



# Advancing Primary Prevention in Human Services: Convening Findings

In August 2022 the Department of Health and Human Services held a convening focused on primary prevention. Discussion highlighted the opportunity for human services to strengthen and support people and families with a shift from *responding* to families once they are in crisis to *preventing* the crisis before it occurs. This shift would center on building a national framework for delivering family supports and prevention services that prioritizes equity, elevates lived expertise, and fully incorporates a human-centered, person-first approach.

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## KEY POINTS

- Broadening and shifting the focus of human services from responding to life crises (such as a mental health crisis or eviction) to supporting people and preventing these crises holds promise for building and enhancing people's strengths and resilience.
- Incorporating primary prevention into human services delivery can uproot the causes of adverse outcomes by reducing risk factors and promoting protective factors, creating the safety and stability needed to avoid adverse experiences in the first place.
- Primary prevention can foster equity and justice by addressing the deeper systemic issues, such as poverty, that lead to adverse experiences.
- To realize the potential of primary prevention in human services, we need a national framework for delivering family supports and prevention services that centers equity and elevates lived expertise as well as policies and services that situate primary prevention within universal efforts to optimally support families and children.
- To create that framework, it is essential to use a human-centered approach to service design by co-creating with the individuals and communities served; integrate services across program areas and sectors; build a primary prevention workforce that adopts a person-first approach to service delivery; and improve accessibility and effectiveness by engaging those with lived expertise to identify and address barriers and assess success.
- To facilitate adopting and implementing a framework, we can leverage evidence of effectiveness of prevention strategies to build political will; engage communities in increasing the importance of primary prevention; and finance services in a way that provides flexibility across funding sources, supports an integrated service delivery system, and empowers community-based service providers.

## WHY PRIMARY PREVENTION IN HUMAN SERVICES?

Currently, human services are most often positioned to respond to crises (such as a mental health crisis or eviction) rather than being established, connected, or resourced with the approaches and opportunities to prevent them from occurring. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) is exploring how to advance the use of primary prevention in human services, to create opportunity, support, or intervene before negative health or social

outcomes occur. The starting premise is that by understanding the root causes of adverse outcomes and addressing these circumstances through primary prevention services and interventions, human services can strengthen and support families, communities, and the nation, and help ensure all people have equitable opportunities to achieve optimal health and social outcomes.

## Types of prevention

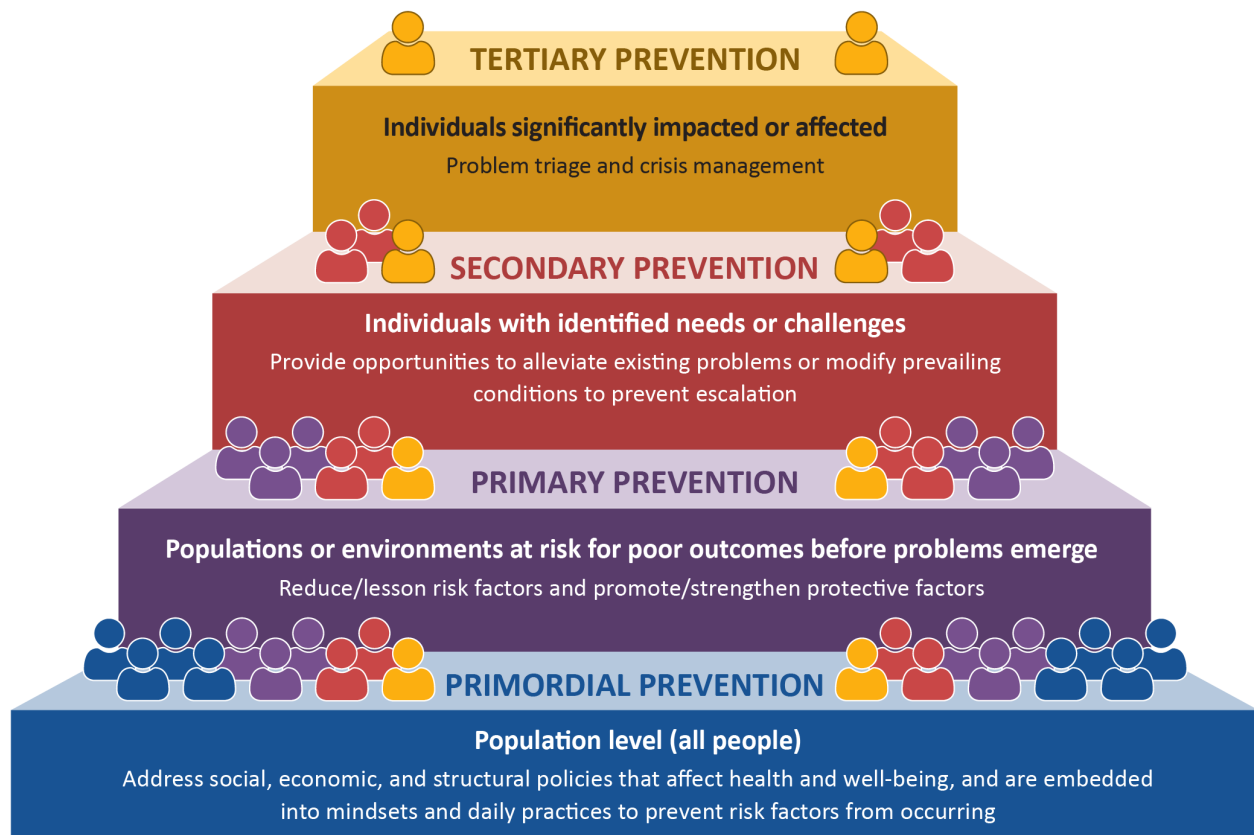
To understand the importance of advancing primary prevention in human services, we must first contextualize primary prevention among other types of prevention: tertiary, secondary, and primordial (Figure 1).<sup>a</sup> In practice, human services focus overwhelmingly on secondary and tertiary prevention rather than on primary or primordial prevention.

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This brief synthesizes input from convening speakers and participants. Throughout, we highlight key ideas in the following forms:

- **Speaker insights** from moderators, panelists, and discussants
  - **Participant perspectives** shared during the event
  - **Spotlights on youth and family homelessness** drawn from speaker and participant input shared throughout the convening
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Figure 1. Types of prevention



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<sup>a</sup> Various human services programs use different terminology. To provide terms that apply across programs, we are using the definitions presented in Figure 1 in this issue brief.

## Primary prevention can shift human services from crisis response to crisis prevention

The convening stressed the importance of human services focusing on the deeper systemic issues that lead to adverse experiences and not solely on adverse outcomes themselves. Human services can strengthen people and families and improve their circumstances with a shift in focus and deployment from responding to crises to preventing crises (that is, from tertiary/secondary prevention to primary/primordial prevention). Waiting until after people develop problems before offering them services is costly, both financially and in terms of human suffering. By focusing more on individuals than on populations and systemic conditions, human services can currently miss the structural root causes of adverse experiences and outcomes and the opportunity to address systemic ongoing needs. Incorporating effective primary prevention into human services structures and delivery can, however, uproot the causes of adverse outcomes by reducing risk factors and promoting protective factors across populations, creating the safety and stability needed to avoid adverse experiences in the first place.

### Primary prevention as means of fostering equity and justice

Equity and justice considerations are at the heart of the need for human services to shift to primary/primordial prevention. Currently, human services systems can reinforce inequity by contributing to disparate outcomes and the corresponding disparate needs for human services. For example, some human services systems may reinforce inequity through structures and policies that are designed and implemented without the input of the communities most impacted, the lack of equitable access to services, and through unconscious bias in service delivery. Further, these systems often use accountability metrics that rely on technical measures of success without working with the community to define success and assessing how well a program or policy engages with the community and builds trust. To foster equity and justice, human services should focus on the most distal factors that are the root causes of disparate outcomes.

## A CONVENING TO ADVANCE PRIMARY PREVENTION

To establish a foundation for increasing the use of evidence-based primary prevention in human services systems, ASPE worked with Mathematica to plan and facilitate an HHS Convening on Advancing Primary Prevention in Human Services in August 2022. The goal of the convening was to establish a foundation for increasing the use of evidence-based primary prevention in human services systems by (1) highlighting gaps in the implementation of primary prevention across human services programs and policies and (2) identifying future directions for advancing primary prevention in human services to promote positive long-term outcomes

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## Speaker insight

*“It is through prevention that we create equity.”*

Assistant Secretary January Contreras  
Administration for Children and Families (ACF)

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## Defining equity

Equity is the consistent and systematic, fair, just, and impartial treatment of all individuals, including those who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American people, Asian Americans and Pacific Islanders and other people of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people; people with disabilities; persons who live in rural areas; and people otherwise adversely affected by persistent poverty or inequality. Definition adapted from [Executive Order 13985](#).

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for individuals and families. The convening wove in prevention of youth and family homelessness as a prominent thread throughout, providing a concrete policy example to help participants consider how to apply the theories and evidence to a human services need. The focus on prevention of youth and family homelessness furthered HHS's efforts as a member of the U.S. Interagency Council on Homelessness contributing to the development of the since released [All In: The Federal Strategic Plan to Prevent and End Homelessness](#).

The convening sought to address the following key questions:

1. Why is it important to advance primary prevention across human services?
2. What primary prevention strategies are evidence-based?
3. How can evidence-based primary prevention strategies be adapted for human services?
4. How can primary prevention best address risk factors and promote protective factors?
5. What are the gaps in implementation of primary prevention across human services?
6. What are the future directions for advancing primary prevention in human services?

The virtual convening consisted of two afternoon sessions. It included a keynote presentation, two panel discussions featuring people with professional expertise, two "spotlights on homelessness" panels featuring people with lived expertise<sup>b</sup>, two interactive breakout sessions, and a final roundtable. At three points during the convening, we engaged participants directly to learn about their perspectives and ideas in real time.

The nearly 370 attendees included academic subject matter experts; program administrators at the state, local, and community levels; philanthropic partners; federal staff; and about 35 people with lived expertise of homelessness, domestic violence, teen pregnancy, the juvenile justice system, or family support programs.

This brief presents key themes and recommendations that emerged from the convening about ways to increase the use of evidence-based primary prevention in human services systems. The appendices provide a theoretical framework for promoting primary prevention in human services and summarize participant input shared during the convening. In Table 1, we present an at-a-glance summary of key themes and recommendations voiced by speakers and participants during the convening.

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## Defining evidence-based primary prevention services

Evidence-based primary prevention services include programs, policies, or other strategies that have been evaluated and demonstrated to be effective in preventing adverse outcomes from occurring by promoting protective factors and reducing risk factors.

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<sup>b</sup> Following Forde et al 2022, we use lived expertise to mean expertise based on someone's perspective, personal identities, and history, beyond their personal or educational experience. People with lived expertise are those directly affected by social, health, public health, or other issues and by the strategies that aim to address those issues, particularly those who are members of groups previously harmed by government systems and who are not regularly and meaningfully at the table for social program and policy discussions. This lived experience and expertise gives them insights that can inform and improve systems, research, policies, practices, and programs.

## KEY THEMES AND RECOMMENDATIONS

In this section, we summarize key themes and recommendations shared by speakers and participants during the convening related to the benefits of and opportunities for increasing the use of evidence-based primary prevention in human services systems.

Table 1. Key themes and recommendations at-a-glance

Key themes and recommendations	
<b>Identify key risk and protective factors</b>	
<i>Primary prevention focuses on reducing risk factors and promoting protective factors. Key considerations include:</i>	
	Focus on the root causes of adverse experiences: poverty and a lack of economic opportunity
	Expand beyond targeting high-risk populations to universal systems and approaches
<b>Design a national framework for delivering prevention services</b>	
<i>Create an integrated national approach for delivering prevention services—centered on equity and elevating lived expertise—with a corresponding workforce for delivering prevention services. Key considerations include:</i>	
	Adopt a human-centered approach to service design that co-creates at all levels and stages of prevention services
	Integrate infrastructure across program areas and sectors
	Build a primary prevention workforce with a person-first approach to service delivery
	Continuously improve service accessibility and effectiveness by engaging those with lived expertise
<b>Support a national system for delivering prevention services</b>	
<i>Essential to establishing a national framework for delivering prevention services is generating the support of policymakers, the public, and funders. Key considerations include:</i>	
	Engage communities to support prevention
	Leverage evidence of effectiveness to build political will
	Finance primary prevention services

## Identify key risk and protective factors

Primary prevention efforts focus on reducing risk factors and promoting protective factors. During the convening, participants identified and discussed key risk and protective factors in their respective human services areas. In Table 2, we present these risk and protective factors by outcome.

**Table 2. Key risk and protective factors that primary prevention might address**

Desired outcome	Risk factor	Protective factor
<b>Economic independence</b>	<ul style="list-style-type: none"> <li>• Individual and family poverty, economic instability</li> <li>• Lack of economic opportunity and living-wage jobs</li> <li>• Social and network poverty</li> </ul>	<ul style="list-style-type: none"> <li>• Economic stability, security, and independence</li> <li>• Employment and access to economic opportunity</li> <li>• Social and network wealth, generational wealth</li> </ul>
<b>Child well-being</b>	<ul style="list-style-type: none"> <li>• Adverse childhood experiences</li> <li>• Childhood trauma</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction of adverse childhood experiences</li> <li>• Supportive family connections</li> </ul>
<b>Quality education</b>	<ul style="list-style-type: none"> <li>• Lack of access to high-quality early childhood education</li> <li>• Underperforming schools</li> <li>• School dropout; lack of high school degree</li> </ul>	<ul style="list-style-type: none"> <li>• Quality education, starting with early childhood</li> <li>• High school degree</li> </ul>
<b>Family well-being</b>	<ul style="list-style-type: none"> <li>• Family instability</li> <li>• Lack of family support</li> </ul>	<ul style="list-style-type: none"> <li>• Strong, positive connections and support from family and parents</li> <li>• Parenting and relationship skills</li> </ul>
<b>Individual well-being: Mental and physical health</b>	<ul style="list-style-type: none"> <li>• Poor mental health or experiencing mental health issues</li> <li>• Lack of access to physical and mental health services and supports</li> </ul>	<ul style="list-style-type: none"> <li>• Access to health care and services</li> <li>• Mental wellness</li> <li>• Physical health (nutrition and exercise)</li> </ul>
<b>Social and community connection</b>	<ul style="list-style-type: none"> <li>• Marginalization and systemic oppression (racism, homophobia, transphobia, ableism, and other systems that cause, enable, or perpetuate inequities)</li> <li>• Lack of social and community support, isolation</li> </ul>	<ul style="list-style-type: none"> <li>• Community connection and support</li> <li>• Healthy relationships</li> <li>• Peer support</li> <li>• Strong social networks</li> </ul>
<b>Stable, safe housing and environment</b>	<ul style="list-style-type: none"> <li>• Lack of affordable housing</li> <li>• Experiencing disaster</li> <li>• Familial or intergenerational housing instability or homelessness</li> <li>• Unsafe neighborhood or environment</li> </ul>	<ul style="list-style-type: none"> <li>• Access to safe, affordable housing</li> <li>• Access to nature</li> <li>• Neighborhood safety</li> </ul>



**Focus on the root causes of adverse experiences: Poverty and a lack of economic opportunity**

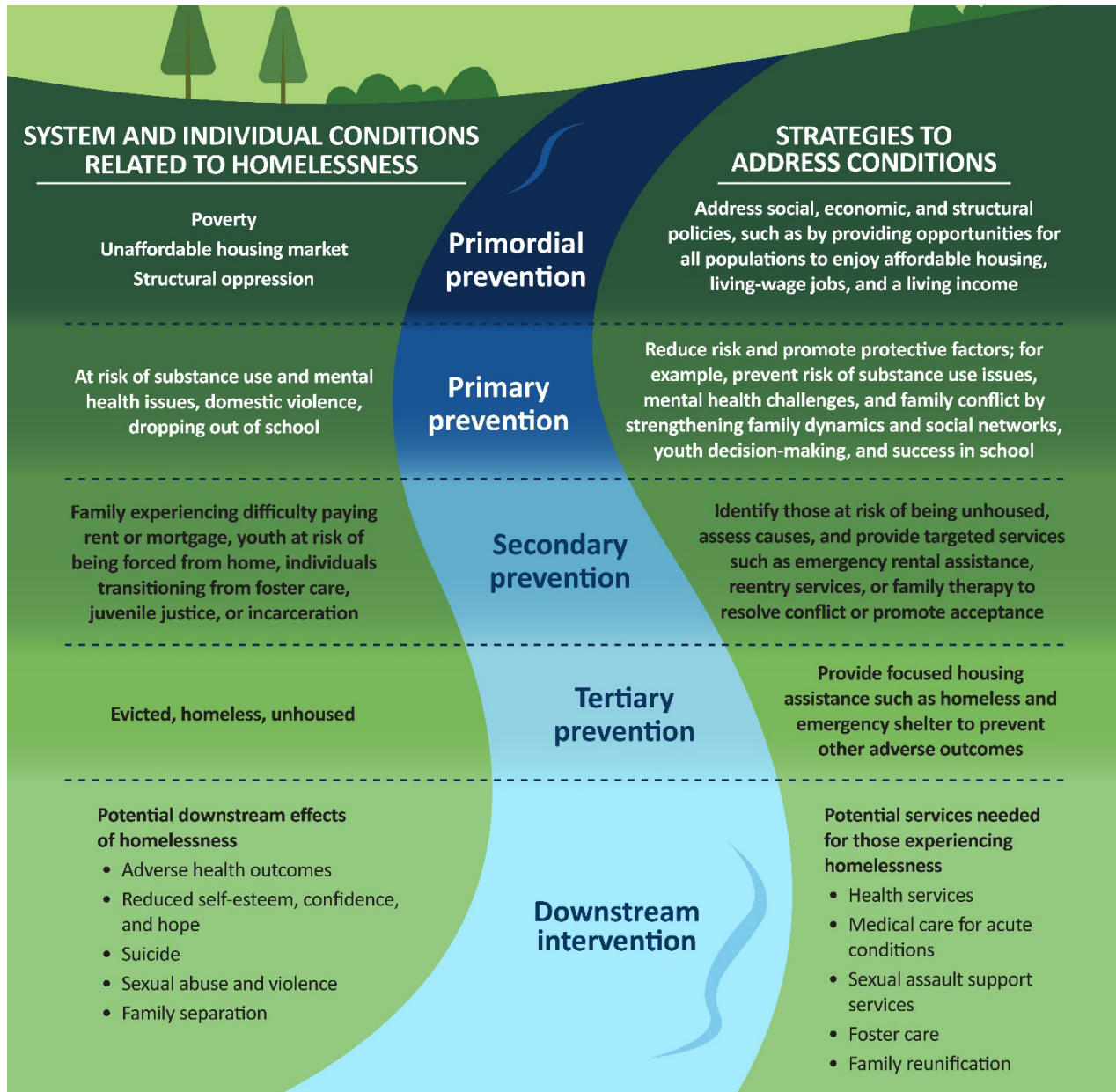
The more distal the factor to be addressed, the more effective primary prevention can be. Human services can more successfully strengthen and empower people and families by including and addressing primary prevention services before detrimental outcomes occur, as well as deeper-rooted “primordial prevention” policies and service approaches that directly prevent the risk factors that cause these adverse outcomes. The root causes of adverse outcomes are deeper systemic issues that have created historic inequities and economic disparities, which in turn lead to service needs and systems involvement. Raised throughout the convening, foremost among these systemic issues is poverty and related economic disparities. The problems addressed by human services often result from poverty and a lack of economic opportunity. Primary prevention can address upstream poverty and other economic-related issues. In the convening, speakers and participants stressed that human services prevention efforts would also benefit by extending to encompass primordial prevention to expose and upend structural oppression—including racism, homophobia, transphobia, and ableism—with the goal of achieving equitable outcomes by removing barriers that are a function of historic and systemic inequities. Figure 2 considers the condition of homelessness, as discussed in the convening, to illustrate the differences between intervening upstream at the earliest opportunity to promote positive outcomes rather than downstream, demonstrating that preventive strategies can stem the need for later reactive services.



## **Spotlight on youth and family homelessness**

To prevent youth and family homelessness, primary prevention efforts should focus on the structures that allow homelessness to occur, such as lack of affordable housing, structural oppression, and poverty.

Figure 2. Upstream versus downstream intervention strategies for preventing homelessness and other related adverse social and health outcomes







Convening discussion emphasized how the effective provision of human services can be greatly enhanced by creating holistic and systematic conditions for economic stability, which requires directly addressing racism and structural oppression as the primordial approach, in conjunction with policy-specific approaches to address and prevent poverty. A primary prevention focus directly addresses malleable risk and protective factors, including poverty and economic instability. A shift to also include primordial prevention can prevent the occurrence of poverty and more fully address the upstream social determinants of health. For example, many adverse outcomes are linked to adverse childhood experiences (ACEs), which in turn are tied to parental health and well-being, which are deeply connected to poverty. Evidence shows that addressing the upstream root causes of ACEs by providing economic supports to families—including income support, tax credits, child care, supportive housing, and child support—effectively prevents poverty, thereby reducing risk factors for adverse outcomes and promoting protective factors for positive outcomes (Macartney et al. 2022). For example, income loss and housing loss are the most reliable predictors of child maltreatment and the earned-income tax credit reduced child maltreatment rates (Berger et al. 2017; Kovski et al. 2022) and foster care rates (Rostad et al. 2020). The earned-income tax credit also improved infant health (Hoynes et al. 2015, Wicks-Lim and Arno 2017, Strully, Rehkopf, and Xuan 2010), early childhood development (Hamad and Rehkopf 2016), and academic test scores and educational attainment (Dahl and Lochner 2012, Chetty et al. 2011). More generally, cash payments to families: increased full-time employment and financial stability and improved emotional and behavioral health and well-being (West et al. 2021, Akee et al. 2018); raised infant brain activity (Troller-Renfree et al. 2022) and children’s educational attainment (Akee et al. 2010); increased positive interactions between parents and children (Akee et al. 2010, Akee et al. 2018); and decreased rates of deviant and aggressive behavior (Costello et al. 2003), criminal activities (Akee et al. 2010), and psychiatric and substance use disorders (Costello et al. 2003, Costello et al. 2010). In Table 3, we present examples of evidence-based primary prevention strategies shared during the convening. We mapped these strategies to their desired outcomes and the related risk and protective factors.

## Speaker insight

*“Primordial prevention is not only about normalizing prevention practices...[it] tackles the social determinants of health and well-being across whole communities, states, and even all of society through social, economic, and structural policies. The focus is on conditions that fundamentally contribute to disparities and inequities that are deeply rooted in our systems and structures.”*

Dr. Diana Fishbein  
UNC-Chapel Hill

**Table 3. Examples of evidence-based primary prevention strategies**

Examples of evidence-based primary prevention strategies	Desired outcome	Risk factors prevented and/or protective factors promoted
Economic supports to parents (such as income supplements, the earned-income tax credit, child tax credit, and Medicaid)	<ul style="list-style-type: none"> <li>• Economic stability and independence</li> <li>• Child, individual, and family well-being</li> </ul>	<ul style="list-style-type: none"> <li>– Poverty, food instability, and homelessness</li> <li>– Child maltreatment and foster care</li> <li>– Aggressive behavior, deviance, and criminal activities</li> <li>+ Infant health</li> <li>+ Childhood health and development</li> <li>+ Adult health and well-being</li> <li>+ Academic performance and attainment</li> <li>+ Positive family interactions</li> </ul>
Provide housing	<ul style="list-style-type: none"> <li>• Child, individual, and family well-being</li> </ul>	<ul style="list-style-type: none"> <li>– Homelessness</li> </ul>
Address or prevent substance use disorders	<ul style="list-style-type: none"> <li>• Economic stability and independence</li> <li>• Child, individual, and family well-being</li> </ul>	<ul style="list-style-type: none"> <li>– Mental health</li> <li>– Substance abuse</li> <li>– Homelessness</li> </ul>
Prevention of child sex trafficking: universal awareness campaigns and comprehensive sexual health education	<ul style="list-style-type: none"> <li>• Child well-being</li> </ul>	<ul style="list-style-type: none"> <li>– Adverse childhood experiences</li> </ul>
School culture efforts (such as a focus on kindness and respect)	<ul style="list-style-type: none"> <li>• Education (achievement and aspiration)</li> <li>• Social and community connection</li> </ul>	<ul style="list-style-type: none"> <li>– Stigma and marginalization</li> <li>– Systemic oppression and bias</li> <li>– Lack of community support</li> <li>– School violence</li> <li>– Substance abuse</li> <li>+ Educational aspirations</li> </ul>
Place-based interventions by trusted community organizations	<ul style="list-style-type: none"> <li>• All</li> </ul>	<ul style="list-style-type: none"> <li>+ Access to and knowledge of human services</li> <li>+ Community collaboration</li> <li>– Stigma and marginalization</li> </ul>
Two-generation programs (such as Head Start)	<ul style="list-style-type: none"> <li>• Education</li> <li>• Child, individual, and family well-being</li> <li>• Stable employment, improved earnings</li> </ul>	<ul style="list-style-type: none"> <li>+ Early childhood development</li> <li>+ Economic opportunity and supports for parents</li> <li>– Adverse childhood experiences</li> </ul>
Programs to support healthy family relationships	<ul style="list-style-type: none"> <li>• Stable, safe housing</li> <li>• Child, individual, and family well-being</li> </ul>	<ul style="list-style-type: none"> <li>– Homelessness</li> <li>– Adverse childhood experiences</li> </ul>

Note: Minus sign indicates a risk factor that the strategy reduces; plus sign indicates a protective factor that the strategy promotes.

### Design a national framework for delivering prevention services

To interrupt pathways to negative outcomes effectively, improve individuals’ health and well-being, and strengthen communities, the convening stressed that primary prevention systems and providers:

- Identify malleable risk and protective factors—that is, risks that can be reduced and protective factors that can be strengthened
- Develop programs and policies and assess their effectiveness
- Determine best practices for implementation, ensuring integrity and fidelity
- Identify optimal means for disseminating and scaling primary prevention efforts
- Inform policymaking

Primary prevention efforts will achieve greater success if we ensure:

- Accessibility of services (for example, providing services that are navigable and stigma-free, with fair and inclusive eligibility requirements)
- Availability of services relative to need
- Understanding of for whom and under what circumstances interventions are more effective
- Normalizing and incentivizing preventive care seeking behavior

To accomplish these goals, we should develop a national approach for delivering family support and prevention services—centered on equity and elevating lived expertise—with a corresponding workforce for delivering prevention services. Below, we present key considerations that emerged at the convening related to establishing this national framework and corresponding workforce for supporting persons and delivering prevention services. Specifically, to create that framework, it is essential to use a human-centered approach to service design by co-creating with the individuals and communities served; integrate services across program areas and sectors; build a primary prevention workforce that adopts a person-first approach to service delivery; and improve accessibility and effectiveness by engaging those with lived expertise to identify and address barriers and assess ongoing success.



**Adopt a human-centered approach to service design that co-creates at all levels and stages of prevention services**

Primary prevention can adopt a human-centered approach to service design by co-creating with the people served across service levels (at the federal policy and financing, organizational, and individual levels) and stages (design, delivery, and research). When designed and implemented by those in the community, primary prevention can be just, equitable, responsive, and place-based.

At the community level, human-centered co-creation requires listening to and truly engaging those in the community with lived expertise, particularly when we formulate research questions, interpret findings, and plan and design services. We can identify which voices to consult by disaggregating data to plan engagement with those most affected by a particular issue. Listening requires time and resources to ensure a thorough and authentic approach to co-creation.

## Speaker insight

*“If WE build it, they may not come. We need to listen to communities; they know best what they need.”*

Dr. Brenda Jones Harden  
Columbia University



## Spotlight on youth and family homelessness

When we fail to co-create with communities, and when we do not let those with lived expertise lead, human services fail, and people turn to black market enterprises to avoid poverty and homelessness.

*“Drug dealers and sex workers have done more to prevent me personally from being homeless than any service or system provider.”*

Mx. Osimiri Sprowal  
True Colors United’s National Youth Forum on Homelessness

At the federal level, true co-creation requires a paradigm shift in terms of power and money—in essence, we need to invite community-based organizations (CBOs) to sit at the policymakers’ table, provide them with funding, and let them do the work. Currently, CBOs struggle to compete for federal funding. When they have

secured funding, CBOs can struggle to meet reporting requirements and merge siloed federal funding sources to provide their full range of services. When the federal government requires detailed technical reporting and tracking, CBOs are limited in their ability to offer nuanced programs designed to meet the needs of a particular community. The federal government could ease the reporting burden by investing in data-sharing across systems and then creating similar data-sharing pathways at the state and local levels.

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## Participant perspectives

- Build trust with communities and families. Until that becomes a priority, we can only expect incremental change.
  - Consider who is the priority when designing interventions.
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### Integrate infrastructure across program areas and sectors

To succeed, primary prevention requires a human services infrastructure that fosters collaboration across program areas and sectors. Currently, human services rely on a primarily siloed system that arose from siloed financing and policymaking, with each system or agency often pointing to another to “solve the problem.” Instead, we need comprehensive, integrated services with a multidisciplinary team response. For example, to support youth, we need a collaborative approach across the child welfare, juvenile justice, and health sectors.

Cross-sector collaboration for primary prevention makes intuitive sense because the root causes of many adverse outcomes are the same across contexts. Likewise, few individuals access only one human services program. Individuals generally receive services from more than one program; therefore, service delivery should follow a cross-program model. An integrated infrastructure should extend to departments beyond HHS, such as labor, housing, and justice. For example, collaboration with legal services and the U.S. Department of Justice can fight corruption and equip individuals to self-advocate; and collaboration with the U.S. Department of Education could lead to school-based efforts to combat systemic oppression, one of the root causes of adverse outcomes.

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## Speaker insight

*“There is an opportunity for us to work together across agencies to invest in complementary, at least, but a lot of times probably identical approaches... So, for example, there’s the mechanisms by which poverty might result in violence or increased risk for chronic disease or homelessness. Those mechanisms might vary, but the ways in which we can effectively address poverty probably don’t vary. They are probably the same kinds of system responses. So, we can work together to identify effective strategies and then implement them.”*

Dr. Sarah DeGue  
Centers for Disease Control and Prevention

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To create an integrated infrastructure, the convening recognized we must shift our focus from *programs* that influence individuals to *strategies and practices* that influence change at the policy, system, and community

levels in response to environmental risks (that is, underlying physical, social, and economic conditions). For example, to prevent homelessness, we should develop strategies and broad sets of policies that prevent substance use and mental health issues (among other experiences and conditions).



## Spotlight on youth and family homelessness

To effectively reduce youth and family homelessness, we need cross-sector policies and wraparound services that extend beyond housing to social work, mental health, job support, and family support. Policies and strategies should also include legal policies and services to open the doors shut by poverty and address the barriers currently posed by a penal-driven system for those trying to rise out of poverty and homelessness.

### Participant perspectives

Ideas for cross-sector collaboration:

- One stop for all prevention resources with quick connection to crisis services when needed
- A system of care with several entry points, featuring a “no wrong door” approach
- Allowing for and building data-sharing infrastructure and access across systems to guide policy, priorities, and funding



#### Build a primary prevention workforce with a person-first approach to service delivery

Convening discussion highlighted that a successfully integrated infrastructure for primary prevention depends on the appropriate workforce. The current human services workforce may not be equipped to provide primary prevention, given that the genesis of many of those programs and the positioning of those programs is to address crises. Asking human services staff to shift to prevention strategies while managing existing crisis- and problem-focused responsibilities may be infeasible in terms of training and workload requirements. Thus, convening participants stressed that we likely need a primary prevention workforce consisting of the appropriate people and supported by training, policies, and resources.

#### Who should be in the primary prevention workforce?

The primary prevention workforce should comprise people with lived expertise in confronting the adverse

### Speaker insight

*“Having peer support does help a lot... Those are the people who have usually experienced exactly what you’re going through. [It’s important to] give people the chance despite their educational and legal background... to get into these roles. I have experienced and seen peer support handling their role with care more than someone who doesn’t... have that experience.”*

Ms. Lauren Long-Humphrey  
Youth Collaboratory’s Youth Catalyst Team

outcomes or experiences that they are trying to prevent, thereby engendering trust with program participants, reducing the stigma of service receipt, and fostering culturally competent services. Ideally, workers should come from the communities they serve and be able to play the role of a peer support specialist or service navigator. Key challenges need to be addressed to make this lived expertise workforce a reality. Some of those challenges include creating an inclusive and welcoming environment for a primarily peer or lived expertise workforce, which may include eliminating educational or legal barriers to employment (for example, for those without advanced degrees or impacted by the criminal justice system).

### What training will they need?

Primary prevention workers should receive training in prevention science (including risk and protective factors), trauma-informed approaches, and a person-first service approach. For example, trauma-informed approaches are integral to addressing ACES.

Regarding a person-first approach, workers should be committed to integrity and equity; training should address antidiscrimination and implicit bias to combat racism, homophobia, ableism, and the sense that people's self-advocacy poses a threat. Specifically, service providers should treat clients with respect and dignity, enabling them to seek help without fear or stigma. Likewise, providers should pursue an integrative approach through which they equip individuals to self-advocate. For workers who do not come from the community, training should cover cultural competence and humility. All workers should undergo training to emphasize and magnify caring more about the person than about pushing the

individual through the system. Such an approach can help build a workforce that demonstrates compassion in dealing with clients' mental and physical health needs. The various types of training can build trust with potential clients, thereby helping improve service accessibility.

### What supports will they need?

We will need to help the helpers in the prevention workforce, ensuring they have needed resources and supports. First, the workforce will need to be paid well. Fair pay incentivizes quality work, and we should not expect those living in poverty to help others out of poverty. Workers will also need mental health and trauma support, given the nature of the work. Finally, workers will need reasonable workloads to ensure that they have the time and energy to take a person-first approach to their work.

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## Participant perspectives

Workforce compensation, high turnover, and training and support in trauma and diversity, equity, and inclusion were identified as important barriers to address.

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## Speaker insight

*"We cannot underestimate what it's going to take to support our work force."*

Ms. Jasmine Hayes  
ICF

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## Continuously improve service accessibility and effectiveness by engaging those with lived expertise

For primary prevention to be effective, we must consult people with lived expertise to understand fully why they do not access services and how services could be more accessible. Currently, we know that the following barriers can impede accessibility:

- A system design that is too onerous to navigate
- Stigma around accessing, receiving, and using services
- Individuals' lack of knowledge, education, language, or skills to access human services
- Individuals' mental health issues
- Eligibility requirements that preclude certain populations, such as those that are undocumented or underage
- Means-testing that fails to funnel services to those in need

Possibilities for improving accessibility include streamlining services, processes, and applications; integrating and communicating across services (enabling information sharing); and measuring need rather than income to determine eligibility.

Beyond improving service accessibility, engaging the individuals and communities served can also enhance the effectiveness of primary prevention services and ensure they are meeting community needs. Convening participants underscored the importance of engaging people with lived expertise on an ongoing basis to inform service implementation, evaluation, and improvement.

### Support a national framework for delivering prevention services

Essential to establishing a national integrated approach for delivering prevention services is earning the support of policymakers, the public, and funders. In the next section, we present key considerations that emerged at the convening related to supporting this national framework. Specifically, we need to engage communities in the importance of primary prevention to facilitate public buy-in, leverage evidence of effectiveness to build political will, and finance services so local communities have more control over the timing and use of funds.

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## Speaker insight

*“To me there's a big outstanding question of those who are not accessing any service... Who's not being served? And what's a prevention frame to find them prior to a real crisis emerging, [so that it's not the most intensive] ends of the system solving what could have been solved through more basic assistance supports, cash supports, or other lower intensity interventions much earlier on... The people who can tell us that are the people who have had that experience. They are the people who tell us how to retool our systems.”*

Ms. Ann Flagg  
ACF

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## Engage communities to support prevention

Implementing a new primary prevention infrastructure will require public buy-in. As discussed, we can achieve some degree of buy-in by co-creating with communities, employing a workforce with lived expertise, and ensuring that service delivery follows a person-first approach. However, we must also engage with and educate the public and service providers about the value of primary prevention. For example, the public will need a better understanding of the science of early childhood, and K–12 teachers may need to recognize the importance of a warm school culture (overcoming notions about when to reward and punish, and when to treat with respect). Engendering buy-in may also require appealing to a community’s self-interest by demonstrating that primary prevention can advance the well-being of all, not just those who actually receive services.

## Participant perspectives

Ideas for building public support:

- Increase social advocacy for funding and resources to support prevention efforts
- Show the financial value of prevention
- Gain commitment and support from elected officials on long-term goals of prevention services

*“The need to have specific outcomes can actually incentivize systems and programs to NOT serve those most in need out of fear/concern they won't meet their outcomes. We have to solve for this in policies.”*

Ms. Darla Bardine  
National Network for Youth



## Leverage evidence of effectiveness to build political will

Convening participants stressed that to build and implement the new primary prevention infrastructure and workforce, we will need the political will to make the necessary policy and funding changes. We will need to capture and characterize the benefits of primary prevention at the societal level (in terms of outcomes, cost effectiveness, and cost-benefit). To generate the requisite evidence, we will need to address several challenges. First, it is critical to identify promising strategies that can successfully address root causes of adverse experiences and outcomes. Participants highlighted that the primary prevention programs for which we already have evidence were not created with an antidiscrimination or equity lens, so we need to better understand their ability to address structural oppression. Likewise, for primordial prevention efforts, we need evidence about their effectiveness generally as well as about how well universal strategies reach the populations that are disproportionately affected by a given issue (for example, awareness campaigns for child sex trafficking). Second, determining how to define success and measure the effectiveness of prevention is key. Specifically, it is important to reach consensus about the primary outcomes to be achieved at the individual, program, and societal levels and how to measure them. Third, once we have identified effective prevention strategies, we can turn to implementation science to guide efforts to replicate and scale those strategies. Finally, we will need to find a way to finance these research and development efforts.





To finance primary prevention services, convening participants called for approaches to funding that provide flexibility across funding sources, support an integrated service delivery system, and empower community-based service providers. Currently, human services programs are commonly funded to react to ongoing issues instead of proactively preventing issues from arising. For example, homelessness agencies may lack capacity for mental health services, parental/child interaction supports, or family conflict therapy because their main resources are not geared toward preventing mental health issues or family disruption. To effectively finance prevention services, government and philanthropic funders must dismantle funding barriers, increase flexibility of funding across sources, invest in an integrated service delivery system, and adjust timelines to match the needs of primary prevention (the short-term nature of some existing grants prevents the provision of effective prevention services). Ultimately, financing primary prevention requires trusting communities to implement programs in the way that is best for them.

## Participant perspectives

Funding was identified as a barrier to key risk and protective factors. This included the lack of funding, siloed funding, inflexibility, and timeline of funding.

## Speaker insight

*“The pathways through which states and local jurisdictions can implement federal policies is really impacted by how technical we require the reporting and tracking to be. The more specific and detailed it becomes, the harder it is for it actually to be a community-driven and nuanced strategy... The issue of sharing information and data across systems—we say we want to do it, but there are lots of barriers and hurdles. [We need to] find some pathways at the federal level for that to happen, then create some pathways at the state and local level.”*

Ms. Rebecca Jones Gaston  
Oregon Department of Human Services

## NEXT STEPS

This brief summarizes, distills, and shares the collaborative discussions during the convening on working towards a goal of increasing the use of evidence-based primary prevention in human services systems. ASPE will hold a series of roundtables to advance select ideas that emerged from the convening, leading to additional considerations and steps to build a framework and potential tools for integrating primary prevention in human services policy and programs. Discussion topics will build on the conclusions, innovative ideas, and next steps generated at the convening. Roundtable participants might include convening speakers and attendees, as well as policy or program experts recommended during the convening by attendees.

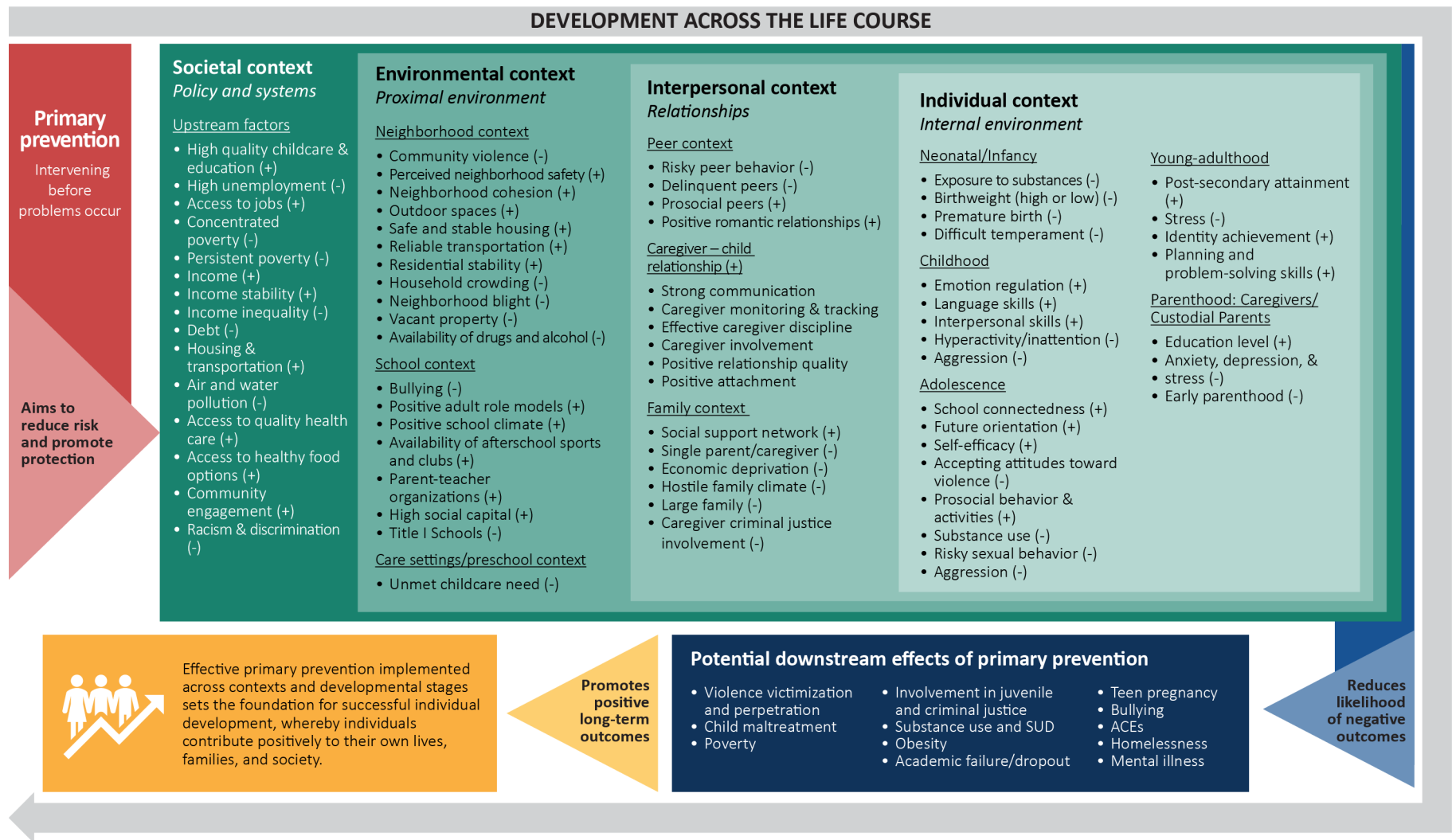
Other briefs in this series will be tailored to share emerging insights with various audiences, including people with lived expertise, research and philanthropic organizations, and program administrators at all levels of government.

## APPENDIX A. THEORETICAL FRAMEWORK

Figure A.1 depicts a theoretical framework for promoting and expanding prevention within the broader context of human services programs and policies. Developed to support and guide the convening, this framework identifies four interconnected contexts: societal, environmental, interpersonal, and individual. The framework also depicts the malleable factors that primary prevention approaches aim to address, and the subsequent potential downstream effects of successful prevention approaches.

Beginning on the left side of the figure, primary prevention approaches are initiated before the problems they aim to prevent. Primary prevention aims to reduce the risk factors and promote the protective factors across the four contexts. The figure illustrates these four contexts as nested, demonstrating their interrelatedness. The arched arrows from primary prevention to each context represent the contextual variety of primary prevention approaches and the importance of carefully selecting implementation contexts. In addition, because of the interrelatedness of the contexts, there are likely to be cascading effects on risk and protective factors across contexts due to primary prevention implemented in another context. For instance, a primary prevention approach situated within the societal context, such as a new federal policy implementing high-quality universal child care, could lead to less stress among caregivers in the interpersonal context and better self-regulation in children's individual context. These changes in risk and protective factors are, in turn, responsible for reductions in the likelihood of negative outcomes and potential downstream effects on a host of social welfare challenges and crises. Lastly, along the bottom of the figure, an arrow represents development over time. Across the life span, there are different points at which primary prevention can be most relevant to people's developmental stages and needs. Primary prevention at various life stages might have consequences regarding the need for and impact of primary prevention at other stages of development. In this way, the experiences of primary prevention are a continuous process throughout the life span.

Figure A.1. Theoretical framework for promoting primary prevention in human service



## APPENDIX B. KEY THEMES FROM PARTICIPANT PERSPECTIVES

### KEY THEMES FROM INTERACTIVE SESSIONS

Two sessions during the convening featured small group, interactive breakouts. In both interactive sessions attendees shared and generated ideas and provided feedback in real time during the convening. This appendix summarizes themes that emerged during the two sessions.

#### Key themes from World Café

The first interactive session of the convening focused on the question, “How can primary prevention best address risk factors and promote protective factors?” The session included three iterative rounds of discussion in breakout rooms (called “tables”). Each round of discussion focused on a different question. At the end of each round, each table voted one or more key ideas to “post” and move forward to share with all participants. Breakout table moderators discussed the highlights and takeaways from these interactive sessions with the full group. Below, we summarize key ideas generated and highlighted, as well as other ideas that commonly surfaced across the 16 tables.

The first topic question asked participants to consider, “What are the key risk and protective factors that your work or program is concerned with? What do you think are the most important risk and protective factors to address?” Table B.1 summarizes the top risk and protective factors that were either posted for the full group or commonly surfaced across the 16 tables.

Table B.1. Summary of Top Risk and Protective Factors

Top risk factors	Top protective factors
<ol style="list-style-type: none"><li><b>Economic.</b> Individual poverty, family poverty, economic instability, lack of living-wage jobs, and social and network poverty</li><li><b>Childhood.</b> Adverse childhood experiences and childhood trauma</li><li><b>Mental and physical health.</b> Poor mental health and lack of access to mental health services and supports</li><li><b>Social and community.</b> Being marginalized or part of a vulnerable population, and poor social supports and networks</li><li><b>Human services and systems.</b> Lack of access to resources and services, and lack of knowledge of support services and systems</li></ol>	<ol style="list-style-type: none"><li><b>Economic.</b> Economic stability, security, and independence; social and network wealth; and employment</li><li><b>Childhood.</b> Strong family support, and few adverse childhood experiences</li><li><b>Mental and physical health.</b> Access to health care and services</li><li><b>Social and community.</b> Community connection and support, social capital, and peer support</li><li><b>Education.</b> Staying in school, and completing high school</li><li><b>Human services and systems.</b> Engaging those with lived expertise (human-centered and collaborative design), and having early access to services for prevention</li></ol>

The second and third topic questions asked, “What are the most important potential barriers to reducing these key risk factors? What are the most important potential barriers to promoting the key protective factors?” Table B.2 combines comments from Topics 2 and 3, given the similarity of participant comments across the two topics. For Topic 3, comments included some ideas for solutions, supports, and catalysts for addressing the barriers.

**Table B.2. Summary of top barriers to reducing risk and promoting protective factors**

Societal barriers	Barriers specific to human services
<ol style="list-style-type: none"> <li>1. <b>Systemic racism, biases, and inequities</b> in society (in our economic, political, and cultural systems), as well as within programs and systems specific to human services</li> <li>2. <b>Societal stigmas</b> that affect individuals (such as those experiencing poverty or requiring mental health services), as well as perceived stigma of those accessing human services</li> <li>3. <b>Trauma and adverse childhood experiences</b>, and their effects on individuals, children, youth, families, and communities</li> <li>4. <b>Policy, politics, and political will</b> to create the proactive, system-wide change to address risk factors and promote protective factors</li> <li>5. <b>Poverty and trauma</b> as key risk factors that are also barriers to many of the other risk and protective factors</li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Lack of funding</b>, including a general lack of funding and inflexibility in funding structures</li> <li>2. <b>Need for large-scale framework transformation</b> that would (1) increase system-wide collaboration and coordination, (2) redesign the system to better address and support primary prevention and improve equitable access, and (3) address current staffing challenges, such as insufficient workforce training, high turnover, and low wages</li> <li>3. <b>Improve participant perception of human services and access</b> by building trust, increasing equitable access to programs, and increasing awareness about human services and programs</li> <li>4. <b>Policies and structures</b> that do not align with primary prevention needs (such as eligibility requirements), lack political support for primary prevention, and operate with outcomes tied to election cycles</li> </ol>

**Key themes from future directions session**

The second interactive session of the convening focused on the question, “What are the future directions for primary prevention in human services?” In the session, participants brainstormed and then prioritized future directions for primary prevention across eight areas: poverty, systems and structures, child well-being, youth well-being, family interactions, community context, bias, and other. Items identified as highest priority across the 16 tables were copied to an overall group priorities graphic. Table moderators shared the ideas generated in the final moderated panel session on next steps.

The following priorities appeared in the overall group priorities graphic or across the 16 tables:

- **Addressing racism and inequity** by integrating lived expertise into system design and change (co-creating, co-leading, and including perspectives and feedback from those with lived expertise); providing diversity, equity, and inclusion training and education to human services staff; ensuring services and programs are culturally responsive; and making access and allocation of resources and services equitable.
- **Increasing system collaboration and coordination** to make human services more user-focused, human-centered, and accessible. Named priorities included creating a one-stop for all prevention services, using a “no wrong door” approach to allow for multiple entry points to service and system access, and aligning goals across services to focus on primary prevention. Other priorities included designing programs and services to meet needs, and better understanding who the priority is when designing interventions.
- **Addressing poverty**, such as by providing economic assistance and support (including a general safety net, basic income, and other assistance), restructuring eligibility and criteria for benefits, creating job opportunities and access to living-wage jobs, providing access to safe and affordable housing, making policy changes (such as tax policy) to ensure no child lives in poverty, and increasing access to mental health services.
- **Addressing trauma and adverse childhood experiences** by offering education and support to families and caregivers, providing trauma-informed training for staff at all stages and levels of prevention and care, and providing access to mental health services.

## KEY THEMES FROM LIVE FEEDBACK OPPORTUNITIES

During the convening, we offered two opportunities for attendees to submit live real-time feedback. This appendix summarizes themes that emerged.

### How programs and policies can be improved through a focus on primary prevention

Theme	Participant suggestions
<b>Addressing root causes</b>	Participants indicated that focusing on primary prevention would help programs and policies address root causes such as poverty, adverse childhood experiences, and child and family well-being.
<b>Funding changes and impacts</b>	Participants felt focusing on primary prevention might improve funding efficiency and flexibility. Such efficiencies might include programs and policies that are more cost-effective in the long term, less siloed funding, and more cross-sector collaboration.
<b>Creating equitable system design</b>	Some participants thought that focusing on primary prevention could make services and systems more equitable by allowing for more focused programming, becoming more culturally responsive and inclusive through co-creation with those with lived expertise, and promoting collaboration and engagement with community-based organizations to meet families where they are and build community trust.
<b>Improving services and changing systems</b>	Participants suggested that a focus on primary prevention can help improve services and catalyze needed system change. Some suggested that a shift to primary prevention could help reallocate or free up resources for other needs, such as wraparound services. Others suggested that focusing on primary prevention could increase cross-sector collaboration and coordination and create other system efficiencies.
<b>Using a proactive, strengths-based approach</b>	Participants felt that focusing on primary prevention could help programs and policies become more proactive by working upstream to circumvent downstream effects, rather than being reactive. Focusing on primary prevention can also move programs to take a strengths-based approach rather than addressing deficits.

### Priority topics in primary prevention for human services programs and interventions to address

Topic	Participant suggestions
<b>Poverty and economic stability</b>	Providing a livable wage and opportunities for workforce development
<b>Housing and homelessness</b>	Supporting affordable housing, rental assistance, and housing stability, and preventing homelessness for youth and families
<b>Adverse childhood experiences and trauma</b>	Identifying and treating trauma, violence, adversity, and stress
<b>Mental and physical health</b>	Improving access to health care, substance abuse prevention and treatment, nutrition and food supports, education on interpersonal and social-emotional skills, and well-being supports
<b>Parent and family support</b>	Offering education to parents on how to support child well-being, early childhood interventions, family supports during adolescence, healthy relationship education and supports, stabilization supports for families to prevent violence, divorce prevention or mediation, support for single parents, and access to high quality child care
<b>Building equitable systems</b>	Addressing system culture, increasing community collaboration across sectors and disciplines, improving program and system accessibility, incorporating human-centered design principles and feedback from those with lived expertise, and addressing diversity, equity, and inclusion issues
<b>Education</b>	Offering early childhood education, increasing high school completion, and improving equitable funding

## Key barriers to primary prevention

Key barriers	Participant suggestions
<b>Root causes, including poverty, adverse childhood experiences, mental health, and housing and homelessness</b>	Some participants suggested that policymakers and the public don't agree on how best to address root causes such as poverty, or don't acknowledge the structural factors that might contribute to or even cause poverty, adverse childhood experiences, and homelessness.
<b>Funding barriers</b>	Many participants mentioned that a lack of funding and financing incentives for primary prevention are key barriers. This includes a lack of available funding, lack of access to funding, and funding restrictions. These funding challenges might make it difficult to bring primary prevention services to scale and might reduce program and system collaboration by keeping funding siloed.
<b>System, program, and resource barriers</b>	Participants indicated that current human services systems, programs, and resources act as barriers to primary prevention. Barriers include system access (such as language barriers to accessing human services and lack of knowledge, awareness, and understanding of available services); system culture (such as a reactive system culture that responds to crisis); the time and resources needed for system change planning; lack of feedback and involvement from the community and those with lived expertise in designing human services; and barriers in staff, leadership capacity, and workforce training and development (such as training workforce in primary prevention and trauma training).
<b>Political and policy barriers</b>	Participants identified client knowledge as a barrier—people cannot access programs and services of which they are unaware.
<b>Data, research, evidence, and evaluation</b>	Some participants felt that there currently is a lack of evidence-based primary prevention methods and approaches. Others suggested more evidence or data was needed to support and show the benefits of primary prevention strategies and approaches.

## Policy changes most needed to advance primary prevention in human services

Key policy changes	Participant suggestions
<b>Provide funding and financial support for primary prevention</b>	Participants expressed the need for increasing funding and creating more flexible funding sources. Participants felt that more flexibility in funding would allow for innovation and collaboration. Others wished for more funding for community-based organizations, such as federally backed financial incentives for local nonprofits that prioritize primary prevention activities. Some said they would like to see funding specifically dedicated for primary prevention to support system-wide changes.
<b>Improve system access and design</b>	Participants wanted to change the design of human services systems and programs to improve access to and knowledge of such programs. Many also wrote that they would like to involve those with lived expertise in creating, designing, and improving human services.
<b>Improve culture, collaboration, coordination, and communication within human services</b>	Participants wished for more human services system collaboration to break down cross-sector siloes, eliminate system red tape, coordinate and co-locate services, build more system infrastructure for primary prevention, and increase collaboration with the community in developing primary prevention strategies.
<b>Change policies to support economic independence</b>	Participants suggested and supported many policy ideas on economic well-being, such as supporting a universal or basic income, other direct economic benefits, and an increased minimum wage.
<b>Change policies to address housing affordability and homelessness</b>	Participants wanted to change policies to make housing a human right, ensure housing for all, increase the supply of affordable housing, and align the work of the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services.

## Most needed changes to the field of primary prevention in human services

Needed changes	Participant suggestions
<b>Addressing diversity, equity, and inclusion issues; discrimination; bias; inequities; and stigmas</b>	Participants called for an integrated effort to disrupt and overcome discrimination and bias at all levels—societal, community, and family—to overcome racism, homophobia, transphobia, and ableism in service delivery.
<b>Changing funding and financial incentives, and increasing supports for primary prevention work, systems, and services</b>	Many participants wanted to make funding changes, including more funding for upstream community-level prevention work. They also wanted more funding to support collaboration across public services (such as public health, economics, justice, and child welfare).
<b>Transforming human service systems, programs, and strategies to focus on primary prevention</b>	Participants noted that workforce change would be essential to this transformation, including creating job opportunities, professional credentials, and increased pay for working in primary prevention. Participants also indicated that this transformation would require system-level change.
<b>Increasing system collaboration, coordination, and communication with partner agencies, community-based organizations, and communities served</b>	Participants indicated that such collaboration would require shared outcome measures and nonduplicated implementation, as well as a shift in system culture to focus on collaborating with community services.
<b>Incorporating feedback from people with lived expertise, employing human-centered design, and improving accessibility to human services</b>	Participants indicated that engaging people with lived expertise in all aspects of planning, implementation, and evaluation of primary prevention would also lower barriers to accessing services.



## Ideas for who to engage when incorporating primary prevention within human services

Who to engage	Participant suggestions
<b>People with lived expertise</b>	Overwhelmingly, many participants expressed interest in hearing more from those with lived expertise—including youth, parents, young adults, families, fathers, communities, Indigenous populations, and historically marginalized communities—to learn about their needs, what would make a difference in their lives, and what changes they want to see. Specific individuals and organizations suggested in this area include Dr. Jessica Ullrich (professor and researcher at the University of Alaska Anchorage with interests in Indigenous concepts of health and well-being) to learn how primary prevention works with Indigenous populations, and the North Dakota Youth Action Board.
<b>People working in policy and government</b>	Participants suggested including government, policymakers, legislators, and elected officials. Some specific suggestions include the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
<b>Housing providers</b>	Participants wish to speak to housing developers, homebuilders, and city planners to better understand the challenges to building affordable housing and addressing homelessness.
<b>Experts in mental health</b>	Participants specifically suggested including Dr. Howard Markman (researcher on couples and marital and family studies) and Dr. Scott Stanley (research professor and co-director of the Center for Marital and Family Studies) at the University of Denver to learn from their work on the Prevention and Relationship Education Program and ask them about their ideas for primary prevention in community mental health.
<b>Experts in adverse childhood experiences and trauma-informed training</b>	Participants wanted to learn how to explain adverse childhood experiences to a wide variety of audiences. Specific suggestions include hearing from staff at ACEs Matter and Dr. Bruce Perry (psychiatrist and senior fellow at Child Trauma Academy in Houston, Texas).
<b>Leaders working on developing prevention systems</b>	Participants suggested speaking to the following leaders: Dr. David Hawkins (psychiatrist, physician, researcher, and author) and Dr. Richard Catalano (professor at the School of Social Work at the University of Washington) to learn about building capacity to incorporate primary prevention at all levels of human service programs and systems, Dr. Abe Wandersman (professor of psychology at the University of South Carolina) to learn about his Interactive Systems Framework, and the Children’s Home Society of America network to learn about how the organization affects the Six Conditions of Systems Change (policies, practices, resource flows, relationships, power dynamics, and mental models).
<b>Others across disciplines</b>	Participants suggested including people from human services, child welfare, and evaluation; educators in academia and schools; and those working in the justice, legal, and prison systems. Specific suggestions included Michael Quinn Patton (organizational development and program evaluation) of the American Evaluation Association.
<b>International experts</b>	Participants suggested they could learn about various perspectives and solutions in other countries to broaden potential ideas and solutions.

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