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Implementing Communities That Care in Australia: A Community Mobilisation Approach to Crime Prevention

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Substantial investment in crime reduction is oriented toward policing and punishment, though a strong case can be made for a greater focus on prevention. The case is based on rapidly advancing knowledge of the factors that influence youth involvement in crime. Practical methods of disseminating the knowledge and practices underlying effective prevention are vitally needed. Communities that Care (CTC) is one program for coordinating local prevention efforts that has proved to be useful in wide-scale implementation in the United States. This paper provides an overview of the CTC approach and reports on plans to trial and evaluate this program in Victoria, through the Centre for Adolescent Health. Centres such as this blend quality research and practice, and the design of the trial is an example of best practice in evaluation research.

Adam Graycar
Director

A range of potentially modifiable factors (within individuals, families, schools, peer groups and communities) can influence the probability that a young person will engage in crime (National Crime Prevention 1999). There is a pressing need to promote understanding of the factors that influence healthy youth adjustment, and actively involving communities in the development and implementation of coordinated prevention programs may be one means of increasing community understanding of these factors. Encouraging this understanding may also be a necessary condition to achieving increased investment in prevention.

The aim of this paper is to provide an overview of one approach to community-based crime prevention, known as "Communities That Care" (CTC). In what follows, some of the assumptions underpinning CTC are examined, and progress toward an Australian implementation and evaluation of this program is described.

What is "Communities That Care"?

Communities that Care (CTC) is a comprehensive, community-wide risk-focused prevention strategy based upon research on predictors of health and behaviour problems. The approach is theoretically

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grounded in the social development model (Catalano & Hawkins 1996; Catalano et al. 1996). Professors J. David Hawkins and Richard Catalano, from the University of Washington Social Development Research Group, developed the CTC program to provide a framework for community intervention which was aimed at modifying factors that undermine healthy youth development (Hawkins, Catalano & Associates 1992). The approach has its roots in substance abuse prevention, but has been widely implemented as a crime prevention program and appears directly relevant to broader adolescent health promotion.

The approach begins by identifying “key leaders” with influence over organisational collaborations and/or resources in a specific community. For the Australian trial of CTC, “community” has been defined as a local geographic unit of approximately 10,000 to 15,000 people, though in the United States larger units have been targeted. Key leaders participate in a training program explaining the CTC approach and its implications for directing resources into evidence-based prevention programs. The CTC process is implemented with the support of the key leaders and focuses initially on building local capacity for community prevention.

The community mobilisation aspects of CTC are further developed through the establishment of a Community Prevention Board, bringing together formal and informal community leaders and intervention personnel. The community board is provided with training and assistance to develop a local prevention strategy using a variety of information sources. A school survey assessing a comprehensive range of community risk and protective factors is an important information source. However, other information is also important to the assessment process, including local community knowledge and values, demographic data and

service analysis information. Local assessment information is used to diagnose community needs and prioritise intervention targets, with the aim of reducing elevated risk factors and increasing depressed protective factors. A list of evaluated interventions that effectively target risk and protective factors is made available to inform the development of local intervention strategies. Through the steps outlined, CTC aims to assist local community boards to select evidence-based interventions tailored to fit local conditions. Once a local prevention plan has been approved, CTC then provides intensive training and support to ensure rigorous implementation of the selected community interventions (Harachi et al. 1996).

The community mobilisation model within CTC is distinguished by its emphasis on training communities to utilise an evidence-based approach to prevention. The scientific basis of CTC derives from the risk-focused approach to prevention pioneered in public health (Hawkins et al. 1992; Institute of Medicine 1996). The approach is a long-term strategy that is initiated with longitudinal research within community samples to identify factors that lead to behavioural problems such as substance abuse and delinquency. The approach has been used to identify **risk factors** (predictors of behavioural and health outcomes) and **protective factors** (moderators and mediators of risk factors) for a range of adolescent health and behaviour problems.

In the risk-focused approach, knowledge of risk and protective factors gained from longitudinal studies is integrated with research from intervention studies. There is a growing body of published research that has demonstrated long-term change in risk factors and problem behaviours using empirically-based community intervention strategies. Although there is a knowledge base that can be used to support effective prevention,

there is a considerable gap between research and current practice.

Background to the Development of CTC in Australia

The Centre for Adolescent Health, an organisational unit within the Women’s and Children’s Health Care Network and the University of Melbourne, initiated efforts to establish CTC in Australia. The Centre was established in 1991 with funding through the Victorian Health Promotion Foundation, and since its inception has placed considerable emphasis on the development of epidemiological methods to understand adolescent adjustment and health compromising behaviours. Centre for Adolescent Health research studies (for example, Patton et al. 1997) have made an international contribution to establishing the co-occurrence of mental health symptoms with a range of adolescent health compromising behaviours, including smoking, dieting and suicidal behaviour.

Longitudinal research (for example, Patton et al. 1998) has established contingent relationships between mental health symptoms, peer relationships and adolescent substance abuse. Factors influencing stability and change between childhood behaviour and adolescent behaviour have been examined in the follow-up into adolescence of the Australian Temperament Project (ATP) cohort. Risk factors for adolescent behaviour problems (including substance abuse, antisocial behaviour and depression) which have been examined through the ATP include childhood behaviour problems, temperament, early school problems, poor parent-child relationships, parenting behaviours, poor social skills and deviant peer relationships (O’Shea et al. 1999).

Advancing knowledge relevant to adolescent health risk factors, together with an expanding understanding of the protec-

tive processes moderating and mediating the influence of risk factors, has provided a promising basis for effective health promotion intervention. The Centre for Adolescent Health has been active in the development of health promotion interventions focusing on adjustment within:

- the family (Toumbourou et al. 1997; Toumbourou & Gregg 1999);
- school (Glover et al. 1998); and
- peer groups (Olsson et al. 1997; Toumbourou, Carr-Gregg & Sloman 1997).

The Centre has also been active in reviewing health promotion and intervention programs to identify health promotion strategies that have evidence for their effectiveness. Recent reports in this series have examined promising programs relevant to depression (Patton 1995); youth suicide and self-harm (Patton & Burns 1999); and adolescent health compromising behaviours including tobacco, alcohol and other substance use, sexual risk-taking, and antisocial behaviour (Toumbourou et al. 1999). Through these activities the Centre has developed a database of evidence for a range of prevention strategies focused on risk factor reduction and the enhancement of protective factors.

Health promotional work with a strong community development strategy was commenced with the Gatehouse Project—a school-based mental health promotion program drawing on a conceptual base of attachment theory. It targets important and modifiable risk factors in the social environment of young people, including:

- victimisation in the school setting;
- absence of supportive and confiding relationships; and
- lack of positive participation in school life.

The intervention takes place at multiple levels—curriculum, classroom, whole school and community—with the program

coordinated by a school-based adolescent health team. Professional development and training in strategy implementation are also provided. Since 1996, the Centre for Adolescent Health has been trialing and evaluating the Gatehouse Project with support from the Victorian Health Promotion Foundation (Glover et al. 1998).

In 1998, with funding through the National Youth Suicide Prevention Program, the Centre was involved in a national trial evaluating the process and impact of parent education interventions universally targeted at parents with early secondary school adolescents. This trial, conducted collaboratively with Parenting Australia (at Jesuit Social Services), Centacare and Anglicare, provided an 8-week parent education course to over 3000 parents across 18 national sites. Parent engagement strategies were developed by local agencies, building on knowledge of school and community culture. Follow-up surveys were conducted with over 800 families (parents and year 8 adolescents) in both control and intervention schools. Results demonstrated that the intervention was well targeted to parents experiencing adolescent behavioural problems, and that a number of risk factors for youth suicide were positively influenced through the intervention. Positive changes were identified in parenting confidence, parent-adolescent conflicts, adolescent-family attachment, youth delinquency and youth drug use (Toumbourou & Gregg 1999).

Although health promotion interventions sited within one domain of adolescent socialisation (for example, the family) are vital, it is assumed that wider-scale advances in adolescent health may be achievable through coordinated multi-level community interventions. Efforts to implement and evaluate ambitious, multi-level community-based prevention activities are now being reported in a variety of areas relevant to

adolescent health, including tobacco control and substance abuse prevention (for example, Perry et al. 1996; Johnson et al. 1990).

Community mobilisation efforts appear attractive, but clearly require a structure for intensive support if they are to be more widely implemented for crime and substance abuse prevention. CTC has been widely implemented within the United States and there is now a growing evidence base supporting effective implementation and impact. The CTC program was first adopted by preventive alcohol and drug abuse agencies. In the state of Washington, 28 local communities developed the “TOGETHER, Communities for Drug Free Youth” program, which was funded by the Department of Education to support prevention of drug abuse by young people (Harachi-Manger et al. 1992). The US Office of Juvenile Justice and Delinquency Prevention (OJJDP) has been supporting US community intervention and has used the CTC framework extensively since late 1994. OJJDP activities are funded through the US Congress, in accordance with the Juvenile Justice and Delinquency Prevention Act of 1974 which provides incentive grant funding to all states to support juvenile delinquency prevention. OJJDP experience supports the local adoption by agencies of the CTC risk-focused prevention approach.

The OJJDP experience with the CTC program in a number of US communities has been the subject of ongoing field evaluations. These have documented progress in the establishment and implementation of evidence-based prevention programs (Bilchik 1996). The OJJDP evaluations demonstrate that US federal expenditure on CTC has stimulated community capacity building in the form of state and county level investment informed by community prevention planning forums. The CTC process has been associated with an increasing local knowledge of risk

and protective factors and evidence-based prevention in a wide range of US communities. Prevention training expenditure has increased, as has the implementation of evidence-based prevention programs. Evidence suggests that these changes have occurred in the context of wide-scale community acceptance and support for the CTC process. Early indicators are demonstrating impacts on targeted risk and protective factors and, in some communities, reductions in targeted outcomes.

The CTC prevention process is also gathering interest outside the US. A pilot of the CTC program was recently established in the United Kingdom using funding provided through the Rowntree Foundation, and based on the recommendations of a Rowntree-funded international review of crime prevention programs conducted in 1996 by Professor David Farrington of the

University of Cambridge. The implementation of CTC in the UK will involve three communities and evaluation is being attempted through comparison against three control communities.

The Implementation of CTC in Victoria

Plans are well under way in Victoria to build the necessary infrastructure for coordinated community prevention.

Beginning in 1997, the Centre for Adolescent Health established links with the team responsible for developing CTC at the University of Washington Social Development Research Group (SDRG). In late 1998, the Centre was funded by the Victorian Department of Human Services to develop and administer a youth survey to measure risk and protective factors amongst young Australians, with

a view to informing preventive interventions. The instrument derived from CTC assessment tools used in the US and UK, with additional items reflecting the local emphasis (for example, measures of homelessness risk and mental health). Focus groups and interviews were completed with selected youth, including those with disabilities and low literacy, to ensure the use of appropriate language. Comments and interpretations from selected youth respondents also assisted the process of item review.

The Centre then piloted the survey in 1998 with a representative sample of 468 year 9 students from 30 schools across Victoria. The survey procedure and item content were accepted across the range of school administrative systems, parents and year 9 students. In general, students appeared to respond to the survey frankly. Less than one per cent were excluded using criteria for invalid response patterns. The psychometric properties of the risk and protective sub-scales were also found to be very satisfactory (Bond et al. 1998).

Important findings were:

- Risk and protective factors assessed by this survey were strongly predictive of substance use and delinquency amongst Victorian youth.
- There was a linear increase in *regular alcohol use and smoking* with the cumulative increase in elevated risk factors and depressed protective factors.
- *Marijuana, other illicit drug use and a range of more serious delinquent behaviours* were associated with increase in risk and decreased protective factors.

The survey has been designed to enable assessment of 23 risk factors and 10 protective factors accurate to a Victorian local government level. Its development and analysis has involved a diverse range of government departments (youth services, family services, education, health promotion, and juvenile justice)

Table 1: Risk and Protective Factors Assessed by the Victorian Survey

Community	School
<p>Risk factors</p> <ul style="list-style-type: none"> Low neighbourhood attachment Community disorganisation Personal transitions & mobility Community transitions & mobility Laws & norms favourable to drug use Perceived availability of drugs <p>Protective factors</p> <ul style="list-style-type: none"> Opportunities for pro-social involvement Rewards for pro-social involvement 	<p>Risk factors</p> <ul style="list-style-type: none"> Academic failure Low commitment to school <p>Protective factors</p> <ul style="list-style-type: none"> Opportunities for pro-social involvement Rewards for pro-social involvement
Family	Peer — Individual
<p>Risk factors</p> <ul style="list-style-type: none"> Poor family management Poor discipline Family conflict Family history of antisocial behaviour Parental attitudes favourable toward drug use Parental attitudes favourable to antisocial behaviour <p>Protective factors</p> <ul style="list-style-type: none"> Attachment Opportunities for pro-social involvement Rewards for pro-social involvement 	<p>Risk factors</p> <ul style="list-style-type: none"> Rebelliousness Early initiation of problem behaviour Impulsiveness Antisocial behaviour Favourable attitudes toward antisocial behaviour Favourable attitudes toward drug use Perceived risks of drug use Interaction with antisocial peers Friends use of drugs Sensation seeking Rewards for antisocial involvement <p>Protective factors</p> <ul style="list-style-type: none"> Religiosity Social skills Belief in the moral order

in a common process of youth risk assessment.

In late 1999 results will be available for a representative sample of over 15,000 Victorian youth. Publication of these findings will provide a baseline for informing Victorian government prevention service investment, and will also increase community awareness of the integrated range of community factors underlying the risk-focused approach to prevention.

Beginning in 2000, the CTC program is to be trialed in Victoria by a consortium including the Women's and Children's Health Care Network and the Rotary Club of Melbourne.

CTC evaluation plan

The evaluation plan for the Victorian trial of CTC should provide the first randomised controlled evaluation of the effectiveness of Communities That Care (CTC).

The report of the findings of the Victorian youth survey, due for release in late 1999, will provide a profile of youth risk and protective factors accurate to a Victorian local government council level. Then, early in 2000, all local government councils in Victoria will be invited to submit expressions of interest to enter the Victorian trial of CTC. Councils will be asked to submit a brief expression of interest indicating youth health issues to be addressed and community readiness to be involved in this program. They will be asked to describe and define communities or neighbourhoods within their boundaries and to select two neighbourhoods to be targeted for CTC intervention.

Six Victorian local government councils will then be randomly allocated to receive the comprehensive CTC intervention and another 6 to receive a control condition involving current best community practice. The 12 communities will be selected on the basis of community readiness to engage in the CTC mobilisation process. Geographic stratification will be used prior

to randomisation to ensure equivalent representation of rural councils in each condition. Each of the 12 councils will be invited to nominate two neighbourhoods of approximately 10,000 to 15,000 people, enabling comparison of 12 intervention communities with 12 control communities.

The major measure of outcome for the Victorian trial of CTC will be an annually repeated cross-sectional survey assessment of youth in the intervention and control communities. In all of the intervention and control communities the Centre will select schools and carry out surveys in each of the years from 2000 to 2002. To ensure comparability, the cross-sectional survey of approximately 8000 students will be repeated in the same schools each year.

In order to supplement the school survey assessment, official records will be utilised to conduct additional community risk factor and outcome monitoring. As a component of the standard CTC process, local level indicators are developed and monitored relevant to:

- police records (e.g. family violence and conflict, youth offences, drug offences);
- council records (e.g. expenditure on vandalism);
- school records (e.g. school discipline problems, school absence and separations); and
- hospital records (e.g. emergencies, hospital drug registrations).

Community indicators will be sub-aggregated to residential address postcode and used as a secondary method for analysing community trends relevant to risk factors and outcomes. CTC experience in the US has led to the development of over 100 local, county-level community indicators, and 41 of these have been validated against student survey data on risk, protection, crime and substance use.

Process evaluation for the CTC trial will include analysis of service reach and targeting,

service implementation and intervention integrity. In addition, community involvement in strategy development and implementation will be monitored. Process monitoring will include a standard resource assessment/service audit within each local community and monitoring of trends and changes in resource investment. The Centre will use key informant interviews to monitor the impact of CTC community leader training and community board activities. Indicators of community knowledge and understanding of prevention planning in both intervention and control communities will also be monitored.

Conclusion

In conclusion, plans are well under way to implement and evaluate the CTC approach in Australia.

This approach has been favourably received in US communities and evidence suggests that the profile of risk and protective factors measured through CTC is also highly associated with youth substance use and delinquency in Victorian youth samples. The Centre for Adolescent Health anticipates that Australian involvement in the CTC program will increase community understanding and acceptance of prevention and provide a foundation for further investment in prevention.

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