

## **Making prevention work in human services for children and youth**

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### **ABSTRACT**

Social research has long recognised that many social problems can be reduced through preventative programs. While governments cannot reasonably counter or reverse all the negative outcomes experienced by every citizen, the rationale of the 'prevention' approach is to anticipate and mitigate the likelihood of negative outcomes. Special relevance for the prevention approach has been claimed for the field of child and youth well-being. The policy intention is both to enhance the developmental well-being of children and young people, and to lessen the social and economic burden of dealing with the serious consequences of poor health, low skills, poverty, and anti-social behaviour later in the life cycle. However, the design and implementation of prevention programs has tended to be 'top-down', with little consultation with target groups (including children) and little debate on the values framework within which prevention programs operate. This paper discusses both technical and theoretical critiques of prevention approaches, and argues for the need to develop new approaches to overcome them.

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## **Introduction: The policy and politics of prevention**

The proverbs of prevention are manifold: a stitch in time saves nine; an apple a day keeps the doctor away; better safe than sorry; even prevention is better than cure. The idea of prevention is deeply ingrained in the way many people think about their own lives, and the way parents think about their children's lives. The idea of prevention is also central to the approaches that policy makers take in addressing a range of issues. For example, both natural and man-made disasters are often followed by an inquiry, the main aim of which is to prevent the disaster from happening again, or to reduce injury and damage resulting from disasters of that type. And in medicine, a considerable premium is placed on preventing illness through vaccination, education and behavioural change.

The prevention approach has been present for a long time in dealing both with child development, and with emergent 'problems' in teenagers and young adults (Weissberg, Kumpfer & Seligman 2003). It is arguably built into the social construction of childhood in post-industrial societies, where the child is perceived as an innocent canvas, a 'clean slate' (Faulkner 2011), an individual who is essentially good, and who can, with the right supportive environment, be assisted to grow up to be a good and healthy adult—someone who makes a positive contribution to society rather than someone who causes pain for others or becomes heavily dependent on others for survival. The philosophical idea of the innocent child became incorporated into Victorian ideas of 'saving' young children from their delinquent or incapable parents (Scott & Swain 2002) and indeed carried into current medical and psychological research on child development. Here the emphasis has been on the importance of 'the early years'—a short space where enlightened policy and practice can exert a strong and lasting influence over children's development, before the harsher realities of the adult world exert their full effects.

At one level therefore, prevention is neither problematic nor controversial. It is about the design of policies to ensure 'best outcomes' for children. Nobody seriously objects to the *idea* that children should wear seat restraints when in cars (even if *practice* is sometimes imperfect), and most parents willingly have their children vaccinated against a range of illnesses (although a small and vocal minority are opposed). At another level, however, some types of prevention initiatives can be problematic in terms of either public support or method of implementation. Some prevention initiatives involve the imposition on parents and their children of values that are not universally shared. This has recently been seen for example in the Northern Territory Emergency Response since 2007. Its principal aim is preventative—to prevent physical and sexual abuse of children in remote Indigenous communities—but it has proved to be deeply divisive within Australian society (Altman & Hinkson 2007). Other prevention initiatives have foundered on practical issues of co-ordination. If prevention is best implemented through a holistic

approach, with several agencies working towards a common goal, then conflict among various agencies and interest groups (and politicians) over the direction and management of the initiative and the distribution of resources required for its implementation can stymie progress and weaken outcomes.

In this paper, we discuss both types of problem. Our core argument implicitly takes on board the ‘clean slate’ approach to child development—that children are inherently capable and sociable, and that they have a right to the best start in life and to opportunity for development to their fullest potential. There is little doubt that prevention approaches can play a significant role in propelling children towards these outcomes. We define prevention and the value bases and challenges for implementation associated with different levels of prevention (from universal to tightly targeted) in the next section, and discuss the social construction of the child in greater detail in the third section. We then discuss the economics of prevention in the fourth section. Although economic arguments tend to gloss over the ethical and bureaucratic problems in the implementation of prevention strategies, they nonetheless provide a major rationale for policy makers to give increased attention to prevention over cure. The fifth section deals with some of the more problematic issues in prevention flagged above—issues associated with coercion, and with co-ordination. This is followed in the sixth section by a brief discussion of the Australian experience of implementation of prevention strategies, bringing into focus the issues discussed in the previous sections—the construction of the child, the importance of economic arguments, and the problems associated with public support and service co-ordination. The final section concludes, with involved reiteration of the importance of understanding values that are implicit in different prevention approaches.

### **Prevention policies, implicit values, and program design**

The concept of prevention, as used in the prevention science literature, is derived from the health sciences. The World Health Organisation’s (WHO) definition of prevention is ‘approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability’ (2005). In this medical conceptualisation, the disease or disorder is unquestioned as an agreed negative state or event that needs to be overcome. WHO and many other organisations propose a three part hierarchy in conceptualising types of prevention (see also Allen Consulting 2008). *Primary* prevention reduces the likelihood of the development of a disease or disorder, and is generally linked to universally available services. For example, mass immunisation to prevent specific diseases can be effectively delivered across a whole population. *Secondary* prevention interrupts, prevents or minimises the progress of a disease or disorder at an early stage, and is thus targeted towards groups with greater risks or vulnerabilities through early intervention programs. *Tertiary* services focus on halting

the progression of damage already done, for example, treating established diseases or conditions. Tertiary services are sometimes termed ‘crisis response’ because they require intensive case-management. The underlying policy purpose of prevention approaches is to reduce the flow of cases into secondary and especially tertiary services, through provision of high quality primary services.

Primary prevention, linked to universal provision, is ideally accessible by all. Universal services with high levels of uptake have the additional advantage of providing an entry point for facilitating contact between hard-to-reach groups and practitioners (McDonald 2010). On the other hand some evidence suggests that disadvantaged or hard-to-reach groups do not always access universal services for a variety of reasons, including geographic location and inadequate transport availability (Walker 2004). Moreover, universal services can often be expensive for government, and have therefore been subject to considerable criticism in Australia and other western nations because subsidised services are available to people who could otherwise pay for them (Saunders 2004). As the name implies, targeted services are focused on particular groups. ‘If the selection of particular individuals or areas can be done accurately, targeted approaches can be an efficient way of preventing later problems and effective in improving the lives of children and their families’ (Centre for Community Child Health 2006, p. 2). However, the approaches are not without difficulty, according to the Centre for Community Child Health. First, universal screening may not be effective in identifying all relevant target groups; secondly, targeted services (for example, those aimed at remediation or imparting basic skills) can sometimes be stigmatising; and third, while it is likely that high *proportions* of particular groups will benefit from an intensive intervention, the *absolute number* of children experiencing the condition may be greater outside these identified target groups. Tertiary treatment services on the other hand tend to be intensive and focused on addressing a particular contingency, such as parental drug use, mental illness, or trauma. While often effective, these targeted services can also be highly stigmatising, especially since they tend to have a strong individual treatment focus (Centre for Community Child Health 2006, p. 2). With the narrower focus comes not only more specialised design of programs, but also more value-laden selectivity (Gillies 2005).

Experts recognise the desirability of making universal and targeted services work well together (Statham 1997; Fine, Pancharatnam & Thomson 2005). The need for better integration has led to many calls, most notably by Tony Blair and New Labour in the United Kingdom, for ‘joined up government’ (Ling 2002) whereby service systems are transformed towards more integrated service delivery models. A well-known UK example was Sure Start, a program to provide integrated care and service delivery (including health and early education services) to children aged under five years (Cabinet Office 2002). Historically, the majority of social policy initiatives over many decades in the United Kingdom and Australia had tended to focus on specific

program initiatives, managed or controlled by different organisations—schools, health clinics, child protection agencies, housing agencies, and so on. The risk was that by focusing resources on highly specific program objectives, the holistic outcomes of child well-being would be lost. Rather than treating each problem in isolation, more effective solutions needed to be informed by the insight that problems are interconnected and that prevention-based solutions need to be carefully designed to reinforce broad outcomes.

Joined-up approaches—spanning government agencies, issues, and geographies—are inherently complex and difficult to organise (Bogdanor 2005; O’Flynn et al. 2011). Effective implementation requires a co-ordinated approach linking organisations across policy domains, collaborative leadership skills, and a long-term approach to funding that allows adaptive learning over time. It is therefore helpful if long-term integrated programs have strong political champions and bi-partisan support to ensure persistence over time, a matter to which we return in the conclusions.

### **The moral construction of childhood in prevention programs**

Children’s rights to be protected from direct harm and exploitation are foundational in every civilised society, and elaborated in the UN Convention on the Rights of the Child. This requirement to prevent harm usually entails in practice that children’s interests are determined on their behalf by their parents and other adult experts. In Australian social policy, in common with social policy in most rich countries, the child is presented as a straightforward category—legally aged under eighteen, financially dependent on parents, and largely incompetent in decision-making (Redmond 2010). A number of cultural assumptions appear to underpin this construction, including that the child is ‘incomplete’ (Thomas 2000), and innocent (Faulkner 2011). Even if the child’s right to be heard on matters affecting her is accepted (Lansdown 2005), adults must decide what is in the child’s interests, since ‘they know best what is good for children’ (Mayall 2006).

Theories of ‘adults know best’ and of innocence present strong implicit arguments in favour of expert-led prevention. If adults know best, then prevention in all its forms and levels can be enacted using a ‘top-down’ approach, with policy makers and experts setting the agenda. While prevention need not always be expert-driven, and could be more inclusive and consultative, the expertise model usually prevails in ‘evidence-based policy’. If children are innocent, then they are also incompetent and in need of protection—herein lies a moral argument for prevention that can be used to over-ride other arguments. The innocence of children moreover appears to be foundational in contemporary debates about childhood, as shown in the recent controversy about photographs of children by the artist Bill Henson (Marr 2008). Joanna Faulkner suggests that:

The maintenance of innocence requires the absence of moral knowledge, as well as of harm and desire. The garden we create for the innocent must be more perfect than God's: a walled garden, with no snakes and no fruit. ... A contamination anxiety is at work here, and a purity fetish for childhood innocence (2011, pp. 8–9).

Children's rights to be protected from hazards, and their right to opportunities for healthy development, are the key drivers of prevention programs in social policy. But Faulkner also suggests that this construction of childhood places children as requiring protection from contact with 'adult' experiences such as those related to sexuality, work, want, and trauma. That said, some 'adult' experiences are unavoidable—see, for example, Bluebond-Langner (1978) on the adult worlds of children experiencing terminal illness, or Smyth and colleagues (2011) on children's roles as carers. Children who experience adult worlds have sometimes been characterised as problematic and even deviant, and therefore all the more in need of prevention. 'Disadvantaged children, for instance, are regularly depicted as bestial little deviants and prescribed harsh discipline in the guise of tough love' (Faulkner 2011, p. 9).

### **Economic arguments for the cost-effectiveness of prevention programs**

If prevention starts with a moral argument, it has been strongly supported by economic ones. The key claim is that investment in prevention will produce developmental benefits for individuals and families, and by extension for society, while at the same time providing longer-term budget savings through lower incidence of poverty, crime and poor health. The Australian Treasury, like its counterparts elsewhere (Deakin & Parry 2000), has recently taken a broader view of how social policy may be instrumental in achieving economic objectives. And in the era of greater interest in 'evidence-based policy' (Head 2008a), Treasuries may be persuaded to support the prospect of measurable benefits from new investments, if the science is reliable and if the messages are well communicated to policy-makers (Bowen et al. 2009).

Perhaps the most famous early intervention project that has been widely used to support economic arguments in favour of prevention has been the Perry Pre-School Project, a longitudinal study of 123 children who were aged three to four years over the period 1962–67 and who lived in the neighbourhood of the Perry Elementary School in Ypsilanti, Michigan. Fifty-eight of the children were assigned to a treatment group and were subject to intense interventions over their pre-school years (a one to two-year period), and 65 were assigned to a control group who received no interventions. The interventions included daily morning sessions at the pre-school, taught by a trained teacher with at least a bachelor's degree where the child-teacher ratio was about 6:1. The teachers also engaged in weekly home visits to mother and

child so as to involve mothers in the education process. The curriculum taught by the teachers focused on active learning, problem solving and child participation (HighScope Educational Research Foundation 2009). This program was very much in the mould, discussed above, of ‘saving’ children from their environments. The consensus among economists is that considerable savings and benefits were achieved, in terms of lower remedial schooling costs in childhood, reduced participation in crime, and greater economic productivity in adulthood (Barnett 1992).

The Perry Pre-School Project, perhaps because of the rigour with which it was conducted as a randomised controlled trial, has been used by Nobel laureate James Heckman and colleagues (Heckman 2006; Heckman & Masterov 2007; Heckman, Stixrud & Urzua 2006) to promote economic arguments for investment in early childhood:

We argue that, on productivity grounds, it makes sense to invest in young children from disadvantaged environments. Substantial evidence shows that these children are more likely to commit crime, have out-of-wedlock births, and drop out of school. Early interventions that partially remediate the effects of adverse environments can reverse some of the harm of disadvantage and have a high economic return. They benefit not only the children themselves, but also their children, as well as society at large (Heckman & Masterov 2007, p. 446).

Heckman and Masterov state that: ‘Investing in disadvantaged young children is a rare public policy with no equity-efficiency tradeoff. It reduces the inequality associated with the accident of birth and at the same time raises the productivity of society at large’ (2007, p. 446). Heckman also draws on a large body of work, principally by psychologists, on the determinants of children’s social and emotional and cognitive development as measured in standard psychological assessment scales (see, for example, Aughinbaugh & Gittleman 2003; Conger & Donnellan 2007; Gershoff et al. 2007; Linver, Brooks-Gunn & Kohen 2002; Shonkoff & Phillips 2000). This work emphasises not only the relationship between non-cognitive development and human capital outcomes, but also the importance of the family as the locus of the child’s development (Taylor 2009). Finally, they are also influenced by a body of evidence that suggests that interventions much later in childhood and in adulthood often have low or uncertain returns (Heckman, Lalonde & Smith 1999)—hence the emphasis on early childhood interventions. It is noteworthy that this focus on investment in early childhood is consistent with the idea of the innocent child who needs to be protected from ‘bad’ neighbourhoods and perhaps ‘bad’ parents. However, the major concern of economists is not with children’s wellbeing in the broader sense, but principally with the relationship between children’s early developmental outcomes and their future economic productivity. This claim underlies many of the Australian rationales for early intervention and prevention

policies, but it assumes the particular construction of childhood discussed above, and leaves open the question of the value-set that underpins these policies, or even whether prevention policies could be better informed by the goals of improving children's current wellbeing, irrespective of longer term productivity benefits.

### **Prevention as coercion or empowerment?**

While economic perspectives on prevention have overwhelmingly been concerned with measuring the long term benefits of programs in comparison with their shorter term costs, social theorists have been centrally concerned with understanding the values that underpin these programs. Lister (2006) refers to the idea proposed by Giddens (1998) in the United Kingdom, after the Labour Party won government in 1997, of the *social investment state*—the idea that the state should invest in children as a top priority because they represent the future of the nation as workers and citizens. At the heart of the social investment state is the idea of the child as a 'becoming'. Lister spells out some implications of this approach to education, which is 'reduced to a utilitarian achievement-oriented measurement culture of tests and exams, with insufficient attention paid to the actual educational experience' (Lister 2006, p. 322). In effect, the emphasis on future development marginalises actual children as beings, and privileges their anticipated future outcomes over their present needs.

Gillies (2005) suggests that social class perspectives implicitly underlie the different ways in which various groups of children and parents are identified and assisted. In her analysis of the UK early intervention strategy Every Child Matters, she argues that support offered to families is targeted, conditional, and directional. It is targeted in the sense that, even in the case of universal services, disadvantaged families are seen as lacking key characteristics of middle class families, such as social capital and parenting skills. One of the main purposes of these support services is to encourage or constrain disadvantaged families to conform more closely to middle class values. She argues that:

recent policy initiatives have gone further than any previous government in seeking to shape and control the practices of parents. Emerging from a distinct moral agenda, this policy is characterized by a form of doublespeak in which autonomy is foregrounded while rigid understandings of personal responsibility and ethical practice are imposed to regulate choice and action. Discourses of support in family policy derive from this notion of obligated freedom, with interventions aimed at enforcing parenting norms and values (Gillies 2005, p. 86).

These critical views of early childhood prevention programs in the United Kingdom have developed from a more fundamental critique of what Fraser (1989) calls 'the politics of need interpretation'. She differentiates between immediate or 'thin' needs, such as food for a hungry person, or shelter for a homeless person, and complex or

‘thick’ needs, which are embedded in broader social contexts in which people find themselves. For example, the problems of a homeless person go beyond the simple need for shelter, giving rise to politically contested proposals for institutional change; and the multiple problems of a disadvantaged child are seen and responded to in debates about appropriate forms of compensatory advantages. Fraser’s point is that the interpretation of needs involves value judgments by one group (such as policy makers) who have power over another group (such as disadvantaged children and their families). This power is routinely used to impose particular discourses of need, and to over-ride competing discourses. Understood in this context, specific prevention programs could sometimes be interpreted as being imposed on marginalised or disadvantaged families and children who are constrained to conform to values other than their own. In pointing to these potential criticisms, we are not claiming that prevention programs are inherently flawed, but that value positions underlying program choices need to be made explicit and that the voices of disadvantaged groups need to be articulated within these debates.

### **Constraints on the take-up of prevention by policy makers**

If the science and the economics of prevention are highly persuasive to policy makers, why have not all governments taken great steps towards adopting the new paradigm? We suggest several constraints on policy-makers and service professionals that need to be appreciated. Some of these are about the construction of persuasive and value-informed arguments for change in the face of short-term and cynical political commentary; and some are about the very serious challenges of reforming the arrangements for co-ordination and service delivery.

Firstly, explaining the benefits of *systemic* change to a public audience, and to a wide range of stakeholders who often have quite narrow sectional interests, has often proved difficult. The key messages for reform need to be distilled into bite-sized elements (Bowen et al. 2009) without distorting the underlying science that underpins the case for change. The delayed or long-term nature of the benefits can make large investments seem less attractive within a short-term political cycle. Complex messages about long-term causes and remedies may be difficult to communicate, in comparison with media-enhanced concerns about the need for more staff in crisis care and more doctors to tackle hospital waiting lists, or with media-enhanced moralizing about whether some disadvantaged people have only themselves to blame for their situations, and therefore, whether they are deserving of any support at all. The benefits of shifting funds into prevention are not easily aligned with the calculus of annual budget processes, where it is often hard to market the benefits of long-term funding for prevention services and evaluation. This difficulty of maintaining long-term commitment is exacerbated by continual changes in government ministers and among public sector managers.

Secondly, the institutional complexity of comprehensive prevention programs requires skilled co-ordination with other programs. Thus, an isolated initiative may be weak and likely to fail unless it is linked to a range of supportive measures co-ordinated across several policy fields. Social problems seldom occur in isolation—for example, substance abuse, school drop-out and depression often co-occur, and are influenced by risks in multiple domains, for example, family, school, peers and individuals' own psychological make-up. Hence complex interventions are necessary, which require careful planning and can be costly across several policy domains. Much has been written about the poor implementation of complex programs aiming to address complex problems. The difficulty of ensuring effective co-ordination across agencies, and the problem of ensuring long-term commitment to programs, are likely to be serious impediments to program success (Fine, Pancharatnam & Thomson 2005; Jones, Phillips & Milligan 2007). There are numerous social policy domains that illustrate this complexity, such as the education objectives articulated in the *Melbourne Declaration* of the Ministerial Council on Education, Employment Training and Youth Affairs (2008) and the subsequent *Action Plan* (2009). For example, long term objectives with respect to reducing inequalities in educational outcomes between Indigenous and non-Indigenous students, or between students of different socio-economic backgrounds, are unlikely to be achieved through isolated school based action; support from other policy areas including health, employment and social security are likely to be part of the solution mix. Collaboration across government agencies, across jurisdictions, and between government and NGO partners, remains challenging despite some decades of experience in co-ordination and collaboration (Bogdanor 2005; Head 2008b; O'Flynn et al. 2011).

Thirdly, shifting the balance between crisis and prevention services is desirable but problematic. Decision-makers are under pressure to respond quickly to real and perceived crises. Critical incidents are highlighted in the media, leading to immediate focus on boosting the adequacy of services for abused, injured or harmed individuals. This sometimes flows through into the findings of special inquiries into critical incidents (most notoriously in cases of child abuse and child mortality), where the recommendations of the Inquiry are usually designed to improve rapid response systems and risk management rather than ensure long-term improvements in the wellbeing of families and children. Policy makers therefore find it all the more difficult to shift resources into long-term prevention when the demand for crisis services remains high.

Finally, the moral case for prevention needs to be more persuasively made. Policy makers have either tended to shy away from explicit debates on values, instead appealing to ideas such as better health or economic development that are presumed to have universal support. However, meanings that people associate with health and development differ across groups in society, and policy makers and scientists need to take the time to engage in genuine consultation, based on the human rights principle

that people who are the target of particular services have the right to be heard on the nature of those services. Such consultation should extend to children and young people, who also have the right to be heard (Head 2011), and who should in any case be consulted as experts in their own lives. The need for extensive consultation and planning has to be defended in a principled way against the simplistic criticism that complex processes are ‘mere’ talkfests, involving endless delays, more reports, and more bureaucracy. Difficult challenges arise from taking client perspectives seriously in the framing of policy problems and the design of practical measures. Evidence-based approaches can too often be driven by experts and managed in a technocratic manner. However, a shift towards more participative forms of policymaking would seem especially useful in dealing with vulnerable and hard-to-reach populations. This could be a particularly important issue for indigenous participation in mainstream prevention programs, and for the design of programs specifically for indigenous communities (O’Flynn et al. 2011). These participative approaches may become increasingly necessary to embed new programs that can be implemented successfully in the long term.

### **Recent Australian experience**

As in other rich countries, universal programs in Australia (often aimed at fulfilling specific ‘thin’ needs as Fraser (1989) characterises them) have been successful in greatly reducing disease and mortality among children, for example, through provision of clean drinking water, efficient sanitation services, and immunisation programs. However, if the easier battles have arguably already been won, the current challenge is to go beyond the prospect of small incremental gains. As shown in the Preventative Health Taskforce report (2009) and the response to it by the Australian Government (2010), prevention policies often still focus on specific health-related issues such as smoking and alcohol. But in the area of child and youth development in particular, the science of prevention has now developed across a much wider range of issues—prevention debates are as much about educational achievement, human capital development and diversion from crime as they are about health. As we have noted earlier, normative areas of development and behaviour are tricky areas for prevention science, since they assume that most people subscribe to the same normative ideals.

A key strategic document *Investing in the Early Years – A National Early Childhood Development Strategy* (Council of Australian Governments 2009a) is a useful example of current Australian policy approaches to prevention and child development in Australia where common values are assumed.<sup>1</sup> *Investing in the Early Years* gives a

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<sup>1</sup> There are other key examples, including the Council of Australian Government’s National Child Protection Framework (2009b).

number of rationales for developing a national strategy on child development: that children are important as children, and as future citizens; that numerous actors (aside from parents) are involved in raising children, and that some co-ordination among them is desirable; that what happens in early childhood matters for children's later development; and that quality early childhood development and support programs can make a positive difference to children's outcomes. However, reference to 'children as children' notwithstanding, human capital development is the main focus of the document, and this may have been decisive in the adoption of the Strategy by governments. Two factors appear to be given particular emphasis: that the benefits of intervention in early childhood outweigh the costs, and that early intervention is an essential component of nation-building:

National effort to improve child outcomes will in turn contribute to increased social inclusion, human capital and productivity in Australia. It will help ensure Australia is well placed to meet social and economic challenges in the future and remain internationally competitive (Council of Australian Governments 2009a, p.4).

The largely economic rationale appears to be central to governmental support for these major initiatives (Boston Consulting Group 2008). The focus on cost effectiveness and economic return has in effect become a key feature of the whole prevention science agenda, no less so in Australia than elsewhere. Nonetheless, governments in Australia have been slow to implement randomised control trials in the manner of the Perry Pre-school Project (Gauntlett et al. 2000). Yet the willingness of policy makers to countenance large investments in early childhood prevention programs even in the absence of thorough cost-benefit analysis suggests perhaps a degree of values-based comfort with these types of programs.

*Investing in the Early Years* categorises early investment in childhood into four dimensions: education, health, social capital and equality, with benefits identified for children in the short and longer term, and for society. Benefits to the child in the shorter term include higher intelligence, improved school performance, less morbidity, better hygiene, and a higher self-concept; with reduced inequalities between children. Benefits to society are identified in terms of greater social cohesion, higher fertility and less crime, as well as higher productivity and enhanced social values. So far, however, most of these benefits have been identified through evidence from initiatives in the United Kingdom and the United States, implemented and evaluated in countries with different local conditions from Australia. While important work on evaluation of preventative programs in this country has commenced, especially for programs focused on the early years (see, for example, Hilferty et al. 2010), much of the hard work remains to be done.

One of the contextual factors that can greatly affect policy implementation in Australia is the particular nature of federal-state relations. Policy and program debates about the benefits of prevention have largely been at the state level where historically most of the direct services have been located for healthcare, child protection, family and community services, education, and criminal justice. But the role of the federal government has gradually become more important over recent decades, not least because the federal government controls the major taxation powers, giving it enormous scope to provide grants to the states and to non-government organisations for the provision of specific services in health, education and social care. Therefore while the Australian experience of policy and program development in human services (and in prevention) has gradually become more centralised in recent decades, it remains heavily influenced by the political economy of federalism, and the need for inter-governmental agreements on policy direction, funding and accountability. This complexity has required major ongoing efforts to improve co-ordination and collaboration (Jackson 2003; Management Advisory Committee 2004).

It has also highlighted differences in approaches and to some extent in underlying values among the different states, and between the states and the centre. These differences have perhaps been most powerfully exposed in the implementation by the federal government of the Northern Territory Emergency Response (NTER), which was introduced by the Howard Government in the Northern Territory in 2007, in large part because the federal government has greater control over policy matters there than it does in the states (that is, the NTER could be imposed by the federal government in the Northern Territory, but not in the states). The NTER comprised a package of measures that were cast as a response to a report detailing widespread physical and sexual abuse of children in some remote Indigenous communities in the Northern Territory. Most controversially, the response in its original form involved the suspension of the Racial Discrimination Act and the permit system that allowed remote Indigenous communities to control access to their lands. It also involved the introduction of 'income management'—the restriction of uses to which government income support payments could be put, compulsory health checks for Indigenous children in the remote NT communities, and the banning of alcohol and pornography in these communities. Controversy surrounding the NTER (now rebadged the Northern Territory Intervention) has been immense (Altman & Hinkson 2007). Some of it might have been avoided if there had been lengthy negotiation of the kind that occurs in the Council of Australian Governments before its implementation. However, it is unlikely that the dominant assumptions regarding prevention as a tool of economic policy and the social construction of the child as innocent and incompetent would have been seriously questioned in the ensuing dialogue.

## Conclusion

According to the editor of the journal *Prevention Science*, ‘the ascendancy of prevention is not simply the result of frustration with the limits of treatment approaches’ (Botvin 2000, p. 1), but also the result of research demonstrating that prevention approaches work. We have argued in this article that shifts towards prevention in related policy domains, including education, social welfare, physical and mental health, and criminal justice need to be carefully considered, particularly in terms of the assumptions that underpin them, and the extent to which different sections of the community buy into these assumptions. It is necessary to have wide-ranging debate as to the desirability of prevention, the aims of prevention, and how we go about prevention—these are not merely technical issues to be resolved through research and cost-benefit analysis. There needs to be some agreement in society about the social aims of prevention, the means by which these are to be achieved, and whether the same goals are appropriate for all sections of society. Clear articulation of the values frameworks within which prevention programs operate, and explicit efforts to engage with target groups on their values and perceived needs, would greatly support this process. Scientific research is but one essential input into the prevention debate, rather than the sole basis of policy (Head 2008a).

In spite of both the technical and the value-driven difficulties noted above, prevention approaches have managed to produce some substantial benefits over the last two decades in health, education, social welfare and community safety. Prevention approaches with alternative bases (for example, rights-based approaches that emphasise participation and address entrenched power relations in society) might lead to different types of programs, the results of which could be of perhaps greater value to target groups, and to society as a whole. Such programs are likely to need not only broad public support, but also bi-partisan support to ensure persistence and follow-through, and better co-ordination between the different arms of government.

We argue that prevention science has much to offer in terms of directing resources towards the improvement of the lives of Australian children and youth. However, we also argue that the value judgments and choices associated with prevention science in the Australian context need to be better articulated and understood, and that new inclusive or participatory models may need to be developed alongside the existing science-driven models. Both can be shown to ‘work’ in producing benefits, and both can be shown to be cost-effective in the long-term.

A more inclusive approach to prevention policies could arguably be helpful in approaching population groups that are characterised by social exclusion and social stigma. Taking a more inclusive approach is more difficult but is more respectful of the groups in question. The transition towards prevention approaches thus raises

moral and political issues, as well as the science challenge and the managerial co-ordination and service-integration challenge. In the quest to produce better outcomes, what should be the balance of policy effort toward changing the behaviour of disadvantaged individuals (who are encouraged or enabled to make better decisions), as against policy efforts towards more systemic change in economic and social conditions and opportunities? And in deciding what will be the top policy priorities in prevention, and which risks should be mitigated/prevented, how should the voices of young people and disadvantaged groups be articulated?

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