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Implementation of the Communities That Care Prevention System by Coalitions in the Community Youth Development Study

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Abstract

While advances in prevention science over the past 2 decades have produced a growing list of tested and effective programs and policies for preventing adolescent delinquency and drug use, widespread dissemination and high-quality implementation of effective programs and policies in communities has not been achieved. The Community Youth Development Study (CYDS) is a randomized, community-level trial of the Communities That Care (CTC) system for promoting science-based prevention in communities. This paper compares 12 community prevention coalitions implementing the CTC system in 12 intervention communities as part of the CYDS to prevention coalitions located in the 12 control communities. As hypothesized, the CYDS coalitions implemented significantly more of the CTC core intervention elements, and also implemented significantly greater numbers of tested, effective prevention programs than the prevention coalitions in the control communities. Implications of the findings for efforts to achieve widespread dissemination of effective prevention programs, policies, and practices are discussed.

Keywords

Prevention; Substance use; Community coalitions

Preventing alcohol, tobacco, and other drug use; delinquency; violence; and related problem behavior among adolescents is a national priority (Centers for Disease Control and Prevention, 2004; The White House, 2002; U.S. Department of Health and Human Services, 2006). Advances in prevention science over the past 2 decades indicate that preventive interventions can effectively prevent adolescent problem behaviors and promote positive youth development (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004; Center for the Study and Prevention of Violence, 2006; Farrington & Welsh, 2006; National Institute on Drug Abuse, 2003; Weissberg, Kumpfer, & Seligman, 2003). Despite these advances in the development of effective prevention strategies, research indicates that tested and effective strategies have not been widely implemented in schools and communities (Ennett et al., 2003; Gottfredson & Gottfredson, 2002; Hallfors, Cho, Livert, & Kadushin, 2002). In a national study of middle schools,

Ringwalt et. al. (2002) found that, while 81.8% of schools were using a substance abuse prevention curriculum, only 26.8% were using 1 of 10 curricula that had been tested and shown to be effective. Methods for disseminating tested and effective prevention policies and programs widely are needed (Elliott & Mihalic, 2004; Farrington & Welsh, 2006; Wandersman, 2003).

Federal initiatives such as the Office of Drug Control Policy's Drug Free Communities program and the Center for Substance Abuse Prevention's Strategic Prevention Framework State Incentive Grants (SPF-SIG) have been launched to promote widespread dissemination of science-based prevention strategies in communities. These initiatives are based, in part, on research that indicates that a comprehensive approach to prevention designed to reduce risk factors while enhancing protective factors in communities is a promising approach for the prevention of adolescent problem behaviors and the promotion of positive youth development (Coie et al., 1993; Durlak, 1998; Hawkins, Catalano, & Arthur, 2002; Mrazek & Haggerty, 1994; Welsh & Farrington, 2006). These initiatives are intended to disseminate prevention research, encourage data-driven prevention planning, and mobilize community stakeholders to utilize tested, effective strategies to prevent adolescent drug use and related problems.

Community coalitions also have been advocated as a mechanism for mobilizing communities to engage in prevention and health promotion efforts because they can bring together diverse community stakeholders to address a shared goal (Butterfoss, Goodman, & Wandersman, 1993; Minkler, 1997; Wandersman & Florin, 2003). Activating a coalition of stakeholders could hold promise for coordinated, widespread change in preventive services across organizations and agencies in a community, including the dissemination of tested, effective strategies (Fixsen, Naoom, Blase, & Wallace, 2005). However, a number of reviews of coalition effectiveness have concluded that the funding and formation of community-based coalitions alone is not enough to improve health and behavior outcomes of young people (Berkowitz, 2001; Hallfors et al., 2002; Klerman, Santelli, & Klein, 2005; Merzel & D'Afflitti, 2003; Stevenson & Mitchell, 2003). The evaluation of the Robert Wood Johnson Foundation's Fighting Back Against Substance Abuse initiative found that none of the 12 funded coalitions achieved the desired outcome of reduced substance use. The evaluation suggested that to be effective, coalitions should have clearly defined, focused, and manageable goals, with corresponding high-quality data sources to monitor progress; coalitions should seek to encourage use of tested and effective programs, with careful attention to monitoring of implementation quality and fidelity; and coalitions should evaluate program impacts on outcomes which are meaningful to the community (Hallfors et al., 2002).

Communities That Care (CTC) is a coalition-based prevention system that activates community stakeholders to collaborate on the development and implementation of a science-based community prevention system. CTC addresses each of the suggestions listed above for improving community coalition outcomes (Feinberg, Greenberg, Osgood, Sartorius, & Bontempo, 2007; Hallfors et al., 2002). The CTC process provides a structure for engaging community stakeholders; a process for establishing a shared community vision regarding the healthy development of young people; data collection and reporting tools for assessing the prevalence of risk and protection, substance use, delinquency, and violence in communities; processes for prioritizing risk and protective factors for community action; and tools for matching prioritized risk and protective factors with tested and effective preventive interventions. CTC guides the coalition to create a strategic prevention plan designed to address the community's profile of risk and protection with tested, effective programs. CTC assists the coalition to implement selected interventions with fidelity, to monitor program implementation and impact, to re-evaluate periodically community levels of risk and

protective factors and outcomes, and to make needed adjustments in prevention programming as indicated by data (Hawkins et al., 2002). CTC is installed in communities through a series of six training events delivered over the course of 6 to 12 months by certified CTC trainers. The content of CTC has been fully codified in a set of manuals for trainers and community stakeholders (<http://preventionplatform.samhsa.gov>).

The community mobilization and training component of Communities That Care is described in greater detail in Hawkins, Catalano, et al. (2008), Hawkins et al. (2002), and Quinby et al. (2008), and incorporates five distinct phases: (1) assessing community readiness to implement the system; (2) getting organized and trained to use CTC; (3) conducting an assessment of community levels of risk, protection, and health and behavior outcomes; (4) creating a community action plan; and, (5) implementing the plan and monitoring and evaluating program implementation and outcomes. These five phases coincide closely with the five phases of the Center for Substance Abuse Prevention's Strategic Prevention Framework (i.e., Assessment, Capacity, Planning, Implementation, & Evaluation). Figure 1 shows how the CTC phases map onto the Strategic Prevention Framework. Each phase of CTC is accompanied by a set of specific milestones and benchmarks, defined actions that mark progress through installation of the CTC system.

Quasi-experimental evaluations of CTC have found evidence that the system helps communities to develop more effective prevention service systems and reduce adolescent health and behavior problems (Arthur, Ayers, Graham, & Hawkins, 2003; Feinberg et al., 2007; Harachi, Ayers, Hawkins, Catalano, & Cushing, 1996; Jenson, Hartman, Smith, Draayer, & Schurtz, 1997), but, prior to the Community Youth Development Study (CYDS), the CTC system had not been subjected to a randomized controlled trial. The CYDS is a randomized, controlled trial designed to assess the effects of installation and implementation of CTC on community prevention service systems and on levels of risk and protection and rates of drug use and delinquent behavior among students (Hawkins, Catalano et al., 2008; Murray, Van Horn, Hawkins, & Arthur, 2006). In order to evaluate the internal validity of the CYDS, it is important to assess the extent to which CTC was implemented with fidelity in the intervention communities during the trial, and also to document that CTC was not implemented in control communities due to potential contamination or diffusion of the CTC system. To date, assessments by university staff and community raters monitoring implementation of CTC in the intervention communities using the CTC Milestones and Benchmarks have indicated that the system was being implemented well in all intervention communities (Quinby et al., 2008), but no comparisons between intervention and control communities in the degree of use of prevention science by local coalitions have been made.

Given the emphasis on community mobilization and interagency collaboration in the CTC system (Hawkins & Catalano, 2003), it is possible that implementation of the CTC framework by the coalitions participating in the CYDS might influence other prevention coalitions in the intervention communities, such as those focusing on teen pregnancy or on early childhood development, to begin implementing aspects of the CTC system. Evidence of diffusion of a science-based approach to prevention to other coalitions in intervention communities would indicate an unintended benefit from CTC and could inform efforts to promote prevention systems transformation across focal issues.

This paper extends the assessment of CTC implementation in the intervention communities participating in the CYDS by comparing the activities of prevention coalitions in the intervention and control communities at baseline in 2002 and in 2007, 4 years after the start of the CYDS. The study has two aims:

1. To evaluate the extent to which the CYDS coalitions in the intervention communities implemented the CTC system to a significantly greater extent than

prevention coalitions in control communities. This would support the internal validity of study conclusions about CTC effects because it would indicate that CTC was well implemented through 4 years of the study when compared to coalition activities in control communities.

2. To assess the degree to which aspects of the CTC system have been diffused to other prevention coalitions in the intervention communities in the CYDS.

Method

Community Sample and Randomization

The CYDS is a study of 12 pairs of communities from the states of Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington matched with regard to size, poverty, diversity, and crime indices in an earlier study. These 12 pairs of matched communities (24 communities total) were recruited in the fall of 2002 to participate in the Community Youth Development Study (CYDS) and comprise the study's sample of communities. Each pair of eligible communities was randomized to intervention or control condition by a coin toss (see Hawkins, Catalano et al., 2008 for a detailed description).

CTC Implementation

The CTC intervention began in the summer of 2003. Randomly assigned intervention communities within each pair were instructed to identify an existing prevention coalition in their community or to form a new coalition to implement the CTC system. Ten communities chose to form a new coalition, while two communities identified an existing coalition to implement the CTC system. These 12 coalitions were trained to use the baseline student survey data collected in 1998, 2000, and 2002 in an earlier study (Hawkins, Catalano et al., 2008; Murray et al., 2006) to prioritize specific risk and protective factors for attention. In the CYDS, the CTC system was installed over a period ranging from 9 to 14 months and averaging 11 months across the 12 communities. By April of 2004, intervention communities had selected preventive interventions to address their prioritized risk factors and had created strategic community plans to implement these interventions. The selected policies and programs were offered in intervention communities beginning in the fall of 2004 and continuing through the spring of 2008.

The 12 communities randomized to the intervention condition in CYDS received annual contracts to hire a full-time project coordinator and to support initial implementation of tested preventive interventions selected by the communities in the 2nd through 5th years of the study. Control communities *did not receive training nor technical assistance* in methods for forming a successful community board, conducting a community risk and resource assessment, using epidemiological data to prioritize specific risk and protective factors for preventive intervention, or selecting and implementing tested, effective preventive interventions.

Coalition Leader Interviews

Telephone interviews with 43 prevention coalition leaders across the 24 communities participating in the CYDS were conducted in the winter and early spring of 2002 as part of the earlier study, prior to the start of the CTC intervention, and 62 prevention coalition leaders in the 24 communities were interviewed in the winter and early spring of 2007, after 4 years of CTC intervention. Coalition leaders in this study were defined as the chairs of the coalitions, and were identified using a snowball sampling approach through telephone interviews conducted with community leaders and directors of community agencies and organizations providing prevention services to youths and their families (see Figure 2).

Interviews with 10 positional (e.g., mayor, school superintendent, police chief) and five prevention community leaders were conducted in the fall of 2001, and again in 2004 and 2007, to assess aspects of each community's prevention services system (see Brown, Hawkins, Arthur, Abbott, & Van Horn, 2008; Brown, Hawkins, Arthur, Briney, & Abbott, 2007). In addition, interviews were conducted during the winter of 2001-2002, and again in 2004-2005 and 2006-2007, with the directors of agencies and organizations providing prevention programs to school-aged youths to document the use of tested, effective prevention programs in each participating community. In each of the 2001 interviews with community leaders, and all three waves of interviews with agency/organization leaders, respondents were asked to name any coalitions in the community providing prevention services and to identify the chair of each coalition. After the initial sample of coalitions was developed in 2002, it was used as a basis for the samples in subsequent waves and was supplemented by further snowball additions from the agency/organization interviews, but not the community leader interviews. These coalition chairs were then interviewed to assess the focus and nature of the prevention activities in which they were engaged. One respondent from each identified coalition was interviewed, and these interviews averaged 45 minutes in length.

Interview questions assessed adoption and implementation of the CTC system, including completion of a number of the specific actions described in the CTC Milestones and Benchmarks (see Quinby et al., 2008 or <http://preventionplatform.samhsa.gov> for information on the CTC Milestones and Benchmarks). Chi-squares and independent samples t-tests were used to test for significant differences between CYDS coalitions and prevention coalitions in the control group in completion of these actions. CYDS coalitions were identified as the coalitions receiving training, technical support, and funding from the CYDS. Tests were also conducted to assess differences between non-CYDS prevention coalitions in the intervention communities (i.e., those not supported by the CYDS) and the coalitions in the control communities.

Measures

The measures used to assess implementation of the CTC system are questions asking about specific benchmarks associated with CTC Phases 2 through 5, the community action phases of CTC that correspond to CSAP's Strategic Prevention Framework (see Figure 1). While these actions correspond to specific benchmarks in the CTC system, the actions are generic enough that the questions were asked in terms that could apply to any prevention coalition. For example, the following questions were asked: "Has your coalition ever been to a training to learn about risk- and protective-focused prevention?" "Has your coalition ever used an assessment of risk and protective factors in your community for prevention planning?" "Has your coalition ever used an assessment of prevention resources in your community for prevention planning?" "Did your coalition develop an action plan as part of planning to implement prevention programs for substance abuse?" "Thinking about (Coalition Name)'s comprehensive plan or activities, were there any specific risk or protective factors that you have been focusing on?" "Were specific programs or activities implemented to address these factors?" "Has (Coalition Name) evaluated or monitored the results of these programs or activities?" Each benchmark was coded based on the responses of the coalition chair as either (0) Not accomplished, or (1) Accomplished by each coalition. Index scores for each of the four phases of CTC implementation were created by summing the number of benchmarks accomplished by the coalition within each phase, and a total score was created indicating the total number of benchmarks completed by the coalition across all four phases.

Analysis

Analyses first compared the 18 prevention coalitions identified in the intervention communities with the 25 prevention coalitions identified in the control conditions in 2002, prior to the start of the CYDS. Analyses compared coalitions in the intervention versus control communities on the completion of each individual benchmark, then on the mean number of benchmarks completed within each CTC Phase, and finally on the total mean number of benchmarks completed across all phases. In 2007, 26 prevention coalitions were identified in the control communities, indicating little change from 2002. In contrast, 36 prevention coalitions were identified in the intervention communities, doubling the number identified in 2002 and suggesting that a large proportion of the intervention communities developed a new coalition to implement CTC as part of the CYDS. The second set of analyses compared the CYDS-trained coalitions in each of the 12 intervention communities to the 26 prevention coalitions identified in the control communities in 2007, 4 years after the initiation of CTC training and technical assistance for the CYDS coalitions. Finally, a third set of analyses compared the 24 non-CYDS-trained coalitions in the intervention communities to the prevention coalitions in the control communities in 2007 to assess the degree to which the CTC system was being adopted by non-CYDS-trained coalitions in the intervention communities.

Results

As shown in Table 1, at baseline in 2002, prior to the initiation of the CYDS project, prevention coalitions in the intervention and control communities reported similar levels of implementation of the CTC system in terms of the proportions of coalitions reporting having completed each of the individual CTC benchmarks measured in the coalition interview. While the majority of coalition leaders reported that their coalition used a risk/protective factor prevention framework and focused programming on specific risk or protective factors, fewer than half of the coalitions in both intervention and control communities reported that the majority of their members had received training in the risk- and protection-focused model, had assessed risk and protective factors in their community using student surveys or archival social indicators, had developed a written action plan, or monitored the impact of their programs on participants. Moreover, none of the prevention coalitions interviewed in any of the 24 communities reported implementing two or more tested, effective prevention programs. As indicated both by the proportions of coalitions achieving specific CTC benchmarks and by the summative benchmark scales in Table 1, prevention coalitions in the intervention and control communities in the CYDS showed similarly low levels and no significant differences in their implementation of the CTC system prior to the start of the CYDS.

In contrast, as shown in Table 1, in 2007, 4 years after the start of the CYDS, the prevention coalitions supported in implementing the CTC system by the CYDS showed significantly higher levels of implementation of the CTC prevention system than prevention coalitions in the control communities. Coalition leaders from the CYDS coalitions were more likely than coalition leaders in the control communities to report that: (a) they used a risk and protective factor framework to prevention; (b) members in the CYDS coalitions were more likely than coalition members in the control communities to have received training in the risk/protective factor prevention framework; and (c) the CYDS coalitions were more likely to have assessed risk and protective factors in their community using student survey and archival social indicators, were more likely to have assessed prevention resources in the community, and were more likely to have developed a written prevention action plan. All CYDS-supported coalitions reported that they had implemented at least two tested, effective prevention programs to address their community's prioritized risk factors, and all were monitoring the impact of their prevention programs on participants. In contrast, none of the prevention

coalitions in the control communities reported having implemented two or more tested, effective programs in their communities and only slightly more than half reported that they monitored the impact of their programs in 2007.

Further, when the individual CTC benchmarks are summed and averaged, the CYDS coalitions had significantly higher scores on each of CTC Stages 2 through 5 (CTC Stage 1, community readiness assessment, was not measured in the interview). In comparing the total number of CTC benchmarks attained by the coalition, the differences between CYDS coalitions and coalitions in the control communities are quite striking. The CYDS coalitions completed an average of 12 of the 15 CTC benchmarks while the coalitions in control communities completed an average of 6 ½ of the CTC benchmarks (see Table 1).

In contrast to the differences observed between the CYDS coalitions and the coalitions in the control communities, few differences in the CTC benchmarks were observed between the non-CYDS coalitions in the CYDS intervention communities and the prevention coalitions in the control communities, suggesting that the CTC system had not diffused to other coalitions in the intervention communities after 4 years of the CTC intervention. As shown in Table 1, no differences were found between the non-CYDS coalitions in the intervention communities and the coalitions in the control communities in the summative scores of CTC benchmarks. Slightly more than half of the non-CYDS coalitions and the prevention coalitions in the control communities reported that they had conducted assessments of risk and protective factors and prevention resources in their communities, though significantly more of the prevention coalitions in the control communities reported that they had focused their prevention efforts on specific risk or protective factors. Somewhat surprisingly, significantly greater numbers of coalitions in the control communities reported that they had implemented programs targeting specific risk or protective factors than non-CYDS coalitions in the intervention communities, yet none of the non-CYDS coalitions in the intervention communities nor the prevention coalitions in the control communities had implemented two or more tested, effective prevention programs to address these factors and half or fewer had evaluated the impact of their programs on the targeted factors. These results indicate that, by 2007, the CTC system had not diffused to either the non-CYDS coalitions in the intervention communities nor to the prevention coalitions in the control communities.

Discussion

Community coalitions are a popular strategy for mobilizing communities to disseminate effective interventions designed to promote public health and prevent adolescent problem behaviors such as alcohol, tobacco, and other drug use; delinquency; violence; and health-risking sexual behavior. This is apparent not only from the fact that 43 prevention coalitions were identified in 2002 and 62 coalitions were identified in 2007 in the 24 communities participating in the Community Youth Development Study, but also from the more than 6,000 local coalitions that are identified as members of the national “Community Anti-Drug Coalitions of America.” Although a few studies have provided evidence that community prevention coalitions can succeed at achieving public health goals (Feinberg et al., 2007; Flewelling et al., 2005; Hawkins, Brown et al., 2008), much of the literature concerning the impact of community prevention coalitions has failed to document their effectiveness at improving public health (e.g., Berkowitz, 2001; Hallfors et al., 2002; Klerman et al., 2005; Roussos & Fawcett, 2000; Saxe et al., 1997; Wandersman & Florin, 2003).

The CYDS is a randomized, controlled trial of community prevention coalition effectiveness. It is important in randomized community trials to document potential threats to the internal validity of the experiment, such as intervention failure, poor implementation

fidelity, or potential contamination due to implementation of the intervention by control communities. These potential threats to the internal validity of the Community Youth Development Study have been addressed by careful measurement of the implementation of the Communities That Care system in the experimental communities (Quinby et al., 2008), and by the analysis of the reports of community coalition leaders from intervention and control communities described here. Interviews of the leaders of prevention coalitions in both the intervention and control communities indicate that the coalitions participating in the CYDS trial of CTC achieved high-fidelity implementation of the CTC system between the start of the intervention in 2003 and 2007, while there was limited evidence of CTC implementation by prevention coalitions in the control communities.

These data also indicate that the CTC system helps community coalitions achieve the qualities of effective prevention coalitions suggested by Hallfors et al. (2002) as important components of coalition success. While the majority of coalitions in both intervention and control communities reported that they were using a risk- and protection-focused prevention approach, few of the coalitions in the control communities or the non-CTC coalitions in the intervention communities reported implementing the components of effective coalitions suggested by Hallfors et al. (2002). These data also indicate that the CTC system is effective in helping communities achieve the five components of the Center for Substance Abuse Prevention's Strategic Prevention Framework. CTC coalitions were more likely than prevention coalitions in the control communities to assess community prevention needs using epidemiologic data, to build the capacity of coalition members to implement science-based approaches to prevention, to develop clear, written community prevention plans, to implement tested, effective prevention programs, and to monitor and evaluate the effects of their programs on participants.

Limitations to the current study should be noted. First, the data were obtained through interviews with a single respondent (typically the coalition's chair) from each coalition. Thus, the perceptions of these respondents may have been influenced by their high level of involvement and investment in the coalitions. However, the concordance between these data on the CYDS coalitions' activities and those obtained from multiple raters' perceptions of coalition activity (see Quinby et al., 2008), does not suggest that these data were biased due to self-report. Second, the study's relative small sample of community prevention coalitions limits ability to examine more complex patterns of interactions between coalition characteristics and CTC implementation that might shed further light on characteristics of effective coalitions.

It is important and somewhat disappointing to note that little diffusion of the CTC approach into other prevention coalitions operating in the intervention communities appeared to occur. Although this is not an explicit objective of the CTC system, diffusion theory suggests that the actions of innovators and early adopters might lead to more widespread adoption of an innovation, in this case the use of prevention science to guide community prevention services needs assessment, planning, strategy selection, implementation, and outcome-focused intervention monitoring (Rogers, 1995). Given the emphasis of the CTC system on community activation and collaboration across multiple youth problem areas (e.g., delinquency, substance use, youth violence, school dropout, and teen pregnancy), it is plausible that implementation of CTC by one coalition in a community might influence the actions of other prevention coalitions operating within the same community. The communities participating in this study are not large, and it is possible that some of the members of the CYDS coalitions may have been members of other prevention coalitions in their communities, or have ties to members of other coalitions. While such naturally occurring diffusion of a prevention science-based approach to planning and implementation of prevention services to other, non-CYDS coalitions has not occurred during the 4 years of

implementation assessed in the CYDS intervention communities, it will be valuable to see if diffusion occurs in these communities in future years, since such natural diffusion may require a longer time span. Future research might examine mechanisms of diffusion, such as collaboration among the CYDS and non-CYDS coalitions, as well as factors that might influence diffusion, such as perceptions of the effectiveness of the CTC coalitions by the members or chairs of non-CYDS coalitions in the community.

The present study provides further evidence that the CTC system was implemented with a high level of fidelity by the coalitions participating in the Community Youth Development Study, suggesting that the study will provide a valid assessment of the effects of the CTC system on the 12 intervention communities. It is apparent that, given training and support to implement the system, communities can implement the CTC system with fidelity. This is important given the evidence that implementation of the CTC system can produce significant, population-level effects in reducing the prevalence of adolescent drug use and delinquency (Feinberg et al., 2007; Hawkins, Brown et al., 2008). Moreover, given the similarities between the CTC system and CSAP's Strategic Prevention Framework (SPF), it appears that CTC provides useful tools, training, and technical assistance to support communities to implement the Strategic Prevention Framework.

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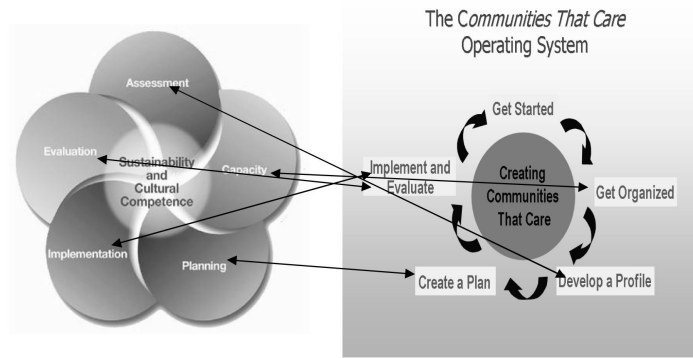
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Strategic Prevention Framework*

Communities That Care**

*Image downloaded from: <http://prevention.samhsa.gov/about/spf.aspx>

**Image downloaded from:

http://en.wikipedia.org/wiki/Communities_That_Care_Promotes_Positive_Youth_Development#Five_Phases_of_Communities_That_Care

Figure 1.
Relationship of the Communities That Care Phases to SAMHSA’s Strategic Prevention Framework.

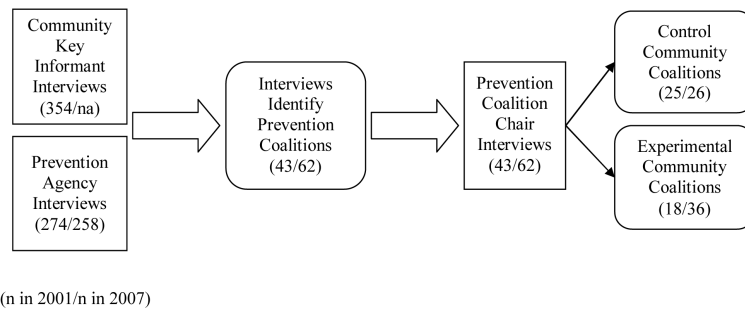


Figure 2.
Flow chart of snowball sampling method used to identify prevention coalitions in study communities.

Table 1
 CTC Benchmarks Completed by Coalitions in Experimental and Control Communities at Baseline and Follow-up

	Intervention 2002 (n=18)	Control 2002 (n=25)	Intervention CTC 2007 (n=12)	Control 2007 (n=26)	Intervention Non-CTC 2007 (n=24)
CTC Stage 2: Organize, Introduce, & Involve (Scale 0 - 3)	1.67	1.20	2.83**	1.54	1.50
Does the coalition use a risk/protective framework?	72%	64%	100%*	77%	67%
Has the coalition received training in the RPF?	61%	44%	100%*	58%	63%
Have 75% or more of coalition members been trained in RPF?	33%	12%	83%*	19%	21%
CTC Stage 3: Develop a Community Profile (Scale 0 - 5)	2.33	2.44	4.83**	3.23	3.25
Has the coalition assessed risk/protective factors in the community?	50%	44%	100%*	62%	71%
...using student surveys?	29%	40%	100%*	50%	58%
...using archival indicators?	39%	32%	92%*	54%	63%
Has the coalition focused on any specific risk or protective factors?	78%	88%	100%	100%	71%*
Has the coalition assessed prevention resources in the community?	39%	40%	92%*	58%	63%
CTC Stage 4: Create Community Action Plan (Scale 0 - 1)	0.22	0.32	0.92**	0.19	0.21
Did the coalition develop an explicit, written plan?	22%	32%	92%*	19%	21%
CTC Stage 5: Implement & Evaluate the Action Plan (Scale 0 - 6)	1.39	1.48	3.58**	1.62	1.58
Were specific programs implemented to address these factors?	50%	72%	100%	85%	54%*
Did the coalition sponsor at least two TEPs?	0%	0%	100%	0%	0%
Has the coalition evaluated or monitored the results of these programs?	44%	48%	100%*	62%	50%
...using pre/post surveys?	39%	40%	100%*	35%	38%
...using changes in participant outcomes (e.g., delinquency, school performance, etc.?)	33%	32%	92%*	39%	42%
...using changes in participant risk and protective factors?	22%	28%	67%*	27%	29%
CTC Milestones & Benchmarks Total (Scale 0 - 15)	5.61	5.44	12.17**	6.58	6.54

Note: All tests for significance used the control group in the same year as the reference

* p<.05;

10<0
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