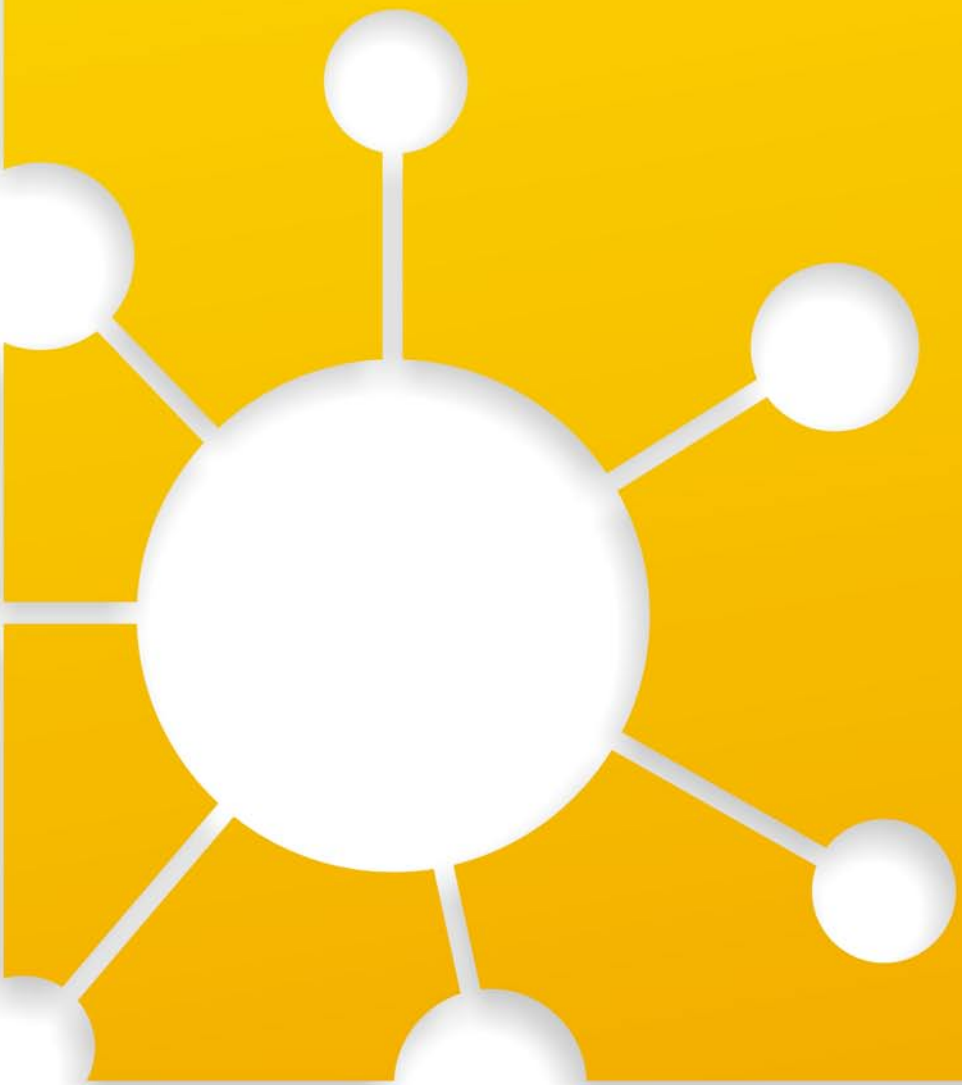
Are you ready?

Community planning to prevent health and social problems for children and young people



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Communities That Care Ltd is a not-for-profit company, formed through a collaboration between the Royal Children's Hospital and the Rotary Club of Melbourne with the objective of implementing, evaluating and disseminating strategies for building community prevention capacity in Australia. The company vision is to promote the healthy development of children and young people through long-term community planning to prevent health and social problems.

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Australia has had considerable success with prevention programs. For example, there was a significant decrease in the rate of suicide for young Australian males aged 20 to 34 years between 1997 and 2003, which has been attributed to the National Youth Suicide Prevention Strategy initiated in 1995 (Morrell, Page & Taylor 2007).

Our purpose in writing this booklet is to outline strategies for preventing harmful behaviours in Australian communities, and thereby improving the health and social wellbeing of residents – particularly children and young people. We believe there are two essential ingredients for successful prevention programs: one is the research knowledge derived from 'what happened' in previous implementations of community-wide planning, such as those using the Communities That Care framework; the other ingredient is the involvement of key people in the local community in the planning and implementing of prevention strategies.

But who are "we"? Colleen Carlon is currently working on a Ph D in community development, she coordinated the first Communities That Care project in Australia and continues to support several Communities That Care prevention projects. John Toumbourou is a Professor at Deakin University, who has done extensive research on risk and protective factors concerning harmful behaviours, especially in the area of substance abuse to support community based health promotion. Both of us are passionately committed to improving environmental conditions for the healthy development of children and young people.

Introduction

In the remainder of this booklet, we start with a definition of prevention, followed by a consideration of why it can be difficult to initiate and organise for prevention. Then we move to outline the steps and stages for planning and implementing, starting with the need to build a picture of prevention. Next we explore the two essential elements of a community-based, multifaceted approach to prevention: research and community involvement, including a look at the research and community participation strategies developed through the implementation of Communities That Care in Australia. Finally, we go on to outline the stages of the community readiness framework and the capacity building strategies required to build a prevention planning coalition. We hope the booklet will be useful for professionals and non-professionals in taking up the challenge of developing Australia's prevention agenda.

Prevention refers to strategic action taken to stop an undesirable event or behaviour. A quick search on Google shows that 'prevention' refers to inducing wellness, hazard prevention, disease control, reducing substance abuse, avoiding teenage pregnancy and so on. In terms of health and social wellbeing, prevention refers to actions taken to stop harmful or potentially harmful behaviours; or, if the behaviour has already occurred, to reduce its harmful effects (see Appendix 1 for formal distinctions). Increasingly, prevention has come to be recognised as proactive, practical ways to improve health and social conditions.

Why is prevention difficult?

The idea that 'prevention is better than cure' has long been part of societal wisdom, yet establishing a community-based prevention effort is not always easy. As we mentioned above, there was a successful program that brought about a decrease in the rate of suicide for young Australian men in the late 1990s; however, the cost benefits of such a program are long-term and often do not fit with current governmental funding priorities. This long timeframe indicates the forward thinking and commitment that are required, and once obtained they need to be sustained. Despite its success, Australian suicide prevention efforts are experiencing difficulties in maintaining national commitments.

As stated above, prevention relies on research and collaborative planning to achieve effectiveness; both of these take time for results to emerge. Media stories may portray a particular problem in unhelpful and graphic ways, increasing community distress and encouraging highly visible yet ineffective responses. Prevention can be difficult precisely because its success is rarely a front-page news story and it usually takes long-term planning and implementation to see results.

What is prevention?

To build momentum for a community-wide prevention effort, the problem has to be recognisable, and you need to develop ways of talking about the problem and the kind of prevention that is needed. In 2006 the Western Australian Office of Road Safety developed a strong picture of the need for motorists to reduce their driving speed. In the TV advertisement a traffic policeman points a speed gun at the camera, eyeballs the audience and says, "There's a reason behind everything we do". Then the camera pans out to show a long line of people standing behind him; no one is injured or maimed, but the message is clear: if you don't slow down, these people could become traffic victims (Office of Road Safety Western Australia 2006).

Of course local communities do not have the resources of a state or federal government at their disposal. But funding can usually be found for well planned and developed prevention programs; and there is a growing knowledge base available from organisations such as Communities that Care. But we think your first step is to build a picture of prevention that has meaning for your local community, one that will sustain effort in the long term.

Building a picture of prevention

Reminding people about prevention campaigns that have been successful can help you to build a picture of how prevention works and to demonstrate the need for a multifaceted approach. Take, for example, the tobacco consumption and road trauma prevention campaigns in Australia, both of which have been in place long term and to good effect (Moodie 2004). Consumption of tobacco in Australia has been on the decline since a prevention campaign was established in the 1960s (de Looper & Bhatia 1998, p. 141), with an estimated 17,400 premature deaths averted by 1998 (Moodie 2004, p. xvi), and with the economic benefit arising from the prevention campaign exceeding its cost by "at least 50:1" (Ross 2005, p. 6).

But a campaign of this nature requires massive, well-coordinated effort nationally and locally. Local activities discouraging tobacco sales to minors, educating children about the hazards of tobacco use, and developing and enforcing smoke-free areas have all contributed to national reductions in adults' use and children's uptake of tobacco smoking.

The prevention approach to road safety in Australia from the 1960s to the 1990s has also seen a significant drop in the mortality rate for children and young people (Stanley 2003).

In 1971, more than 1000 people died on the roads of the Australian state of Victoria. As a result of community-wide road trauma prevention programs, there are now, per year, 600 fewer deaths and 6000 fewer serious injuries (Moodie 2004, p. xvi).

Attempts to prevent road trauma, through a combination of community-wide activities, including environmental, engineering, enforcement and education strategies, were first instigated in the 1970s (Moodie 2004). Local policing strategies and local government road engineering have contributed to the national efforts that reduced the road toll.

These successful prevention campaigns illustrate the need for a community-wide approach, supported by state and national policy and legislation. They can also be invoked to help people realise that entrenched attitudes in the community can change over time.

Prevention typically needs to focus on more than one setting. For example, in road safety it might look to reforming engineering practices for improved road design, and to modifying alcohol service practices

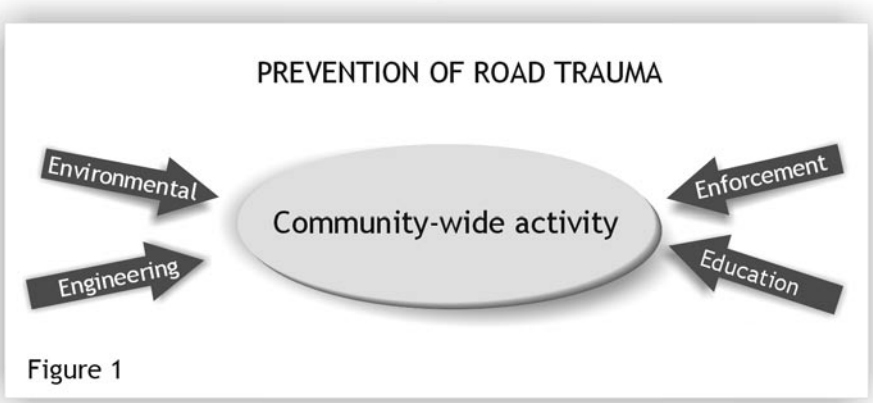


Figure 1

to reduce alcohol-related road trauma. Prevention also needs to focus on more than one stage in the development of behaviours. For example, in substance abuse, on the one hand, it can aim to interrupt or stop established substance use and work to prevent relapse; on the other hand, it can intervene in the living environments of children and young people to support healthy development and delay the age of first use. Thus at the community level these strategies need to complement and overlap with each other to form systems of broader influence.

Figures 1 and 2 are ways of representing a multifaceted approach to community prevention. Their content can be changed to suit the situation in your community both to build a picture of prevention and to emphasise the need to approach prevention from a number of angles.

Figure 1 shows the perspectives that combine to make the road trauma prevention campaign a success. Current understandings of prevention indicate that a multi-pronged approach such as this is vital to long-term success.

Figure 2 is an example of how issues pertaining to child development in your community could be approached from a range of perspectives. A multi-pronged approach to preventing problem behaviours might consider education and law enforcement strategies along with strategies for promoting healthy development and building positive living environments for children and young people.

In the context of building your picture of prevention, as well as talking about familiar and successful prevention campaigns, it is advisable for you to

Figure 2

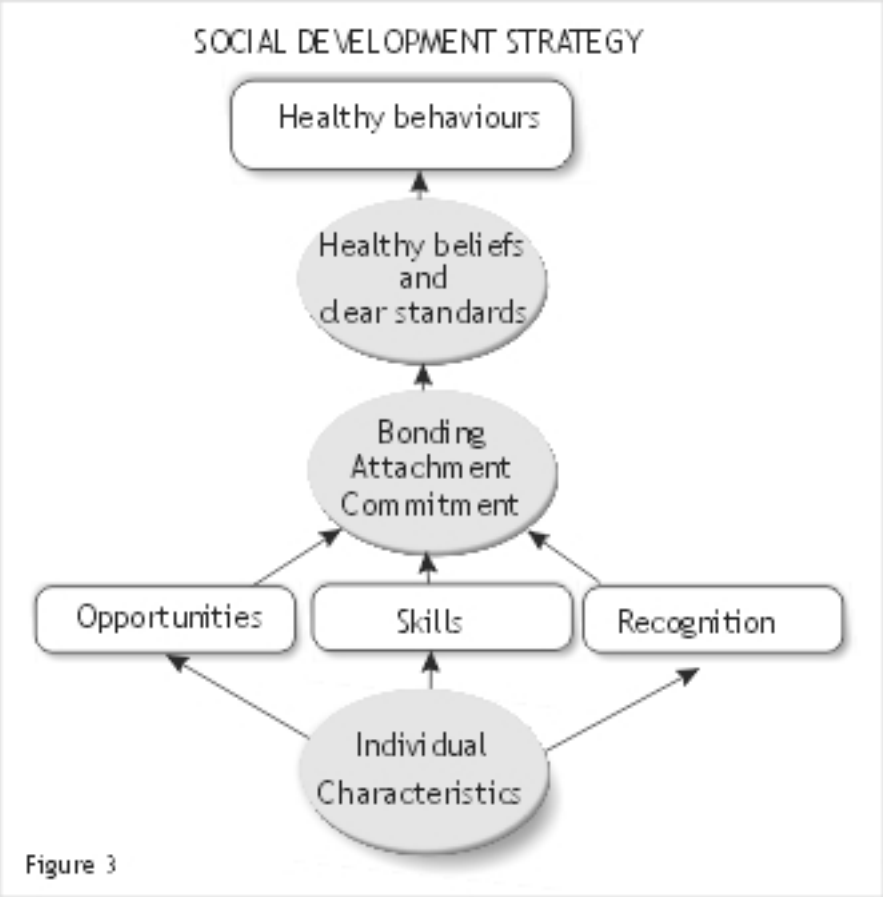
consider national prevention policies. This can enable you to connect stories and events in your community with the broader language of prevention.

National policy

The National Drug Strategy uses the harm minimisation framework to talk about preventing or delaying drug use and preventing harm during drug use (Intergovernmental Committee on Drugs and the Australian National Council on Drugs 2004, p. 6). 'Pathways to Prevention' talks about reducing the development of criminality across the population by targeted interventions at different stages in the life span of children and young people (National Crime Prevention 1998, pp. 7-11). And the National Mental Health Plan refers to the influences on mental health in our living environments (Australian Health Ministers 2003, p. 9).

Becoming familiar with the language of prevention used in these policy documents enables your community to tap into national prevention research knowledge and can assist in aligning your local strategy to possible funding opportunities by using the language of prevention to tell local stories.

We next look at the two essential elements of a community-based, multifaceted approach to prevention: research and community involvement. Research aims to understand influences affecting health and social problems, and can guide the mechanics of a prevention response and the frameworks for monitoring its effectiveness. Community is increasingly being recognised as the implementation site for prevention, where knowledge of culture and values is crucial to adapting prevention efforts to local conditions.


SOCIAL DEVELOPMENT STRATEGY
Healthy behaviours
Healthy beliefs and clear standards
Bonding Attachment Commitment
Opportunities
Skills
Recognition
Individual Characteristics
Figure 3

Research

Studies of the health and wellbeing of Australians reveal that a number of problems faced by adults can be traced to their health and social circumstances as children (Loxley et al. 2004). The health-compromising behaviours of young people, such as alcohol misuse, tobacco use, illicit drug use, unprotected sex, depression, self harm, stealing, fighting and underage driving can result in adverse repercussions later in life. The Communities That Care framework has been designed to address these health and social problems, but it does so through developmental prevention approaches that focus on the living environments of children and young people rather than on their behaviours.

The research that underpins Communities That Care identifies influences – in the form of risk and protective factors – in the living environments of children and young people; these factors are predictive of and protective against the emergence of health-compromising behaviours (Catalano & Hawkins 1996; Pollard et al. 1999; Williams et al. 2005).

The overall aim of the research has been to decrease undesirable behaviours by reducing risk factors and increasing protective factors. Examples of risk factors are: family conflict, low commitment to school, friends' use of drugs, and community norms that are conducive to drug use. Protective factors stem from positive involvement in community, family, school and peer activities and safeguard against risk.

'The Social Development Strategy' (Figure 3) is a model for thinking about how young people can be protected by the quality of their living environments (Catalano & Hawkins 1996). It is based on two key protective processes: the first is bonding, that is, young people having a sense of social attachment and commitment to their community, their school, their family and their peer environments, which is a protective factor against behaviour that is "outside the group's norms" (Arthur et al. 2003, p. 130). The second key protective process is that positive healthy behaviours, beliefs and clear standards are the norm in these environments, that is, the behaviours

are clearly known, expected and reinforced. These protective processes are exemplified in Figure 3.

Using the Social development strategy as a thinking tool in your community allows you to take the focus off the behaviours of your young people and to look, from a prevention perspective, at 'what is happening' in their living environments. For example, you could ask whether children, adolescents and young adults have a commitment to their community, school, families and peer groups, and whether they:

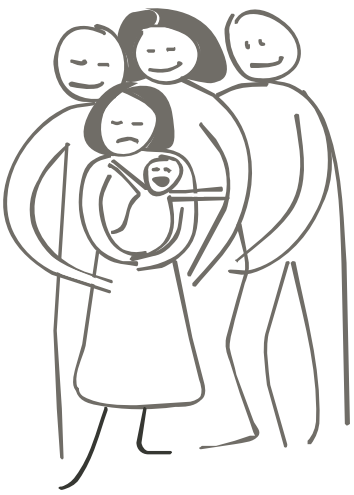
- Form relationships (attachments) in the community, school, family and peer group?
- Contribute to their community, school, family and peer group?
- Have the skills to take advantage of the opportunities that exist?
- Get recognition and acknowledgement for their efforts?

Then you might ask whether these environments model healthy beliefs and accept clear standards.

The Communities That Care research shows that the more risk factors in a young person's environment the more likely he or she will develop health and social problems. For example, a large Australian study showed that 80 % of young people with 10 or more risk factors in their lives become regular drinkers by mid-high school; whereas for those with one or less risk factors the rate was only 10% (Bond et al, 2000). And the research on protective factors has shown that 60% of young people with 1 or no protective factors adopted regular drinking, whereas the rate was reduced to 15% for those with 7 to 10 protective factors in their lives (Bond et al, 2000). It follows that a decrease in risk factors and an increase in protective

factors in the community will result in fewer young people adopting problem behaviours.

But research is not just for those in 'ivory towers'; for you to use the concepts of risk and protective factors effectively in your community, you will need to conduct supplementary research. And to aid you in this Communities That Care has developed the 'Healthy neighbourhood survey' for you to make community-level measurements of child and adolescent risk and protective factors. The Healthy neighbourhood survey measures the factors that research has consistently shown to be predictive of or protective against the emergence of health and social problems (Arthur et al. 2003, p. 141). We have already begun to show the importance of local community involvement in prevention. In the next section, we will explore ideas to help you with community engagement and community participation.



There are many different ways of defining communities. For example a place-based definition identifies all those residing in a geographic area as a community. However, residents are likely to experience their sense of belonging or common identity differently, with some people living in the area experiencing detachment and isolation. It is important to investigate the extent to which a geographic location is experienced as a community.

Common identity is another way of defining community, with the identity stemming from association with the place's physicality or from identifying with a particular group according to race, religion, culture, age, length of residence, or shared interests. In line with the principles of the social development strategy outlined above, people and groups within the community gain a sense of belonging by experiencing social attachment and commitment to the community. Thus common identity is about having a sense of belonging in a community.

However, different experiences of belonging raise issues of inclusion, exclusion and representation – the politics of community. When trying to establish a coordinated prevention effort based on a concept of community, you need to be aware of these differences and to somehow adequately represent different groups in the community.

We have found that establishing participation processes that are fluid and open is an important safeguard in keeping a prevention planning coalition relevant to the community in which it is based. Being open and inclusive in participation can enable community coalitions to build effective, multifaceted approaches to prevention. A flexible and open

participation structure enables community members, groups and organisations to move in and out of the coalition according to their interest and resource capacity. For example, a situation where community-based organisations are actively competing for program funds is not conducive to sharing information and developing collaborative approaches to service delivery. Local planning coalitions that carry out research, which they make available in the local community, can build a culture of information sharing and establish an evidence base for local collaborative service delivery.

The following strategies developed through the implementation experience of Communities That Care projects in an Australian context, may serve as a checklist for devising your own approach to community participation.

Strategies to encourage fluid and open community participation

1. Make participation open to all community members, organisations and agencies at all times (The participation of children is an exception: arrangements must be in line with the normal "working with children" requirements)
2. Run meetings at regular times in accessible locations
3. Advertise meeting times and venues regularly
4. Ensure that coalition documents, such as minutes, research reports, and planning documents are accessible in the public domain, either by website or at a community library
5. Have a mailing list (snail or email) for coalition

documents; this list can extend beyond the membership to people or organisations not presently committed to the planning process but wanting to be fully informed

6. Hold regular orientations for new members
7. Leave the door open for the return of people or organisations who decide to stop participating in the coalition
8. Keep the work of the coalition in the public domain through the local media; also run public forums and send guest speakers to other community groups or events

Strategies of this ilk are crucial when bringing people together to form a local coalition and even more so when the coalition begins to operate. Through the processes of meeting and working together, hopefully, members will develop a sense of community within the coalition and bond to the group.

Working across differences effectively

The diversity of views that emerge in a prevention planning coalition may be daunting, but they can be its greatest strength. Working in a constructive and proactive way with this diversity may be your greatest challenge. One way of looking at how to work across the different perspectives that may be present in a community coalition is to explore the different ideas that people bring to the coalition. The following example outlines some differences in perspective that may come together in your local group.

Community action has a strong tradition in the Australian context, within two distinct approaches: community development and public health. We think that comparing these two approaches, and noting their differences, can help you to integrate the divergent forces in your community.

First, the community development tradition in Australia takes a social justice perspective on society. Its central assumption is that change will come through a redistribution of power and/or resources. Understandings of community are fluid and best defined through engagement in each location, with active participation in community decision-making the key component. It is assumed that change works from the grassroots level using local knowledge to address disadvantage. Outcomes are defined in terms of the process of how the group is working together and how it is representative of the community, and knowledge is validated by local understandings of community conditions.

Table 1

Comparing views in the prevention planning coalition

Different people in the prevention planning process	
The community activist focus	The health professional focus
Fluid understandings of community	Health catchment understood as community
Start where they are at	Start with needs assessment
Community participation Rely on grassroots action	Rational planning Rely on planning and logic
Community assessment Community understandings of influences of behaviour	Community assessment Scientific understandings of the influences on behaviour
Values local knowledge	Values research knowledge
Trust in flat decision-making processes	Trust in hierarchical decision-making processes
Empowerment through community-participation processes	Empowerment through community education and service planning

Second, the public health approach takes a rational perspective on society. Its central assumption is that change will come through providing environments that support individuals in making good health choices. It is assumed that geographic boundaries determine community. Research identifies the underlying influences of problem behaviours in the community, and the central assumption is that change will come through research and logical steps adapted to the situation. The specific outcomes for each site are determined by the use of objective, validated research knowledge.

Table 1 sets out these differences and encourages you to think about how people from the two different perspectives could contribute to prevention planning. Using this framework in your community will help to highlight ways of bringing the two perspectives together.

Next, we present ideal-typical examples of the two approaches.

Community development activist

An ideal community development activist would be one of the stakeholders in a prevention coalition who has been proactive in addressing community issues and has a long history of participating in and generating community action. Such a person would be a great asset because she/he would have a strong commitment to the community, and have the capacity to mobilise other community members. People with vast experience in community action skills have connections across the community and have an understanding of how decisions are made and action generated in the local area.

Public health professional

A local health professional, proactive in collaborative approaches to prevention, with a long history of working on public health campaigns would be a valuable stakeholder in the coalition. Such a person, ideally, would have a strong commitment to the local community, be a leader in the health sector, have the

capacity to reorient health services, have connections with local and state government authorities, and have knowledge of and experience in public health prevention planning.

At the local level these two community members may have the same goal, such as "to protect young people from drug harm in our community"; however, the assumptions they hold about how to achieve this goal would lead to very different forms of action, and there may be tensions arising from the differences. The first point of tension may be about who should participate. The community activist would seek to facilitate broad community participation and consultation processes, wanting to include people from across the community who are concerned about young people's vulnerability to drug-related harm, including young people themselves. The health professional, while being open to this, would be more focused on the health and social service sector of the community, and would seek to involve managers with control of health services in coalition planning.

These and other points of difference could emerge in a prevention planning coalition, requiring your awareness, mediation and negotiation. We believe that having both types of people stay active in the coalition is vital to accommodating the diversity of views and to establishing a multifaceted prevention response. For instance, a prevention planning coalition seeking to protect young people from drug harm would increase its chance of successful implementation by including both service managers and young people. The particular knowledge and sphere of influence of each group would be important to developing strategies that are suited to local conditions and readily adopted by local health services.

As stated above, vital components of a prevention campaign are reliance on research for understanding causal pathways and on local knowledge of community conditions. Studies of the Communities That Care approach to planning for developmental prevention attest to this proposition. The studies also highlight the advantages of the 'Healthy

neighbourhoods survey' for building prevention strategies and measuring long-term effectiveness (Arthur et al. 2003).

A study of the implementation of Communities That Care in Pennsylvania demonstrated that community-based prevention planning can reduce problem behaviours in a local area providing the prevention planning coalition functions effectively. The factors found to be predictive of effective coalitions were community readiness, training to increase the knowledge of coalition members, and ongoing assistance in the use of research-based prevention knowledge to guide the work of the coalition as depicted in Figure 4.

Research and community involvement can be a powerful combination for developing effective prevention strategies in your community. Research evidence guides effective action and assesses results, whereas local knowledge directs the application of this evidence to best effect.

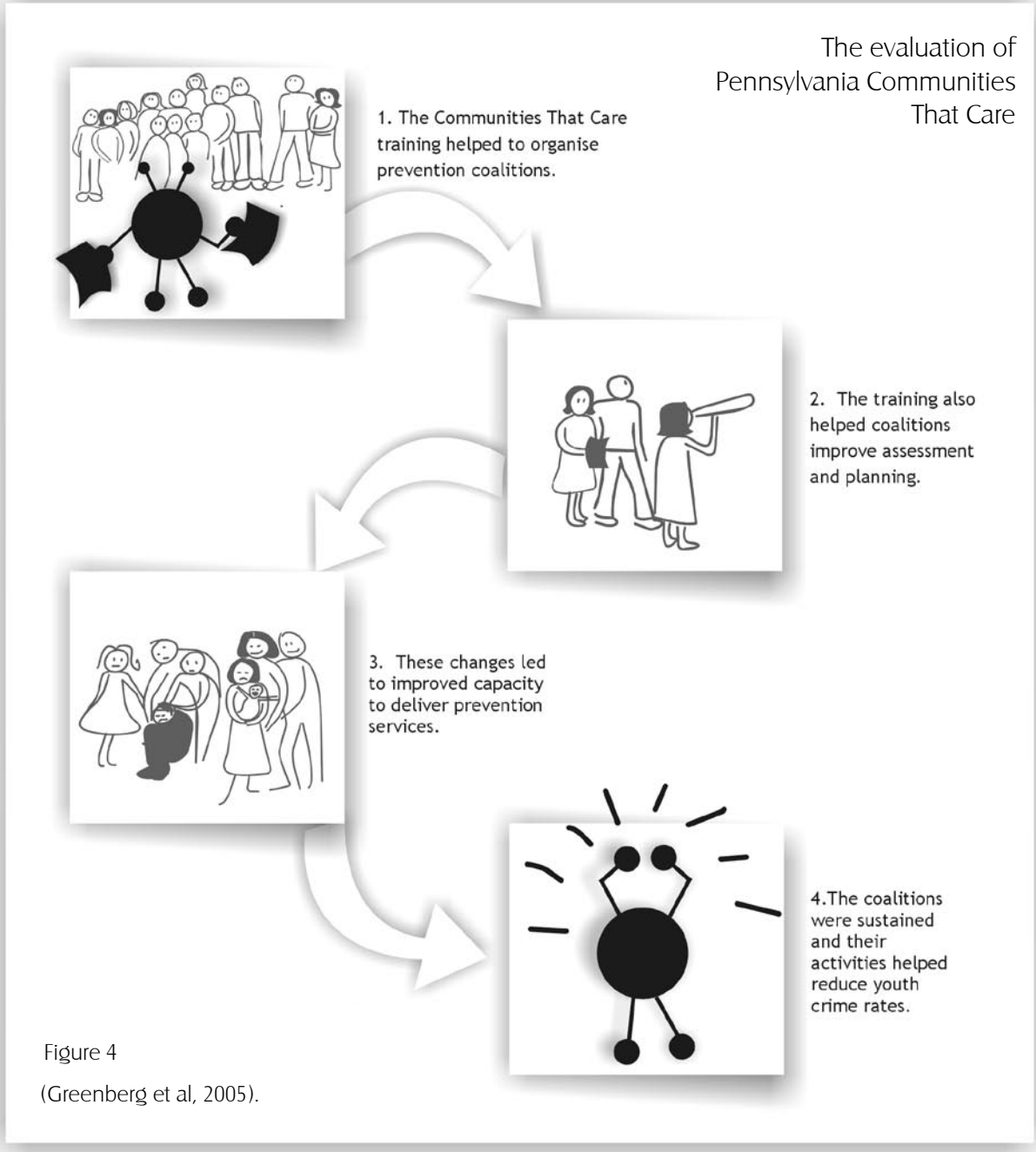


Figure 4

(Greenberg et al, 2005).

Table 2

Different types of knowledge

Knowledge	Accepted as knowledge	Examples
Community	– Situational knowledge – Community norms – Cultural understandings – Service histories	- Places, spaces and people - Accepted ways of doing things
Research	– Thinking frameworks – Science-based evidence – Risk and protective factors	Policy, programs, planning
Media	– Opinion and exposé – Portrayal of victims and rescuers	Headlines, lead stories, newspapers, television, radio, web

Adapted from (Adams 2004, p. 36)

Combining research and community knowledge

We contend that research knowledge provides the groundwork for local action on prevention, and community knowledge allows it to be adapted to local conditions. Balancing the two is central to effective prevention planning, and acknowledging the differences between community and research knowledge is the first step in achieving this balance. Table 2 depicts how different forms of knowledge, in this case community, research and media knowledge, produce different types of information.

Community knowledge is place-based; it stems from experience in the local situation and demonstrates understandings of how a community functions, such as values that determine preferred social environments, and community perceptions of healthy development and service history. There are a broad array of perceptions and values operating in any community setting.

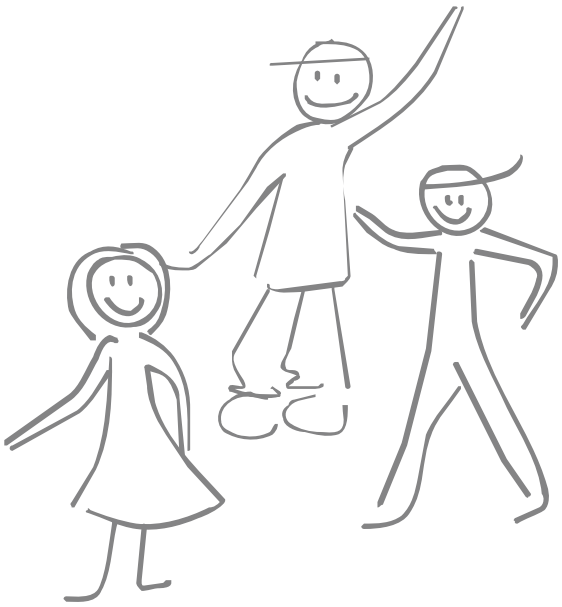
On the other hand, research knowledge stems from the systematic exploration of ideas and issues. Researchers use previous studies as the starting point to build investigative frameworks. In the case of population research, they look for response patterns in a representative sample of the population to indicate trends in behaviours and environmental influences across the community. But, as with community knowledge, research has a diverse range of perspectives and approaches.

Media knowledge/information is purpose built: it seeks to inform and/or entertain. It is generally accepted that the media portrayal of young people is unbalanced, with too much emphasis on the problems of youth. Newspapers and magazines tend to offer limited and negative information about young people

Table 3

Different ways of talking about issues

Information	Portrayal of young people and drinking
Community	"Young people in our community need to know how to enjoy themselves without drinking" "Kids round here have been drinking down there as long as I can remember"
Research	There are a high number of risk factors in the living environments of young people in this community We may be able to reduce the incidence of adolescent drinking with community and school-based interventions
Media	Teen binge rampage Do you know where your teenager is?



– presumably because this is the kind of news the public wants (Youth Affairs Council of Victoria 2004).

It follows that a community event or incident will be presented very differently by community, research or media accounts. Table 3 outlines typical portrayals of an episode of adolescent binge drinking by the three approaches to knowledge construction.

Of course, this table does not show the full diversity of views that could exist around such an incident. Prevention planning coalitions need to be aware of these differences, clear about what is informing coalition action, and able to use information to assert a constructive discussion of issues in the local media. If, for example, a local radio station insists on leading a talkback session that is critical of parents whenever the issue of adolescent drinking comes up in the community, a prevention coalition can bring some balance to the debate. It could refer to research showing that adolescent alcohol misuse is a nation-wide issue facing many communities, that the living environments of young people go beyond the family, and that there are ways for communities, schools and families to support each other in reducing these problems by creating healthier living environments for young people. While talking to the radio, a coalition member might use the airtime to invite people into the local planning process and invite local media personnel to participate in the planning effort and shift the community debate. Over time, hopefully, the coalition would develop a local prevention plan to move the community forward to address these issues in a long-term collaborative and proactive way.

To sum up: research and community knowledge can be combined to offer a credible assessment of local issues; in so doing it would draw on national and international public health trends, and cultural understandings of community norms and service practices. This would enable a local coalition to present issues to the media in the context of broader social trends and with plans for proactive community prevention. The Communities That Care prevention framework offers communities resources in the form of quality research and community training services as part of the essential elements of successful prevention planning.

Table 4

Stages and definitions of community readiness

Stages	Definitions
Low prevention awareness	Health and social problems of children and young people are considered normal and prevention is a low priority.
Resistance to prevention	Health and social problems of children and young people receive only moderate acknowledgement, although some community leaders are arguing for prevention.
Awareness of prevention	Health and social problems of children and young people are a priority, but there is low support for prevention.
Prevention preplanning	There is moderate support for prevention and conditions, such as organisational harmony and local ties and attachments, are emerging, enabling the community to work together.
Organisational preparation for prevention planning	There is a recognised partnership/collaboration and strong leadership support for prevention.
Initiation of prevention-planning activities	Local planning forums acknowledge diversity in participation and the inclusion of young people. A local coordinator and office have been funded to support prevention. Prevention services and resources have been documented.
First community prevention plan successfully completed	A community action plan to engage in strategic action to enhance the healthy development of children and young people in the locality has been completed and evaluated. There is a high level of community and government support for local prevention capacity.
Experience implementing and evaluating a prevention plan	A second prevention plan has been developed, reflecting evaluation of the previously completed and evaluated plan.
Expansion of prevention planning systems beyond a single focus	Organisations tackling different prevention issues cooperate, coordinate and share resources based on an agreed local prevention plan.
Community ownership of prevention planning and monitoring systems	Positive youth development targets are institutionalised into local planning and governance. Youth participation in governance forums has been sustained over at least 2 years. High levels of community support for prevention.

Source: Williams et al (2005) developed the above; mostly based on the Colorado Tri-Ethnic Framework (e.g., Jumper-Thurman et al, 2001) but also draws on the readiness concepts promoted by the University of Washington, Social Development Research Group (Arthur & Blitz, 2000).

Community readiness for prevention

Despite evidence that community prevention and health promotion are achievable, research shows that communities have different rates of success with their prevention efforts (Williams et al. 2005). By exploring previous prevention efforts, we know that certain conditions must prevail for communities to be ready to move forward effectively with prevention planning. Researchers have developed a framework that identifies stages of readiness for prevention. These stages are set out in Table 4.

The framework presents a progression of stages in working towards and carrying out prevention planning. For example, if there is no acknowledgement that health or social issues need to be addressed in your community then prevention is a low priority. Statements such as, "Kids round here have been drinking down there as long as I can remember", are a sign that alcohol use by young people is considered the norm. Alternatively, there may be an awareness of health and social issues but low interest in addressing those issues through a systems approach to prevention. For example, community perceptions that health and social issues are a direct result of family dysfunction may lead to community action around child protection strategies with no interest in a more broad-based prevention approach.

> Readiness is an important factor because differences in readiness indicate what can be done and what needs to be done (Jumper-Thurman et al. 2001, p. 1).

The Centre for Adolescent Health in Melbourne completed a study in four Australian regional communities to determine the applicability of the concept of community readiness in Australian settings and subsequently developed the Communities That Care 'Healthy neighbourhoods prevention planning survey' (Williams et al. 2005; Jumper-Thurman et al. 2001; Arthur & Blitz 2000). The survey explores community perceptions of current prevention efforts, community awareness of these efforts, leadership, and understanding of the issues to be addressed, and it offers specific recommendations for a way forward from each stage of readiness.

The Communities That Care 'Prevention planning survey' identifies the stage of readiness for prevention planning that exists at the community level and provides reliable baseline data for planning and evaluation of capacity building strategies.

The readiness framework can also be used to help you to think about how different groups in the community respond to local issues. For example, you may want to establish a prevention planning coalition to address issues of alcohol use by young people. If you are having trouble generating interest in prevention, you need to think about how community members perceive young people's use of alcohol. Do they perceive it as a problem or not? The types of interventions suitable to moving communities through the early stages of readiness are outlined in Table 5. Where there is low readiness, you need to start capacity building for prevention by identifying people with influence and working with them to create awareness of the problem before you can effectively establish a prevention planning coalition.

The first few stages may be applicable to different groups or sectors in your community at different times. The Prevention planning survey can provide you with an evidence-based assessment of the local situation at a community-wide level, whereas using the readiness framework as a guide for capacity building can assist you with developing strategies for particular sectors or groups in your community. Table 6 outlines how the Communities That Care services fit into the stages of readiness framework.

Table 5

Building initial community readiness

Stage	Situation in community	Capacity building activity (Interventions)
Low prevention awareness	•Very few community members recognise health and social issues for children and young people as a problem •May not be possible to form a local partnership around this issue	•Identify people with influence and work with them to create awareness of the problem •Visit families and neighbours one-on-one to increase awareness of problem •Give informal presentations to existing small groups (phone calls can be effective) •Guided by knowledge of local context and culture, select influential people sympathetic to viewing the health and social issues as a problem
Resistance to prevention	•If enough recognition of the problem, form a small team	•Create awareness of the problem in the community, and that something may be done about it •Describe local incidents, personalise case reports or critical incidents (these carry more impact for a community) •Focus greater awareness on the problem through media articles, presentations to community or civic groups, and educational posters/flyers/brochures
Awareness of prevention	•The problem is recognised as a priority, but there is low support for prevention	•Hold small-group events (sponsored by a community organisation) to increase community awareness of benefits of prevention and to rally support •Use newspaper editorials/articles and publication of local data to show factors that influence the positive development of young people •(National or state-wide data may make less impression on community residents)
Prevention preplanning	•Moderate support for prevention has been generated. Community teams focus on raising awareness, with some concrete ideas about how to begin making changes	•Gather information about where/by whom prevention is being implemented •Find examples of how prevention resources might be extended and equitably applied •Bring key community leaders into the process to bolster resources •Conduct local focus groups or forums to identify community strengths and resources •Focus on local information in media interventions, and pull in national data for comparison •Develop stories about the prevention strategies available so people are more aware and knowledgeable

Table 6

Using *Communities That Care* services to build prevention readiness

	Capacity milestone	Community prevention progress indicators	Communities That Care services	Community readiness stages
Preparation	Champions advocate community prevention	Awareness that health/ social problems of children and young people are a local issue	•Prevention planning survey •Prevention readiness workshop	•Low prevention awareness •Resistance to prevention •Awareness of prevention •Prevention preplanning
Introductory Services	A community prevention partnership	A community partnership, with an explicit mission to plan, implement and evaluate an effective community prevention strategy	•Community board orientation •Key leader orientation	•Organisational preparation for prevention planning

Advanced Services	A local prevention action plan	A community agreement to engage in strategic action that has support for claims it can reduce local health/social problems for children and young people	•Child and youth survey •Community assessment training •Community resource assessment training •Community planning training	•Initiation of prevention planning activities •First community prevention plan successfully completed
	Effective prevention activities	•Documented impact and outcomes evaluation of planned prevention activities •Delivering evidence-based community prevention activities	Implementation and monitoring assistance	•Experience implementing and evaluating a prevention plan •Expansion of prevention planning systems beyond a single focus
	Positive youth development	•Youth participation incorporated into governance •Local planning includes positive youth development targets	Advocacy and networking with experienced communities	Community ownership of prevention planning and monitoring systems

As stated above, you may need to use some of the capacity building strategies for the early stages of community readiness before you can get started with prevention planning in your community.

'Capacity building' is a useful idea for thinking about working, not just with the citizens in the community but also with service providers. Capacity building is really a new label for community and workforce development, which entails tapping into and extending the existing abilities of individuals, communities, and organisations to enhance involvement, decision-making and ownership of local issues (VicHealth). As outlined in the previous section, you may also need to build awareness of the health and social issues you are trying to address before you can effectively establish a prevention coalition.

The purpose of a prevention planning coalition is to bring together stakeholders from across the community, not to establish another service provider. An effective coalition can enhance the capacity of current service providers and community groups to take a developmental approach to prevention and to address local issues.

People participate in prevention planning coalitions for a variety of reasons. For some, participation stems from their personal or professional commitment to the community or to the prevention issue. Participants represent different sectors of the community, including residents, leaders, parents, young people, educators, police, and health or social service professionals.

A prevention planning coalition may function as a sub-committee of an existing organisation or as an affiliation of interested organisations and community members. There may be opportunities to establish a prevention planning coalition through the existing networks or collaborative structures of a community, especially when a group has already come together around a community health or social issue and the prevention planning goals can be aligned with what the group is trying to achieve.

As outlined above, community members and service providers bring different perspectives to the idea of prevention. An important step in bringing people together is to link their activity to the concept of prevention. One way to do this is to discuss the roles of service providers and community members

Prevention planning coalition

and identify what they are seeking to prevent in the pursuit of these roles, as illustrated in Table 7. People are busy working within their role and they may not immediately link prevention planning to their work or sphere of influence. If you are facilitating collaboration for prevention, you will need to make these links when talking to people about participating in a coalition.

Table 7

What would you like to prevent?

Role in community	Focus on	Wants to prevent
High school teacher	School achievement	Non-attendance at school
Local government	Community amenity	Antisocial behaviour
Drug and alcohol counsellor	Drug and alcohol users	Harmful use of alcohol and other drugs
Soccer coach	Participation and game skills	Non-participation in community sport
Community member	Community cohesion	Alienation
Accident and emergency health staff	Healing trauma	Injury
Police officer	Community safety	Crime & under-age drinking
Primary school teacher	School achievement	Behaviour problems in classroom
Parent	Child development/family cohesion	Negative influences on child

To take a multi-pronged approach to prevention in your community, it is important for you to locate how prevention fits in with existing health and social services. Prevention should not be seen as separate to treatment and continuing care, but be incorporated into a continuum of care across the community. Table 8 gives examples of strategies for harmful alcohol consumption across a service continuum.

Locating prevention strategies in the service continuum of a community helps to clarify different understandings of prevention, and indicates where there may be competing and potentially compatible interests in the current service sector. You may find a drug and alcohol counsellor thinks about prevention in terms of relapse prevention at the treatment or continuing care end of the service continuum; whereas a community member thinks about universal prevention strategies, such as promoting participation of young people in community events. A service provider located in a youth accommodation agency may focus on harm minimisation and preventing homelessness in line with treatment services; whereas an agency that operates in a public health framework may focus on drug use patterns across the population by implementing universal or targeted strategies to improve early child development outcomes. There is room for all of these understandings of and approaches to prevention in a community-based prevention plan. Clarity about the differences between these perspectives will help a coalition: to develop a balanced approach to prevention, to seek to address issues present in the community, and also to invest in strategies to improve health outcomes into the future.

Research in the field of prevention has shown that a carefully selected combination of prevention strategies has the greatest chance of reducing risk and increasing protection across the community (Loxley et al. 2004, p. 9). As well as meeting immediate and long-term needs, a balanced approach to prevention requires a mix of universal and targeted strategies, as explained in Table 9.

The range of possibilities for prevention, outlined in Tables 8 and 9, highlights the importance of community-level planning to take full advantage of knowledge of community function. Attention to these different foci in a prevention planning coalition enables a balancing of cultural relevance in the community, with strong reference to prevention research.

Table 8

Continuum of care for alcohol related harm

Prevention		Treatment		Continuing care	
•Universal population focus •Targeting average risk	•Targeted individual focus •Targeting raised risk	Case identification	Standard treatment	Relapse prevention	Long-term care
•Strategies such as Good Sports • Community participation contexts that model healthy behaviour in alcohol consumption	Targeted parent education programs	For example, intoxication effects, such as family conflict, domestic violence services	•Drug counselling •Detoxification •Treatment for drug dependent parents	•Parmacotherapy •Longer term harm minimisation strategies •AA meetings •Targeted parent education programs	•Disability support •Assisting children where parents have acquired brain injury

The categories of prevention, treatment and continuing care in the table above are based on the mental health intervention spectrum posited by Mrazek and Haggerty (1994, pp. 19-29; National Public Health Partnership 2006). The table demonstrates how prevention and treatment can be considered in an integrated way. For more information on Good Sports www.goodsports.com.au

Table 9

Targeted and universal strategies

Prevention strategies	Focus	Address For example
Targeted individual focus	Sub-populations or individuals selected due to high level of risk	Less common patterns of alcohol use, including dependence or very high risk patterns of use
Universal population focus	Whole of the population to reduce common risk or harm	Relatively common patterns of use, such as binge drinking and drinking above recommended levels

Building collaboration

Attending prevention planning coalition meetings to discuss strategies and exchange general information is often thought of as collaboration, but we think this activity is more accurately described as networking. We regard collaboration as a complex set of activities, as illustrated in Table 10 .

Here is a scenario to depict the different levels of collaboration: An organisation sends a staff member along to meetings as a representative and this person makes commitments to collaborate on behalf of the organisation. If all this person does is attend meetings then he/she is networking, which is important in itself but is mistakenly regarded as collaboration. To achieve full-fledged collaboration, representatives must be aware of the capacity of their organisation in order to make realistic commitments and to effectively communicate and negotiate action within the organisation to meet those commitments. For example, coalition members who speak from a management position for a large organisation or government agency may commit their staff to implementing strategies in a prevention plan. But for this to work they need to communicate the purpose of the coalition and the extent of the commitment back through their own organisation. This will open up discussions around collaboration and the impact it may have on the organisation. How does the

organisation commit to a coalition in the long term or at a structural level? How are staff being informed about or actively involved in the coalition? And how is their active involvement being acknowledged in their overall duties? These are key questions that managers need to consider in "bringing their staff with them" to achieve collaboration.

To sum up: the work of a prevention planning coalition is to first establish the grounds for collaboration by bringing together different stakeholders from across the community to make a combined effort in addressing local issues. Then, hopefully, the individuals within the coalition would take the work of the coalition back to their own sphere of influence, to broaden awareness of its work, to facilitate ongoing participation, and, eventually, to prepare for the implementation of a community prevention plan.

Table 10

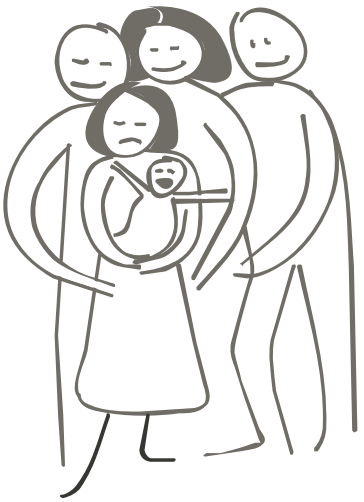
Levels of collaboration

Building	Process	Purpose
Low	Networking	– To exchange information for mutual benefit – Requires little time and trust between partners – Clearinghouse for information
	Coordination	– Exchange information and alter activities for a common purpose – Match and coordinate needs and activities – Limit duplication of services
	Cooperation	– As above plus sharing of resources – Requires a significant amount of time and high level of trust between partners
High	Collaboration	– (In addition to the other activities described) – Enhance the capacity of the other partners for mutual benefit and a common purpose – Build interdependent systems to address issues and opportunities – Share resources and make equal commitment

Adapted from 'The partnership analysis tool' (VicHealth, p.3)

What next?

We hope this workbook has indicated the promise that community-based prevention holds for improving the lives of people in your community. In our experience working to encourage community prevention is both challenging and enormously rewarding. We hope that the ideas presented above will be resourceful for your efforts in generating local interest and planning for your community's prevention. Additional workbooks and resources are available through Communities That Care to aid interested communities to form sustainable prevention coalitions and to deliver and monitor effective prevention strategies.



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Appendix 1:

Harm minimisation: underpins the Australian National Drug Strategy. It consists of implementing three types of strategies: reducing the supply of alcohol and other drugs, reducing the demand for licit and illicit substances, and reducing the harm caused to individuals and communities (Loxley et al 2004, p 3).

Primary, secondary and tertiary prevention: distinguishes the different populations (Loxley et al 2004, p 6). Primary prevention is directed at populations who do not currently experience problems with substance use and seek to reduce uptake of harmful patterns of use; secondary prevention is directed at populations where uptake has occurred and interventions have been enacted to prevent further progression to harmful use; and tertiary prevention and treatment is directed at populations where use has become entrenched and where prevention activities with these individuals seek to limit further harm.

Universal, selected and indicated prevention: describes different levels of prevention activity on the basis of influencing (risk) factors (Loxley et al 2004, p 6). Universal prevention aims to reduce risk factors across the whole population (e.g., by using TV advertising to discourage drink-driving); selective intervention targets those at above-average risk (e.g., encouraging pregnant women to avoid alcohol use); and indicated prevention is aimed at those who already have early signs of substance use problems (e.g., encouraging patients with early signs of liver disease to reduce alcohol consumption).

Developmental pathways prevention approach: is one aspect of the risk-focussed approach to prevention and involves the use of information from studies of the life course. This approach analyses how underlying factors in individuals' lives during childhood and adolescence may contribute to an increased risk of developing alcohol and other drug problems later in life (Loxley et al 2004, p 6). It also attempts to identify factors that can protect healthy development in populations with high levels of risk. The developmental approach to prevention is particularly relevant in areas where there are high proportions of children and young people.

Definitions in alcohol and drug health promotion

The systems and social determinants frameworks: considers how economic, structural, cultural and environmental factors impact on developmental pathways. These frameworks encourage a broad view of how local conditions integrate with national and international factors to influence differences in patterns of substance use and harm (Loxley et al 2004, p 12). For example, the developmental pathways of young Indigenous Australians can be affected by the social and cultural consequences of colonisation, such as high unemployment and less educational opportunity, all of which combine to impact on the health inequalities experienced by many Indigenous Australians.

Health promotion: is defined in the 1986 Ottawa Charter (http://www.ldb.org/iuhpe/ottawa.htm) as the "process of enabling people to increase control over, and to improve, their health. It defines health promotion action as having five important components: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These actions need to be integrated in a planning process and then enacted. The Jakarta Declaration on Health Promotion (World Health Organisation 1997; http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf) reinforced the Ottawa Charter and called for five new areas of action to strengthen health: promoting social responsibility for health, increasing investment to address health and social inequities, consolidating and expanding partnerships for health, strengthening communities and increasing community capacity to empower individuals, and securing infrastructure for health promotion.

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