

# ***Excellence in Prevention*** – descriptions of the prevention programs and strategies with the greatest evidence of success

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## **Name of Program/Strategy: Communities that Care**

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### **1. Overview and description**

Communities That Care (CTC) is a program of the Center for Substance Abuse Prevention (CSAP) in the office of the United States Government's Substance Abuse and Mental Health Services Administration (SAMHSA). CTC is a coalition-based prevention operating system that uses a public health approach to prevent youth problem behaviors such as violence, delinquency, school dropout and substance abuse. Using strategic consultation, training, and research-based tools, CTC is designed to help community stakeholders and decision makers understand and apply information about risk and protective factors, and programs that are proven to make a difference in promoting healthy youth development, in order to most effectively address the specific issues facing their community's youth.

Developed by Drs. J. David Hawkins and Richard Catalano at the University of Washington's Social Development Research Group (SDRG), CTC's principal strategy, the Social Development Strategy, focuses on strengthening protective factors that can buffer young people from problem behaviors and promote positive youth development.

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CTC is grounded in rigorous research from social work, public health, psychology, education, medicine, criminology, and organizational development. It engages all community members who have a stake in healthy futures for young people and sets priorities for action based on community challenges and strengths. Clear, measurable outcomes are tracked over time to show progress and ensure accountability.

## **2. Implementation considerations (if available)**

## **3. Descriptive information**

<b>Areas of Interest</b>	Substance Abuse Prevention Violence Prevention Delinquency Prevention School Drop Out Prevention
<b>Outcomes</b>	1: Exposure to targeted risk factors 2: Initiation of substance abuse and delinquency 3: Substance use 4: Delinquent Behaviors
<b>Outcome Categories</b>	Alcohol Crime Delinquency Drugs Tobacco Violence Teen Pregnancy Environmental Change
<b>Ages</b>	0-5 (Early childhood) 6-12 (Childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)
<b>Gender</b>	Male Female

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***Excellence in Prevention*** is a project of Oregon Addiction and Mental Health Services and Washington Division of Behavioral Health and Recovery. Information is drawn from many sources, including the National Registry for Effective Prevention Programs (NREPP), sponsored by the Center for Substance Abuse Prevention.

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<b>Races/Ethnicities</b>	American Indian or Alaska Native Asian Black or African American Hispanic or Latino White Race/ethnicity unspecified
<b>Settings</b>	Other Community Settings
<b>Geographic Locations</b>	Urban Suburban Rural and/or frontier
<b>Implementation History</b>	Results from a 7-state experimental trial involving 24 communities show that within 4 years of adopting the CTC system, community coalitions can reduce the incidence of delinquent behaviors and of alcohol, tobacco, and smokeless tobacco use as well as the prevalence of alcohol use, binge drinking, smokeless tobacco use, and delinquent behavior among young people community wide by the spring of grade 8.
<b>NIH Funding/CER Studies</b>	
<b>Adaptations</b>	
<b>Adverse Effects</b>	No adverse effects, concerns, or unintended consequences were identified by the developer.
<b>IOM Prevention Categories</b>	Universal

### **4. Outcomes**

#### **Outcome 1: Exposure to targeted risk factors**

<b>Description of Measures</b>	Among youths consented into a longitudinal panel in 5th and 6th grades, these significant effects of CTC were found by spring of grade 8:
<b>Key Findings</b>	Exposure to targeted risk factors increased less rapidly in CTC than in control communities.
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	

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<b>Quality of Research Rating</b>	
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## **Outcome 2: Initiation of substance use and delinquency**

<b>Description of Measures</b>	Among youths consented into a longitudinal panel in 5th and 6th grades, these significant effects of CTC were found by spring of grade 8:
<b>Key Findings</b>	During 8th grade, compared to students in the control communities, students from CTC communities were: <ol style="list-style-type: none"> <li>1. 25% less likely to initiate delinquent behavior</li> <li>2. 32% less likely to initiate the use of alcohol</li> <li>3. 33% less likely to initiate cigarette use</li> <li>4. 33% less likely to initiate the use of smokeless tobacco</li> </ol>
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	
<b>Quality of Research Rating</b>	

## **Outcome 3: Substance use**

<b>Description of Measures</b>	Among youths consented into a longitudinal panel in 5th and 6th grades, these significant effects of CTC were found by spring of grade 8:
<b>Key Findings</b>	By 8th grade, compared to students in the control communities, students from CTC communities were: <ol style="list-style-type: none"> <li>1. 23% less likely to use alcohol in the past 30 days</li> <li>2. 48% less likely to use smokeless tobacco in the past 30 days</li> <li>3. 37% less likely to have engaged in binge drinking in the past two weeks</li> </ol>
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	
<b>Quality of Research Rating</b>	

## **Outcome 4: Delinquent behaviors**

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<b>Description of Measures</b>	Among youths consented into a longitudinal panel in 5th and 6th grades, these significant effects of CTC were found by spring of grade 8:
<b>Key Findings</b>	In 8th grade, students from CTC communities committed 31% fewer different delinquent behaviors than students in the control communities.
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	
<b>Quality of Research Rating</b>	

5. **Cost effectiveness report (Washington State Institute of Public Policy – if available)**
6. **Washington State results (from Performance Based Prevention System (PBPS) – if available)**
7. **Who is using this program/strategy**

<b>Washington Counties</b>	<b>Oregon Counties</b>
Cowlitz, Jefferson, Snohomish	Benton, Columbia, Douglas, Jefferson, Lane, Linn, Marion, Morrow, Washington, Yamhill

## **8. Study populations**

## **9. Quality of studies**

### **Study 1**

Hawkins, J. David, Oesterle, Sabrina, Brown, Eric C., Arthur, Michael W., Abbott, Robert D., Fagan, Abigail A., Catalano, Richard F. (2009). Results of a type 2 translational research trial to prevent adolescent drug use and delinquency: A test of Communities That Care. *Archives of Pediatrics and Adolescent Medicine*, 163(9), 789-798

## **Research base for Communities that Care**

### **Public health understanding of risk and protective factors**

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The field of public health has developed a systematic methodology for understanding and effectively preventing health problems. Through rigorous research, the etiology of diseases has been documented, and the factors contributing to those diseases have been identified. Once these contributing factors are understood, careful study and application of approaches to amend those factors have demonstrated reductions in the disease burden. For example, heart disease has been one of the primary causes of death among American adults. We now know, however, that adequate exercise, a healthy diet, and avoidance of smoking can help to prevent heart disease. These behaviors are considered protective factors, just as smoking, high blood pressure, and a family history of heart disease are considered risk factors for poor heart health.

Since the late 1970s, researchers in a variety of disciplines (for example, criminology, sociology, social work, psychology, community psychology, education) have been applying this public health approach to the study of the healthy development of young people. This work has created a field called prevention science, which identifies the factors that contribute to the healthy development of children and youth (protective factors) and the factors that impede that development (risk factors).

## **Etiology: Longitudinal studies of youth development**

*Protective Factors and the Social Development Model.* The prevention of health and behavior problems in young people requires, at its foundation, the promotion of the factors required for positive development. Research shows that five basic factors promote positive social development: opportunities for developmentally appropriate involvement, skills, recognition for effort, improvement and achievement, strong social bonds, and clear, consistent standards for behavior. All children need opportunities to be actively involved with positive adults and peers, the skills to participate and succeed in social, school, and civic settings, and recognition for their efforts, improvements, and accomplishments. When young people are provided with opportunities, skills, and recognition, they develop strong social bonds, that is connections with and commitment to the families, schools, and communities that provided them. When families, schools, and communities communicate to young people clear standards for behavior, those who feel bonded, emotionally connected, invested in the group, will follow those standards that promote health and success. These five factors are protective factors that promote positive development in young people (Hawkins & Weis, 1985), and form the basis for the Social Development Model.

*Risk Factors.* Research has also identified risk factors that can interrupt the process of positive social development. High quality longitudinal studies have identified risk factors in neighborhoods and communities, families, schools, and peer groups, as well as in individuals themselves. These factors increase the probability of delinquency, violence, substance abuse, teen pregnancy, dropping out of school, and other behavior problems in young people. The risk factors shown in the risk factor chart (right) have been found in at least two high-quality studies to predict later health and behavior problems in young people. Many of these risk factors predict multiple problems. For example, the risk factor of “Poor Family Management” has been shown to predict five youth problem behaviors: substance abuse,

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delinquency, teen pregnancy, school drop-out, and violence. Providing effective parent training programs in a community, therefore, could potentially impact all five of these undesirable outcomes.

## **Intervention: Testing effectiveness of interventions**

The identification of risk and protective factors provides the foundation for advances in preventing adolescent health and behavior problems. Prevention scientists have rigorously tested programs and policies that address these risk and protective factors in studies funded largely by the National Institutes of Health, and an increasing number and range of effective prevention approaches have now been identified. By 2004, 56 tested and effective programs were available in the United States that have been demonstrated to reduce involvement in problem behaviors and/or increase positive outcomes for youth. These 56 effective programs and policies are summarized in CTC's Prevention Strategies Guide at [www.preventionplatform.samhsa.gov](http://www.preventionplatform.samhsa.gov). Sixteen of these programs have been tested at least twice with replicated findings and have been designated as *Blueprint model programs*, which, if rigorously followed, will significantly reduce youth violence and substance abuse. Programs range from prenatal (for example, Olds, 1997) and early childhood interventions (for example, Reid et al., 2001), to community policies related to alcohol (e.g. Holder et al., 2000<sup>4</sup>), to school-based curricula that teach youth social and emotional skills that will help them navigate life (e.g. Botvin et al., 2003, Eisen et al., 2002, and Grossman et al., 1997).

## **Systems: Researching systems change in states and communities**

Prevention scientists understand that the final task arising from these research findings is the application of proven prevention programs, policies and strategies in the real world in order to enhance youth development on the ground in communities. In collaboration with communities and state and federal governments, researchers are studying the impact that prevention science can have on the effectiveness of prevention efforts within those systems. [link to History section of this article, to be added]

## **Evaluation results**

### **Evaluation of implementation**

The CYDS evaluated community efforts to faithfully implement (1) the core principles of the CTC prevention system, and (2) tested and effective prevention programs with respect to content and delivery specifications. The study found that CTC communities achieved high implementation fidelity at the system and program levels when supported by training and technical assistance in CTC. Control communities did not achieve these things. At the start of the CYDS, CTC and control communities did not differ in their use of a science-based approach to prevention. By the third year of the intervention, key leaders in CTC communities reported a higher stage of adoption of science-based prevention, relative to control communities. They also were willing to provide greater funding for prevention. Differences were sustained

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one year after the implementation phase of the trial ended. At this point, key leaders in CTC communities also reported significantly stronger community norms against adolescent drug use. The CTC Milestones and Benchmarks Survey was used to track progress in the implementation of core components of the CTC prevention system. In each year of the intervention, CTC communities enacted an average of 90% of the key features of the CTC prevention system, including developing a community board, prioritizing risk and protective factors, selecting tested and effective preventive interventions from the Communities That Care Prevention Strategies Guide, implementing selected implementation programs with fidelity, and periodically assessing risk and protective factors and child and adolescent well-being through surveys of students. One year after the implementation phase of the trial had ended, eleven of 12 CTC coalitions continued to operate in CTC communities. These coalitions continued to implement key CTC milestones and benchmarks to a significantly greater degree than coalitions in control communities, even without ongoing study-provided support. Control communities did not make this progress over time in completing CTC milestones and benchmarks, implementing scientifically proven prevention programs, and monitoring program impacts. Over the course of the trial, the 12 CTC communities demonstrated faithful implementation of 17 different school-based, after-school, and parenting interventions selected from a menu of 39 possible tested and effective programs for 5th through 9th grade students contained in the Communities That Care Prevention Strategies Guide. On average, CTC communities implemented 2.75 tested and effective prevention programs per year (range: 1-5). High rates of fidelity were achieved consistently over time with respect to adherence to program objectives and core components (average = 91-94% per year) and dosage (number, length, and frequency of intervention sessions; average = 93-95% per year). Faithful implementation continued two years after study support ended. CTC coalitions still offered significantly more tested and effective intervention programs, implemented them with high quality, monitored implementation to a significantly greater degree, and reached significantly more children and parents, compared to control coalitions.

### **Impact evaluations**

- **Pennsylvania**

The Prevention Research Center at Pennsylvania State University has been studying the process and impact of the statewide CTC system since its inception in the early 1990s. Summaries of their findings will be posted here soon.

- **Community Youth Development Study**

The Community Youth Development Study (CYDS) is the first controlled experimental trial of the Communities That Care system. Twenty-four communities in 7 states agreed to participate in the study. These communities consisted of 12 matched pairs which had equivalent demographics and equivalent levels of youth risks and problem behaviors at the start of the study. Communities were randomly assigned to intervention or control conditions. The intervention communities received funding to hire a full



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time community coordinator, who formed a community coalition that subsequently participated in the full cycle of CTC trainings. These communities then created community action plans, and were awarded up to \$75,000 per year for the next four years to implement the tested, effective prevention strategies selected as part of the action planning process. Control communities continued prevention business as usual.

Hawkins et al. 2008, reported finding no significant differences between CTC and control communities in average levels of community-targeted risks among students in fifth grade, prior to the start of the CTC programs. By the third year of the intervention, key leaders in CTC communities reported a higher stage of adoption of science-based prevention, relative to control communities. They also were willing to provide greater funding for prevention. Differences were sustained one year after the implementation phase of the trial ended. At this point, key leaders in CTC communities also reported significantly stronger community norms against adolescent drug use. The longitudinal panel youth in CTC and control communities reported similar levels of targeted risk in Grade 5, when the intervention began, but targeted risk exposure grew more slowly for youth in CTC communities between Grade 5 and Grade 10. Significantly lower levels of targeted risk were first reported by CTC panel youth 1.67 years into the intervention, in Grade 7, and have continued to be reported by CTC panel youth through Grade 10.

Panel youth from CTC and control communities also reported similar levels of delinquency, alcohol use, and cigarette smoking at Grade 5 baseline. However, between Grades 5 and 10, CTC had significant effects on the initiation of these behaviors by youth. Significant differences in the initiation of delinquency were first observed in the spring of Grade 7. Panel youth from CTC communities were 25% less likely than panel youth from control communities to initiate delinquent behavior, and they remained so in Grade 8. Significantly lower delinquency initiation rates were sustained through Grade 10, when panel youth from CTC communities were 17% less likely to initiate delinquency than panel youth from control communities.

Preventive effects on alcohol use and cigarette use were first observed in the spring of Grade 8, 2.67 years after intervention programs were implemented. Grade 8 youth from CTC communities were 32% less likely to initiate alcohol use, and 33% less likely to initiate cigarette smoking than Grade 8 youth from control communities (Hawkins et al., 2009). Preventive effects were again sustained through Grade 10 when CTC panel youth were 29% less likely to initiate alcohol use and 28% less likely to initiate cigarette smoking than panel youth from control communities.

Differences in the initiation of delinquency, alcohol use, and cigarette smoking from Grade 5 through Grade 10 led to cumulatively lower rates of initiation over time: 62% of 10th-grade youth in the panel from CTC communities had engaged in delinquent behavior compared with 70% of 10th-grade youth in the panel from control communities; 67% vs. 75% had initiated alcohol use; and 44% vs. 52% had smoked cigarettes.

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CTC also significantly reduced the prevalence of youth problem behaviors in Grade 8 and Grade 10. In Grade 8, the prevalence of alcohol use in the past month, binge drinking (five or more drinks in a row) in the past two weeks, and the variety of delinquent behaviors committed in the past year were all significantly lower in CTC panel youth compared to control community panel youth. The CYDS also found significant effects of CTC in reducing the prevalence of cigarette use in the past month and delinquent behavior and violence in the past year in the spring of Grade 10.

*Conclusions:* CTC's theory of change hypothesizes that it takes from 2 to 5 years to observe community-level effects on risk factors, and 5 or more years to observe effects on adolescent delinquency or substance use [insert CTC timeline graphic]. These early findings from the first randomized community trial of CTC are promising, suggesting that CTC is slowing the usual developmental increase in adolescents' risk exposure. Longer follow-up measurements are needed to determine if CTC can significantly reduce community levels of delinquency and drug use as hypothesized. The Community Youth Development Study will collect additional data from these students in 2007 and 2008. These data will allow tests of CTC's effects on community rates of delinquency and substance use initiation among young people through the spring of grade 9, almost 5 years after CTC was introduced in the intervention communities and approximately 3½ years after communities began implementing tested and effective prevention programs chosen through the CTC system.

### **Additional Resources**

Rhew, I.C.; Brown, E.C., Hawkins, J.D. Briney, J.S.. "Sustained effects of Communities That Care on prevention service system transformation". Under review.

Hawkins JD, Catalano RF, & Associates. 1992. *Communities That Care: Action for drug abuse prevention*. San Francisco: Jossey-Bass, Inc.

Fagan, A.A., Hawkins, J.D., Catalano, R.F. (2008). Using community epidemiologic data to improve social settings: The Communities That Care prevention system. In M. Shin (Ed.) *Toward positive youth development: Transforming schools and community programs* (pp. 292–312). Oxford; New York: Oxford University Press.

Hawkins, J. D.; Weis, J. G. (1985). "The social development model: An integrated approach to delinquency prevention". *Journal of Primary Prevention* 6 (2): 73–97.

Hawkins, J. D.; Catalano, R. F.; Arthur, M. W. (2002). "Promoting science-based prevention in communities". *Addictive Behaviors* 27 (6): 951–976.

Hawkins, J. D.; Catalano, R. F.; Miller, J. Y. (1992). "Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention". *Psychological Bulletin* 112 (1): 64–105.

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Hawkins, J.D., Herrenkohl, T.I., Farrington, D.P., Brewer, D., Catalano, R.F., Harachi, T.W., Cothorn, L. (2000). Predictors of youth violence. *OJJDP Juvenile Justice Bulletin*, April.

Elliott, D. S. (1997). *Blueprints for Violence Prevention*. Boulder, CO: University of Colorado, Institute of Behavioral Science, Center for the Study and Prevention of Violence.

Olds, D.L. (1997). The Prenatal/Early Infancy Project: Fifteen years later. In G.W. Albee & T. Bullotta (Eds.), *Primary prevention works* (pp.41–67). Thousand Oaks, CA: Sage Publications.

Reid, M.J.; Webster-Stratton, C. (2001). "The Incredible Years parent, teacher, and child intervention: Targeting multiple areas of risk for a young child with pervasive conduct problems using a flexible, manualized treatment program". *Cognitive and Behavioral Practice* 8 (4): 377–386.

Holder, H.D.; Gruenewald, P.J.; Ponicki, W.R.; Treno, A.J.; Grube, J.W.; Saltz, R.F. et al.; Voas, RB; Reynolds, R et al (2000). "Effect of community-based interventions on high-risk drinking and alcohol-related injuries". *Journal of the American Medical Association* 284 (18): 2341–2347.

Botvin, G. J.; Griffin, K. W.; Paul, E.; Macaulay, A. P. (2003). "Preventing tobacco and alcohol use among elementary school students through LifeSkills Training". *Journal of Child & Adolescent Substance Abuse* 12 (4): 1–17.

Eisen, M.; Zellman, G.L.; Massett, H.A.; Murray, D.M. (2002). "Evaluating the Lions-Quest "Skills for Adolescence" drug education program: First-year behavior outcomes". *Addictive Behaviors* 27 (4): 619–632.

Grossman, D. C.; Neckerman, J. J.; Liu, T. D.; Asher, K.NI; Beland, K.; -1#Koepsell, P-Y. et al.; Frey, K; Rivara, FP (1997). "Effectiveness of a violence prevention curriculum among children in elementary school: A randomized controlled trial". *Journal of the American Medical Association* 277 (20): 1605–1611.

Hawkins, J.D.; Catalano, R.F.; Arthur, M.W.; Egan, E.; Brown, E.C.; Abbott, R.D.; Murray, D.M. (2008). "Testing Communities That Care: The Rationale, Design and Behavioral Baseline Equivalence of the Community Youth Development Study". *Prevention Science* 9 (3): 178–190.

Brown, E.C.; Hawkins, J.D.; Arthur, M.W.; Briney, J.S.; A.A., Fagan (2011). "Prevention service system transformation using Communities That Care". *Journal of Community Psychology*. 39 (2): 183–201.

Rhew, I.C.; Brown, E.C.; Hawkins, J.D. (under review). Sustained effects of Communities That Care on prevention service system transformation.

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Fagan, A.A.; Arthur, M.W.; Hanson, K.; Briney, J.S.; Hawkins, J.D. (under review). Effects of Communities That Care on the adoption and implementation fidelity of evidence-based prevention programs in communities: Results from a randomized controlled trial.

Fagan, A.A.; Hanson, K.; Hawkins, J.D.; Arthur, M.W. (2008). "Bridging science to practice: Achieving prevention program implementation fidelity in the Community Youth Development Study". *American Journal of Community Psychology*. 41 (3–4): 235–249.

Fagan, A.A.; Hanson, K.; Hawkins, J.D.; Arthur, M.W. (2008). "Implementing effective community-based prevention programs in the Community Youth Development Study". *Youth Violence and Juvenile Justice*. 6 (3): 256–278.

Fagan, A.A.; Hanson, K.; Briney, J.S.; Hawkins, J.D. (under review). "Sustaining the utilization and high quality implementation of tested and effective prevention programs using the Communities That Care prevention system". *American Journal of Community Psychology*.

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Brown, E.C.; Arthur, M.W.; Briney, J.S.; Fagan, A.A.; Fagan, Abigail A. (2011). "Prevention service system transformation using Communities That Care". *Journal of Community Psychology* 39 (2): 183–201.

Hawkins, J.D.; Oesterle, S.; Brown, E.C. (under review). Sustained decreases in exposure and youth problem behaviors after installation of the Communities That Care prevention system in a randomized trial.

## **10. Readiness for Dissemination**

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## **11. Costs (if available)**

All CTC training materials are available for download free of charge from CSAP's Prevention Platform . Installing the CTC system requires an on-site community coordinator to manage the CTC coalition; administration, analysis and reporting of the CTC Youth Survey; and trainer costs for the six CTC trainings. Additionally, the costs of the prevention programs selected for implementation through the CTC process are needed.

### **Additional Information**

A listserv is available in order facilitate communication between communities who are implementing Communities That Care, CTC trainers and consultants, and interested individuals. This is a mechanism for individuals to provide insights into their experiences in implementing CTC and ask colleagues for solutions to issues or problems they are having.

## **12. Contacts**

### **For information on implementation/research:**

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**Learn More by Visiting:** <http://www.sdrp.org/CTCInterventions.asp>