editor, with Dennis Fox, of *Critical Psychology* (1997, Sage). Isaac is interested in the promotion of value-based practice and interventions in community mental health and believes that social justice is a key value in the prevention of psychological problems and in the promotion of personal and collective wellness.

**Peggy Nickels** completed the Master of Arts Program in Community Psychology at Wilfrid Laurier University and is a longtime worker in the fields of community and international development. She is currently the Program Coordinator of the Kitchener Downtown Inter-Community Health Centre Project. The focus of her work is community-based social change, primarily in the areas of health, the environment, immigrant and refugee issues, and social justice.

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