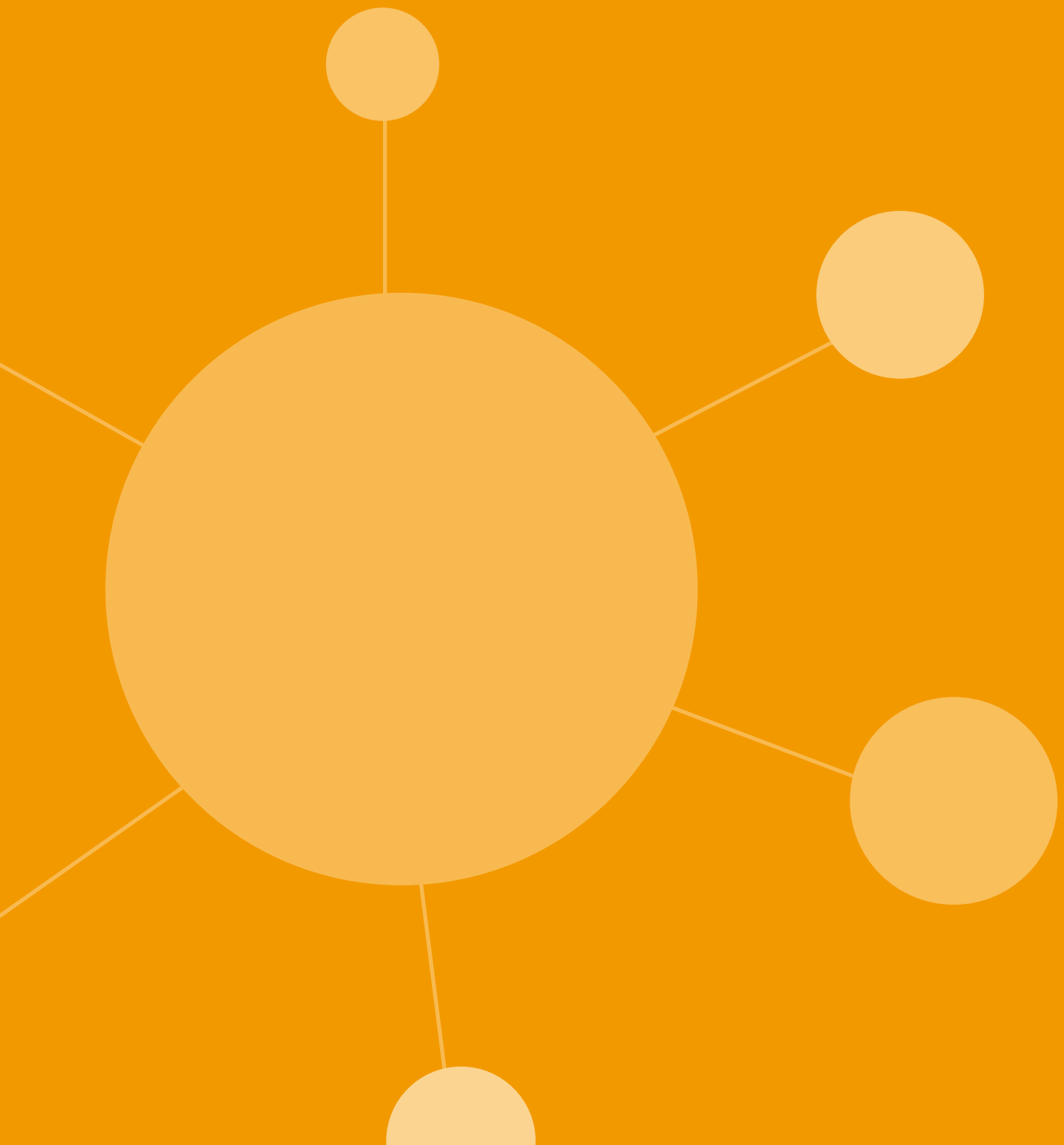
INTRODUCING

Communities That Care®

Helping communities build better futures for children and young people



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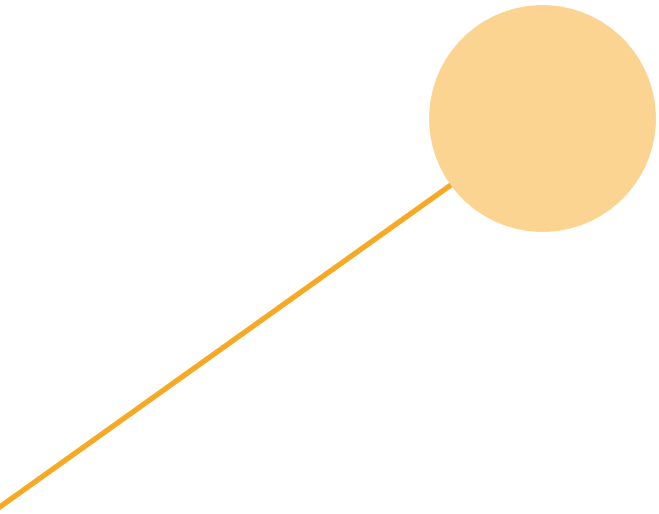

INTRODUCING

Communities That Care®

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Preface

Originating in the United States of America, the *Communities That Care®(CTC)* process has been adapted for use in Australia by *Communities That Care® Ltd. (Australia)*. *Communities That Care® Ltd.* is the sole licensed provider of the *CTC* process in Australia. It is a non-profit company set up under a joint initiative of the Women's and Children's Health Network, and the Rotary Club of Melbourne. Since 2000 the work of *CTC Ltd.* in Australia has been financially supported by the Rotary Club of Melbourne, the Victorian Health Promotion Foundation (Vic Health), and a number of philanthropic organisations.

Communities That Care® was developed in the USA by Professor J David Hawkins and Professor Richard F Catalano, at the University of Washington, Seattle. In America, *CTC*, provided by the Prevention Science Group of Channing Bete Company, has been implemented in over 500 communities. The experience of *CTC* in America has resulted in increased local investment in prevention, and the improved understanding of prevention. *Communities That Care®* is now operating in the United Kingdom, the Netherlands and Australia.

Since 2000 three communities have implemented *Communities That Care® Ltd.* pilots in Australia – Bunbury (Western Australia), Mornington Peninsula and Ballarat (both in Victoria). The Centre for Adolescent Health has supported the early establishment stages of the *CTC* implementation process in these communities. Planning is underway to involve a number of new communities throughout Australia.

The Australian work of *Communities That Care® Ltd.* is directed by the *Communities That Care® Ltd.* Board, with membership from both the Rotary Club of Melbourne and the Women's & Children's Health Network.

Communities That Care® in your community: An Overview

CTC vision

To promote the healthy development of children and young people, and to prevent health and social problems by addressing the factors that increase the likelihood of positive development and decrease the likelihood of adverse outcomes for children and young people.

Guiding principles

CTC:

- is based on rigorous research from fields including public health, sociology, psychology, education, criminology, medicine and organisational development
- is informed by a social development model
- is adaptable to the needs of different and distinct communities
- engages all areas of the community
- empowers communities to build prevention capacity.

Implementation process

Facilitate the way a community promotes the healthy development of children and young people.

Identify and address priority areas to promote healthy development before young people become involved in problem behaviours.

Enable communities to use their unique data-based profile to craft a comprehensive, long-range plan for strengthening existing resources and filling identified gaps to promote healthy development of children and young people.

Outcome

Healthy development of children and young people.

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Introduction

Communities That Care® (CTC) is the application, in communities, of research-based prevention science for the healthy development of children and young people. This is achieved by bringing together a diverse range of people, programs and initiatives to promote the community-wide *CTC* process. The *CTC* process is a long-term, comprehensive, risk and protective-focussed prevention strategy based on research of predictors of health and behaviour problems. By using an early intervention and prevention framework, communities are guided towards understanding their local, identified needs, then refining, and/or developing and implementing tested, effective strategies to address those needs. In particular, in the Australian context, the *CTC* process provides an integrated approach to the prevention of problem behaviours, including harmful substance use, low academic achievement, early school leaving, sexual risk-taking, and violence.

In the early phase of implementing the *CTC* process, key community leaders are identified. Key Leaders are those in the community who hold existing recognised positions of responsibility and influence in individual communities. These people are those who know the community well and are able to influence policy and organisational change, are in a position to develop community collaborations, and are able to direct resources. Key Leaders are responsible for initiating community engagement that involves all sectors of the community in the strategy.

A Community Board is then established, comprising a group of interested members of the community, who work with the Key Leaders to analyse the unique needs of the community, and to plan and implement tested, effective programs to foster the healthy development of children and young people. In concert with the Key Leaders, the Community Board is a decision-making body representing a range of organisations, community members and young people. Its members come from a diversity of backgrounds and interests, have a commitment to fostering healthy development for children and young people, and, importantly, have a capacity to be involved. The training and support provided by *CTC* Ltd. guides the Community Board towards determining local needs, and implementing appropriate evaluated intervention strategies that lead to safer, more supportive communities for children and young people.

In the planning and implementation process undertaken by your community, *Communities That Care® Ltd.* will provide:

- a five-phase process of stages and steps
- strategic consultation
- training
- technical assistance
- administration, analysis and reporting of the *CTC* Young People's Health and Wellbeing Survey*
- a Prevention Strategies Guide.

* The survey is used as a data-measuring tool to provide community specific data on young people's involvement in health compromising behaviours, and the prevalence of risk and protective factors that predict these behaviours. It is recommended that the Young People's Health and Wellbeing Survey be completed every 2-3 years to chart progress of outcomes targeted during the *CTC* planning and implementation process. Doing so enables the Community Board to monitor effectiveness of policies, programs and practices implemented, and to determine necessary new initiatives.

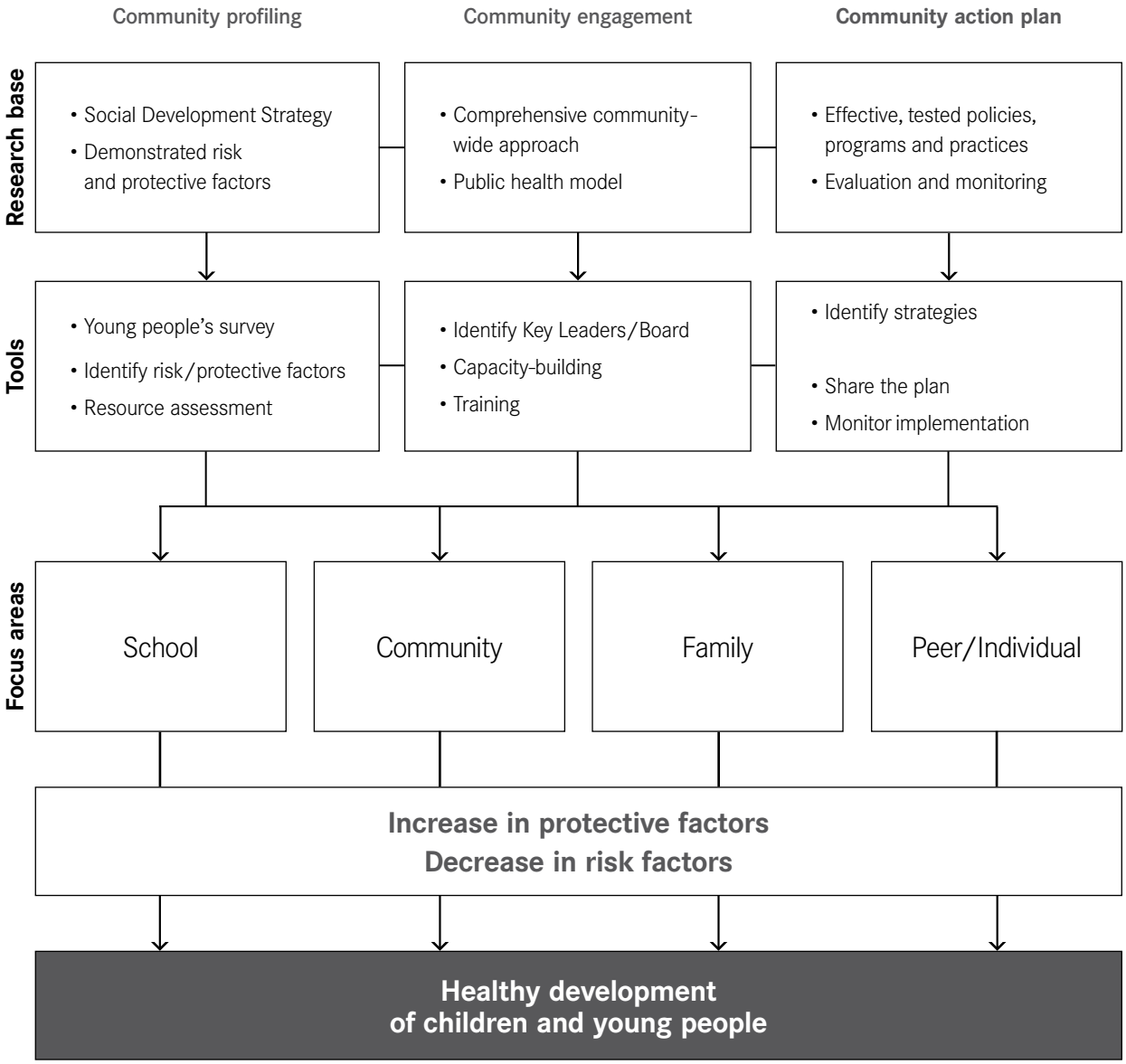
How to use this material

This material is designed to provide an introduction to the *Communities That Care® Ltd.* process. It provides communities with the background information necessary for a preliminary understanding of the process that enables the initiation of healthy development and local prevention planning for children and young people. *Introducing Communities That Care®* is followed by *Communities That Care®: Guidelines for Implementation* that provides technical guidance through the phases, stages and steps of implementation.

A key goal of *Communities That Care® Ltd.* is to remain current with prevention science in order to keep communities at the cutting edge. Materials are regularly revised to incorporate new research findings, particularly in areas such as risk and protective factors, and evaluation of prevention programs.

The *Communities That Care*® Conceptual Framework

This framework provides an overview of the *Communities That Care*® process.



Background and Rationale

What is the role of *Communities That Care*®?

CTC helps communities to:

- engage all members of the community who have a stake in healthy futures for children and young people, including elected Key Leaders, children, young people, local government, parents, law enforcement, local youth and family services and organisations, schools, recreation providers, the religious, cultural and spiritual community, health, mental health, social services, the business community, and residents,
- establish a shared vision, a common language, and a collaborative planning structure to integrate diverse community efforts addressing issues facing children, young people and families,
- establish priorities for action based on an evidence-based profile of community strengths and challenges,
- define clear and measurable outcomes that can be tracked over time to show progress and ensure accountability,
- identify gaps in the current response to priorities
- select tested, effective policies, programs and practices that have demonstrated effectiveness to fill identified gaps,
- evaluate progress towards desired outcomes.

Research foundation

One of the hallmarks of the *CTC* framework is its grounding in rigorous research from a variety of disciplines. There are four primary areas of research that form the foundation of *CTC*:

- The Social Development Strategy
- A comprehensive, community-wide approach
- Data-based predictors of risk and protective factors
- Effective, tested policies, programs and practices.

1. The Social Development Strategy

The Social Development Strategy is the research framework that guides communities towards their vision of positive futures for children and young people. Based on research that has identified protective factors that can buffer children and young people from risks, and promote their healthy development, the framework has a goal of *healthy, positive behaviours* for children and young people. Further, research indicates that the development of healthy behaviours in young people occurs when they are immersed in environments that support:

- consistent communication of *healthy beliefs and clear standards* for behaviours. *CTC* engages all community members in a dialogue about core beliefs that help children and young people develop into healthy, productive citizens who avoid adverse behaviours. *CTC* aims to infuse those beliefs into every aspect of a young person's life.
- the development of strong *bonds* to their families, schools, communities and peer groups. Children become more invested in following the beliefs and standards held by these groups. Research shows a child living in a high-risk environment can be protected from adverse behaviour by a strong, affectionate relationship with an adult, who cares about, and is committed to his/her healthy development. The adult can be a parent, a teacher, an extended family member, a coach, an employer, or an adult from the child's religious or spiritual community – any caring adult. The most critical aspect of this relationship is that the child or young person has a long-term investment in the relationship, and believes that the relationship is worth protecting. This investment motivates them to abide by the healthy beliefs and clear standards held by these important adults in their lives.

These bonds are created by providing *opportunities* for young people to be involved in meaningful ways, *skills* for successful involvement, and *recognition* for their involvement.

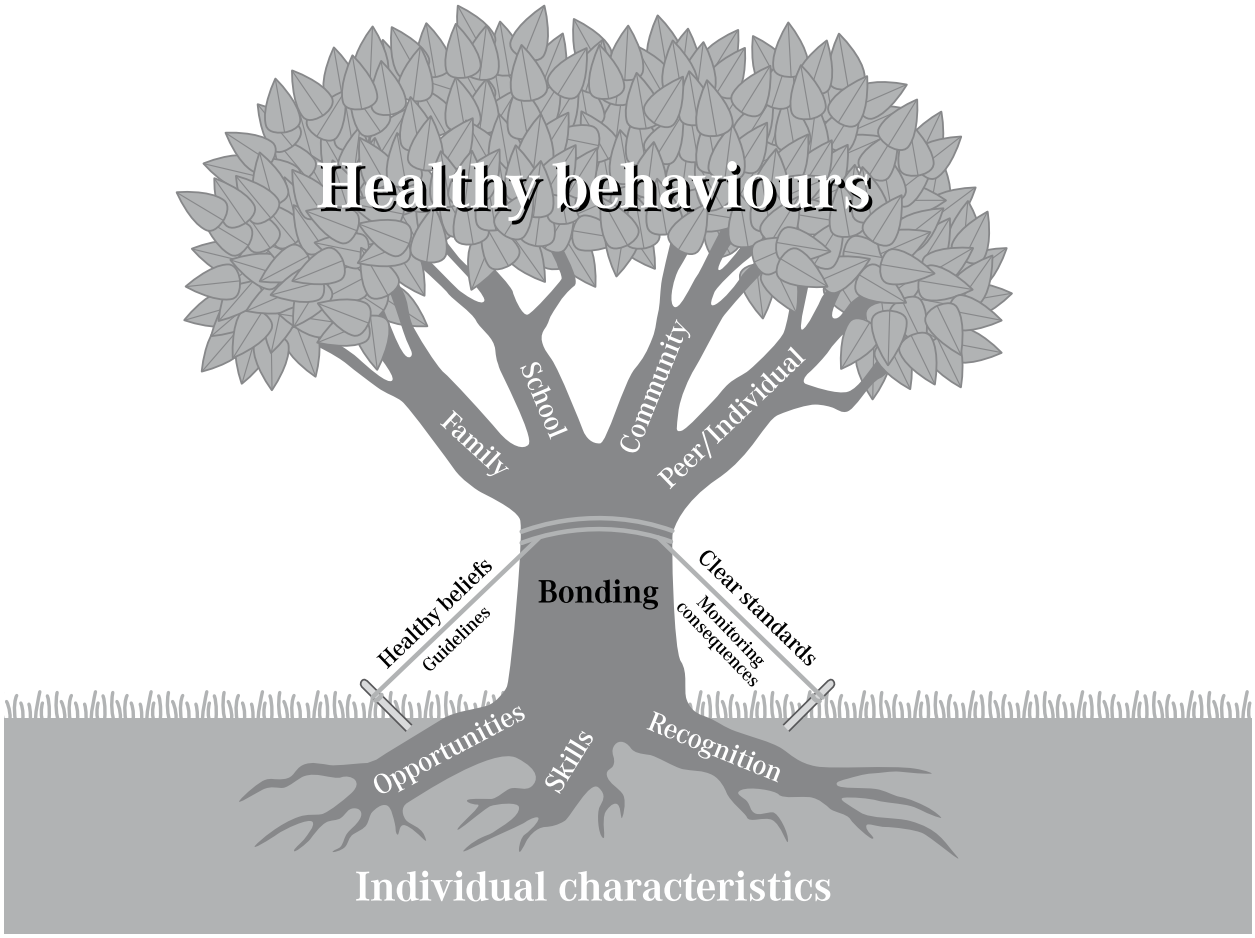
Strong bonds are built when children and young people have opportunities to be involved in their families, schools, communities and peer groups, to make a real contribution, and to feel valued for it. In order for children and young people to take advantage of the opportunities provided for them in their families, schools, communities and peer groups, they need to be equipped with the skills that create success in that involvement. These skills are social skills, cognitive skills, emotional skills, and behavioural skills. Recognising children and young people's involvement encourages them to contribute in meaningful ways, and assists them to accept productive feedback when necessary.

Recognising *individual characteristics*, and acknowledging that each child and young person presents with a different set of skills and abilities, is important in promoting their positive development. It is important for adults connected with children and young people, such as community members, and health development and prevention program personnel, to be aware of the range of skills and abilities of children and young people, and to respond accordingly. For children born without the protective advantages of a positive social orientation, without coping skills and without learning capacity, we need to have the strategies in place to provide opportunities for involvement. All children and young people need access to social, emotional, and cognitive competency, and recognition for their efforts, as well as their successes.

The Social Development Strategy below can be used as a framework for strengthening a range of areas in the community. These might include:

- Individual relationships established between adults and children and young people. These serve as healthy role models and provide opportunities and recognition for prosocial involvement.
- Youth-servicing organisations and programs. These can provide young people with opportunities for *bonding* and to interact with adults and prosocial peers, skills to take part successfully in those opportunities, and recognition for their involvement.

Social Development Strategy



Adapted (2003) from *Communities That Care*® (US) *Social Development Strategy,* 1998 with permission from Channing Bete Company, Inc.

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- Links between different sections of the community. This is as diverse as the family environment, shopping areas, private and public sector organisations, fitness and leisure facilities, parks and gardens, community police, law and policy.

2. A comprehensive community-wide approach

Why use a public health approach?
Engaging all segments of the community in preventive campaigns to educate and promote behaviour change is, today, an accepted approach in the field of public health. This approach is supported by research that has documented the effectiveness of a *community-wide* approach to public health issues. Health issues such as heart disease, breast cancer, and alcohol-affected driving have successfully been addressed in this way. Prevention of heart disease, for example, has been approached on many fronts: supermarkets and restaurants offer 'low-fat, heart-healthy' foods; buildings, restaurants, and workplaces are smoke-free; gyms, jogging tracks, and aerobic classes are more available and more popular; television publicity campaigns promote healthy living; and schools include health in curricula.

This comprehensive approach, adopted to multi-illness prevention, has proven successful in altering attitudes and behaviour where other methods have produced limited results. We can apply this same strategy to problem behaviours in children and young people.

What does research tell us?
Research tells us that a community-wide approach is effective because it:

- affects the entire social environment. The focus is on influencing norms, values and policies that promote a safe and healthy community, as well as changing the conditions that place children at risk for adolescent health and behaviour problems.
- develops a broad base of support and teamwork. By involving all parts of the community, everyone will have a role to play; no single organisation, strategy, person or institution bears the burden of responsibility to address the challenges alone.
- brings results that are long lasting. Programs and strategies are integrated into the services and activities of existing organisations and institutions. This institutionalises positive health development and prevention for children and young people, and minimises the impact of changes in funding streams.

Why does the *Communities That Care*® process work?
The *CTC* process recognises that no single entity can ensure healthy development for all of a community's young people, therefore it engages key stakeholders to address a variety of health development issues with multiple strategies in all the areas of children's and young people's lives, and engages all areas of the community in promoting their healthy development.

3. Evidence-based predictors of risk and protective factors

What are risk and protective factors?
Risk factors are those elements in a young person's environment that increase the likelihood of engaging in health compromising behaviours. They exist in all domains of social development – community, family, school and peer/individual. Risk factors used in *CTC* must have been shown, in multiple longitudinal studies, to be reliable predictors of one or more of the five adolescent health and behaviour problems. Identifiable throughout the developmental continuum, risk factors are consistent in effects across races and cultures. *CTC* provides tools for measuring levels of risk factors in communities, selecting priority risk factors on which a strategic plan can be focussed. Progress is then tracked towards desired changes in those priority risk factors

Protective factors are factors which, when present in a young person's developmental environment, provide a buffer between them and the development of health compromising behaviours. They either reduce the impact of the risk, or change the way the child or young person responds to it. Protective factors, as defined by *CTC*, derive from a research base; occur in all areas of social development – community, family, school and peer/individual; are measurable; predictive of healthy development; reduce the effects of exposure to risks; and can be influenced in both formal and informal contexts.

Why identify risk and protective factors?
Identifying evidence-based predictors of risk and protective factors builds on the successful public health approach to preventing heart and lung disease. For example, a high-fat diet is a *risk factor* that increases the chances of a heart

attack. Regular exercise is a *protective factor* against the risk of having a heart attack. By focussing prevention initiatives on risk and protective factors, public health campaigns are succeeding in reducing the rate of premature deaths from heart failure.

The success of this approach can be measured by the ability of Australians of all ages to identify many of the risk factors for heart disease: high-fat diet, high blood pressure, obesity, and family history. In following that model, *Communities That Care®* aims to create awareness of the risk and protective factors of healthy development, and to improve the future for children and young people by strengthening social behaviour in the four domains of:

- **Community**
- **Family**
- **School**
- **Peer/Individual.**

Research shows there are influential risk factors in children's and young people's lives that increase the chances they will develop health and behaviour problems, as they grow older. Table 1, *Risk factors and associated problem behaviours,* below, based on longitudinal studies conducted internationally, shows the association between risk factors and problem behaviours. **25 risk factors** have been included as reliable predictors of substance abuse, delinquency, teen pregnancy, school drop-out and violence. Equally important, **10 protective factors** (*Communities That Care® Ltd. Australia* identifies 9) have been included as predictors that help to shield young people from problems in circumstances that would otherwise place them at risk. Table 2 below, *Which risk and protective factors are linked with which problem behaviours?* demonstrates the associations between risk and protective factors and two areas of adolescent problem behaviour. The table summarises findings from overseas longitudinal studies. (DHS 2000, *Improving the Lives of Young Victorians in our Community,* p.8.)

A summary of research findings on risk and protective factors

Understanding and identifying risk and protective factors can help communities understand what they can do to prevent problem behaviours and adverse health outcomes. The following generalisations may be made about risk and protective factors:

- Risk and protective factors exist in many domains. Community efforts can focus on reducing risk factors and enhancing protective factors in all domains of a child's and young person's life: community, family, school, and peer/individual.
- The more risk factors present, the greater the risk and the greater the likelihood of health and social problems.
- Protective factors buffer exposure to risk. Enhancing protective factors allows the promotion of positive health development, while methodically tackling risk reduction.
- Diverse behaviour problems have common risk and protective factors. Risk and protective factors are predictive of a number of problem behaviours, including harmful substance use, antisocial behaviour, sexual risk-taking, school disengagement and violence, as well as positive behaviours, including academic achievement and social and emotional competence.
- Risk and protective factors show consistency in their effects across different races and cultures. While levels of risk and protection may vary in different racial or cultural groups, the way in which these risk and protective factors work appears to be similar.

Table 1: Risk factors and associated problem behaviours

Risk factors	Adolescent problem behaviours				
	Substance abuse	Delinquency	Teen pregnancy	School drop-out	Violence
Community					
Availability of drugs	✓				✓
Availability of firearms		✓			✓
Community laws and norms favourable toward drug use, firearms, and crime	✓	✓			✓
Media portrayals of violence					✓
Transitions and mobility	✓	✓		✓	
Low neighbourhood attachment and community disorganisation	✓	✓			✓
Extreme economic deprivation	✓	✓	✓	✓	✓
Family					
Family history of the problem behaviour	✓	✓	✓	✓	✓
Family management problems	✓	✓	✓	✓	✓
Family conflict	✓	✓	✓	✓	✓
Favourable parental attitudes and involvement in the problem behaviour	✓	✓			✓
School					
Early and persistent antisocial behaviour	✓	✓	✓	✓	✓
Academic failure beginning in late elementary school	✓	✓	✓	✓	✓
Lack of commitment to school	✓	✓	✓	✓	✓
Individual/Peer					
Alienation and rebelliousness	✓	✓		✓	
Friends who engage in the problem behaviour	✓	✓	✓	✓	✓
Favourable attitudes towards the problem behaviour	✓	✓	✓	✓	
Early initiation of the problem behaviour	✓	✓	✓	✓	✓
Constitutional factors	✓	✓			✓

This table is based on longitudinal studies conducted internationally, and shows the association between risk factors and problem behaviours. *Communities That Care*® is based on this material.

© Developmental Research and Programs 1998

Table 2: Which risk and protective factors are linked with which problem behaviours?

Link between risk factors and problem behaviours

Risk and protective factors	Drug abuse	Delinquency/crime
Community		
Low neighbourhood attachment	✓	✓
Community disorganisation	✓	✓
Personal transitions & mobility	✓	✓
Community transitions & mobility	✓	✓
Laws & norms favourable to drug use	✓	
Perceived availability of drugs	✓	
◆ Opportunities for prosocial involvement	✓	✓
◆ Rewards for prosocial involvement	✓	✓
Family		
Poor family management	✓	✓
Poor discipline	✓	✓
Family conflict	✓	✓
Family history of antisocial behaviour		✓
Parental attitudes favourable to drug use	✓	
Parental attitudes favourable to antisocial behaviour	✓	✓
◆ Attachment	✓	✓
◆ Opportunities for prosocial involvement	✓	✓
◆ Rewards for prosocial involvement	✓	✓
School		
Academic failure	✓	✓
Low commitment to school	✓	✓
◆ Opportunities for prosocial involvement	✓	✓
◆ Rewards for prosocial involvement	✓	✓
Peer/Individual		
Rebelliousness	✓	✓
Early initiation of problem behaviour	✓	✓
Impulsiveness	✓	✓
Antisocial behaviour	✓	✓
Favourable attitudes towards antisocial behaviour		✓
Favourable attitudes towards drug use	✓	
Perceived risks of drug use	✓	
Interaction with antisocial peers	✓	✓
Friends' use of drugs	✓	✓
Sensation seeking	✓	✓
Rewards for antisocial involvement		✓
◆ Religiosity	✓	✓
◆ Social skills	✓	✓
◆ Belief in the moral order	✓	✓

◆ = protective factors (Sourced from DHS 2000, *Improving the Lives of Young Victorians in Our Community*)

This table summarises findings from overseas longitudinal studies. It shows how risk and protective factors increase or decrease the probability that a young person will face problems. For example, it shows that a history of family conflict or low neighbourhood attachment predict drug use, delinquency or crime. A protective factor reduces the likelihood of these problems, even when there is exposure to the risk factors.

This material has been adapted from J.C. Howell, B. Krisberg, J.D. Hawkins and J.J. Wilson. (1995) (eds.) *A Sourcebook: Serious, Violent, & Chronic Juvenile Offenders.* SAGE: International (p. 25).

Descriptions of risk and protective factors

The following charts have been designed to provide descriptions of *Communities That Care*® Risk and Protective factors within the four domains of community, family, school, and peer/individual. The left-hand column lists the risk and protective factors under each domain, while the right-hand column describes the factors, and provides an example of one of the questions/ response prompts used in the measurement scales in the Young People's Health and Wellbeing Survey used by communities to survey their young people. (It should be noted that the detail below is subject to change, based on a review of risk and protective factors.)

Risk factors	Descriptions and examples
Community domain	
Low neighbourhood attachment	Neighbourhoods where residents report low levels of bonding to the neighbourhood have higher rates of juvenile crime, violence and drug use. Example: *People move in and out of my neighbourhood a lot.*
Community disorganisation	Neighbourhoods with high population density, lack of natural surveillance of public places, physical deterioration, and high rates of adult crime, have higher rates of juvenile crime, violence and drug use. Example: *There is lots of graffiti in my neighbourhood.*
Personal transitions and mobility	Young people without stability and strong personal relationships are more likely to use drugs and become involved in antisocial behaviours. Example: *Have you changed schools in the past year?*
Community transitions and mobility	Young people who feel their community is not stable, and that it is not easy to establish lasting personal relationships, are more likely to use drugs and become involved in antisocial behaviours. Example: *People move in and out of my neighbourhood a lot.*
Community laws and norms favourable to substance use	Communities where laws regulating alcohol and other drug use are poorly enforced have higher rates of youth alcohol and drug use, violence, and crime. Further, rates of youth alcohol, harmful substance use and violence are higher in communities where adults believe it is normative or acceptable for minors to use alcohol or other drugs. Example: *Have you known any adults personally, who in the past year have: sold or dealt drugs, done other things that could get them into trouble with the police?*
Perceived availability of drugs	The availability of cigarettes, alcohol, marijuana, and other illegal drugs is related to a higher risk of harmful substance use and violence among adolescents. Example: *How easy would it be for you to get any of the following: cigarettes, marijuana?*

Family domain	
Poor family management	Parents' use of inconsistent and/or unusually harsh or severe punishment with their children places the children at higher risk for substance use and other problem behaviours. Parents' failure to provide clear expectations and to monitor their children's behaviour makes it more likely that they will engage in drug use and other problem behaviours. Example: *My parents would know if I didn't come home on time.*
Poor family discipline	Parents' failure to provide clear expectations, and to monitor their children's behaviour makes it more likely that they will engage in harmful substance use and other problem behaviours. Example: *If you wagged school, would you be caught by your parents?*
Family conflict	Children raised in families high in conflict are at risk for violence, crime, leaving school early, teenage pregnancy, and harmful substance use. Example: *People in my family often insult or yell at each other.*
Family history of antisocial behaviour	Children from families with a history of problem behaviours (e.g. crime, harmful substance use and violence) are more likely to engage in these behaviours. Example: *Has anyone in your family ever had a severe alcohol or drug problem?*
Parental attitudes favourable towards drug use	In families where parents are tolerant of their children's alcohol or drug use, children are more likely to become problem drug users. The risk is further increased if parents involve children in their own drug or alcohol using behaviour, e.g. by asking a child to light the parent's cigarette, or to bring the parent a beer from the refrigerator. Example: *How wrong do you think your parents feel it would be for you to: drink beer, alcoholic soda or wine regularly?*
Parental attitudes favourable towards antisocial behaviour	In families where parents are tolerant of their children's problem behaviours, including violent or antisocial behaviour, children are more likely to become involved in crime and violence during adolescence. Example: *How wrong do your parents feel it would be to: steal anything worth more than $10?*
School domain	
Academic failure (Low academic achievement)	Beginning in late primary (Years 4 - 6), children who fall behind academically for any reason, are at greater risk for harmful drug use, leaving school early, teenage pregnancy, violence and crime. Example: *Putting them all together, what were your marks like last year?*
Low commitment to school (Low engagement with school)	Factors such as not liking school, spending little time on homework, and perceiving coursework as irrelevant, are predictive of harmful substance use, violence, crime, and leaving school early. Example: *How important do you think the things you are learning in school are going to be for your later life?*

Peer/Individual domain	
Rebelliousness	Young people who do not have a sense of belonging to society, are a peer group, and see no purpose in rules, are at a higher risk for antisocial behaviours, including substance use. Example: *I like to see how much I can get away with.*
Early initiation of problem behaviour	Children who exhibit aggressive and antisocial behaviour in their early years, are at increased risk for violence, early school leaving, and drug use later in life. Example: *Have you ever been suspended from school, or carried a weapon? If so, how old were you when you first did?*
Antisocial behaviour	Young people who display antisocial behaviour are at increased risk of harmful substance use and becoming involved in crime. Example: *In the past year (12 months) have you: attacked someone with the idea of seriously hurting them?*
Favourable attitudes towards antisocial behaviour	Young people who accept or condone antisocial behaviour are more likely to engage in a variety of problem behaviours. Example: *How wrong do you think it is for someone your age to: stay away from school all day when their parents think they are at school?*
Favourable attitudes towards drug use	Young people who express positive attitudes towards drug use are at higher risk for subsequent harmful substance use. Example: *How wrong do you think it is for someone your age to: use ecstasy, LSD, speed or another illegal drug.*
Perceived risks of drug use	Young people who do not perceive drug use to be risky are more likely to engage in drug use. Example: *How much do you think people risk harming themselves (physically or in other ways) if they: have one or two alcoholic drinks every day.*
Interaction with antisocial peers	Young people who interact with other young people who display antisocial behaviour are at increased risk of harmful substance use and becoming involved in crime. Example: *Think of your four best friends (the friends you feel closest to. In the past year (12 months), have any of your best friends: stolen, or tried to steal a car or a motorbike?*
Friends' use of drugs	Young people who associate with peers who are engaging in alcohol or harmful substance use are much more likely to engage in the same behaviour. Example: *In the past year (12 months), have any of your best friends: tried beer, wine, alcoholic soda or spirits when their parents didn't know about it.*
Sensation seeking	Young people who seek out opportunities for dangerous, risky behaviour in general, are at higher risk for engaging in harmful substance use and other problem behaviours. Example: *Done 'crazy' things, even if they are a little dangerous.*
Rewards for antisocial involvement	Young people who see antisocial behaviour as rewarding, and having few costs, are at higher risk for engaging in antisocial behaviour. Example: *What are the chances you would be seen as cool if you: carried a weapon?*
Gang involvement	Young people who belong to gangs are more likely to engage in violence and crime. Example: *Have you ever belonged to a gang?*

Protective factors	Descriptions and examples
Community domain	
Opportunities for prosocial involvement	When opportunities for positive participation are available in a community, children are more likely to become bonded to the community. Example: *Which of the following activities for people your age are available in your community? Sports teams; Scouts/Guides*
Rewards for prosocial involvement	Rewards for positive participation in community activities, helps children bond to the community, thus lowering their risk for problem behaviours. Example: *There are people in my neighbourhood who are proud of me when I do something well.*
Family domain	
Family attachment	Young people who feel strongly bonded to their family are less likely to engage in substance use and other problem behaviours. Example: *Do you feel very close to your mother?*
Opportunities for prosocial involvement	Young people who have more opportunities to participate meaningfully in the responsibilities and activities of the family, are more likely to develop strong bonds to the family. Example: *My parents ask me what I think before most family decisions affecting me are made.*
Rewards for prosocial involvement	When parents, siblings, and other family members praise, encourage and reward things done well by their child, children are more likely to develop strong bonds to the family. Example: *How often do your parents tell you they're proud of you for something you've done.*
School domain	
Opportunities for prosocial involvement	When young people are given more opportunities to participate meaningfully in the classroom and school, they are more likely to develop strong bonds of attachment and commitment to school. Example: *In my school, students have lots of chances to help decide things like class activities and rules.*
Rewards for prosocial involvement	When young people are rewarded for their contributions, efforts, and progress in school, they are more likely to develop strong bonds of attachment and commitment to school. Example: *My teachers notice when I am doing something well, and let me know.*
Peer/Individual domain	
Social skills	Young people who are socially competent are less likely to use drugs and engage in other problem behaviours. Example: *You are at a party at someone's house, and one of your friends offers you a drink containing alcohol. What would you say or do?*
Belief in the moral order	Young people who have a belief in what is 'right' or 'wrong' are less likely to use drugs or engage in antisocial, or other problem behaviours. Example: *I think sometimes it's okay to cheat at school.*

4. Effective, Tested Policies, Programs and Practices

The final component of the research foundation for *Communities That Care*® is effective, tested policies, programs and practices. These are strategies that are culturally appropriate, feasible for wide-scale implementation, have been supported by evaluation, and are effective in reducing specific risk factors and enhancing protective factors. Extensive research reviews have identified policies, programs and practices in families, schools and communities that have shown significant effects on reducing risk factors and enhancing protective factors.

When undertaking a resource and gap assessment as part of the implementation of *Communities That Care*®, existing policies, programs and practices are assessed, and community specific risk and protective factors are identified, then prioritised. On the basis of this assessment, effective tested policies, programs and practices are introduced.

These tested approaches are compiled in *Communities That Care® Prevention Strategies: A Research Guide to What Works.* The Guide includes strategies drawn from across the developmental spectrum from before birth through adolescence and in all areas of young people's lives. Communities can use this guide as a resource for selecting programs for implementation. Programs in the Guide meet the criteria of having a strong research design (experimental or quasi-experimental) and demonstrated effect on risk or protective factors.

The Centre for Adolescent Health publication, *Improving the Lives of Young Victorians in Our Community: A Menu of Services* provides a range of evaluated intervention programs that can be used in the prevention of adolescent health and behaviour problems. It is available to Australian communities implementing the *Communities That Care*® intervention process. *Communities That Care® Comprehensive Community Planning Training* helps community teams match useful approaches to the unique risk and protective factor profile of their community. *Communities That Care® Prevention Strategies: A Research Guide to What Works,* developed by Developmental Research and Programs, Inc, USA categorises programs into the following focus areas:

Family focus
Prenatal/infancy
Marital and family therapy
Early childhood education
Parent training

School focus
Organisational change
Classroom organisation, management and instruction
Classroom curricula for social competence promotion
School behaviour management
Multi-component programs based in schools

Community-based youth focus
After-school recreation
Community-based youth involvement
Mentoring
Youth employment with education

Community focus
Community mobilisation
Community/school policies
Community policing strategies

Implementation

In the implementation of *Communities That Care®* it is important to be aware that the process involves more than a process of training. A range of tools is available to assist communities with the implementation of tested, effective programs that address a community's unique profile of risk and protective factors, and increase the probability of healthy development for children and young people. The tools include: a five-phase process of implementation, incorporating stages, which represent goals to achieve the phases, and steps which represent tasks to achieve the goals within the phases; strategic consultation provided through staff based at the Centre for Adolescent Health; training that incorporates six key training sessions strategically undertaken in the phases of the implementation process; the administration, analysis and reporting of the *Communities That Care® Young People's Health and Wellbeing Survey*; and a *Prevention Strategies Guide* that provides advice on programs available to address risk and protective factors.

(See *Communities That Care®: Guidelines for Implementation* for more detailed information on the phases, stages and steps of implementation.)

The five-phase process of implementation

Communities That Care® provides a five-phase process of stages and steps for implementation. The five phases, their associated stages, training and technical support are outlined below.

Phases	Stages	Training & Technical Support
Phase One: Establish *CTC*	• Create interest in the community • Define scope of planning for engaging the community • Identify community readiness issues	• *Communities That Care®: Guidelines for Implementation* • Strategic consultation
Phase Two: Organise *CTC*	• Key Leaders address readiness issues • Engage additional key community leaders • Raise awareness and engage the community • Create a Community Board	• *Communities That Care®: Guidelines for Implementation* • *Key Leader Orientation (KLO)* • *Community Board Orientation (CBO)* • Technical assistance
Phase Three: Develop a Community Profile	• Build the Community Board's capacity for community assessment and prioritisation • Collect and prepare community risk and protective factor assessment information • Prioritise risk and protective factors • Conduct a resource assessment	• *Communities That Care®: Guidelines for Implementation* • *Community Assessment Training (CAT)* • *Community Resources and Strengths Assessment Training (CRST)* • Technical assistance
Phase Four: Create a Comprehensive Plan	• Build the Community Board's capacity to create a comprehensive health development plan for children and young people • Identify strategies to address priorities • Share the comprehensive plan with the community	• *Communities That Care®: Guidelines for Implementation* • *Community Planning Training (CPT)* • Technical assistance
Phase Five: Implement and Evaluate the Plan	• Review the role of the Community Board • Monitor the implementation process • Conduct evaluation and refine strategies of health development plan • Share and celebrate implementation results • Ensure ongoing development and review	• *Communities That Care®: Guidelines for Implementation* • *Community Planning Implementation Training (CPIT)* • Technical assistance

What training is available?

Working from a common understanding of prevention, *Communities That Care® Ltd.* facilitates training in communities, and assists with the design and implementation of comprehensive local prevention strategies. Many communities already have a history of collaborative efforts and have engaged in much planning to address issues affecting the healthy development of children and young people, therefore community structures, data profiles, policies, programs and practices may already exist. *Communities That Care® Ltd.* staff assist communities to develop a unifying framework for integrating these community activities, and building new ones. Within the phases (see the chart above, 'Training and Technical Support') the following training, along with technical assistance, is available to guide communities through the implementation process.

Key Leader Orientation (KLO)

Community Board Orientation (CBO)

Community Assessment Training (CAT)

Community Resources and Strengths Assessment Training (CRST)

Community Planning Training (CPT)

Community Planning Implementation Training (CPIT)

How long does implementation take?

Experience working with communities indicates that the five phases of *Communities That Care® Ltd.* can be implemented in the timeline represented below. While the timeline implies distinct time periods for each phase, there may be considerable overlap and variance between the different phases. The period of time taken to undertake the *Communities That Care®* process will vary widely from community to community.

See table below.

CTC process timeline

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Establish *CTC*	■	■																
Organise *CTC*		■	■															
Develop a Community Profile			■	■	■	■	■											
Create a Comprehensive Plan							■	■	■									
Implement and Evaluate the Plan									■	■	■	■	■	■	■	■	■	■

Months

Communities That Care® Limited (Aust) is a long-term prevention program designed to promote healthy development of children and young people, and to prevent health and social problems by addressing the factors that increase the likelihood of positive development, and decrease the likelihood of adverse outcomes for children and young people.

CTC is flexible, adaptable to suit specific community environments, and brings together a diverse range of people, programs and initiatives to promote a community-wide process.

This introduction to *Communities That Care®* is suitable for individuals and communities wanting to know more about the *CTC* process.

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