MEASUREMENT OF ‘COMMUNITY READINESS’ FOR THE PREVENTION OF ADOLESCENT SUBSTANCE ABUSE: A PILOT STUDY IN FOUR AUSTRALIAN REGIONAL COMMUNITIES

This dissertation is submitted as total fulfilment for the Doctor of Philosophy degree at the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

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Stephanie Louise Jones

Bachelor Applied Science (Advanced Nursing), Master of Business

Centre for Adolescent Heath, Murdoch Children’s Research Institute, Royal Children’s Hospital, Department of Paediatrics, University of Melbourne
ABSTRACT

Health promotion and public health research increasingly recognise that a range of community organisation and attitudinal factors are important to a community’s level of readiness, or capacity, to undertake effective prevention activity required to reduce population rates of adolescent substance abuse. Although the importance of tailoring community capacity building to readiness levels is acknowledged, little research has been done to date, to develop a systematic framework for measuring readiness in Australia.

Equally in Australia where national and state government drive public health drug policy and programme development, their interaction and support of community level interventions and efforts has not been widely examined.

This methodological study of 100 telephone interviews with 60 community practitioners (15 in each community) was conducted to identify and assess the specific attitudinal, systemic and resource characteristics of four regional communities in order to extend their capacity or readiness to address adolescent substance abuse within their community. The study provided the opportunity to assess the feasibility, reliability and validity and utility of two North American questionnaires that had been developed to provide quantitative measurement of community readiness. Additional questions were included to try and gauge to what extent state government engaged with, and responded to, the four regional communities in the planning and initiation of prevention activity. Examination of this domain would also contribute to the understanding of state and community engagement with community empowerment.

Each of the readiness questionnaires appeared comprehensible within the Australian context, requiring only minor modifications to wording and format to obtain reliable responses from community practitioners. Community readiness ratings for the four communities were consistent across the two instruments with each questionnaire assessing some overlapping and some distinct domains.

The comparison of results from the two community readiness survey instruments suggested some advantages for the TECPR instrument in its slightly higher face validity to key informants and its ability to significantly discriminate the total readiness scores for the four communities. Analysis revealed some associations between the two readiness assessment methods; supporting the view that they were assessing some common underlying dimensions but also that they each provided some
unique information. Analysis of the additional questions related to community empowerment suggested that the two assessment methods each contributed unique information in predicting local perceptions of community empowerment.

It is concluded that each questionnaire has the potential to elicit detailed and reliable data concerning community-readiness, which can be quantitatively analysed; and is not unduly time-consuming or burdensome to the researcher or the respondents. One of the questionnaires holds particular merit for communities where research expertise is not available. Measurement of community readiness appears feasible in the Australian context opening opportunities for improved planning and evaluating of community development initiatives aimed at preventing adolescent substance abuse.
DECLARATION

This dissertation does not contain any material that has been accepted for another degree, at any university. To the best of my knowledge and belief, this dissertation does not contain any material that has been previously published or written by another person, except where due reference is given in the text.

This is to certify that

a) the thesis comprises only my original work towards the PhD
b) due acknowledgement has been made in the text to all other material used
c) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

Stephanie Louise Jones
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I would like to acknowledge the wonderful people that have kindly assisted me with the technical, research and academic skills required in the development of this study. To ensure that they are not forgotten I have listed them in the final pages of this document.

I want to make special mention of my two supervisors, John Toumbourou and Joanne Williams, who have supported me on a long journey of learning. Professor Toumbourou now holds the first chair in Health Psychology in Victoria and is highly regarded for his work in adolescent substance use. Dr Williams is an epidemiologist, highly regarded for her population studies, including her recent work in adolescent health and well-being.

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CHAPTER 1: INTRODUCTION TO THE THESIS

1.1 INTRODUCTION TO THE CHAPTER

The purpose of this chapter is to briefly introduce the reader to the context and outline of this PhD study by describing the author’s motivation for studying the problem of addressing adolescent substance abuse within communities, introducing the main concepts and providing an overview of the method and content. As the data collection for the present study was conducted in 2002-2003, the references cited refer to that period.

1.2 STUDY RATIONALE

Tobacco use, harmful alcohol use and illicit drug use represent the major contributors to preventable health and social costs in Australia and in other nations (Collins & Lapsley, 2002). It is estimated that 20 percent of deaths each year in Australia are drug-related (Australian Bureau of Statistics, 2002). These include acute drug deaths and death resulting from chronic illness related to use of the drug. Community concern led by media portrayals, tends to focus on illicit drugs but in fact 79% of drug deaths (more than 19,000) were due to tobacco, 16% to alcohol and 3.5% (about 1000) to illicit drugs (Australian Institute of Health and Welfare, 1999). Aside from the personal and human cost, the economic cost associated with licit and illicit drug use in the Australian community was $34.5 billion in the years between 1998 and 1999; tobacco accounted for 60 percent, alcohol 22 percent and illicit drugs, 17 percent (Collins & Lapsley, 2002).

Data collected over a number of years shows that the human and financial burden from drug abuse is a major public health problem that is growing in magnitude, despite significant intervention from governments, academics and health and welfare organisations. Whilst there has been some public health advances in addressing tobacco and harmful alcohol use in the general population, rates remain high amongst adolescents and young adults (Arthur & Blitz, 2000; Hill, White, & Effendi, 2002; Loxley et al., 2004).

The mid to late 1990’s had seen an increase in illicit drug use in Australia, particularly heroin. The situation was becoming alarming to a number of community leaders, health professionals and members of the public, as a result of the number of deaths from drug overdose; and intensive media coverage (Fitzgerald, 1999)
This alarm was also being felt in country towns that previously had not been exposed to illicit drug use, in the same way as the cities had been exposed.

The PhD student had been head of a regional community health service, a major provider of drug treatment services, immediately prior to commencing this study. As a consequence of her position she was invited to take part in a number of community fora and inter-agency meetings, to address the alarm from drugs in the local community. Despite a number of gatherings, the efforts did not lead to action or any change in regard to the local drug issue, even with a number of influential (such as politicians and community leaders), capable (health and welfare professionals) and very motivated people being involved, such as the parent of a young man who had died from a heroin overdose.

Those involved were left with a sense of failure, and the community a sense of helplessness and fear in the face of increasing illicit drug use. The question uppermost in her mind at the time was; why did the well-intended efforts of the community fail despite significant input from leaders and concerned individuals?

At about the same time, the State Government of Victoria had tried to introduce safe injecting facilities into a number of communities. The government was forced to abandon this effort as a result of strong community resistance despite many deaths from drug overdose (Wallis Consulting Group Pty Ltd, 2000). This too raised the question: why were these communities resistant to an approach that assisted those in danger from death by overdose? Some of the key issues from this situation that are relevant to the present study will be raised in the next chapter.

The Victorian Health Promotion Foundation (known as Vic Health) was likewise finding that communities involved in their mental health intervention, that included drug and alcohol programmes, were “not ready”, as they were not achieving their objectives. The reasons for their lack of readiness were not apparent (personal communication: Walker, (2001), so if these community groups were not ready, is there a way of assessing readiness within communities or coalitions ahead of introducing an intervention or change strategy?

Contrary to these scenarios, there is growing evidence that community prevention approaches can successfully reduce the levels of alcohol and drug use; and the related harm (Alcohol and Public Health Research Unit, 1999; Durlak, 1999; Harachi, Hawkins, Haggerty, & Catalano, 1992; Loxley et al., 2004; Mrazek & Haggerty, 1994; Werner & Smith, 1992). Current prevention and early intervention approaches encourage communities to play a part in developing coordinated strategies
(Freudenberg & others, 1995; Green & Kreuter, 2001; Labonte, 1992; Minkler & Wallerstein, 1997). Achieving the required level of strategic coordination however, can be difficult in communities where adolescent substance use is poorly understood, reliable information is lacking; where few members are knowledgeable about prevention, and where organisational systems generally do not encourage community members and organisations to work together. These features in a community have been described as important factors that contribute to ‘community readiness’ for substance abuse prevention.

The theory of ‘Individual Readiness’ articulated by Prochaska and Di Clemente in 1992, is now widely understood and considered in the fields of psychology and health promotion, as an important aspect to understanding and supporting individual behaviour change. ‘Community Readiness’ however is a relatively new concept in Australian public health discourse and there is little research about how the concept applies at the community level, particularly to community change; and importantly whether it is relevant to the prevention of adolescent substance use. A systematic framework for assessing community readiness that is methodically sound and strategically relevant could assist community groups, policy makers and funding bodies in their understanding of community readiness factors that enhances their planning and coordination of community prevention interventions.

1.3 AIM OF THE STUDY

The aim of the present study was therefore to expand understanding of community readiness and its assessment in a manner that could enhance the capacity of communities to address issues of concern, in this case, adolescent substance abuse. The present study would provide the opportunity to assess and compare two USA community readiness assessment instruments, and their appropriateness to the Australian context.

1.4 BRIEF METHODOLOGY STATEMENT

A methodological study of 100 telephone interviews was conducted with 60 community practitioners in four regional communities of Australia to enable the two community readiness assessment instruments to be compared; and to provide a more detailed understanding of the community factors that underpin community readiness. The research questions were investigated within the limitations of a doctorate study where detailed information was sought from a relatively small sample of respondents.
1.5 STRUCTURE OF THE DISSERTATION

The scope and findings from this study will be elaborated in six chapters:

**Chapter One** introduces the reader to the problem, and the intent of the present study.

**Chapter Two** provides background information for the present study that gives a context for the problem of adolescent substance use and abuse in communities and community capacity to address the issue. This is achieved through a review of scientific literature and other published work as well as material gleaned from six research centres visited during the course of the present study, in the UK and the USA. It was these visits that led to refinement of the present study and selection of the questionnaires. The concept of community readiness is introduced in this chapter.

**Chapter Three** provides detail of the research design, the two readiness assessment instruments and the additional questions developed to assess state and community interaction in the development and support of prevention interventions. The process of engagement of the communities, selection of the study participants and interview protocol is provided along with information on the collation, coding and analysis of the data. The three research questions are stated at the beginning of this chapter.

**Chapter Four** provides simple descriptive data about the study respondents, their response rates and their views about the survey instruments. The community readiness scores obtained from the two instruments for the four communities are illustrated separately to provide clarity to the reader. The two instruments are then compared for their similarities and differences in the information provided and their reliability and validity characteristics. The responses to the additional questions on State government and community engagement are discussed last.

**Chapter Five** discusses the findings in reference to the aim of the study, the research questions and the policy, practice and theory discussed in Chapter 2; and provides some conclusions for the present study.

**Chapter Six**, the final chapter will summarise the study and comment on how the findings can contribute to the development of policy and practice in regard to community capacity to address adolescent substance abuse as well as provide some thoughts on further research on community readiness.
1.6 CONCLUSION TO THE CHAPTER

This chapter has described how the author came to study the issue of adolescent substance use and the associated harm; as well as highlighted some of the challenges for communities in addressing the problem. The concept of community readiness assessment has been introduced as an approach to assisting communities in the prevention of adolescent substance use. The last section provided a brief statement about the study design and an overview of the chapter structure so that the reader can see how each chapter will contribute to the development of the thesis.

The next chapter will provide an in-depth examination of adolescent substance use, relevant government policy, the strengths and limitations of existing community prevention interventions and the contribution of community readiness assessment to building the capacity of communities to address issues of concern, in this case, adolescent substance abuse. This will be achieved through a discussion of the scientific literature and material gleaned from the research centres visited to provide a clear context for the thesis and the development of the research questions.
CHAPTER 2: CONTEXT FOR THE STUDY

2.1 INTRODUCTION TO THE CHAPTER

The purpose of this chapter is to provide the policy, practice and theoretical context for the present study on adolescent substance abuse that was conducted in 2002 and 2003 in four local government areas of Australia; as well as building the argument that community readiness assessment would enhance community capacity to address adolescent substance abuse. The scientific literature presented mostly reflects what was known at that time.

The following is a brief synopsis that gives the reader an overall summary of the thesis before proceeding into the detail of the related theory and practice.

Drug use contributes to significant illness and disease, injury, workplace concerns, violence, crime and breakdown in families and relationships in Australia. Collins and Lapsley estimated that the economic costs associated with licit and illicit drug use in 1998 to 1999 amounted to $34.5 billion of which tobacco accounted for 60%, alcohol 22% and illicit drugs 17%.

Since the publication of the 1970 World Health Organisation report on community initiatives, increasing attention has been paid to the ‘community’ as the context for achieving large-scale change in both primary prevention and treatment of chronic health and social problems (Blackburn, ; Farquhar, 1985; Farquhar et al., 1990; Green, 1986; Jacobs et al., 1986; Lefebvre, Lasater, Carleton, & Peterson, 1987). This links with the notion that individuals are influenced by the physical and social environment in which they live and work. Community approaches were originally developed to address cardio-vascular disease but have since been extended to other health and social problems including substance abuse (Aguirre-Molina & Gorman, 1996; Harachi et al., 1992; Jacobs et al., 1986; Pentz et al., 1989; Peterson, Hawkins, & Catalano, 1992). As the societal and economic impacts of substance abuse can be overwhelming on local communities (Alinsky, 1972; Reitzes & Reitzes, 1980) so prevention, through community action can play an important role in maintaining community stability.

Research is also showing that successful reduction of drug use requires the wide-scale involvement of multiple segments of a community (Pentz, 1986). Prevention approaches more recently, have begun to take a broader perspective of both the problem and the solution. Rather than viewing substance abuse as a problem
whose prevention is the responsibility of a single isolated group within the community, such as schools, prevention now emphasises the need to view substance abuse as a problem of the wider community whose members must collectively share in the responsibility for substance abuse prevention. This move is supported by developments in both theory and practice that have enabled the growth of comprehensive community approaches (Feinberg, Greenberg, Osgood, Anderson, & Babinski, 2002).

Implicit in these developments is a growing understanding of some of the important factors that support a community’s ability to respond to some of its problems. Principal amongst these is the concept of ‘community empowerment’, viewed as an enabling process through which individuals or communities take control over their lives and their environment (Rappaport, 1984); a competent community (‘community competence’) with the ability to solve its problems (Cottrell, 1983; Ross, 1955) and an awareness that gives a community the ability to identify its problems - ‘community consciousness’ (Freire, 1970).

Community approaches require an understanding of how social systems operate, how change occurs within and among systems and how community changes influence people’s behaviour and health (Glanz, K., Lewis, F., Marcus, & Rimer, B., K., 1997a). Community readiness assessments could potentially assist a range of community stakeholders such as government departments, community groups, organisations and community leaders, in better understanding these complexities, as a way of ensuring successful community interventions.

This chapter will therefore focus on these key issues; that form the basis of a thesis that suggests that community readiness assessment is a valuable method for assisting communities to be strategic in tackling adolescent substance abuse; and provides a useful tool for ensuring that strategies are targeted and cost efficient.

To achieve this, the chapter is divided into several headings, beginning with a definition and description of adolescent substance use in Australia. This is discussed first so that the problem can be located within a review on current policy and practice that follows. The role and function of a community in addressing such a problem is basic to this study so there is an expanded section to cover the range of community factors that influence adolescent substance abuse.

Whilst undertaking the present study the PhD student received a scholarship to travel to the USA and England to hear first hand what is currently known about community readiness and its assessment in these countries. The readiness work of the eight
centres visited is illustrated in this chapter and provides a contemporary context for discussion of readiness models.

To conclude this section, the following diagram illustrates the connection in this thesis between the problem of adolescent substance abuse in the community with the community factors and key theories relevant to community capacity to address the problem through change; with the contribution that measurement of community readiness can provide to building the required community capacity.
2.2 ADOLESCENT SUBSTANCE ABUSE

The issue of adolescent substance abuse has at least two important aspects: 1) harmful substance use in young people remains a major public health problem and 2) the impact of this is being felt in communities across Australia that feel limited in their capacity to respond.

The teenage years are formative years encompassing the transition from childhood to adulthood, the growth of individual identity, extension of friendships, relationships and interests outside the family and the progression towards emotional and financial independence. These years can also be a time when young people push the boundaries they are given and become increasingly exposed to influences outside the family sphere. In this environment, teenagers can be vulnerable to pressures to conform to the behaviour of their peers and other role models presented to them in popular culture (Patience, 1992).

Most young people in Australia, an estimated 80-90 per cent of the youth population, live healthy lives and make the transition to adulthood relatively well (Bond, Thomas, Toumbourou, Patton, & Catalano, 2000). The Australian Institute of Health and Welfare’s report examining the health of young Australians aged 12-24 years (Moon, Meyer, & Grau, 1999) demonstrated a number of very positive trends. Two thirds of young people perceived their health to be excellent or very good. Youth death rates had declined from 85:100,000 in 1979 to 60:100,000 in 1997 mostly attributed to the decline in vehicle accident deaths. Rates of new HIV and syphilis infections had declined since the early 1990’s and teenage birth rates had declined from 55:1000 women in 1971 to 20:1000 in 1988 and has been stable over the remaining decade (Toumbourou, 2000).

There has been concern for the 10-20 per cent of young people however, who are at risk and, who experience problems associated with mental health, drug abuse, homelessness, crime, risky sexual behaviour and who generally fail to reach their full potential. The rise in youth suicide and drug use in particular, had called for leaders and authorities to find solutions to these social problems (Fiske, 2000).

The Victorian Department of Human Service’s study of the risk and protective factor profile of 9,000 Victorian adolescents (Bond et al., 2000) provided some important indicators relevant to the prevalence of problematic behaviour among secondary school students in Victoria. Although the majority of the adolescents surveyed
indicated they had few problems and were healthy, the prevalence rates by Year 11, indicated rates of particular psycho-social problems in young people as:

- Alcohol use: 67 per cent,
- Marijuana use: 40 per cent.
- Smoking: 37 per cent
- Youth depression: 22 per cent
- Anti-social behaviour: 21 per cent (peak rate -Year 9)

For some teenagers, drugs represent a major risk. Whilst statistics on substance use and abuse in Australia from 1988 to 1998 suggested that there had been a general decline in the consumption of alcohol and tobacco by the Australian community, secondary school students had shown a general increase in the percentage of students using alcohol, tobacco (except Victoria) and other illicit substances. Surveys by the Western Australian Health department indicated that alcohol use had remained static although overall substance use among secondary students had generally declined.

Hawkins et al (1992), and more recently Loxley et al (2004) have reviewed evidence that demonstrated that a range of modifiable risk factors at the individual, the family, the school and the community level have contributed to the development of these problems for young people. These will be discussed later in the chapter.

**Prevalence of drug use in young people**

Tobacco use, harmful alcohol use and to some extent, illicit drug use, represent the major contributors to preventable health and social costs in Australia, as in other nations (Collins & Lapsley, 2002). Despite public health advances in addressing tobacco and harmful alcohol use in the general population, rates of use continued to increase for adolescents and young adults through the 1990s (Arthur & Blitz, 2000; Hill et al., 2002; Loxley et al., 2004).

Although adolescents may have access to many illicit drugs, alcohol and tobacco are the most readily available and most commonly consumed in Australia (Australian Institute of Health and Welfare, 2002).

Data on adolescent drug use was available in Australia from 1987-1999 from regular surveys of secondary school students aged 12-17 years through the National Secondary Schools Drug Surveys (NSSDS). Since, it has been collected from 14-19 year olds as part of the National Drug Strategy Household Surveys (NDSHS). The Australian Institute of Health and Welfare (AIHW) publishes this information each year.
Estimates of the extent of adolescent substance use vary for a number of reasons including the age range sampled, the range of substances included, the methods of assessment used, the impact of different moderating variables such as gender and location (Odgers, 1998).

**Tobacco**

The 1999 National Secondary School Drug Survey data revealed that more than 70% of 17 year olds have tried cigarette smoking, and more than 30 per cent were smoking on a weekly or more regular basis (Hill et al., 2002). Tobacco use among young people is of concern due to its tendency to lead to tobacco dependence, and via this mechanism, to serious health impacts. The major determinants of smoking in young people appear to be social factors such as community availability and acceptance, parental and peer smoking, favourable attitudes as well as adjustment problems (externalising and internalising) (Patton et al., 1998).

Surveys show that rates of tobacco use increase steadily through adolescence with increasing age. By 2004, almost all (95.7%) of Australians aged 12-15 years had never smoked, but one in fifty (2.3%) smoked daily and one in a hundred (1.2%) were ex-smokers. However, by the time they were 18-19 years, one in six (16.9%) were daily smokers, equivalent to the total population rate (aged 12 years and older). Daily smoking was more than twice as likely among males aged 18 years and older than it was among those younger than 18 years. This margin was greatly decreased for females although females in the 16-17 year age range were almost twice as likely as males to smoke daily (Australian Institute of Health and Welfare, 2002; Patton et al., 1998).

Prevention efforts are focussed on preventing young people taking up smoking and encouraging those already smoking to stop (Commonwealth Department of Health and Ageing, 2005).

**Alcohol**

Alcohol is second only to tobacco in the scale of preventable harm it exacts upon Australian society (Collins & Lapsley, 2002). There has been a significant increase in the extent of alcohol use by young people and indications of hazardous binge drinking at young ages; many adolescents drink alcohol with the aim of getting drunk quickly, which they view as being 'out of control’. Drunkenness is not seen as harmful by many teenagers (Shanahan & Hewitt, 1999; White, 2001). Up to 20% of young people also report alcohol-related aggression or sexual risk-taking such as
unwanted intercourse and/or sex without condoms or contraception resulting in teenage pregnancy (Bonomo et al., 2001; Shanahan & Hewitt, 1999).

As is the case for tobacco use, surveys typically show that rates of alcohol use increase steadily with increasing age through adolescence. In 2004, two in three (64.8%) Australians aged 12-15 years had never had a full glass of alcohol, one in a thousand (0.1%) consumed alcohol daily, one in thirty (3.3%) consumed alcohol weekly and three in ten (29.1%) consumed alcohol less frequently than weekly. In this age group there was little difference between boy’s and girl’s alcohol consumption rates. In the years between the ages of 12-15 years and 16-17 years however, there was a six-fold increase in daily and weekly alcohol consumption (daily to 0.6%; weekly to 21.6% and less than weekly to 55.2%) and for those aged 18-19 years daily and weekly alcohol consumption had increased by tenfold.

The harm from alcohol use in young people is mostly associated with the acute harm resulting from accidents and injuries. Acute harm is highest in Australia for the 18-24 years age group (Heale, Stockwell, Dietze, Chikritzhs, & Catalano, 2001; Loxley et al., 2004).

There is a relationship between patterns of use in adolescence and problems with use later in life. Bonomo and her colleagues (2001) found that young people who drank alcohol regularly during their high school years (on more than 2 days each week) had a greater likelihood of alcohol dependence in early adulthood. Age of alcohol initiation has also been shown to predict later alcohol problems amongst young people (Bachman, O’Malley, & Johnston, 1984; Fergusson, Lynskey, & Horwood, 1994; Grant & Dawson, 1998).

Prevention programmes are currently focussed on reducing the amount of alcohol consumed by young people as well as targeting binge drinking behaviour. However the findings above suggest that prevention might focus on delaying the age of first alcohol use (Toumbourou, Rowland, Williams, & Hemphill, 2004).

Cannabis
Cannabis is the most widely used illicit drug in Australia. Cannabis use typically commences in mid adolescence at around 16-17 years of age and peaks in late adolescence to young adulthood (Degenhardt, Darke, & Dillon, 2002). In 2004, one in fourteen (7.2%) 12-15 years olds had used an illicit drug with cannabis making up the bulk of that figure. Some surveys indicated that more than 50 percent of secondary students report having used the drug by the time they have completed their secondary schooling. There were disparities between the different states of
Australia; the percentage of secondary students that had tried marijuana varied between New South Wales (27%), Victoria (23%) and Western Australia (31%) (Odgers, 1996).

Many young people who use cannabis do so infrequently and do not experience problems. However those who use cannabis heavily or over a prolonged period, can experience a range of health, social and inter-personal difficulties related to its use (Bonomo, 2004). Health problems can include long-term cognitive impairment (Ashton, 2002), respiratory side-effects (Hall, 1998) and precipitation of psychosis (Hall & Degenhardt, 2000). There is now consistent evidence that adolescent cannabis use increases the risk of subsequent illicit drug use. Coffey et al., (2000) estimated that, after controlling for other influences, early cannabis use approximately doubled the odds of escalation to frequent cannabis use in late secondary school.

**Methyl amphetamines**

Methyl amphetamines, including the ‘party’ drug ecstasy, is a commonly used illicit drug but more so by older adolescents and young adults. About 10% of young people report using amphetamines (Moon et al., 1999). They do not consider amphetamines as dangerous and use them primarily for their effect of extra energy and euphoria. At low doses, amphetamines impart a sense of increased self awareness, self-confidence, heightened alertness and increase capacity for concentration adding to their popularity. Chronic use however can lead to dependence, aggressions, violence and paranoid psychosis (Bonomo, 2004).

**Heroin**

In comparison to other substance use, a minority of young Australians use heroin. The increased production and availability of heroin however has been associated with a decrease in the age of onset of heroin use in Australia – approximately 1% of young people have tried heroin (Australian Institute of Health and Welfare, 2002; Bonomo, 2004).

**Predictors of substance use in young people at the individual, the family, the school and the community level** (the information below has been annotated from Loxley et al. (2004).)

Drug use among young people is characterised by clear developmental stages of use and changes over time in relation to use (Kosterman, Hawkins, Guo, Catalano, & Abbott, 2000; Loxley et al., 2004). Those who use tobacco (Costello, Erkanli, Federman, & Angold, 1999; Cummings, Vito, & Gabriel, 1995; Patton et al., 1998) and or alcohol (Guo, Hawkins, Hill, & Abbott, 2001; Guy, Smith, & Bentler, 1993; Ulmer,
Preusser, Williams, Ferguson, & Farmer, 2000) in early adolescence are more likely than their peers to progress to heavier drug use (Coffey et al., 2000; McGee, Williams, Poulton, & Moffitt, 2000), become dependent on tobacco (Costello et al., 1999; Patton et al., 1998) and experience other drug related problems (Kandel, Yamguchi, & Chen, 1992). Drinking in the early teenage years has been linked to subsequent tobacco use (Jackson, Sher, & Wood, 2000; Kandel et al., 1992) and the onset of some patterns of crime and anti-social behaviour (Brook, Cohen, & Brook, 1998; Newcomb & Bentler, 1988), while use of cannabis during those years significantly increases the risks of later use of other illicit drugs (Newcomb & Bentler, 1988; Newcomb & Felix-Ortiz, 1992), although only around 10 % of cannabis users follow this path (Williams, Sanson, Toumbourou, & Smart, 2000).

Attachment to family helps to protect adolescents against harmful drug use (Brook et al., 1998; Nelson, Patience, & MacDonald, 1999) as does parental harmony (Fergusson & Horwood, 1997; McMorris, Tyler, Whitbeck, & Hoyt, 2002), parents who monitor and supervise their children (Kosterman et al., 2000; Loeber & Dishion, 1983) and parents who have good skills in communication and negotiation (Barnes, Reifman, Farrell, & Dintcheff, 2000; Williams et al., 2000). Young people are at increased risk where there is parent-adolescent conflict (Brody & Forehand, 1993), parental alcohol and other drug problems (Hussong & Chassin, 1997), favourable parental attitudes to drug use and parental approval of (e.g. alcohol) use in childhood or early adolescence (Johnson & Pandina, 1991; Lynskey & Fergusson, 1995). Adolescents are more likely to drink alcohol if their parents do so (Li, Pentz, & Chou, 2002; Rothe, 2005; Windle, 1996).

Drug problems are also more likely in young people who do not complete high school, with school retention influenced by earlier childhood development, including school adjustment and behaviour problems (Darke, Ross, Hando, Hall, & Degenhardt, 2000). Academic achievement and feelings toward school are also relevant to illicit drug use (Campo & Rohner, 1992; Williams et al., 2000). Association with peers who engage in drug use appears to be an important risk factor in the early secondary school period influencing subsequent involvement in harmful drug use (Coffey et al., 2000; Fergusson & Horwood, 1997; Kosterman et al., 2000; Miller, Burgoon, Grandpre, & Alvaro, 2006; Williams et al., 2000). Anti-social behaviour in adolescence is also a risk factor (McGee et al., 2000; Pulkkinen & Piikanen, 1994; Williams et al., 2000) but the influence of adolescent anxiety and depression is unclear. Other risk factors at this age include sensation seeking and an adventurous personality (Fergusson & Horwood, 1997; Hawkins et al., 1992; Williams et al., 2000)
and favourable attitudes to drug use (Brook, Whiteman, Finch, & Cohen, 1998; Fergusson & Horwood, 1997).

Teenagers who are involved in sporting and other community activities with adults, however, are at lower risk of early drug use than teenagers who are less involved (Williams et al., 2000). Religious involvement is also protective (Hawkins et al., 1992; Orford, 2001).

The risk of harmful drug use in young people is heightened where there are higher levels (perceived or actual) of drug use in the community, social and economic disadvantage and community problems (Hawkins et al., 1992; Petronis & Anthony, 1999; Smart, Adlaf, & Walsh, 1994). Ready availability of drugs (Hawkins et al., 1992) and positive media portrayals of drug use (Flynn et al., 1997) have also been found to be influential, as well as young people’s perceptions about adult drug use (Huba & Bentler, 1980).

**Risk and protective factors in young people**

The identification of the predictors described in the previous section has given rise to prevention approaches that attempt to reduce factors that predict an increased probability of young people developing harmful substance use (risk factors) and increase protective factors that ameliorate risk. The risk and protective approach to prevention is derived from scientific studies in developmental psychology and disease aetiology that show that the more risk factors experienced by a young person or child, the more likely he or she will be to develop substance use problems and to experience related problems in adolescence or young adulthood (Bry & Krinsley, 1990; Harachi et al., 1992; Mrazek & Haggerty, 1994; Newcomb & Felix-Ortiz, 1992). The model has provided a useful guide to prevention planning approaches.

Developmental risk factors include biological, psychological, behavioural, social, and environmental characteristics such as family history of substance abuse, conduct problems or anti-social personality disorder, or residence in neighbourhoods where substance use is prevalent. Researchers have also found that, the more the risks in a child’s life can be reduced, for example, by effectively treating child behaviour disorders, improving parents’ family management skills, and stepping up enforcement of laws related to the sales of illicit drugs to minors or to drinking and driving, the less vulnerable that child will be to subsequent health and social problems (Brounstein, Zweig, & Gardner, 2001; Hawkins et al., 1992).

Protective factors such as a strong family connection and the capacity to succeed at school help to moderate and mediate the negative impact of existing risk factors,
including substance abuse (Hawkins et al., 1992; Mrazek & Haggerty, 1994; Wolin & Wolin, 1995). Risk and protective factors exist at every level in society at which an individual interacts with others; for young people this is principally within the family, their peer group, the school, and their community. The table below (Table 2.1) notes the risk and protective factors within these four major domains of a young person’s life.
Table 2-1: Risk and protective factors predicting drug abuse, anti-social behaviour and depression in young people in the community, family, school and peer/individual setting

<table>
<thead>
<tr>
<th>Risk &amp; Protective Factors</th>
<th>Drug abuse</th>
<th>Anti-social behaviour</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Low neighbourhood attachment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Community disorganisation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Personal transitions &amp; mobility</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Community transitions &amp; mobility</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Laws &amp; norms favourable to drug use</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Perceived availability of drugs</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>P Opportunities for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P Rewards for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Poor family management</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>R Poor discipline</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>R Family conflict</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Family history of antisocial behaviour</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>R Parental attitudes favourable toward drug use</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Parental attitudes favourable to antisocial behaviour</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P Attachment</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>P Opportunities for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>P Rewards for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Academic failure</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>R Low commitment to school</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>P Opportunities for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>P Rewards for pro-social involvement</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Peer /Individual</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Rebelliousness</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>R Early initiation of problem behaviour</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
## Risk & Protective Factors

<table>
<thead>
<tr>
<th>Risk &amp; Protective Factors</th>
<th>Drug abuse</th>
<th>Anti-social behaviour</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>R Impulsiveness</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Antisocial behaviour</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Favourable attitudes toward antisocial behaviour</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Favourable attitudes toward drug use</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Perceived risks of drug use</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Interaction with anti-social peers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Friends use of drugs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Sensation seeking</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Rewards for anti-social involvement</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>P Religious belief</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>P Social skills</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P Belief in the moral order</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. The ‘P’ symbol in the first column indicates a ‘protective factor.’
2. The ‘R’ symbol in the first column a ‘risk factor’.
3. Ticks in the first two columns indicate a consensus in previous literature (Hawkins et al., 1992) suggesting the risk (or protective) factor was predictive of the problem outcome (drug abuse, anti-social behaviour/ crime).
4. Ticks in the final column (depression) indicate significant cross-sectional relationships amongst Victorian year 9 students surveyed in 1999 (Bond et al., 2000).

Current knowledge about the development of substance abuse in young people suggest that interventions that reduce risk factors and increase protective factors within a community or population hold a great deal of promise for reducing the future incidence and ultimately the prevalence of substance abuse problems (Farrington, 2000; Hawkins, Catalano, & Arthur, 2002; Mrazek & Haggerty, 1994). Some believe however, that greater debate needs to take place about the limitations and problems of the risk and protective paradigm before wholeheartedly supporting it as an effective prevention model (Bessant, Hill, & Watts, 2003; Crow, France, Hacking, & Hart, 2004; Pitts, 2000; Wikstrom & Sampson, 2003).

### Comparison of drug use in Victorian and Western Australian young people

The present study focussed on four regional communities in two states of Australia; Western Australia (W.A.) and Victoria in the south east of the country. Figure 2.1 illustrated the variations in the ‘principle drugs of concern’ between the two states.
('principle drug of concern' describes the drug that leads a person aged 10-19 years old to seek treatment). In W.A. the main drugs of concern in 2005 were cannabis (55%), alcohol (17%) and amphetamines (17%), compared with the Victorian drugs of concern, which were cannabis (41%), alcohol (22%) and heroin (16%).

Figure 2.1: Closed treatment episodes by principal drug of concern for 10-19 year olds living in Victoria and Western Australia, Australian Institute of Health and Welfare (2005a)

Note: Total number closed episodes in Victoria – 6,523 (state population 4 million)
Total number closed episodes in Western Australia – 2,290 (state population 1.8 million)
Drug use patterns between rural young people and city dwellers

As the present study focussed on non-metropolitan areas, some consideration was given to the differences in problematic substance use between country and city dwellers.

Young people in rural (and regional) Australia have poorer health status than their metropolitan counterparts, as demonstrated by higher death and hospitalisation rates, with road trauma and suicide the leading causes of death (Moon et al., 1999). Graham (2006) noted that rural young people face geographical isolation and structural disadvantage that includes socio-economic disparities, limited educational, employment and recreational opportunities and reduced access to health services compared to young people living in urban areas (Australian Institute of Health and Welfare, 1998). These factors may contribute to their risk-taking behaviour (Patterson & Pegg, 1999; Quine et al., 2003).

According to the Mission Australia Survey (2005), alcohol and other drugs were a major issue of concern for 36.6% of all respondents from non-metropolitan areas compared to 30.8% of those from capital cities (total number respondents 11,300 young people). Research also suggested that adolescents in rural areas were more likely to consume alcohol and suffer the effects of risky drinking than their metropolitan counterparts (Bond et al., 2000; Williams et al., 2000). This is reflected in a non-metropolitan alcohol attributed death rate in 15-24 year olds that is 1.7 times higher than for metropolitan areas (Chikritzhs & Pascal, 2004). Adolescents in rural areas are also more likely to attribute early alcohol initiation to external factors such as advertising, legal issues, easy access to alcohol (Shanahan & Hewitt, 1999) and affordability (Oh, Hemphill, & Munro, 2003).

Andrew and his colleagues (Andrew, Hall, Teesson, & Henderson, 1999) and Bond et al (Bond et al., 2000) however, found that there were no differences in the likelihood of alcohol and drug disorders between rural and urban areas.

Drug use harm

Harm occurs at all levels of community life with problems more evident in some groups than others. The mortality figures presented in Chapter 1 only provide a partial illustration of drug-related harm. Alcohol and heroin are disproportionately responsible for the deaths among young people; in 1997, 50% of drug related deaths in the 15-34 age range were from alcohol, 42% from illicit drugs and 9% from tobacco (Mather, Vos, & Stevenson, 1999). Alcohol dependence, harmful drug use and road traffic accidents as a result of drug use (mostly alcohol (Chikritzhs,
Stockwell, Heale, Dietze, & Webb, 1999) are the leading causes of health costs for those in the 15-34 age range (Mather et al., 1999) calculated through DALY (Disability Adjusted Life years) (Ryder, Salmon, & Walker, 2001).

Harm can also accrue to people around the substance user, including family, friends and strangers such as other road users. Rumbold and Hamilton (1998) suggest that for every person who drinks alcohol in harmful ways (large or frequent quantities) the lives of at least four other people are negatively affected (Semlitz & Gold, 1986). Perhaps the most difficult drug-related harm to assess is the indirect harm that accrues to local communities that often reflect the social problems and processes of society in general (Alinsky, 1972). As a community feels more fearful, anxious, and less capable to deal with a social issue, so they loose some resilience and capacity to manage other problems. According to Hamilton (1998), this sense of decreased capacity and competence can be profound.

Whilst awareness of negative signs in a community, such as drunkenness, graffiti, gangs and witnessing illegal drug sales may result in fear of crime and social withdrawal on the one hand (Ahlbrandt & Cunnigham, 1979; Peterson & Reid, 2003; Skogan & Maxfield, 1981), it can also provide the motivation to action on the other (Chavis & Wandersman, 1990; Gaziano, 1988; Peterson & Reid, 2003). Crenson (1978) discussed formation of organisations in response to perceived threat or reality of community problems while Perkins and colleagues (1990) showed how awareness of neighbourhood problems served as a catalyst for participation in voluntary organisations. Media studies have also shown that significant knowledge gaps are less likely when community mobilisation occurs in response to social conflict (Donohue, Tichenor, & Olien, 1975). Community mobilisation efforts recognise this paradox and promote activities that strengthen the emotional connections that support feelings of safety and security in communities and buffer the emotional impact of resident’s awareness of substance abuse problems in their communities (Peterson & Reid, 2003).

**Conceptualising adolescent substance use within a community context**

It is now commonly accepted that the determinants of health and well-being lie largely outside the scope of the curative health services and more in the realm of public health (Wilkinson & Marmot, 1998). This perspective moved away from the emphasis on individuals as the primary agent of change toward a model that conceptualises the individual as enmeshed in a complex system of factors that influence behaviour (Wicker, 1979; Wilkinson & Marmot, 1998). It emphasised the dynamic interaction between biology, behaviour and the environment (Magnusson,
Researchers in the fields of community psychology, public health and community development have long focused on changing community environments in order to change individuals’ behaviour (Cottrell, 1983; Kelly, 1988; Thompson & Kinne, 1990), although the extent to which genetic, environmental and learned behaviours interact to determine substance abuse remains the subject of considerable research (Butterworth, 1993). The shift in conceptualising problematic behaviour from the individual to a broader social determinant was also seen to emerge in the field of health education during the 1970’s and 1980’s (Glanz, Lewis, & Rimer, 1997b).

In 1988, McLeroy and his colleagues described five levels of influence on health behaviour, three of which related to the individual’s environment; institutional or organisational factors, community factors and public policy. Ten years later, Mary-Ann Pentz described three key influences specific to adolescent behaviour and substance use, two of which focussed on the individual’s external environment: ‘situational factors’ and ‘environment-level factors’ (Pentz, 1999). In her typology, ‘situational factors’ included the inter-personal and group influences of drug-use modelling, pressures or offers to use drugs, peer and family communication and support, and peer group transitions. ‘Environment-level factors’ include the extra-personal media influences, resources, community norms and policies and demographic factors (Hawkins et al., 1992; Murray & Perry, 1985; Pentz, 1986, 1994a, 1994b, 1995).

Later, Hawkins, Catalano and Miller (1992) added their landmark study of risk and protective factors research that firmly established the scientific validity of prevention approaches in a range of settings relevant to adolescent substance use (refer Table 2.1); three of four settings focussing on the young person’s external environment. Follow-up studies by Coie (1993) focused on the powerful role played by cultural beliefs and community norms and behaviours on adolescent substance use. He proposed that prevention adopt general systems theory by exploring the prevention effects resulting from the interaction between multiple influences that included family, school, peer, workplace and community; and that prevention carefully addresses the interaction of social influences as well as biology across the development life course (Bukoski, 2003).

Rowland (2006) takes a practical stance to the conceptual shift and points out that while there is good evidence that drug and alcohol interventions targeted at the individual have been successful in changing the behaviour of those individuals, the sustainability of such an approach is difficult when there are so many countervailing
social influences and pressures such as the media, the marketing of drugs and unhealthy social norms (McLeroy et al., 1988; Rutten, 1995; Salis & Owen, 1997; Smedley & Syme, 2000). Equally, individual approaches can only reach a small number of individuals, limiting the overall benefit for the community (Cohen & Schribner, 2000).

More recently the term ‘social ecology’ has been used in the literature to describe the approach to community interventions that are comprehensive and tackle issues through a range of settings and contexts, including the individual (Cohen & Schribner, 2000). They can include policies, social and environmental conditions, institutional factors and social norms (McLeroy et al., 1988; Salis & Owen, 1997).

This conceptual approach acknowledged that whilst prevention efforts were often targeted toward individuals, smoking, alcohol and other drug taking behaviours occur by and large in social group settings (Hawkins & Weiss, 1985; Holder & Giesbrecht, 1990; Kellehear & Cvetkovski, 2004; Kumpfer & Turner, 1990). The community environment in which they occur in turn influences these group settings (Fitzpatrick & Gerard, 1993; Moos & Lemke, 1994). In a comprehensive review of community approaches to drug, alcohol and tobacco prevention, Aguirre-Molina and Gorman (1996) reported that the most successful interventions were those that took the ecological approach (Rowland, 2006).

The ‘ecological’ or ‘social ecological’ framework as they are interchangeably termed assumes that as behaviour occurs within a social context that large-scale behaviour change requires changing the social context (Arthur et al., 1999; Butterworth, 1993; Moos, 1996). This change is more likely to occur when those affected by the problem are involved in defining and solving the problem (Casswell, 2000; Puska et al., 1985; Thompson, Wallack, Lichtenstein, & Pechacek, 1990-1991).

Having outlined some of the features of adolescent substance use in Australia, the next section will outline how the problem is being addressed by the three tiers of government through policy, how this relates to communities and also describe some of the community efforts thus far to reduce the problem.
2.3 HOW IS THE PROBLEM BEING ADDRESSED IN AUSTRALIA?

2.3.1 Government drug policy

A health-focussed approach to dealing with drugs emerged in Australia in late 1984 when the then Prime Minister, Bob Hawke talked about his daughter’s involvement with drugs. As part of his government’s re-election strategy he set up the National Campaign against Drug Abuse (NCADA) with approval from the states and territories. The funding that followed shifted efforts from law enforcement toward a multi-faceted approach to drug problems. In launching NCADA, the Health Minister stated that the aim of the campaign was to ‘minimise the harmful effects of drugs on Australian society’. In 1993, NCADA was re-named the National Drug Strategy.

The ‘harm minimisation’ approach to drug policy has since formed the basis of successive phases of the Australian National Drug Strategy. It remains the key principle underpinning programmes for all levels of government in Australia:

“More realistic goals include attempting to reduce the frequency of use, the quantity and toxicity of drugs consumed and to reduce harm to drug users and the community generally. Harm reduction must be embraced” (Hellawell, 1995p.319).

“Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of integrated approaches” (Ministerial Council On Drug Strategy, 2004 p.15).

The approach was not without controversy; in the early days, some viewed ‘harm minimisation’ as an approach that was tantamount to legalising drug use. This confusion of meaning presented a major impediment to gaining public agreement about this approach in drug policy. These days the drug strategy clearly states: “harm minimisation does not condone drug use” (2004-2009), rather it refers to policies and programmes aimed at reducing drug related harm, that include abstinence-oriented strategies, much like in the USA (Fitzgerald & Sewards, 2002).

The ‘harm minimisation approach’ can be applied to both licit drugs such as tobacco and alcohol and illicit drugs such as heroin, cocaine and cannabis and
includes strategies that address ‘Supply Reduction’ (strategies that disrupt production and supply), ‘Demand Reduction’ (strategies to prevent the uptake of harmful drug use) and ‘Harm Reduction’ (strategies to reduce drug related harm for individuals and communities) (Rumbold & Hamilton, 1998).

The development of Australian drug policy since the early 1990’s had involved a particular style of interaction between government and special interest groups, loosely termed the ‘policy community’. Similar to any policy-making arena, it was shaped by a system of advisory structures where its members shared a common language, in this case the drug policy framework. Consensus was achieved by government departments recognising the relevant interest groups and mobilising this ‘policy community’ on agreed upon policies. Jordan and Richardson (1987) described how a notable feature of this approach was the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation through an extensive network of consultative processes. This approach however, distanced the broader community from participation in the development of drug policy, as well as the research evidence for policy decisions.

This separation of the ‘policy community’ and the involvement of the broader community was catastrophic for the Victoria government in 1999 (refer Ch.1) when its $12 million strategy to set up ‘safe injecting facilities’ (Drug Policy Expert Committee, 2000) was overwhelmingly rejected by two of the five targeted communities; and the Bill was rejected in State parliament shortly afterwards. The communities involved did not believe the information that was presented by the government-appointed experts (Oetting et al., 1995). The relevant local governments were also powerless to assist as they too were excluded from the ‘policy community’. Since that time the Victorian government has moved to a more community-based policy infrastructure that potentially engages communities in policy-making (Hamilton et al., 1998; VicHealth, 2000).

The Western Australian drug strategy ‘Together Against Drugs’ emphasises the importance of community involvement in projects that aim to reduce drug related harm but described the process of involving community members as challenging (WA Drug and Alcohol Office, 1999).

Many problems remained however, for the development of drug policy; particularly the ongoing debate as to what constituted a successful outcome from drug treatment. Drug detoxification was rarely successful in producing long-term abstinence; counselling was rarely successful in preventing drug use; there was
virtually no evidence that drug education and mainstream media campaigns had any success in preventing or reducing drug use (Rumbold & Hamilton, 1998). There was even some evidence that aggressive policing increased the risk of blood-borne virus transmission in street drug environments (James & Sutton, 2000; Maher et al., 2001).

The current National Drug Strategy 2004-2009 (Commonwealth of Australia, 2004) has eight priority areas:

1. Prevention
2. Reduction of supply (‘Supply Reduction’)
3. Reduction of drug use and related harms (‘Harm Reduction’)
4. Improved access to quality treatment
5. Development of the workforce, organisations and systems
6. Strengthened partnerships
8. Identification and response to emerging trends


One of the priorities of this strategy (6: ‘Strengthening Partnerships’) is to encourage greater community understanding of drug-related harm and greater engagement of community members and organisations in designing and delivering services tailored to the needs of particular groups and localities (Phillips, 2000). The three tiers of government in Australia; federal (national government), state and local government have a role in the application of the strategy.

The strategy is the responsibility of the Ministerial Council on Drug Strategy (MCDS), the peak policy and decision making body on drugs in Australia. It functions as a national ministerial-level forum responsible for developing policies and programmes to reduce the mortality, morbidity, social and economic cost experienced by Australians from drug use. It brings together federal government, state and territory ministers responsible for health and law enforcement and the Australian Government minister responsible for education.

The MCDS also liaises with the Australasian Police Minister’s Council, the Australian Health Minister’s Council, the Ministerial Council for Employment, Education, Training and Youth Affairs and other ministerial councils on matters of joint responsibility and priority in relations to the National Drug Strategy.
At the federal level there are three key advisory bodies that collectively provide input to the Ministerial Council on Drug Strategy; the Inter-Governmental Committee on Drugs, the Australian National Council on Drugs and the National Expert Advisory Panel as well as two national research centres that support the interface between research and service provision; the National Drug and Alcohol Research Centre in Sydney, New South Wales, and the National Drug Research Institute in Perth, Western Australia.

The states and territories, that have developed specific drug and alcohol plans aligned to the national strategy, are primarily responsible for drug treatment services, reducing harm through prevention and public health approaches such as the needle and syringe exchange programme, improving access to services, and reducing supply through law enforcement and licensing, although government resources are still skewed towards law enforcement rather than community-based approaches (Phillips, 2000).

Although local government in Australia does not specifically provide drug and alcohol services they have a key role in the planning and provision of a range of youth and social services outlined in the respective state Health Act. In Victoria, the Health (General Amendment) Act 1988 states that “it is the function of every council to seek to prevent diseases, prolong life and promote public health through organised programmes including prevention ”("Health (General Amendment) Act, Parliament of Victoria," 1988). Importantly, local government carries responsibility for maintaining a dialogue with the community and ensuring their involvement in decision-making processes through its elected councillors and planning obligations. In Victoria, the Drug Action Plan provided for “a coordinated framework for local government and the community to respond to drug problems” (Drug Policy Expert Committee, 2000 p.21).

Local government often brings together relevant service providers and others to manage local issues, such as the police, health providers, traders, social and welfare groups, but has little role in drug policy governance. This is left to a small number of peak bodies in each state that represent local government on drug policy. In Victoria this includes the Victorian Local Governance Association which takes a lead role in issues relating to syringe disposal, the Municipal Association of Victoria that has a lead role in tobacco control and the five targeted local government areas described as ‘hotspots’ for illicit drug use, that have a primary role in the Municipal Drug Strategy(Department of Human Services, 2007; Victorian Government, 2000). In Western Australia this includes the government department of WA Drug and Alcohol
Office, ‘Safer WA’ and the West Australian Network of Alcohol and other Drug Agencies (WANADA).

Other local government roles may include research and data collection on drug trends, mapping of services and needs identification, information dissemination and community education and public space management (Menner, 2003).

**Government community building policy**

‘Community building’ has been a broad shift in policy by governments over the last decade, based on a growing awareness of geographically-based disadvantage and the need for a response that will involve all stakeholders. ‘Community building’ strategies and ‘place-oriented’ policies designed to address social issues have developed a higher profile as many communities across the globe, both rural and urban have become sufficiently distressed and this has made collaboration between government and communities in addressing local concerns a high priority (Wallerstein, 1992). Community building is simultaneously intended to promote the capacity of local communities to develop their own solution to problems while also strengthening the ability of government to boost the social and economic outcomes, particularly of disadvantaged communities (Department of Victorian Communities, 2004; Glanz & Rimmer, 1995; Howe & Cleary, 2001). McLeroy (2003) sees community building as a pathway to health; an important paradigm underlying community intervention strategies.

The community building paradigm has shifted somewhat from a ‘need’s or ‘deficits’ model to a ‘strengths’ or ‘assets’ model (Kretzmann & McKnight, 1993) where community building strategies use community organising techniques with the goals of, a) enhancing the ability of a community to resolve its own problems, b) increasing the community’s role in making decisions that have important implications for community life and c) resolving specific problems (Rowling, Martin, & Walker, 2002).

Acting in concert with those who have local knowledge and resources, governments can make themselves and their communities far more effective (Peterson & Reid, 2003). To become sustainable however requires improved forms of local governance and appropriate policy (Department of Victorian Communities, 2004).
2.3.2 Prevention conceptual models and frameworks

Academics, public health and health promotion practitioners and government departments in developed countries have engaged a number of conceptual models and frameworks to address substance use in communities over the last decade. The next section summarises some of those approaches.

The World Health Organisation’s Ottawa Charter (1986) was one of the first health manifestos written as a charter and mandate for different sectors to work together to improve health: “Health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industry and by the media” (1986). The Ottawa Charter for Health Promotion specifically called for an approach to health promotion that gave equal status to the creation of supportive environments alongside the development of personal skills and a reorientation of health services. Although the Charter did not discuss specific health problems such as drug abuse, it implied that health problems are affected by the economic, social and political characteristics of those societies (Mellor, 1998).

Labonte (1992) described three main approaches to addressing a health need: the ‘medical approach’ that tries to return sick people to a illness-free state through the delivery of health services, the ‘behavioural approach’ that promotes healthy lifestyles and the ‘socio-environmental approach’ that is concerned with the totality of health experiences and the factors that help to maintain health, including those connected directly with people (behaviour, self esteem and genes) and environment (income, housing and employment) (Table: 2.2). The socio-environmental approach would not lead to change on its own but that it was an essential ingredient that dictated how quickly change occurred and how long it lasted; the more a community struggles and succeeds, the more capacity it will have for future efforts through participating in the collective problem solving processes (Heaney & Israel, 1997; Israel, 1982; Kreuter, Lezin, Kreuter, & Green, 2003). Labonte described the medical and behavioural approaches as more potent when incorporated within the broader framework offered by the socio-environmental model (Baum, 1998).

Table 2.2 highlights the differences in Labonte's three approaches; the most notable difference in the three is the significance of a sense of ‘empowerment’ or control over one's destiny offered by the socio-environmental approach from the definition of health through to the success criteria.
<table>
<thead>
<tr>
<th>Focus</th>
<th>Medical</th>
<th>Behavioural</th>
<th>Socio-environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individuals with unhealthy lifestyles</td>
<td>Individuals and groups</td>
<td>Communities</td>
</tr>
</tbody>
</table>

**Definition of Health**

<table>
<thead>
<tr>
<th>How problems are defined</th>
<th>Medical definition.</th>
<th>Expert definition.</th>
<th>Socio-environmental risks (e.g. poverty, unsafe or stressful living and working conditions). Psycho-social risks (e.g. isolation, lack of social support, low self esteem).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease categories and physiological risk factors (e.g. cardio-vascular disease, HIV/AIDS, diabetes, cancer).</td>
<td>Behavioural risk factors (e.g. smoking, poor nutrition, lack of fitness, alcohol abuse, poor coping skills).</td>
<td>Strong personal and community relationships. Feeling of ability to achieve goals and be in control</td>
<td></td>
</tr>
</tbody>
</table>

**Main strategies**

<table>
<thead>
<tr>
<th>Success criteria</th>
<th>Decrease in morbidity and mortality and decrease in physiological risk factors</th>
<th>Behaviour change, decline in risk factors for disease</th>
<th>Individuals have more control, social networks and stronger, collective action for health evident, decrease in inequities between population groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness care, screening, immunisation, medically managed behaviour change.</td>
<td>Mass media behaviour change campaigns, social marketing, advocacy for policies to control harmful agents (e.g. drink-driving, smoke free public places)</td>
<td>Encouraging community organisation, action and empowerment. Political action and advocacy.</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Labonte (1992) in Baum (1998)

The Institute of Medicine’s report “Reducing the Risks for Mental Disorders” (Mrazek & Haggerty, 1994) provided an important contribution by advancing the conceptual basis of prevention intervention with the inclusion of a ‘mental health intervention spectrum’ model that has been adapted for substance abuse. The spectrum matched the primary, secondary and tertiary prevention relevant to medical interventions to ‘universal’, ‘selected’ and ‘indicated’ interventions relevant to mental health and substance abuse (Figure 2.2)
Figure 2.2: The mental health intervention spectrum for mental disorders

(Mrazek & Haggerty, 1994)

‘Universal’ interventions are offered to the entire population such as smoking prevention; ‘selective’ interventions are targeted to those at greater than average risk than the rest of the population such as older adolescents may be of greater risk of accident resulting from alcohol consumption. ‘Indicated’ interventions are provided to high-risk individuals or those experiencing early symptoms of a disorder such as young people who have started to experiment with drugs. An important feature of this model as with the others described is that all three levels of prevention can be implemented in an applied setting - for young people these settings include the individual, family, school, peer and community.

The Center for Substance Abuse Prevention (CSAP), the major drug prevention funding agency in the USA, described four prevention intervention conceptual models; the ‘Disease Model’, the ‘Community Systems Model’, the ‘Harm Reduction Model’ and the ‘Risk and Protective Factor Model’, described earlier in this chapter (Centre for Substance Abuse Prevention, 1996).

The ‘Disease Model’, as with Labonte’s ‘Medical Approach’ focuses on the provision of services that try to return sick people to an illness-free state. The ‘Community Systems Model’ focuses on laws, regulation and policies of community systems that have a demonstrated effect on reducing substance use (Toomey & Wagenaar, 1999; Ulmer et al., 2000). This model favours prevention activities that encourage restrictions on availability, sanctions against problem behaviour and changes in
community norms regarding substance use. This would be similar to the Australian ‘supply’ and ‘demand’ reduction approaches described in the national and state drug strategies (Commonwealth of Australia, 2004; Victorian Department of Human Services, 2006; Western Australian Department of Health, 2005).

The ‘Harm Reduction Model’ seeks to prevent the specific harmful consequences of substance abuse, rather than the substance abusing behaviour. Harmful consequences might include injuries and fatalities from drunk-driving, sexually transmitted diseases from unsafe sex as a result of substance abuse, violence associated with intoxication or selling illegal drugs. This model does not necessarily try to reduce the prevalence of use in the population, but tries to reduce the frequency and quantity of use in situations where harm might occur (Arthur et al., 1999).

No one model is seen as the key to preventing substance abuse in communities; more the different models can be viewed as complimentary in that they address different populations, targets and levels (Loxley et al., 2004)

2.3.3 The role of community in addressing adolescent substance abuse

The concept of community

Integral to any discussion on community function and its role in addressing substance abuse is the concept of community. It is a term that has been widely used yet it has multiple meanings that have been studied from varying perspectives by sociologists, geographers, health providers, anthropologists, town planners and governments.

The term ‘community’ suggests some form of geographical and social proximity of people to each other. It also suggests a commonality that in some way links or bonds individuals and groups together. This common element is frequently associated with geographical areas and political interests and hence implies some form of affiliation among its members (Holder, 1992). On a large scale ‘community’ can refer to towns, cities or even countries and on a small scale, it can refer to subdivision of neighbourhoods, schools, workplaces and university campuses (Giesbrecht, Krempulec, & West, 1993).

Green and Kreuter (2001) found it helpful to define ‘community’ in terms of two characteristics; structure and function. Structurally, like Giesbrecht’s definition, a community is an area with geographic and often political boundaries that demarcate it in some way, be it as a district, a county, a metropolitan area, a
township or a neighbourhood. Functionally, a community is a place where “members have a sense of identity and belonging, shared values, norms, communications and helping patterns” (Israel, 1985p.72).

Communities can also be based on shared interests or characteristics such as ethnicity, sexual orientation or occupation (Fellin, 1995). Hawe (1994) described communities as social systems, an ‘eco-system’ with a capacity to work towards solutions to its own community-identified problems. Members may live many miles away, yet identify a place as their community and likewise be seen as an active member by locals (Haglund, Weisbrod, & Bracht, 1990). This would be a typical situation in rural Australia, where a farmer may live hundreds of kilometres from a town, yet see it as the place where he or she shops, socialises, banks and sells their produce, to give an example.

The characteristics of community structure and interaction can include diverse concepts such as ‘community complexity’, ‘horizontal and vertical linkage’ among institutions, ‘centralisation of authority’, regional autonomy’, ‘community identification’ and ‘social integration’ of the population. Minkler and Wallerstein (1997) contend however, that there are two sets of theories in the health promotion literature that are key to understanding the concept of community; those of the ‘ecological system’ and the ‘social system’.

They describe the ‘ecological system’ as particularly useful in the study of the geographical characteristics of communities that focus on population size, density and heterogeneity, the physical environment, the social organisation or structure of a community and the technological forces affecting it. Whereas the ‘social systems’ perspective described by Fellin (1995) focussed primarily on the formal organisations that operate within a given community, exploring the interactions of community sub-systems both horizontally within the community, and vertically as they relate to each other and to outside systems. Warren’s (1978) view of a community as a social system envisioned communities as dynamic entities that change their structure and function to accommodate various social, political and economic developments.

The underlying principle of these descriptions is that community is made up of an inter-dependent group of people that share through its culture, values, norms and an attachment to the community (MacQueen et al., 2001; Sarason, 1974). Critiques of the use of the term ‘community’ have noted that this view of community can obscure the conflicting interests in the social and political life. Young (1990) suggests that the relationship between different groups within communities is far from
homogenous but “blotted by racism, sexism, xenophobia, homophobia, suspicion and mockery” (p.319).

The function of community

A community’s capacity to maintain well-being is influenced by the broader function of society according to Alinsky (1972). This includes income through employment and access to welfare assistance, affordable housing, childcare, sport and recreational facilities, public transport, schools and other learning centres. Key to this diversity of function is the involvement of government and organisations working in partnership with business and local communities (Rowling et al., 2002).

Gauntlett et al (2000) proposed a number of functions of a strong and healthy community:

a) Provides a clean safe environment
b) Meets the basic needs of residents
c) Comprises residents that respect and support each other
d) Involves the community in local government
e) Promotes and celebrates their historical and cultural heritage
f) Provides easily accessible health services
g) Possesses a diverse innovative economy and,
h) Rests on a sustainable eco-system.

To achieve these characteristics of a healthy and strong community requires effective leadership, established and productive networks within and with other communities, the ability to build on existing assets and resources, a ‘can-do’ spirit and an optimism about the future, the ability to grasp opportunities, a sense of belonging amongst its members and the ability to embrace change (Kenyon & Black, 2001).

An important though largely non-modifiable factor affecting community function however is the structure and size of communities. Large communities are characterised by greater specialisation in interest groups, services and institutions including government, business, media and other organised centres of power; small towns are less ‘specialised’ and differentiated across all these sectors (Viswanath & Finnegan, 1997). It has been suggested that in certain domains such as in health, the greater availability of diverse sources may work to the advantage of residents of larger communities (Viswanath & Finnegan, 1995), yet knowledge gaps and the potential for conflict, are higher than in smaller communities because of their diversity and specialisation (Donohue et al., 1975; Ettema, Brown, & Luepker, 1983;
Gaziano, 1988; Shinghi & Mody, 1976). Viswanath and others (1994) found the contrary, however, that knowledge gaps were more likely in smaller communities.

**Community prevention interventions addressing adolescent substance abuse**

The health promotion and prevention literature use a number of terms to describe community efforts; ‘community interventions’ to refer to community-wide approaches that seek small but pervasive changes that apply to the majority of the population and; ‘interventions in the community’ that seek more intensive or profound change in a sub-population by targeting those in a particular setting such as the workplace or schools (Green & Kreuter, 2001). ‘Programmes’ are defined as vehicles for delivering and sequencing interventions over time (Toumbourou, 2004) and strategies are approaches used to roll out programmes.

Community has been the locus of health promotion, prevention and community interventions over many years (Fiske, 2000; Schmidt, 2000; Wise & Signal, 2000). Community-based prevention approaches implemented through locally driven coalitions have become increasingly popular (Kumpfer, Turner, Hopkins, & Librett, 1993). This approach was originally developed within the agent/host/environment public health model to address cardiovascular disease (Joffres et al., 2004; Puska et al., 1985; Puska, Salonen, Toumillehto, Nissinen, & Kottke, 1983) but has been extended to other health problems, as well as behavioural problems such as alcohol and substance abuse (Mayer et al., 1998; Roussos & Fawcett, 2000). The evidence is increasing that community approaches can successfully reduce the levels of alcohol and drug use and the related-harm (Aguirre-Molina & Gorman, 1996; Farquhar, 1985; Mrazek & Haggerty, 1994; Perry et al., 1993; Perry et al., 1996).

There is a diversity of approaches that have been shown to be effective in preventing adolescent substance abuse at the various ‘ecological’ levels (Durlak, 1999; Nation et al., 2003); principally at the community and neighbourhood level, in schools, families and peer groups, and at the individual level (Hawkins et al., 1992; Loxley et al., 2004; Mrazek & Haggerty, 1994; Werner & Smith, 1992). Findings from a number of community-level trials have provided evidence that community-wide risk-reduction interventions can prevent alcohol and tobacco use among adolescents (Biglan et al., 1996; Biglan & Taylor, 2000; Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995; Forster et al., 1988; Nutbeam, 1997; Perry et al., 1996; Wagenaar et al., 2000; Wagenaar et al., 1996). ‘The Midwestern Prevention Project’ combined individual skills training for students, parenting skills training, school policy and curriculum changes as well as community-wide norm and policy interventions (Li et al., 2002; Pentz et al., 1989). ‘Project Northland’ combined parent involvement and education
programmes, behavioural curricula, peer participation, and community task force activities to change community, family and peer group norms (Perry et al., 1993; Perry et al., 1996; Roski et al., 1997; Wagenaar et al., 1993). ‘Communities Mobilizing for Change on Alcohol’ focussed on mobilising the community to change norms and young people’s access to alcohol through policy change and collaboration (Wagenaar, Gehan, & Jones-Webb, 1999).

Toumbourou (2004) reviewed a number of adolescent drug prevention approaches that have been shown to have some effect. He found that whilst discrete interventions can be effective there appeared to be important advantages for intervention strategies to be creatively integrated and coordinated across time (Goodstadt, 1989). Programmes incorporating more than one health promotion strategy appeared consistently effective (Flynn et al., 1997), and programmes that targeted more than one risk factor could possibly increase the likelihood of an effect. One-off school interventions or interventions for only one school year were less successful than those maintained across a number of years. These considerations led to the conclusion that prevention activities should aim to maintain a coordinated set of activities throughout childhood and adolescence that addressed the developmental stages of young people, and subsequent activities should build on earlier components (Weissberg, Kumpfer, & Seligman, 2003).

Programmes have also focussed on controlling access to substances and educating people as to their harmful effects. In some examples this has been achieved by better managing the community environment for the sale and use of alcohol and other drugs. Community-wide policy changes to reduce the availability of tobacco to young people have resulted in decreased cigarette smoking among adolescents (Forster et al., 1988; Jason, Ji, Anes, & Birkhead, 1991; Rigotti et al., 1997). Similarly, community-wide policy changes to reduce availability of alcohol to young people including increasing the drinking age (Cook & Tauchen, 1984; Joksch, 1988) and restricting how alcohol is sold (Hingson, Strunin, Berlin, & Heeren, 1990; Holder & Reynolds, 1998; Holder et al., 1997); have decreased consumption and the frequency of alcohol-related traffic accidents and deaths (Hawkins et al., 2002).

In other examples, the focus has been on improving developmental settings to encourage good beginnings for children and the healthy growth of young people (Feinberg, Greenberg, & Osgood, 2004) such as the Australian government’s ‘Stronger Families and Communities Strategy’ that was launched in 2000 as a way of strengthening the role of the family and early childhood development. Whilst the strategy did not directly address young people’s issues, its early intervention and
prevention approach will hopefully bring community benefits such as the reduction of harmful drug use (Commonwealth Department of Family and Community Services, 2000).

Bracht and Gleason (1990) indicated that community approaches (when combined with supplementary clinical and, or individual approaches such as smoking cessation clinics) have a number of advantages over other approaches:

1. The burden of chronic or environmentally induced disease cuts across most sectors of the community. The causes of these diseases are complex and rooted for the most part in cultural phenomena.
2. Community approaches affect the social milieu of individuals and are oriented toward changing the norms, values and policies surrounding behaviour.
3. Community approaches are better integrated into the total community since interventions are built into existing community structures.
4. Community approaches better ensure longevity of change because the social context of behaviour proscribes certain activities and local ownership generates responsibility.
5. Community approaches are generally more comprehensive and ensure better allocation and coordination of scarce resources.
6. Community approaches reflect shared responsibility for health and move away from the individual strategies only, or ‘victim blaming’. Community approaches actually augment individual capacity for change.

The success of these many and varied approaches to community intervention however, continues to be debated. Community-based interventions have to contend with three possible problems: ‘theory failure’, ‘implementation failure’ and ‘measurement failure’:

‘program failure can result from misapplication of relevant theory just as surely as from improper execution or inappropriate measurement’ (Weiss, 1972 p.38).

‘Theory failure’ occurs when the theory underpinning the community project (what it plans to do and why it sees this as a means of tackling the problem it is aiming to address) is basically flawed (Arthur & Blitz, 2000; Fulbright-Anderson, Kubisch, & Connell, 1999). ‘Implementation failure’ occurs when local projects have not delivered measurable outcomes so evaluators have nothing to measure (Weiss, 1998). ‘Measurement failure’ occurs when it cannot be demonstrated whether any
benefit has occurred because the evaluation or measurement technique is flawed or inadequate (Fulbright-Anderson et al., 1999; Hollister & Hill, 1999; Peterson et al., 1992; Weiss, 1998).

In light of research showing that prevention can be effective, the failure of substance abuse prevention efforts to produce meaningful reductions in the prevalence of alcohol, tobacco and other drug use among adolescents has prompted an examination of the gap between prevention research and prevention practice (Altman, 1995; Morrissey et al., 1997). Evidence that some well-intentioned school drug education programmes actually increase drug use behaviour (Hawthorne, Garrard, & Dunt, 1995; Swisher, Crawford, & Goldstein, 1971; Wallace & Steiger, 1998) also emphasises the importance of programme evaluations for prevention interventions (Commonwealth Department of Health and Aged Care, 2000b; Giesbrecht & Haydon, 2006). A number of reasons for this gap between research and practice have been identified, including: differing professional backgrounds, training and perspectives on prevention, resource limitations, lack of community readiness and system-level barriers such as competing political interest and funding priorities (Morrissey et al., 1997). Another reason for the limited adoption of research-based prevention strategies lies in the sheer number of strategies and programmes from which prevention providers must choose (Arthur & Blitz, 2000).

Arthur and Blitz (2000) also described some of the structural barriers to establishing effective prevention work in communities. A major problem was often the long-term nature of prevention activities, which did not fit the short-term requirements of political priorities (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999). A second major problem was that public opinion often required immediate responses to immediate problems. A third problem confronting prevention efforts was that they may not easily fit the brief of existing service organisations in their requirement for long-term work across multiple settings. The final problem they described was that many of the ‘self-evident’ methods of encouraging prevention are ineffective (Beatty & Cazares, 1984; Ennett, Tobler, Ringwalt, & Flewelling, 1994; Gottfredson & Gottfredson, 2002; Kaftarian & Wandersman, 2000; Lynam et al., 1999; Morrissey et al., 1997). In their view, successful prevention required that evidence-based strategies are appropriately selected and then applied in a manner that retains the effective elements.

A large share of the failure is attributable to the fact that prevention interventions often receive little or no moral support in many communities and some efforts are met with outright resistance. For example, it is already known that alcohol abuse
prevention is more difficult to introduce in communities whose employment base is dominated by occupations where drinking is part of the after-work lifestyle (Hawkins et al., 1992).

Merzel and D’Affitti’s important review (2003) of community-based programmes over the last 20 years indicated that many had only modest impact, with the notable exception of HIV prevention programmes. The reasons for the poor outcomes however were largely research-based and included methodological challenges to study design and evaluation, concurrent secular trends, smaller than expected effect sizes, limitations of the intervention and the limitation of the theories used. The effectiveness of the HIV programmes related in part to extensive formative research and an emphasis on changing social norms.

Whilst considerable progress has been made over the last decades in articulating programme and implementation theories, there have been relatively few advances in developing a theory of community change, particularly ‘norm’ and ‘value’ change; relying instead on measuring individual change (Farquhar, 1985; Hawe, 1994; Leventhal, Safer, Cleary, & Gutmann, 1980; Stevenson, Mitchell, & Florin, 2001). This inadequacy of theory seriously hampered the evaluation of community-based programmes (McLeroy et al., 2003) as many implementation theories are relatively generic and may not be linked to community dynamics. Although they may use information on context, it is frequently not clear how community context should affect the implementation process (McLeroy et al., 2003). Community change theory would benefit from further research that explores the various factors affecting community change, linkages among the factors and the conditions under which those linkages occur (McLeroy et al., 2003).

It has been demonstrated however that sustaining any enhancement of health and well-being is improved when the initiatives are ‘owned’ by organisations and groups that make up local communities, not just the curative services (Bracht & Gleason, 1990; Casswell, 2000; Rissel, Finnegan, & Bracht, 1995). Health promotion and prevention developments over time have emphasised the importance of community involvement in the development and operation of prevention efforts referring to the ‘principle of participation’. The ‘principle of participation’ described by Gielen and McDonald (1997) states that success in achieving change is enhanced by the active participation of members of the target audience in defining their own high-priority problems and goals and in developing and implementing solutions (Freudenberg & others, 1995; Green & Kreuter, 2001; Labonte, 1992; Minkler & Wallerstein, 1997). This principle derives from community
development roots as well as the empowerment education models exemplified by Freire’s early work (1970) and by the more recent work of Wallerstein (1994), Minkler (1980) and Israel (1994).

This is particularly important for health promotion activity with special population groups or ethnic minorities. Early involvement of community members in identifying their own needs, setting their own priorities and planning their own programmes is in itself a form of intervention; it can lead to a sense of empowerment and self-determination (Green & Kreuter, 2001). Complex urban environments often develop more formal avenues and infrastructures through which citizen involvement is mediated and realised whereas informal, more ad hoc citizen approaches are more frequently seen in rural areas (Bracht & Gleason, 1990).

Gaining broad-based community participation has been problematic however, where efforts to engage the community occur after the planning has been started (usually by university research or government departments). There appears to be a concern that early activation of the community in the planning process may raise false hopes and expectations should funding not be secured (Green, 1977). The compelling evidence pointing to the benefits of community participation demand a continuing search for funding mechanisms between levels of government; and for procedures of grant-making that require and facilitate greater community involvement (Crisp, Swerrissen, & Duckett, 2000; Green, 1986).

2.3.4 Community as an ‘agent of change’ for community-based prevention

Although community is often regarded as though it were a singular model of practice, several typologies have been developed in relation to community-based prevention (Alinsky, 1972; Braithwaite, Murphy, Lythcott, & Blumenthal, 1989; Himmelman, 1992; Ross, 1955; Rothman & Tropman, 1987; Warren, 1978).


As a ‘setting’ the community is primarily defined geographically and is the location where interventions take place. Whilst setting approaches such as ‘Heart Health’ (Heart Foundation, 1998) and ‘Life Be In It’ (Department of Sport and Recreation, 1975) might engage with a range of community organisations, their principal task is to change individual behaviour as a method of reducing the problem; the target of
change may be populations, but the population change is defined as the aggregate of individual changes.

The community as ‘a target’ of change refers to interventions such as ‘Safer Cities’ (Department of Justice, 1996) and ‘Drink Drive’ (Transport Accident Commission, 1989) that aim to create healthy environments through broad systemic changes in public policy as well as community-wide institutions and services. Strategies are generally tied to indicators and success is defined as an improvement in those indicators over time.

Community as ‘a resource’ is commonly applied in community-based health promotion because of the widely-endorsed belief that a high degree of community participation is essential for sustained success in population-level health outcomes. These programmes are aimed at marshalling a community’s internal resources or assets, often across community sectors, to strategically focus their attention on a selected set of priority health-related strategies. Whether the health issue is predetermined or whether the community selects its own priorities, these interventions involve external players and resources that aim to achieve health outcomes by working through community institutions. Examples of the use of this function include the WHO ‘Healthy Cities’ initiative (Kickbusch, 1989) and ‘Communities That Care’ (Fiske, 2000) discussed later in this chapter.

McLeroy’s fourth role for community in community-based interventions is community as ‘an agent’. Although closely linked to the above, the emphasis of this approach is on respecting and reinforcing the natural adaptive, supportive and developmental capacities of communities:

“Community is also a unit of resolution in society. It is a process through which people take initiative and act collectively. It varies from one area to another, but generally it is based on the belief that problems in communities have solutions in communities and that people should participate in the matters that affect them at the community level”

(Israel et al., 1994)

Social ecology, referred to earlier in the chapter, places the behaviour of individuals, including substance-using behaviour, within a broad context including the developmental history of the individual, psychological characteristics such as norms, values and attitudes; interpersonal relationships such as family and social networks; neighbourhood, organisations, community, public policy, the physical environment...
and culture (Bronfenbrenner, 1979; McLeroy et al., 1988; Poland, Green, & Rootman, 2000; Stokols, 1992). Behaviour therefore is viewed not just as the result of knowledge, values and attitudes of individuals but as the result of a host of social influences including the people with whom one associates, the organisations that one belongs to and the communities in which people live. If an individual’s behaviour is the result of social influences at different levels then changing behaviour may require using social influences as strategies for change.

Communities can be mobilised to act as change agents to achieve the social and behavioural outcomes. Conceptualising communities as the change agents means that they give legitimacy to the values and norms for desirable behaviours, and make the social and physical environment more conducive for individuals to act (Bracht, 1990). Although community approaches often count on individual ‘innovators’ to blaze the trail for social change, communities can reinforce those changes and increasingly reach others by building greater environmental and normative supports for change (Goodstadt, 1989; Pentz, 2000). The task of community is to provide both the general environmental and social supports for change through policies (Stevenson & Mitchell, 2002) and mass media, and the institutional interventions to strengthen psychological readiness through families, schools, worksites and health care settings where more individualised communications can be organised (Sussman, 1992). The combination of interventions at multiple levels achieves the community diffusion effect necessary to reach those who cannot be reached personally by health professionals (Green & Kreuter, 2001). The Institute of Medicine’s panel on the prevention of mental disorders, including substance use, summarised this position:

“The ultimate goal to achieve optimal prevention should be to build the principles of prevention into the ordinary activities of everyday life and into community structures to enhance development over the life-span” (Mrazek & Haggerty, 1994 p. 504).

Community factors facilitating change

To achieve community change, a number of structural and systemic factors have been described in the literature. From their community capacity research Norton and colleagues (2002) identified several dimensions for effective community function to improve the health status of its members:
a) Leadership: skills in communication, analysis and judgement, coaching, visioning, trust building, teamwork, reflection and learning and partnerships.

b) Collaboration: structures and mechanisms for community dialogue, coalitions, voluntary associations and other convenor or catalytic organisations such as foundations or task forces.

c) Resources: skills, knowledge and resources such as strategic planning and group process skills.

d) Civic participation & representation, power sharing, appropriate structures, networks and ties within a community,

e) Value systems such as community norms, standards and expectations regarding core values such as equity, participation, collaboration, inclusion and collective responsibility,

f) A learning culture that reflects self-awareness, institutional memory and an ability to learn from the past.

Goodman and colleagues (1998) similarly described the community factors that they identified as central to sustaining health promotion interventions in the community: participation and leadership, skills, resources, social and inter-organisational networks, sense of community, understanding of community history, community power, community values and critical reflection. Goodman’s purpose in identifying these factors was not only to move toward consensus definitions of key health promotion indicators, but to establish a basis for measurement in the evaluation or research of community interventions (Mitchell, 2002).

Some of the key community factors will be discussed in further detail in the next section.

Community leadership

The literature revealed a consistent association between leadership style, strength and competence with successful strategy implementation. A competent leadership may affect the immediacy, magnitude and durability of programme success in community change efforts of community coalitions (Butterfoss, Goodman, & Wandersman, 1993; Fawcett, Paine, & Francisco, 1993; Kumpfer et al., 1993; McHugh, Stattili, & Felland, 2004). Goodman (1996) hypothesised that if key leaders displayed significant awareness, concern and action the community would experience a greater number of effective health promotion policies and programmes.
Leaders can promote community change efforts in various ways including emphasising the need for change, articulating a clear vision for the future (Beckhard & Harris, 1987; Wakefield & Wilson, 1986), expressing support for the organisation’s ability to implement the change (Nadler & Tushman, 1989) and managing the costs, benefits, and incentives for community members to participate in the change efforts (Prestby, Wandersman, Florin, Rich, & Chavis, 1990). Characteristics of effective leaders include the following:

- Communication and interpersonal skills (Andrews, 1990; Brown, 1984)
- Administrative skills (Feighery & Rogers, 1989)
- Competence in negotiation, problem-solving and conflict resolution (Brown, 1984)
- Political knowledge, commitment, and competence (Prestby & Wandersman, 1985; Rich, 1980)
- An empowering leadership style that promotes cohesion and involvement (Kumpfer et al., 1993; Prestby & Wandersman, 1985; Rich, 1980)
- Flexibility (Cohen, 1989)
- Easy access to media and decision-making centres of the community (National Assembly of National Health and Social Welfare Organizations, 1991)

Nix (1977) identified the following types of leaders as relevant to community change initiatives: a) top-level community influential leaders who legitimise an initiative b) neighbourhood leaders if the initiative includes more than one area c) key health leaders d) leaders of the most influential companies or organisations e) leaders of factions and those who can act as go-betweens or links to several groups f) leaders of the target population g) specialist with skills and knowledge relevant to the goals of the initiative and h) officials who control or support health initiatives such as government heads of departments.

Studies of community power and urban leadership (Purdue, 2001) suggest that community leaders may be identified by their leadership position or by their reputation (Bonjean & Olsen, 1964). In the programme context, ‘positional’ leaders (those who have been elected or appointed) are often introduced as organisers because they are seen to have the necessary management skills and expertise (Patton, 1997). However, Rifkin (1990) pointed out that programmes that ignore the ‘reputational’ leaders (those who informally serve the community and are historically and culturally determined) have little chance of success of being accepted or utilised by the primary stakeholders in most communities (Rogers, 1995; Zakus &
Lysack, 1998). As a solution to the problem of selecting appropriate leadership, Goodman et al (1998) argued that a pluralistic approach with an interplay between both the ‘positional’ and ‘reputational’ leaders in the community has a better chance of leading community change (Laverack & Wallerstein, 2001). To achieve this leaders require adequate training and support.

Community collaboration
In a review of two decades of community-based health interventions in Finland, Puska and colleagues (1985) concluded that even the most rigorous evaluations were likely to fail in the absence of community participation and collaboration (Rowland, 2006). Stevenson and Mitchell (2002) concluded that community collaboration strategies targeting policy change have the strongest evidence for successful substance abuse prevention. Community mobilisation through the development of coalitions has been central to the structure and functioning of a number of notable community health promotion and disease prevention projects (Bracht & Gleason, 1990; Pentz et al., 1989; Thompson & Kinne, 1990).

Comprehensive community interventions that include a community coalition component have been shown to be effective in reducing cardio-vascular disease (Farquhar, 1985; Puska et al., 1985), tobacco use (Lichtenstein, Nettekoven, & Ockene, 1991; Thompson et al., 1990-1991) and alcohol and other drug abuse (Johnson & Pandina, 1991; Mansergh, Rohrbach, Montgomery, Pentz, & Johnson, 1996; Pentz et al., 1989). Collaboration through this process has been associated with improved outcomes (McHugh et al., 2004; Morrisey, Tausig, & Lindsey, 1985; Rogers & Whetten, 1982) and a broader base of commitment for prevention (Andrews, 1990).

Toumbourou (2004) viewed community mobilisation as an effective approach for preventing harmful drug use amongst young people. In this context, community mobilisation is described as “a defined community engaging in coordinated planning and social action to advance youth development and prevent harmful drug use” (p.65). It is not a collection of individuals pursuing their own interests but rather groups of people pursuing common goals (McLeroy et al., 2003). Several key documents such as Pathways to Prevention (National Crime Prevention Department, 1999) also highlight the importance of collaboration across governments and communities as integral to promoting mental health and preventing problems and disorders in young people (Rogers & Whetten, 1982; Wickizer et al., 1993). One of the practical challenges in planning and implementing successful large scale change programmes lies in the extent to which central health authorities and community organisations can work co-operatively in pursuit of common goals (Feinberg et al., 2004; Wakefield & Wilson, 1986).
Purdue (2001) reported that ‘social capital’ between a community and its leaders can contribute to the effectiveness of community efforts. ‘Social capital’, a widely-used term in recent community discourse (Bourdieu, 1993; Putnam, 1993; Coleman, 1988; Cox, 1997), is described as key to effective community action. It has been purported to be an indicator of the extent that a community works together towards a common goal (Rowland, 2006). ‘Social capital’ describes the norms of trust and reciprocity that exist within networks of people and it is these two elements combined that are argued to enable effective action (Stone, 2001). Although there has been some promising work in developing quantitative measures of social capital in Australia (Onyx, 1996; Baum, 1999), measures of norms of trust and reciprocity are not well developed and this constrains efforts to build community capacity.

Community resources
According to Steuart, in Steckler et al, (1993); communities provide resources to meet the day-to-day needs of their citizens through community institutions that include families, social networks, neighbourhoods, schools, the workplace, businesses, voluntary agencies and political structures. These naturally occurring units within a community meet the needs of many, if not most, of its members without the benefit of direct professional intervention, yet developed countries have placed their management of health and welfare issues into the hands of ‘experts’ who in turn are typically associated with large centralised bureaucracies, replacing the traditional social structure and cultural patterns developed over hundreds of years (Green & Raeburn, 1988). The goal of community-based interventions should be to work with these naturally occurring units. Equally as important for prevention effectiveness is that community members and workers understand the dynamic social characteristics and the less dynamic cultural traditions of a community, and plan interventions with sensitivity to them (Edwards, Jumper-Thurman, Pleased, Oetting, & Swanson, 2000; Green & Kreuter, 2001).

However, while much of community organisation theory (Cox, Erlich, Rothman, & Tropman, 1979) suggested that the impetus for community change comes from grass-roots groups with change efforts largely directed by citizens themselves, social improvements are also governed by many external resources, organisations and policies. Few communities are independent of larger regional, federal and international social and economic influences. Peterson (1988) analysed the relationship between ‘bottom-up’ and ‘top-down’ strategies in Sweden and recommended a balance between the two as few communities possess the range of technical and professional attributes that are required to address complex phenomena (such as substance abuse). In a programme context, outside agents...
have been identified as playing an important role in facilitating action through infrastructure support (Constantino-David, 1995), skills development (Minkler & Cox, 1980; Rogers, 1995), raising level of critical awareness (O’Gorman, 1995), technical expertise (Feinberg, Greenberg, & Osgood, 2004b; Hildebrandt, 1966), fostering the support of leaders (Vindhya & Kaipana, 1988) and the provision of finances (Wheat, 1997).

The assistance of the media is an important resource and essential to successful interventions (Kumpfer, Whiteside, Wandersman, Hansen, & Sorensen, 1997). Media campaigns in health promotion (Farquhar, 1985) and substance abuse prevention (Pentz et al., 1989) are most successful when combined with other community substance abuse interventions. The media can be used to shape public opinion, increase community readiness, educate the public on possible problem solutions, help recruit interested members as well as solicit contributions (Kumpfer et al., 1997). Winsten and DeJong (1989) defined six core elements for successful media campaigns with young people but Viswanath and Finnegan suggested that as media has a differential impact on audiences that is mediated by the social and structural conditions in which they live, strategies must vary in response to the context.

Communication studies have shown a high correlation however, between media coverage of issues and the public’s opinion of the importance and interest of those issues; implying a direct link between the media’s agenda of what is important and the public’s agenda of important issues (Harwood, Wilson, Fan, & Wagenaar, 2005). This can have implications on a community’s perception of reality, particularly where it relates to information about risk and how community members relate risk information to themselves (Glanz & Young, 1996; Slovic, Fischoff, & Lichtenstein, 1981; Weinstein, 1984).

**Community climate**

Some theorists suggest that the extent to which a community change intervention is effective is partially dependent upon the social and political climate of the community experiencing the intervention (Casswell, 2000; Rootman & Goodstadt, 1996; Schwab & Syme, 1997).

Purdue and his colleagues (2000) found in their evaluation of community renewal interventions in the UK that:

“Power does not lie in the hands of community leaders but in government policies and the structures of central and
local government. Despite the shift from local government to local governance, heralded by the plethora of partnerships in recent years, many established power relationships remain undisturbed. Central government imposes tight limits on the activities of regeneration partnerships and local authorities presenting a major stumbling block to empowering communities and their leaders” (p.44).

Even the newly-qualified health worker quickly realises that failure to pay attention to the political issues can prevent programmes from getting off the ground or ensuring success (Casswell, 2000; Rootman & Goodstadt, 1996; Schwab & Syme, 1997). Many health workers though, are prevented or at least discouraged from taking what might be construed as political action, such as talking to others about the nature of the problem or advocating for change (a current example in the state of Victoria is that services providing counselling and support for problem gamblers are not allowed to disclose the numbers of people seeking help to outsiders in advocating for change). Coalitions or informal groups that convene to address an issue often take on the ‘political’ role in communities as a result, relieving organisations or individuals of direct political action. The process of selecting coalition members therefore requires careful consideration (Eng, Hatch, & Callan, 1985; Green & Kreuter, 2001) and due care must be given to issues of governance, trust, coalition empowerment and coalition readiness to ensure their effectiveness (Feinberg et al., 2004; Parker et al., 2003; Purdue, 2001; Stevenson et al., 2001).

Whilst coalitions can play an important role, there has been a significant recognition in the literature of three key community factors predicting overall community effectiveness: community competence, community consciousness and community empowerment (Hamilton et al., 1998; Hawe, 1994; Minkler & Wallerstein, 1997). As early as 1984, Iscoe (Iscoe & Harris, 1984) crystallised that the purpose of community work was to build a competent community that could: “care for its members and help them to cope with or change external forces” (Iscoe & Harris, 1984). More recently, Hawe (1994) outlined how a competent community is able to tackle the problems that beset it through harnessing the skills and collective energy and experiences of its members and using both internal and external resources for community-determined solutions. To achieve this Sarason (1974) proposed there must be a psychological sense of community of belonging and shared ties among its members that give meaning and perspective to life’ (Chavis & Wandersman, 1990; Davidson & Cotter, 1989; McMilian & Chavis, 1986). The increase in the sense of
community leads to an increase in participation (Chavis & Wandersman, 1990) and problem-solving behaviour (Bachrach & Zautra, 1985). At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies (Rappaport, 1984; World Health Organization, 1986). If a competent community were conceived as the goal then empowerment was seen as the way of getting there and moving beyond:

"People are unlikely to take action on problems that they do not believe they will be able to solve" (Bandura, 1986)

In 1986, the Ottawa Charter identified community empowerment as being a central theme of health promotion discourse (Laverack & Wallerstein, 2001). Within the public health field, community empowerment has been variously defined as communities achieving equity (Biegel, 1984; Katz, 1984), as communities having the capacity to identify problems and solutions (Braithwaite & Lythcott, 1989; Cottrell, 1983) and as communities fostering participatory self-competence in the political life of the community (Florin, Giamartino, Kenny, & Wandersman, 1990; Kieffer, 1984). Labonte (1992), Jackson et al (2000) and Rissel (1995) have described the key domains of community empowerment as a dynamic continuum from individual empowerment through to small groups, community organisation, partnerships and political action (Jackson, Mitchell, & Wright, 1989; Labonte, 1994; Laverack & Wallerstein, 2001; Rissel, 1994). Importantly, an empowered community has the ability to influence decisions and changes in the larger social system (Israel et al., 1994). Green and Raeburn (1988) stress that this is the most effective vehicle for health promotion activity whether directed at policy, environmental change, institutional change, or personal skills and development.

Programmes that do not address community concerns and that do not allow the stakeholders to participate in the process of assessment have been shown not to achieve their purpose (Rifkin, 1990).

Community empowerment can help a community move beyond its steady state (Kelly, 1979) or perceived hopelessness or helplessness about a problem or issue (Gordon, 1985). It can support better utilisation of skills and resources in collective efforts to meet their respective needs (Israel et al., 1994) and provide enhanced support for each other (Rissel, 1994).

Whilst the conceptual issues concerning the measurement of community empowerment have been addressed in the literature (Bernstein et al., 1994; Israel et al., 1994; Rappaport, 1984; Rissel, 1994; Wallerstein, 1992), there have been few
attempts to address the practical question of measurement, an exception to this being the work of Fetterman (1996) and Israel (1994) (Israel et al., 1994; Rissel, 1994; Wallerstein, 1992). In a small study to develop a quantitative measure of community empowerment, Israel (1994) found that participation in organisations that attempt to influence public policy, taking an active leadership role, and a belief that taking action is an effective means to influence community decisions, were important predictors of perceived control at the organisational and community level.

Another important domain relevant to community empowerment is the ability of the community to be able to critically assess the social, political, economic and other contextual causes that contribute to their ‘disempowerment’ (or lack of effectiveness) as a community (Laverack & Wallerstein, 2001). This process has been termed ‘critical awareness’, ‘critical thinking’ or critical conscientiousness’ and has its origins in the work of Paulo Freire (Freire, 1970). ‘Conscientisation’ involves the development of a sense of identification with a group, of shared fate with that group and of self and collective efficacy. The latter component involves both the belief that effective action is possible and the capability to develop effective strategies for action (Israel et al., 1994). Freire proposed a three-step methodology as a way of achieving conscientisation:

1. Listening, to understand felt issues or themes
2. Participatory dialogue, using a problem posing approach and,
3. Actions identified by the community to resolve the issues identified during their dialogue in groups (Freire, 1973).

The process has been successfully used in a number of community empowering programmes (Wallerstein, 1992; Wallerstein & Sanchez-Merki, 1994) as well as health education (Minkler & Cox, 1980; Werner, 1988) and community development (Hope & Timmel, 1984).

**Community readiness**

Communities clearly have a role in changing environments through planning and policy development as well as giving legitimacy to acceptable community behaviour - often described in the literature as ‘community norms’- and values. Key to this is good leadership, collaborative processes, adequate resources and a positive social and political climate working with the “natural adaptive, supportive and developmental capacities of communities” (McLeroy et al., 2003 p.529). This necessitates a careful assessment of community assets, structures and processes in advance of any intervention. It also requires an understanding of the community to be able to identify and work with these ‘naturally occurring units of solution’ to address community problems. An understanding of the community’s ecology can
lead to a better match with community-based health promotion interventions and can provide tools and resources for making gains against complex public health problems, such as substance abuse.

A growing body of evidence suggests that the selection of an innovation such as multi-levelled interventions is not only contingent on the understanding of community structure and processes but also on the community’s stage of readiness (Boruch & Shadish, 1983; Cottrel, 1976; Goeppinger & Baglioni, 1985; Murphy-Berman, Schnoes, & Chambers, 2000). The notion that appropriate interventions are related to stages of readiness is consistent with the ecological principle of adaptation, which refers to the community’s ability to react constructively to changes in the environment (Kelly, 1966).

One of the crucial elements of the decision to adopt an innovation however, is the perception of the need for the change (Arthur et al., 1999; Bennis, Benne, & Chin, 1961; Lewin, 1951). Successful implementation of prevention efforts requires that the members of the focal population feel that the problem is severe enough to warrant the investment of time and the effort to implement an intervention (Bell, 1994; Scratchins & Solomon, 1996); that it is a priority in the community. Often competing priorities direct resources toward other goals (Morrissey et al., 1997; Ulmer et al., 2000). The application of an effective strategy, but at an inappropriate state of readiness, can actually delay or disable a project (Goodman & Steckler, 1990).

The principle of stages of readiness is consistent with contingency theory which posits that the presenting conditions at a given stage should influence the careful selection of the most efficacious strategies (Kaluzny & Hernandez, 1988); and that these strategies should facilitate development from one stage to the next. Whilst ‘community readiness’ is believed to be an important criterion to assist communities to move through stages of change, there appears to have been little research work to date to assist with understanding and assessing community readiness. For community leaders, government departments and policy makers that are attempting to drive change within communities, it is essential that this process is better understood.

The next section will discuss community readiness, the theories that underpin it, assessment approaches and some illustration of readiness in practice.
2.4 WHAT IS COMMUNITY READINESS?

Professor Mary Ann Pentz was credited with coining the phrase ‘community readiness’ from her work on drug prevention in the late ’1980’s (Edwards et al., 2000; Pentz et al., 1989). A dictionary definition described readiness as “a ready or prepared state” (Allen, 1987). Karol Kumpfer (1997) described ‘community readiness’ as “the extent to which a community is adequately prepared to implement a prevention effort” (p.6).

Readiness is a major factor in determining whether prevention efforts can be effectively implemented and supported by the community, such as implementing new programmes or interventions, accepting innovation, mobilising to meet community social or environmental challenges and to change practices that are not beneficial to individuals and the community (Edwards & Briggs, 2006; Edwards et al., 2000). Although there have been a number of projects, principally in the USA, that have examined community readiness (Feinberg et al., 2002), Arthur and his colleagues (Arthur et al., 1999) noted that little research had been conducted on assessing readiness for change at the state or community level.

‘Community readiness’ remains a relatively new and therefore little understood concept in Australian public health discourse and practice. There has been no research to date to identify whether it can be assessed or measured reliably in the Australian context.

2.4.1 Readiness theories

The theory behind community readiness (for prevention) has arisen from two conceptual frameworks, those of ‘Psychological Readiness’ (Prochaska & Di Clemente, 1983) and ‘Community Development’ (Beal, 1964; Rogers, Burbridge, Korching, & Donnermeyer, 1989; Warren, 1978) the stages of which are summarised in Table 2.3.

The theory of individual ‘readiness’ formed by Prochaska and Di Clemente in the early 1980’s is widely understood in the fields of psychology and health promotion as an important aspect to understanding and supporting behaviour change (Prochaska, 1989; Prochaska & Di Clemente, 1983; Prochaska, Di Clemente, & Norcross, 1992).

Their stages of change for psychological readiness operated on the assumption that people do not change chronic behaviours all at once. That is smokers do not just
stop smoking nor do sedentary people suddenly become active; instead they change their habitual behaviour continuously through five stages:

1. ‘Pre-Contemplation’ Stage: a condition in which people have expressed no interest or are not thinking about change.
2. ‘Contemplation’ Stage: the period in which some thought is given to changing their behaviour but no action
3. ‘Preparation’ Stage: the problem is recognised and options for change are considered
4. ‘Action’ Stage: the period after an overt effort to change has been made
5. ‘Maintenance’ Stage: the period after behaviour change until the behavioural problem in question is completely terminated.

The ‘stages of change’ model recognised that different strategies were required to assist the individual to change their behaviour dependent on their stage of psychological readiness. According to Prochaska (1989) however, the vast majority of prevention programmes are designed for a small minority of the people who are in the ‘action stage’. If practitioners are unaware of the implications of the stages of change approach, then there is a risk of ‘implementation failure’ (Weiss, 1998) referred to earlier in this chapter.

Paralleling the individual level process of adopting new ideas and behaviours is the field of community development that incorporates Roger’s ‘Diffusion of Innovation’ (1983) and Warren’s ‘Social Action’ theory (1978). These processes describe how change is initiated and legitimised within a community setting (Table 2.3). All three processes have parallel stages that include the presence of a felt need, a period of information gathering, a stage of considering alternatives and developing plans, some form of initial implementation, and a commitment to continue beyond the initial adoption period. Although the processes suggest a linear progression, it is widely recognised that action may stop anywhere along the continuum, that regression often occurs, and that action at differing stages can occur simultaneously. Importantly the new behaviours or innovation may not be adopted or maintained (Oetting et al., 1995).
Table 2-3: Summary of stages of change within theories that underpin community readiness theory

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<td>'Individual Readiness'</td>
<td>'Group Readiness'</td>
<td>'Diffusion of Innovations'</td>
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<td>1</td>
<td>Pre-contemplation stage-</td>
<td>Stimulation of interest-</td>
<td>Knowledge-first awareness of an innovation</td>
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<td>minimal awareness of the</td>
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<td>little desire to change</td>
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<td>2</td>
<td>Contemplation stage-</td>
<td>Initiation-development</td>
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<td>awareness but no</td>
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<td>3</td>
<td>Preparation stage-</td>
<td>Legitimisation-local</td>
<td>Decision-adopting</td>
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<td>recognition of the</td>
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<td>4</td>
<td>Action stage-</td>
<td>Decision to act-</td>
<td>Implementation-</td>
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<td>5</td>
<td>Maintenance stage-</td>
<td>Action-</td>
<td>Confirmation-</td>
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<td>consolidation and relapse</td>
<td>implementation</td>
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Taken from Community Readiness Handbook (2003)

Miller (1990) compared the three types of readiness: individual, group and community. 'Individual readiness' is based upon psychological needs, an individual’s dissatisfaction based on the perception of a discrepancy between what is expected and what is reality. ‘Group readiness’ is similar to individual readiness.
because it is also based upon the identification of a need or discrepancy between expectations and reality. However, the decision making process of the group can modify the way in which problems are identified, solutions are examined and action is taken. Group readiness is a slower process because decision-making involves more than one person and the shared values and norms salient to the need or issue require consensus among the members.

Leadership within the group becomes an important dimension because members of the group vary in their influence on decision-making.

‘Community readiness’ is similar to group readiness, including shared norms and values, group decision-making and the dimension of leadership. However as many citizens or community members do not participate in community decision-making (Rogers et al., 1989); they fail to vote, do not show up for public forums, do not attend council meetings, or sign petitions, and do not join volunteer groups, Donnermeyer et al (1997) suggests that this leads to an uneven distribution of community values and norms. Local leaders and professionals who have a stake in the issue under consideration therefore become very important for assessing community readiness.

Studies of individual and organisational change indicate that the effectiveness of change efforts is strongly influenced by the readiness of the individuals or systems undergoing change (Cottrel, 1976; Kelly, 1979; Thompson & Kinne, 1990; Thompson et al., 1990-1991). Similar conclusions are likely to extend to communities; prevention efforts are unlikely to succeed if individuals or community sub-systems are not ready to make the intended changes (Arthur et al., 1999).

Arthur (1999) noted that were two important principles from the literature regarding community readiness for change that guided the development of readiness assessment frameworks in the USA. Firstly, communities had been described as complex, open systems with multiple interrelated sub-systems made up of the political sector, the economic sector, the health sector, the education sector, the communication sector, the religious sector, the social and recreational sector and the welfare sector. Community organisation studies have also identified the voluntary and civic sector and other groups that may be specific to a community, as important for achieving change in the community system (Thompson & Kinne, 1990). Thompson and Kinne (1990) went on to describe how changes could be measured in each of these components of community, in the sub-systems as well as the whole community, that could provide a guide for effective community action.
The benefit of analysis across multiple components of the community is that it provided multiple indicators rather than relying on only one, as commonly occurs in community interventions e.g. the reduction in smoking levels (Weiss, 1972).

Secondly, both attitudinal and structural characteristics had been consistently reported to be important influences on a community’s ability to change (Covin & Kilman, 1990; Oetting et al., 1995; Prochaska et al., 1992). As a result, readiness assessments should not only define the specific community system to be assessed but include methods for assessing both the attitudinal and structural characteristics of the targeted system and its sub-systems (Arthur et al., 1999).

Community readiness assessment is elaborated on in the next section.

### 2.4.2 Community readiness assessment

“Community readiness assessment is a process for assessing the characteristics of a community, its population, community leaders and prevention service systems that can influence the success of a prevention strategy” (Kumpfer, Whiteside, Wandersman, Hansen, & Sorensen, 1994) or change effort.

Haglund (1990) considered readiness assessment, as a component of a much broader process of assessing community needs, opportunities and resources for health promotion. He cites:

“Analysis blends quantitative health and illness statistics and demographic indicators with qualitative information on political and socio-cultural factors. The analysis should also include a community’s image of itself and its goals, its past history and recent civic changes and its current resources, readiness and capacity for health promotion activities” (Haglund et al., 1990 p.91)

Although evaluation research on alcohol and drug use programmes had been quite extensive there had been almost no attempt to document how the readiness of communities to accept prevention programming could be measured (Hawkins et al., 1992; Tobler, 1986). Yet past experience clearly indicated that prevention programme effectiveness could be greatly influenced by acceptance levels among key members of the community, or could be thwarted by community ‘norms’ that
fail to identify a problem or its seriousness at the same level as programme developers (Fitzpatrick & Gerard, 1993; Kolbe, 1986).

A critical area of assessment is the determination of readiness for, and commitment to, community change (Haglund et al., 1990) such as:

- Information and expected level of participation from key leaders,
- Perceptions of need and priorities among the general public (Nebelkopf & King, 2003),
- The extent to which a community shares a common vision for the future,
- The ability to utilise or develop resources in a concerted way
- Conflicting agendas among community groups
- Past conflicts particularly amongst leaders
- Community networks

“Level of cooperation is, in itself a factor in assessing community readiness” (Haglund et al., 1990 p.92)

The information provided through readiness assessment could be used in a range of ways. Government planners and funding bodies may want to assess the degree of readiness of community groups and organisations to support a new government initiative, thus providing guidance in allocating resources to where their investment is most likely to produce intended results. It can be used to select particular agencies or groups which show the most promise to effectively deliver prevention programmes and activities (Kaltreider & St. Pierre, 1995) in Arthur et al, 1999). Community initiatives can use readiness information as a tool to assist with prevention planning, selecting appropriate prevention strategies, targeting resources as well as a mechanism for assessing change over time:

“Readiness needs to define the community that will be involved, identifying key stakeholders who should be engaged, recruiting a community leader to champion the process, assessing conditions, activities and initiatives already operating in the community, and assessing conditions that could inhibit successful implementation” (Hawkins et al, 2002, p. 959)

Crow (2004) and Stablein (2003) identified assessment as a tool to identify the areas of risk that were likely to occur during the course of a project; assisting project workers to prepare for problems in advance, through having risk management
strategies in place. It could be used as a guide to the development and delivery of awareness campaigns by both state and community. Readiness information can be used internally by organisations wishing to implement new programmes (Arthur, 1999; Jason, Pokorny, Kunz, & Adams, 2004; Zeira & Avedisian, 1989) and as a research tool to assess the distribution of levels of readiness across a group of communities (Thurman, Plested, Edwards, Foley, & Burnside, 2003).

France and Crow (2004) and Feinberg et al (2002) emphasised that assessment needs to occur at the beginning of a proposed intervention or change, as any negative perspectives to prevention from the professionals involved can act as a barrier to implementation. Assessment in Haglund’s view should be conducted with the community and not on the community, providing the opportunity for citizen involvement in community well-being that can lead to greater awareness and ownership of the issue. This view is anchored in the community development approach that considers citizen empowerment as vital to improvement in health status (Biddle & Biddle, 1985; Duhl, 1986; Freire, 1970).

Measurement in itself is insufficient to empower the stakeholders of a community change programme, and it is the transformation of information, identified by the stakeholders into social and political action and the ability to make changes through careful strategic planning that is characteristic of an empowering approach (Laverack & Wallerstein, 2001).

2.4.3 Overseas study tour to observe readiness work in practice

A travel scholarship in 2001 was used to fund a trip to the United Kingdom (UK) and the United States of America (USA) so that the PhD student could talk to academics and community leaders in a number of key centres that were using a community readiness framework in their prevention work or community practice.

The trip supported the development of the thesis by:

1. Providing an enhanced understanding of the theoretical framework of ‘community readiness’ by talking to academics directly involved in this work,
2. Spending time with community leaders to better understand how community readiness theory translated into practice,
3. Comparing the readiness assessment approaches used by the USA and UK in light of their cultural, policy and prevention intervention practices and the application to the Australian context,
4. Collecting detailed case notes from the authors of the two readiness assessment instruments that were to be used in the present study.
Importantly, the governments of the United States and Australia had both identified substance abuse as a policy priority; however, their strategies for addressing the problem had quite different emphases. The fundamental aim of the US National Drug Control Strategy (The White House, 2004) was to reduce the use of drugs (Caulkins & Reuter, 1997) whereas the overarching goal of Australia’s National Drug Strategy (Commonwealth of Australia, 2004) was to reduce the harm associated with drug use. Policy makers in both countries recognised that ‘use reduction’ and ‘harm reduction’ were logically related but the respective emphases resulted in meaningful differences in strategy, particularly in relation to young people. The ‘use reduction’ goal was linked to ‘abstinence-based’ and ‘zero-tolerance’ approaches to adolescent substance abuse. ‘Harm minimisation’ policies included encouragement for young people to remain abstinent from drug use, but they also acknowledged that some young people use drugs (Beyers, Evans-Whipp, Mathers, Toumbourou, & Catalano, 2005). The study trip provided the opportunity to discuss this difference in policy in the application of prevention work.

The study trip included attendance at the National Drug Prevention Research conference.

Research centres visited on the study trip:

1. Institute for Prevention Policy Research
University of Southern California,
Alhambra, California

Telephone discussion with Dr Kami McClure, Research Fellow.
Professor Mary-Ann Pentz, Director of the Institute, is credited with coining the phrase ‘community readiness’ in the early 1990’s from her work on drug prevention in the Mid-Western Project. The PhD student was interested to hear more about the ten-step ‘Readiness Inventory’ developed by Professor Pentz that was being incorporated into community drug prevention interventions across five States of the USA at that time.

Professor Pentz’s model was grounded in Rothman’s structural model for community organisation (1987) with an evaluation approach similar to those proposed by Green (1985) and Watzlawick (1974). The inventory (listed below) consisted of ten distinct organisational steps from initial entry into the community through actual programme implementation. The model incorporated a formal decision making process of adoption by community leaders which preceded any formal programme planning.
Programme implementers were subsequently trained and supported to advance early adoption and implementation. At each organisational step, a continuous evaluation of organisational process and outcome is emphasised to ensure effective programme implementation. This ‘Readiness Inventory’ process is preceded by a community needs assessment and school surveys that determine the risk and protective profile of the young people within the community.

The ten-step readiness inventory consisted of the following stages:

1. Identify target population
2. Conceptualise community unit
3. Identify community leaders (local government, business, media, health, religious, youth, policy, parents)
4. Conduct introductory workshops and training
5. Meet to select and adopt the programmes and strategies (evidence-based)
6. Establish the coordinating structures—steering group and work groups
7. Conduct programme planning
8. Train programme implementers
9. Implement programme and strategies with target population
10. Reinforce and recognise the efforts and the implementers (Pentz, 1986)

The discussion with Dr McLure on the centre’s readiness inventory supported the importance of community leader engagement and commitment to prevention activity, as indicated by the Cities Research Centre, discussed later. Professor Pentz had also written extensively on community coalitions and their capacity to achieve changes within communities; also key to the present study.

2. Tri-Ethnic Centre for Prevention Research (TECPR)
Department of Psychology, Colorado State University
Fort Collins, Colorado, USA

The PhD student spent four days with Professor Ruth Edwards, the Centre Director, and her staff that included attendance at their training course on the assessment process for their ‘Community Readiness’ model. The approach is based on qualitative assessment that is converted to provide overall community readiness scores. The TECPR had the most developed and long-standing model in community readiness for the prevention of youth substance abuse internationally. In view of the advanced development of the model, their survey instrument was used in the present study.
The community readiness model developed by the TECPR in the mid 1990’s was a conceptual model for understanding and assessing the characteristics of a community, its population, community leaders and prevention service systems that could influence the success of prevention or change strategies. TECPR had spent 5 years developing the model.

Their model was able to generate reliable assessments of readiness based on interviews with a small number of community leaders - as few as 5 per 20,000 population. It had been used in many communities including rural communities, communities of minority groups, Native American reservations, and in Europe and Africa.

The readiness model was also developed to meet research needs (e.g. matching treatment and control communities for an experimental intervention) as well as provide a practical tool to help communities mobilise change. The model defined nine stages of community readiness ranging from ‘No Awareness’ of the problem to ‘Professionalisation’, in the response to an identified problem within the community. Assessment of the stage of readiness was accomplished using key informant interviews, with questions on six different dimensions related to a community’s readiness to respond to a specific issue.

Once a community had achieved a stage of readiness where local efforts could be initiated, community teams were trained in the use of the community readiness model. These teams could develop specific, culturally appropriate efforts that used local resources to guide the community to more advanced levels of readiness, eventually leading to long-term sustainability of local community efforts (Edwards et al., 2000).

The community readiness model was based on several underlying premises:

a) that communities are at different stages of readiness for dealing with a specific problem,

b) that the stage of readiness can be accurately assessed,

c) that communities can be moved through a series of stages to develop, implement, maintain and improve effective programmes, and

d) that it is critical to identify the stage of readiness because interventions to move communities to the next stage differ for each stage of readiness (Edwards et al., 2000).

The model stemmed from the precepts of, ‘Trans-Theoretical’ Theory (Prochaska et
The model was developed to help communities assess readiness quickly and with minimal effort. It was considered particularly suitable in situations where resources for conducting comprehensive surveys or large-scale assessments were not feasible or desirable. Assessment for prevention was seen to have two purposes: 1) it provided a basis for understanding how community dynamics related to prevention and 2) it had direct implications for effectively intervening to move communities to higher stages of readiness. The model also provided a way of measuring community readiness across community sectors as well as over time. The authors have also described how the response variations can be used more effectively than available statistical data to give an awareness of a problem within communities that are generally not aware (Oetting, Jumper-Thurman, Plested, & Edwards, 2001).

Although it was developed to assess drug and alcohol prevention readiness, it has been widely used for a range of health, social and environmental issues. The readiness assessment from one set of interviews is issue specific, however. A measure of readiness for one issue does not reflect the measure of readiness for another issue.

The TECPR has written a guide for communities using their readiness assessment tool that can be downloaded from their website and used freely by others.

3. Social Development Research Group
School of Social Work, University of Washington
Seattle, Washington.

The PhD student spent several days with Dr Michael Arthur, Dr Caryn Blitz and SDRG staff. The Social Development Research Group used a quantitative assessment approach that has been influenced by the work of Professor Pentz and the Tri-Ethnic Center for Prevention Research. It has been developed further within their ‘Communities That Care’ programme that is described later.

The Social Development Research Group (SDRG) had developed a prevention intervention called ‘Communities That Care’ (CTC) that was being implemented in Australia at the time. The visit provided the opportunity to learn more about its local dissemination and effectiveness; as well as find out more about the readiness assessment they had developed as part of the evaluation of the CTC initiative.
Although their principle aim had been to assess how well CTC had been taken up by a community (The Diffusion Study), they had also wanted to assess how “ready” these communities were to undertake the intervention. The assessment would also assist planners with useful information that allowed them:

a) to assess a match between current prevention programming and identified prevention needs;

b) to allocate new prevention resources to close gaps in existing prevention efforts;

c) to improve accountability of prevention services and track costs;

d) to predict the impact of federal and state funding mechanisms; and

e) to develop a comprehensive view of health care that includes an effective prevention system.

The SDRG modelled ‘Communities That Care’ (CTC) on the theory of ‘prevention science’ (Mrazek & Haggerty, 1994), the main conceptual model used by the Centre for Substance Abuse Prevention (CSAP), the major funding body in the USA for drug and alcohol interventions that had also funded CTC. The goal of ‘prevention science’ was to prevent or moderate major human dysfunction, before the illness or problem had fully manifested, through manipulation of the risk and protective factors of individuals (Coie et al., 1993).

‘Risk factors’, as described earlier in the chapter are variables associated with a high probability of onset, greater severity, and longer duration of problem behaviours. ‘Protective factors’, in contrast, refer to conditions that improve people’s resistance to risk factors and disorder (Coie et al., 1993). The CTC framework, discussed in the next chapter (3.10), is a process for facilitating the delivery of coordinated services that reduce risk factors and increase protective factors for young people. The interventions are clustered around four domains; the individual, the family, school and the community.

The SDRG viewed communities as systems comprising of multiple components that could be assessed for their readiness for change prior to the implementation of a new prevention strategy. The two key constructs assessed in their readiness assessment were discriminated as ‘attitudinal’ and ‘organisational’. Either could support or hinder change within a community. The ‘attitudinal’ construct included the values, beliefs and attitudes of those within the community. (Definitions of attitudes suggest there are three major components: the cognitive, affective and behavioural components. The cognitive component involves what a person believes about the object, whether true or not; the affective component is the feelings about
the attitude object which influences its evaluation; the behavioural component reflects the actual behaviour of the individual (Burns, 1994).

As the SDRG quantitative readiness survey was used in the present study the PhD student spent time with the authors discussing its development, the pilot stages and its application locally.

The PhD student also met with Dr Barbara McMorris and the research team at SDRG to discuss the practical implementation of the International Youth Development Study (IYDS) being conducted by the SDRG and the PhD student’s department at the University of Melbourne in Australia.

The IYDS study aimed to investigate and compare the risk and protective factors for drug use, including tobacco and alcohol, as well as other aspects of health and well-being, in young people in Victoria, Australia and Washington State in the USA. The study aimed to recruit matched samples of 3,000 students in each State, 1,000 in separate cohorts from Grades 5, 7 and 9 who would complete a ‘Health and Well-Being’ questionnaire each year for three years.

The information from the students would be combined with information from principals and parents, school policies and their application and substance use statistics. This research would be used for cross-national comparison, and the development of policies for substance use prevention.

The discussion with Dr McMorris and her team provided an opportunity to compare drug use patterns between the two countries at different stages of adolescence; and consider the influence of drug policy and community ‘norms’ on substance using behaviours.

4. Bureau of Substance Abuse Prevention
Division of Community Health and Prevention
Chicago, Illinois, USA
Minnesota Institute of Public Health,
University of Minnesota
Anoka, Minnesota, USA

As a result of changed travel plans following the tragic events of 11th September 2001 in the USA, the PhD student had occasion to talk to Kimberley Fornero, the Director of the Bureau of Substance Abuse Prevention, as they travelled in the early hours of the morning by mini-bus to Chicago. Her department had used a quantitative community readiness survey that had been developed by the
Minnesota Institute of Public Health (Beebe, Harrison, Sharma, & Hedger, 2001) in their community drug prevention planning work. The survey development had also been influenced by the work of Mary-Ann Pentz, referred to earlier in this section.

The questionnaire was a 52-item survey, administered by mail, of community attitudes to adolescent alcohol, tobacco and other drug use. The Bureau of Substance Abuse Prevention used the results of the questionnaire to:

- strengthen existing prevention strategies in the community,
- raise awareness of community norms and attitudes towards alcohol, tobacco and other drugs with community groups and,
- focus prevention efforts on the areas of greatest need.

Ms Fornero felt that the readiness survey was easy to use and useful to their prevention work. As the PhD student did not receive a copy of the questionnaire until several weeks after her return to Australia, it was not considered for inclusion in the present study.

5. Youth Tobacco Access Research Team,
Centre for Community Research, DePaul University,
Chicago, Illinois, USA

The PhD student met with Centre Director, Professor Len Jason and Dr Steve Pokorny, and attended their research meeting that included a presentation on ‘Community Readiness’ by Dr Pokorny.

The Youth Tobacco Access Research team has been working with a model of community readines developed by the Tri-Ethnic Centre for Prevention Research (TECPR) in Colorado. They have adapted the model for use with the Police Department in Chicago and surrounding areas, who were responsible for policing the sale of tobacco to minors and through Local Ordinance Laws, regulating the possession of tobacco by minors (Jason et al., 1991; Jason et al., 2004).

At the time of the visit, twenty-four communities, linked to particular police jurisdictions, were participating in a trial to reduce tobacco sales to minors and increase the policing of tobacco consumption by young people (under 16 years). Project staff had noted that an assessment of a community’s readiness level had built awareness of the problem early on in the project, that efforts were better directed, with a better use of resources; and that the assessment provided useful information to the evaluation process.
The project was considered to be an important model for the prevention of smoking related disease, which costs the American economy $5,000US million each year.

This visit provided the opportunity to discuss how the TECPR theoretical model for community readiness translated into practice. As the Youth Tobacco Access Research team had also adapted the TECPR survey questions to specific police department activity so that they could examine behaviour change this proved useful when considering similar adaptation in the present study.

6. Cities Research Centre, Faculty of the Built Environment, University of the West of England, Bristol, UK

The Cities Research Centre’s research programme is built around urban and regional change and the processes through which change is planned, implemented and evaluated. The PhD student was particularly interested in their work on community governance and leadership. She met with Professor Murray Stewart, Dr Derrick Purdue, and Ms Celia Robbins.

The Centre had recently undertaken a qualitative evaluation of the role of community leaders in the urban regeneration projects of the Blair government’s Neighbourhood Renewal National Strategy (Social Exclusion Unit, 2001). Community representation was widely accepted as crucial to the success of urban regeneration partnerships, yet there had been little research into the involvement of individual community leaders in area regeneration.

The report of their study 'Community Leadership in Area Regeneration' (Purdue et al, 2001) addressed the issues on community leadership, describing, analysing and making recommendations about the ways in which significant people from local communities become involved in partnerships, how they exercised their leadership role and how that role could be enhanced. The study highlighted the importance of recognising diversity between communities and explored community leaders own experiences of area regeneration programmes, focussing on participation, capacity building, monitoring and evaluation. The study identified five key themes, which the investigators believed would enhance community leadership practise and policy development. The five themes were summarised as follows:

a. The policy context of community leadership.

Policy makers and public service managers undervalue the contribution of community leaders to area regeneration policy and practise. Community leaders have much responsibility but little power.
b. The impact of working in partnership.
Regeneration partners (i.e. government, funding body) do not always trust community leaders or acknowledge that they play an equal role in partnerships.

c. The personal experience of leadership.
The personal experience of leadership is an internalised and often an un-shareable mixture of energy and commitment, juggling time and money, fighting off burnout, balancing conflicting loyalties between community roots and the wider partnership.

d. Representation and accountability.
The concept of a unified community within any geographical area is misleading. The representativeness and accountability of community leaders is limited by patterns of social division.

e. Leadership succession and capacity building.
Tensions often arise between a first generation of community leaders, recruited at speed to legitimate a regeneration bid, and a second generation, who emerge as a result of local capacity building.

The study findings summarised that if government was to achieve its aim of tackling the problems of ‘socially-excluded’ neighbourhoods, regeneration (government) partners needed to empower communities and their leaders by making regeneration policy more community friendly particularly in supporting and strengthening community leadership.

As both questionnaires in the present study included an examination of the community leader role and impact on community prevention activity, the Cities Research Centre’s work was considered key to understanding the importance of community leaders in building community capacity.

7. Division of Substance and Alcohol Abuse
Dept. of Social and Health Services
Olympia, Washington State, USA

Meeting with Ms Mary-Ann LaFazia, Project Supervisor to discuss the State Incentive Grants (SIG) in Washington State.

State Incentive Grants (SIG) are federally funded grants to increase drug prevention activity through community initiatives. The Federal Government intended to provide SIG’s in every State in the USA.
Mary-Ann oversaw 18 SIG projects with a $9 million (US) grant over 3 years that focussed on the 4th to 8th grades in schools, which included a number of ‘Communities That Care’ projects aligned to the Social Development Research Group. The implementation of the Washington state SIG was discussed with a particular focus on the process of building community capacity to undertake these projects. Mary-Ann described how the project implementation groups were generally quite effective in the early stages in that they were well organised, productive in completing needs assessments, able to prioritise needs and develop modest plans, yet the groups clearly had difficulty moving to the next stage that required translating the plan into effective community action. Even when groups had moved to the activation phase, there was a protracted period before any outcomes could be recorded.

Mary-Ann was unable to identify the SIG project implementation issues that might contribute to this delay in progress but similar events had been recorded in the scientific literature (Butterfoss, Goodman, & Wandersman, 1996; Crow et al., 2004; Goodman, Steckler, Hoover, & Schwartz, 1993).

The Washington SIG project was concurrently developing a web-based data-management tool that allowed community groups to analyse data from their projects that would give them an indicator of the effectiveness of their programs against the risk and protective factor profile of the young people in their catchment.

This discussion proved helpful to considering how a better understanding of community readiness may assist these SIGs in the implementation progress of their projects. The immediate response from the data system being developed also held promise as a tool to support more effective application of programmes and other community efforts.

8. Centre for the Study of Childhood and Youth
Department of Sociological Studies, University of Sheffield
Sheffield, UK
The PhD student had met with Dr. Alan France, Director of the Centre for the Study of Childhood and Youth in an earlier visit to the UK. Dr France was conducting the evaluation of the three Communities That Care (CTC) demonstration projects in the United Kingdom using a number of quantitative and qualitative methods to investigate project outcomes and community changes. This included an action research approach where researchers became directly involved and spent time building relationships with the community groups in the three areas.
Discussion focussed on the community organisational features that supported or hindered the effective implementation of CTC as well as some of the challenges to evaluating a multi-dimensional initiative such as CTC. As a coalition of community leaders and local representatives is a key component of CTC, a number of points were raised about the formation of coalitions. Dr France outlined some of his early observations that related to coalition membership, communication between parties, and their readiness to implement CTC:

- The ‘Community Board’ (a coalition of community members and leaders representing the relevant sectors involved in young people) was set up to represent the broader community but in the ‘demonstration projects’, they were largely represented by the professional community. Tenants and parents were not involved because the professionals were asked to name the ‘community leaders’ and named each other. Whatever the composition of the Board the members soon became ‘experts’ on CTC, making it difficult for new members to join who felt overshadowed by the ‘experts’.
  
  Maintaining Community Board membership had been problematic as professionals often moved to other positions. Dr France held the view that the CTC Co-ordinators, who were generally experienced community development workers, should be appointed before the Community Boards so they could be involved in the formation of the Community Board to ensure appropriate representation.

- There were delays at the start of CTC as the projects did not engage some key organisations until much later such as Health Visitors and schools. The ‘Key Leaders’ (who generally headed up organisations) did not necessarily communicate with those in their organisation that might be involved with CTC (often lower down in the organisation), as had been assumed by CTC staff. The people who were expected to be involved were often not aware, informed or committed to being involved with CTC.

- Each ‘Community Board’ seemed to be struggling with issues that related to its membership. One Board, for example, was dominated by church groups who seemed to be using the Community Board to criticise other professionals, and champion their own cause. In another, the professionals, who came from a range of disciplines, appeared to be in conflict, one that related to their professional beliefs and practice.
In an evaluation report concluded five years after the commencement of the CTC trials (Crow et al., 2004), the authors made specific recommendations in regard to community readiness. They proposed that a readiness assessment should be conducted at the beginning of any new prevention intervention project to ascertain the commitment and support of coalition members and seniors partners, to identify problems in partnerships that can then be addressed, to identify possible areas of risk and to examine the commitment of key stakeholders to prevention as an approach to service delivery.

The study tour had provided an opportunity to gain a level of detail of information not easily gained through other modes of communication or searching. It provided a crucial insight into the challenges of making changes at the community level; from a policy perspective; through to the selection and organisation of community leaders; the structures that were set up to support change, the attitudes of ‘communities’ and organisational staff, the development of readiness frameworks and their application within communities or government departments. The sizeable and multi-dimensional nature of the projects underway, such as those in the UK (CTC and Neighbourhood Renewal) and in Chicago (Tobacco Control), clearly demonstrated the importance of understanding community dynamics to assist with effective planning and implementation of initiatives. This included an understanding of community readiness to make changes. This understanding was helpful in shaping the context of the present study on return to Australia; as well as provided first-hand observation of the use of the two instruments being considered.

The time spent in the USA also provided an insight into the culture of a society that had to date maintained a lead role in ‘community readiness’ research and activity. In observing this culture at close hand, the PhD student was able to consider how models and frameworks developed in the USA might replicate in Australia, a country whose culture is different in many areas.
2.5 CONCLUSION TO THE CHAPTER

The literature on substance abuse clearly highlights the negative effects that alcohol, tobacco, and other drugs can have on individuals, families and communities. As the total cost of substance abuse (financial and human) in society continues to rise, the need to develop and implement effective prevention strategies combined with appropriate community capacity building policy becomes increasingly urgent (Snell-Johns, Imm, Wandersman, & Claypoole, 2003). In light of the research showing that prevention can be effective, the failure of Australia’s substance abuse prevention efforts to produce meaningful reductions in the prevalence of alcohol, tobacco and other drug use among adolescents in the 1990’s suggested a gap between prevention research and prevention practice (Altman, 1995; Morrissey et al., 1997).

As the community constitutes an important influence on changing perceived and actual social norms for drug use – the strongest predictors of youth drug use after previous use - and an influence most amenable to change through a prevention intervention (Hansen, 1992; MacKinnon et al., 1991), successful reduction of drug use may be enhanced through wide-scale community involvement (Pentz, 1986). Despite inconsistent findings regarding the ability of community interventions to impact on drug use rates, most studies highlight the need for improvement rather than abandonment of community level interventions (Wandersman & Florin, 2003).

Successful implementation of community health promotion programmes and prevention interventions depend however on accurate analysis and understanding of many community and social factors (Haglund et al., 1990). Community readiness assessment could assist in better understanding the complexities of how social systems operate (Glanz et al., 1997a) and the community factors that support a community’s ability to respond (Lew, Tanjasiri, Kagawa-Singer, & Yu, 2001; Norton et al., 2002). Equally, in Australia where federal and state government drives drug and alcohol policy and funding, their interaction and support of community level interventions and efforts has not been widely examined.

The developments in theory on ‘community empowerment’, ‘community competence’ and ‘community consciousness, and practice, have enabled the growth of comprehensive community approaches (Feinberg et al., 2002), but there has been limited research on the part played by ‘community readiness’. The research literature suggests that measurement of community capacity is critical if success or change is to be achieved, and must take account of community
resources, processes and leadership as well as outcomes. Little research has been conducted however, to develop a systematic framework for understanding, measuring and addressing readiness for prevention at the community level (Oetting et al., 1995).

Research into the contribution of community readiness in addressing the problem of adolescent substance abuse is clearly important yet it is still early days in the development of readiness models and the adequacy of their measurement and evaluation. There appears to be little documented evidence of community readiness research or evaluation in Australia. The research that has been conducted to date has being conducted abroad and the existing readiness assessment instruments have not been tested in the Australian context.

This raises the question as to whether the tools used abroad are relevant to the Australian context, or whether Australia needs to develop its own measures. In the absence of available Australian studies on this topic, the research to be undertaken in this study was clearly of significance, although limited by the size and scope of a PhD study.

The next chapter outlines the research design for a feasibility study of the selected North American readiness assessment instruments and their relevance to the Australian context; and the development of additional questions that examine state government interaction and support for community prevention interventions.
CHAPTER 3: RESEARCH DESIGN

3.1 INTRODUCTION TO THE CHAPTER

There are at least five major conclusions that can be distilled from the previous chapter. They are that:

1. Substance use and abuse is a major health and social problem in Australia.
2. Community prevention intervention approaches hold much potential but to date have shown limited success in curbing alcohol, cannabis and the use of other illicit drugs such as methamphetamine in the adolescent and young adult age group in Australia. This may be a result of the gap between prevention research and prevention practice.
3. The construct of community readiness is poorly understood or defined as it relates to community capacity factors to address the issue of adolescent substance abuse.
4. Whilst a number of indicators have been developed, community readiness measures have not been tested in Australia that may be a means of improving the effectiveness of community prevention interventions.
5. Federal and state government interaction and support of community level interventions has not been widely examined.

An important task of the present study therefore is to attempt to narrow a gap between prevention research and prevention practice by considering what is currently known about community readiness for prevention, about assessment of community readiness and how this relates to the ability of communities to tackle issues of concern. Whilst a number of indicators have been developed, there is a need for a tool or tools that are methodologically sound and strategically relevant that are useful for community groups, as well as researchers, policy makers and funding bodies. Two survey instruments that were developed in the USA were selected for use in this study. If they could be shown to give reliable results for Australian communities, then this could expedite the translation of readiness research to the Australian context.

The function of this chapter is to outline the design of the present study beginning with the research questions (3.2) followed by a discussion on the selection of a research methodology (3.3), the data collection methods considered (3.4) and the analytic strategy (3.5). The methods used for the present study are outlined in 3.6, followed by detailed information about the two survey instruments and the
additional questions that were included, in sections 3.7, 3.8 and 3.9. Section 3.10 describes the four communities involved in the present study. The procedure for data collection is described in 3.11, before concluding remarks in 3.12.

3.2 DEVELOPMENT OF THE STUDY DESIGN AND THE RESEARCH QUESTIONS

The aim of this study was to expand understanding of community readiness and its assessment that could assist in enhancing the capacity of communities to address adolescent substance abuse. The present study would assess and compare two USA readiness assessment instruments and their appropriateness to the Australian context in four regional communities. In view of this, three fundamental questions emerged:

1. Is readiness assessment feasible in the Australian context?
2. How reliable and valid are the two readiness assessment approaches in the Australian context?
3. How useful are readiness assessment reports to Australian communities?

The underlying premise of the study was that an assessment of community readiness would provide communities with greater insight into their ‘internal’ functioning that would assist them in directing their community improvement efforts efficiently and effectively.

A small number of questions were also developed and piloted to examine state government interaction and support of community-initiated prevention efforts contributing to community empowerment.

Hypotheses

Several hypotheses were matched to the research questions, which assisted in setting up the study design (Table 3.1). The tests that were set up to validate or refute these hypotheses are discussed later in the chapter in section 3.5.
Table 3-1: Hypotheses for each research question

<table>
<thead>
<tr>
<th>Q1: Is readiness assessment feasible in the Australian context?</th>
<th>Q2: How reliable and valid are the two readiness assessment instruments in the Australian context?</th>
<th>Q3: How useful are readiness assessment reports to Australian communities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1.1: There will be at least an 80% response rate (ideal response rate for questionnaires).</td>
<td>H2.1: Readiness assessment scores will be internally reliable.</td>
<td>H2.1: Assessment will provide specific information on community characteristics to guide community change</td>
</tr>
<tr>
<td>H1.2: Surveys can be completed in under 40 minutes (matched to USA tests).</td>
<td>H2.2: Stakeholder evaluative comments will indicate favourable face validity.</td>
<td>H2.2: Assessment will provide a basis for understanding how community dynamics relate to the prevention of adolescent substance abuse.</td>
</tr>
<tr>
<td>H1.3: Stakeholder evaluation of the questionnaires and survey process will be favourable.</td>
<td>H2.3: Assessments will identify significant differences between communities (discriminant validity).</td>
<td>H2.3: Stakeholder evaluation of readiness assessment models and their assessment reports will be favourable.</td>
</tr>
<tr>
<td>H1.4: Few modifications will be required to the questionnaires and assessment methodology.</td>
<td>H2.4: Assessments will match the ranking of experts (criterion validity).</td>
<td></td>
</tr>
</tbody>
</table>
3.3 CONSIDERATIONS INFLUENCING THE SELECTION OF A RESEARCH METHODOLOGY

3.3.1 Methodological approach

Five methodological approaches were considered for this present study, ahead of the decision to trial the two American instruments. They were: a qualitative or quantitative approach, action research, case study design and an evaluation approach. Brief comments about why these were considered are presented below.

1. Selection of a quantitative or qualitative methodology

The PhD student was based in a department that had a strong and long history in quantitative methods of study, so there was an expertise and commitment to this type of research (Banks, 1979; Goodwin & Goodwin, 1984). The PhD student’s prior experience, although limited, was in qualitative work, namely action research. The PhD student would have felt much more confident in undertaking a qualitative study but was mindful that this might limit the impact of the study; as well as her own learning potential. Much time was spent talking to research experts about the use of the two approaches in the social sciences.

Guba and Lincoln, (1985) defined the epistemological approaches underlying what they saw as the four key research paradigms that encapsulated the range of methodological approaches in the social sciences:

1. ‘Positivism’ aimed for the identification of objective underlying truth and emphasised methodologies that reduced relationships to numeric functions.

2. ‘Post-Positivism’ retained the basic beliefs of positivism but accepted some of the criticisms of the search for absolute truth by seeking hypothesis falsification rather than verification. It incorporated qualitative techniques to add a subjective perspective to the otherwise objective one.

3. ‘Critical Theory’ focused on critiquing and understanding inequities in society, seeking to change them as a result of research. Both quantitative and qualitative models are employed, and,

4. ‘Constructivism’ is the joint creation of knowledge between the researcher and the researched. In this view there is no static truth, but instead multiple and shifting realities. Qualitative methodologies are emphasised.
The desirability of either a qualitative or quantitative approach appeared to be underpinned by the researchers' beliefs about the nature of knowledge and understanding. In public health research, the biomedical and epidemiological researchers have asserted the superiority of knowledge of health determinants generated by clinical experimentation, especially the randomised control trial (Christie & Gordon, 1987). Social scientists have argued however, that knowledge of health determinants is relative; its understanding dependent on a range of social and cultural factors. It supposes that attention must be paid to the bio-psycho-social complexity and socially constructed meanings that vary within different social contexts. As early as 1979, Eisner campaigned that:

“there can be little meaning, impact or quality in an event isolated from the context in which it is found” (1979 p. 14-15).

Quantitative research with its structured approach that is centred on precision and control is not designed to capture the human element such as meaning, expression and narrative that has been increasingly recognised as critical to the identification of subjective knowledge and meaning underlying health behaviour variation (Bell & Roberts, 1984; Oakley, 1988; Wakeford, 1981).

Whilst there has been much debate about the epistemological issues between quantitative and qualitative research methods, there has also been debate about the technical issues (Baum, 1998). Adequate validity and reliability is the major criticism of qualitative research; as well as the time required for data collection, analysis and interpretation (Burns, 1994; Gorman, Jacobs, & McAlpine, 1994).

There appeared to be a general view in research texts that qualitative measurement could be difficult, in that the complex material presented may not easily be reduced to a summative conclusion; and required researcher expertise to code and analyse the data. Gorman (1994) confirms that qualitative research can be time-consuming, often cannot be generalised to other settings, and can hold difficulties in the interpretation:

“Qualitative techniques are frequently used in the field of research where there are methodological complexities. The strength of these, i.e. the wealth of rich descriptive data they yield – represents a potential weakness in that such material cannot easily be reduced to a numerical value and used in quantitative analysis” (p.270)

Even the Lancet, a reputable scientific journal, had also recognised the limitations of a purely experimental scientific approach:
“Research on health of populations is still dominated by experimental designs based on simplistic notions of causality that try to remove the variation and complexity of real-life health and disease process” (Anon, in the Lancet, 1994, p. 429 (Baum, 1998).

Gorman (1994) believed that the selection of a quantitative or qualitative method should be dependent on the context of the study:

“Accordingly it has been suggested that qualitative techniques are most appropriate to exploratory research concerned with hypothesis development, while the more rigorous task of hypothesis testing requires the use of quantitative methods such as standardized questionnaires” (p.270).

Roche (1990) suggested that there may be a potential interface between qualitative and quantitative methods through the use of semi-structured interviews, a feature also supported by Gorman (1994):

“As an alternative to viewing the two as appropriate to different stages of the research process, the development of a system whereby the wealth of material generated by qualitative methods can be quantified would allow them much broader application” (p.270).

Whilst quantitative and qualitative methods have differing strengths, their application is clearly dependent on the research task. There remains, however an increasing call in public health research for a recognition of the need of a greater diversity of methods (Baum, 1995; Black, 1994; Popay & Williams, 1996).

The eventual design for the present study incorporated both approaches, as it was felt that a combined approach could lead to a broader understanding (Bryman, 1988; Epstein, 2001). The integration of methods is discussed further in the section on triangulation of data later in the chapter.

2. An ‘action research’ approach?

Action research was a construct first coined by the social psychologist Kurt Lewin in 1946 (1951). Since, there has been a strong Australian input with the work of Kemmis and his colleagues at Deakin University in Melbourne (Kemmis & McTaggart, 2000, 1988a, 1988b). In line with the critical theorists, Lewin challenged the orthodoxy of
the social scientist as the disinterested, ‘objective’ observer of human affairs. Instead he combined the generation of theory with changing the social system, through the research process acting on, or in the social system (Susman & Evered, 1978).

Burns (1994) describes ‘Action research’ as:

“The application of fact finding to practical problem solving in a social situation with a view to improving the quality of action within it, involving the collaboration and co-operation of researchers, practitioners and laymen” (p.293).

An action research study, where there was an active engagement with the communities in the research process, appealed to the PhD student because in itself it could provide a number of benefits. It could provide some ownership over the study by the participants (Kennedy, 1995) and in doing so ensure a greater likelihood of following up on the findings in their respective communities; as well as fit with her work preference for collaborative problem solving. Local ownership is also seen as key to the success of community health promotion interventions (Haglund et al., 1990; Holder & Giesbrecht, 1990; Watt & Rodmell, 1988).

“A cornerstone of the action research movement is its criticism of traditional research for trying to initiate change through dissemination of research results, rather than through the involvement of more people in the research process” (Burns, 1994, p.302).

Conducting an action research study with a community could also add to a community’s competency in this area of investigation; an important construct of community function, as described in Chapter 2 (Eng & Parker, 1994; Fellin, 1995; Mayer, 1996; Stevenson et al., 2001).

The large distance required to travel to each community was the limiting factor in considering this methodology, as regular interaction is desirable. The time limitations of the PhD together with the travel distance precluded the use of this methodology.

3. A ‘case study’ approach?

Some time was spent considering whether the present study should take the case study approach, as there were four distinct communities under observation.
Case study design is widely used in policy, organisational and social sciences research (Yin, 1994). A ‘case’ is characterised by patterns of behaviour or clear boundaries that may be simple, such as the examination of an illness in a single patient, or complex such as multiple programmes within an organisation (Stake, 2000). Yin (1994) suggests that case studies are particularly useful when the research is exploratory or there are complex phenomena and contextual issues, over which the researcher has little control. They are ideal where there are multiple variables that require triangulation of data from different sources (Yin, 1994). Case studies are often used to test or build theory, generate hypotheses or examine the consequences of a decision, but rarely to produce ‘hard and fast’ conclusions (Evans & Gruba, 2002). Case studies are often used as example studies that can then be generalised to new areas of investigation.

As with other qualitative approaches, the case study approach to research had been criticised for a lack of rigour, an inability to generalise, for being time-consuming and generating too much data. Yin (1994) argued however that this could be overcome if case study research adopted the accepted standards of reliability and validity through adherence to a clear protocol that included the selection of ‘cases’, identification of the data sources, a systematic data collection protocol and cross-case analysis from which the conclusions were drawn. Typical techniques include observation (both participant and non-participant), interviewing—both structured and unstructured, and document analysis (Burns, 1994). The case study approach however is somewhat dependent on the researcher spending time in the ‘research’ setting.

As with the action research approach, a case study approach was discounted because of the time required for data collection, analysis and interpretation; as well as the distance to some of the communities, which precluded the PhD student from spending adequate time in the ‘research setting’.

4. An evaluation approach?

As the PhD student initially intended to evaluate the effectiveness of an intervention called Communities That Care (referred to in Chapter 2) in regard to community readiness, it was important that an evaluation design was considered along with other methodological approaches.

Evaluation can be defined as:
“Attributing value to an intervention by gathering reliable and valid information about it in a systematic way, and by making comparisons for the purposes of making more informed decisions, or understanding causal mechanisms and general principles” (Ovretveit, 1998 p.9).

Grigg (2003) refers to four broad epistemological approaches to evaluation:

1. post-positive,
2. utilitarian (or pragmatic),
3. interpretivist (or constructivist), and
4. critical approaches.

Briefly, ‘post-positive’ approaches are mainly based on quantitative methods, such as structured surveys, experimental designs and cost-benefit analyses. This is the dominant model in programme evaluation and reflects the interest of funding bodies, policy makers and managers with an emphasis on efficiency and effectiveness.

‘Utilitarian’, or ‘pragmatic’ approaches focus on the utility of generating the information required for practical decision-making. Such approaches apply mixed methods, using both quantitative and qualitative data to evaluate the effectiveness of a programme. This second approach arose in response to the limitations of post-positivism and the difficulties of experimental approaches in real-life situations.

‘Interpretivist approaches use qualitative methods as they seek to understand the broader context of the intervention, or area under investigation.

‘Critical approaches’ are often explicitly ideological, with aims such as the promotion of social justice or the empowerment of intervention participants. They are founded within the critical social sciences and seek to promote empowerment and change (Greene, 2000).

At a minimum, an evaluation design would have required communities to be selected based on variation in their intervention status. The intervention characteristics and application would need to have been described and then examined in relationship to readiness characteristics. Time and resources were eventually recognised as too constrained to enable appropriate completion of an evaluation design.
3.4 CONSIDERATIONS INFLUENCING THE DATA COLLECTION METHOD

“There is no correct research method. Research methods are more or less appropriate given the question that is to be answered or the context for the research” (Fox, McDermott, Hamilton, & Toumbourou, 1996)

According to Arthur and his colleagues (1999), as readiness assessment involves systematically collecting information about attitudes, organisational structures and processes from members of the focal community and agencies. A number of data collection methods could be used to collect readiness information. They include:

- Community-wide surveys
- Key informant interviews
- Focus groups
- Ethnographic observation
- Community forums
- Analysis of public records and media sources, and
- Prevention programme grant applications and contracts.

Earlier comments on the selection of the methodology for the present study noted that some of these methods would not be suitable due to the large distance to communities, and the time required collecting sufficient data.

However, three of the methods were considered for the present study: survey questionnaires, focus groups and key informant interviews. Each involved interviewing community members.

There are a number of definitions of interviewing, each tied to the particular form or context for the interview, for example; interviews conducted by journalists differ from those conducted by doctors which differ from those conducted by employers. Maccoby and Maccoby (1954) bring together the common elements in their definition:

“A face-to-face verbal interchange in which one person, the interviewer, attempts to elicit information or expressions of opinion or belief from another person or persons” (p.499).

Research interviews can take a variety of forms, seen by some as lying along a continuum from structured interviews to in-depth interviewing (Table 3.2) (Babbie, 1989; Bailey, 1989; Kidder & Judd, 1986; Taylor & Bogdan, 1984).
Table 3-2: Interview methods: a continuum model

<table>
<thead>
<tr>
<th>Structured Interviews</th>
<th>Focus or semi-structured interviews</th>
<th>Unstructured interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised interviews</td>
<td>In-depth interviews</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>Survey interviews</td>
<td>Survey interviews</td>
<td>Clinical interviews</td>
</tr>
<tr>
<td>Clinical history taking</td>
<td>Group interviews</td>
<td>Group interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral or life-history interviews</td>
</tr>
</tbody>
</table>

The benefits of an interview include the opportunity to encourage the person to take part in the interview, allow for clarification of questions and process, can encompass more complex issues and generally does not take much time. Interviews usually obtain a higher response rate, partly because of the personal contact but because they are more acceptable to people with low levels of literacy or who do not write English well (Baum, 1998). However, whilst the researcher might aim to establish greater trust and rapport with the respondent through this approach, there are risks in getting over-involved in a way that influences the objectivity of the questioning and introduces a bias into the research (Bailey, 1989).

Despite being the most widely-used method of data collection in public health research, survey methods have their limitations. Baum (Baum, 1998) described surveys as being halfway between experiments and qualitative research. Unlike the experiment, where the researcher has total control over the experiment’s environment, this control is not possible within surveys. Each person will answer in different circumstances and bring to it a different set of assumptions, history and values. This is particularly so with attitude surveys.

Burns defines attitudes as predispositions to react positively or negatively to some social object (Burns, 1994). He outlined three major components to attitudes; the cognitive, the affective and the behavioural component. The cognitive component involves what a person believes about the object, whether true or not; the affective component is the feelings about the object which influences its evaluation, and the behavioural component reflects the actual behaviour of the individual, although this is rather an unreliable indicator of an attitude. The main criticism of attitude scales is
the indirectness of measurement in that verbal statements are used as the basis of inferences about fact. However, individual items of statements in attitude surveys are usually not of interest in themselves, the interest is usually in the total score or sub-scores.

Oakley (1988) and Busfield and Paddon (1977) have also highlighted limitations and argued that the aggregation of data from surveys means that assumptions are made that might not be justified, when variables are examined in context. Aggregation assumes that meanings are un-problematic and that words have uniform and agreed meanings that are not contingent on the respondent’s wider set of ideas and values.

Wadsworth (1984) criticised surveys for other reasons in that they constitute ‘data raids’ in which researchers ‘swoop down’ on participants, collect data and then rarely return to the participants for validation. Baum (1998) believes practices are changing however, whereby researchers at least report back their findings to those involved and some have moved to involving local communities in data collection and interpretation.

Interviews conducted through surveys are therefore not without their limitations and in view of this, surveys should only be used to suggest correlations between variables, not causality (Baum, 1998).

1. Questionnaires

Survey data is usually obtained by means of a questionnaire, a series of pre-determined questions that can be either self-administered, administered by post or asked by interviews. When the questionnaire is administered by interview, it is often called an interview schedule. An interview schedule is particularly suited to descriptive data that describes the extent of phenomenon or factual data, such as that collected in the census. Three kinds of items are generally used in the construction of interview schedules and questionnaires: closed items, open-ended items and scale items (Burns, 1994). The use of questionnaires in research is based on the underlying assumption that the respondents will be both willing and able to give truthful answers.

Structured interview schedules consist of standardised questions that are carefully ordered and worded so that every respondent is asked the same questions in the same order as all the other respondents. This is done to ensure compatibility with other studies and to try and prevent differences or biases between interviews. The
respondent is generally asked to choose between several pre-determined answers. Surveys conducted in this way are relatively cheap to administer, although mail surveys are generally cheaper to conduct as response times are minimised and coding is straightforward (Sarantakos, 1993). This easy administration means that they can be used with large numbers of respondents with relatively quick results (Baum, 1998).

The primary criticism of the closed-ended question approach is that it does not allow the researcher to find out what is relevant to the respondent, or allow them to express different views:

...interviews are seen as having no personal meaning in terms of social interaction, so that their meaning tends to be confined to their statistical comparability with other interviews and the data obtained from them... (Roberts, 1988 p.30).

The assumption is that the researcher is asking questions relevant to the area of inquiry and therefore controls the flow of the conversation in seeking responses to those questions – rather than the respondent informing through participation in a conversation (Minichiello, Aroni, Timewell, & Alexander, 1990).

A semi-structured interview on the other hand includes standardised questions that are ordered as in a structured interview but the questions are open-ended questions. These are questions where the researcher asks the respondent how he or she feels about the topic under investigation and then records whatever the respondent says.

The semi-structured interview and rating procedure provides a system whereby qualitative data can be quantified and hence used to address a broad range of research issues (Gorman et al., 1994; Roche, 1990). This technique is widely used in other areas of research such as the study of family interactions (Brown & Rutter, 1966), self esteem (Brown, Andrews, Bifulco, & Veiel, 1990), life events (Gorman & Brown, 1992), childhood experiences (Harris, Brown, & Bifulco, 1986), personality (Hill, Harrington, Fudge, Rutter, & Pickles, 1989) and psychopathology (Harrington et al., 1988). This type of research is driven by the dual demands that information can be collected that is both sensitive to the complexity of the phenomena under study, and suitable for testing causal hypotheses through quantitative analysis.

This approach had found favour with social scientists because it allowed greater flexibility and provided a more in-depth examination of the topic. This aligns with the
‘investigator – based’ tradition of research. (Harrington et al., 1988; Hill et al., 1989; Roche, Guray, & Saunders, 1991). A criticism highlighted already is the time taken to conduct and analyse the data obtained through this method, as well as the reduced capacity to compare interviews within the same study.

2. Focus groups

Group interviews or focus groups as they are commonly known, are those interviews where the interviewer gathers together a group of informants in order to engage them in conversation for the purpose of research. They were developed in the 1940’s in order to facilitate advertising and market research by gathering consumer opinions of products, service delivery or advertising effectiveness (Minichiello et al., 1990).

Fontana and Frey (1994) suggest that the group interview can be used for many purposes ranging from exploratory and phenomenological research through to pre-testing other research tools. They can also be used to overcome the pragmatic aspects of the research process such as restricted access to a particular sample (such as minority groups), funding restrictions or time constraints.

A weakness of this method is that focus group participants may not be representative of the organisation, community or group to which they belong (Arthur et al, 1999).

Focus groups were considered for the present study as a way of triangulating data obtained from the readiness questionnaires. One approach proposed interviewing community members to ask them about what they thought was readiness and its importance (if any) to building community capacity. This stage would have been followed by community interviews using one of the readiness assessment questionnaires to see if similar views emerged. A second consideration was to run focus groups with a number of the study participants after the surveys, in order to gather more detailed information about the key themes that had emerged from those interviews.

The inclusion of focus groups was eventually omitted in order to limit the size of the PhD study. The inclusion of an open-ended study format to some extent reduced the need to open up the concept of community readiness to broader discussion through focus groups, as the open-ended questions accommodated a range of responses and views.
3. Key informant interviews

‘Key informant’ interviews were used in the present study. The ‘key informant’ survey method, taken from the discipline of community psychology, has had a long history of being an effective tool for assessing community characteristics (Hagedorn, Beck, Neubert, & Werlin, 1976; Shinn, 1990; Warheit, Bell, & Schwab, 1977). A key informant is described as a person who knows the community and can provide specific information about what is happening in that community. He or she may be, but is not necessarily, a key decision maker (Arthur et al., 1999; Edwards et al., 2000).

This approach is often used in community surveys as it is less time-consuming and therefore less expensive than population (community-wide) or targeted surveys (groups or organisations) (Rice & Ezzy, 1999). As with the ‘focus group’ method however, ‘key informants’ may not be representative of the community or organisation under investigation (Arthur et al., 1999).

Key informants are often recruited using the ‘snowball technique’ where one subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on (Vogt, 1999). The technique takes advantage of the social networks of identified respondents giving the researcher an ever-expanding set of potential contacts (Berg, 1988; Thomson, 1997). It had been a useful technique in finding ‘hidden’ populations; people in stigmatising situations such as the unemployed, criminals, prostitutes and drug users. It has also been shown to be useful where the respondents are few in number or where a level of trust is required to initiate contact (Atkinson & Flint, 2001).

The primary concern of snowball sampling research is the potential selection bias that limits the validity of the sample. Sourcing new recruits is dependent on the subjective choice of the respondents first accessed and that they may identify people with different views or knowledge of the issue (Kaplan, Korf, & Sterk, 1987; Van Meter, 1990). Samples can also be biased toward individuals that belong to similar social networks missing out on those isolated from these networks. Atkinson and Flint (2001) suggested that the problem of selection bias could be minimised by recruiting respondents from a larger sample or recruiting respondents from multiple starting points rather than a single chain of referral in each community. The latter approach was used in the present study as a way of minimising sample bias.

There were three other factors that influenced the final selection of the data collection method:
1. The PhD student wanted to find a survey approach that could be used by health professionals in a variety of community settings, without requiring the expertise of researchers or vast sums of money to achieve a result. The reason being, that in Australia research funding is mostly directed to universities and research institutions, not community organisations, and government programme funding does not include funds for an evaluation; this has to be applied for separately and is not easily available. These factors make it difficult for community groups to access, and therefore benefit from research input in their own work.

The authors of one of the questionnaires under consideration for the present study described its application as similar to a ‘rapid rural appraisal’ as it was designed to help community practitioners systematically assess the local situation quickly and economically (Donnermeyer et al., 1997). ‘Rapid rural appraisal’ is a needs assessment technique that was widely used in developing countries but is now applicable in a range of settings (Needle, Trotter, Goosby, Bates, & Von Zinkernagel, 2000; Ong, 1996). As it is relatively cheap and can provide information quickly it is of maximum use when the assessment is needed by decision makers; as well as linking research and action more directly (Baum, 1998; Gow, 1990).

2. As a consequence of the PhD student’s travel scholarship, she was able to meet the authors of the two survey questionnaires and develop a good understanding of their application, which was influential in the selection of the data collection method.

3. As the department intended to trial the survey questionnaire developed by the SDRG for use with CTC in future Australian studies, it was convenient to use this as the second survey instrument within the PhD study.
3.5 CONSIDERATIONS INFLUENCING THE ANALYTIC STRATEGY

In this section, considerations affecting the choice of data analysis strategies are discussed.

3.5.1 ‘Validity’ and ‘reliability’ criteria

Although Abercrombie and colleagues (1988) suggested that there are divisions of opinion as to whether objectivity or objective knowledge can always be achieved, the aim of scientific investigation is to try and deliver objective information that is free from bias or prejudice. To achieve this, researchers use the concepts of ‘reliability’, ‘validity’ and ‘generalisability’ in both quantitative and qualitative research. Reliability and validity (internal validity) are used to refer to the extent to which a method has achieved stability and agreement of findings relative to alternative methods. Generalisability (external validity) refers to the extent to which research findings can be applied to other settings and still have some meaning (Baum, 1998).

Reliability can be defined as the accuracy, stability and relative lack of error in the measuring instrument (Burns, 1994) and refers to research consistency that reaches a stable finding (Baum, 1998).

‘Validity’ information gives some indication of how well a test measures a given area under certain circumstances and within a group (Burns, 1994). There are several tests for validity of which four were used in the present study: face validity, discriminant validity, criterion validity and construct validity (Last, 1995) that are described below.

‘Face validity’ indicates whether the survey asks questions that appear to participants to relate accurately to what is being measured. In Burn’s (1994) view this holds appeal to the research participant as the relevance to the topic under investigation is evident through the questions. High face validity therefore, is often sought in social research such as in work, schools and health settings. Face validity, however, can be difficult to measure (Burns, 1994).

‘Discriminant validity’ is a sub-type of construct validity. It is a measure of constructs that should not be related to each other as opposed to ‘convergent validity’ that measure constructs that should be related to each other (Trochim, 2006).

‘Criterion validity’ is the extent to which the measurement correlates with an external criterion of the phenomena under investigation (Last, 1995). An example from the
present study is the predicted match between overall community readiness results and expert opinion.

‘Construct validity’ is described as the extent to which the measurement corresponds to theoretical concepts (constructs) concerning the phenomena under investigation (Last, 1995), in this case, the dimension of community readiness. ‘Construct validity’ can be checked through the correlation of two instruments that have been developed to assess the same concept.

Qualitative studies have appeared to provoke a range of polarised views as to how they meet reliability and validity criteria. Hammersley and Atkinson (1995) attempted to summarise the main position for both types of research in regard to this issue:

1. Qualitative and quantitative studies should be judged using the same criteria (Kirk & Miller, 1986), and
2. Issues of validity and reliability are the same in all research, but the means of achieving this is amended in qualitative studies.

3.5.2 Triangulation of data

‘Triangulation’ of data has been a commonly used analytic strategy, where findings from multiple methods are compared in the study of phenomena. It is employed for two main purposes: 1) to overcome the bias inherent in using only one method and 2) to increase the validity of a study because different methods highlight different aspects of phenomena (Denzin & Lincoln, 2000). It is an important component of an ‘ecological’ assessment because it allows for a rich depiction of complex social systems (Denzin & Lincoln, 2000).

Lincoln & Guba, (1985), two well-known authors on research methods, refined a set of strategies for ‘triangulation’ so that the results of qualitative studies could achieve credibility alongside quantitatively-focussed research. The principle methods they recommended to ensure triangulation of data that were incorporated into the present study were:

- **Inter-observer reliability**, where more than one researcher (e.g. PhD student and research assistant) was involved in data collection and analysis, and the consistency between researchers was evaluated,
- **Intra-observer reliability**, where the same researcher evaluated a data set repeatedly to measure the consistency of their analysis process,
- **Construct validity**, where different research methods were used to give rise to matching results,
- Deliberate searching for ‘negative cases’ i.e. data contrary to the developing understanding of the research,
- Concurrent validity, where results fit with current understanding and knowledge,
- Member-checking, where analysis and interpretation of the data is verified with the participants,
- Multiple methods, where different perspectives are sought to further clarify a phenomenon, by the use of multiple data sources or methods.

The use of triangulation is not without controversy. One of the controversial views is that triangulation has limited utility because the multiple methods come from different and incompatible philosophical positions (Blaikie, 1991). Others though, contend that multiple approaches, whether qualitative or quantitative can be combined productively (Maxwell, Bashook, & Sandlow, 1987; Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). Steckler (1992) went on to say that the challenge was to see how they could be combined to produce more effective evaluation strategies.
3.6 METHOD USED IN THE PRESENT STUDY

A combined methodology of both quantitative and qualitative research was finally selected with the decision to use two questionnaires, one an open-ended survey, the other a structured survey, as interview schedules with key informants from four regional communities in Australia. The two questionnaires are described in the next section. The PhD student was mindful of the different theoretical bases of each questionnaire in setting up the study design although the data was collected and analysed within the tradition of each particular method.

The triangulation strategies described previously (refer 3.5.2) were incorporated into the research design of the present study ‘Inter-observer reliability’ was considered with the active participation of five research assistants as well as the PhD student. The PhD student evaluated the data set repeatedly to achieve ‘intra-observer reliability’ and in this process searched for negative cases. ‘Construct validity’ was considered with the use of two survey questionnaires and the development of additional questions. ‘Concurrent validity’ was attempted through matching responses with current scientific literature articulated in Chapter 2. Finally triangulation of data was achieved with multiple data sources: perspectives from CTC staff and use of two questionnaires.

‘Member–checking’ was initially considered through the use of focus groups and the feedback stage to the communities, but limited resources precluded the use of this strategy. This is explained later in this chapter.

The two questionnaires were administered by interview over the telephone, as both had been designed to use this method. One questionnaire was designed to be administered via a computer-aided telephone interview (C.A.T.I.), but this was unavailable at the time and will be discussed later.

Analytic strategy

The analytic strategy for this study examined the overall readiness score for each community and a community ranking from each survey as well as the dimension and sub-scale scores. Data was also examined to assess the following criteria (refer Table 3.1):

Research Question 1: Is readiness assessment feasible in the Australian context?

1. The response rates from each community.
2. Time taken to conduct the interviews.
3. Participants’ evaluative comments on the surveys.
4. Any modifications required to the questionnaires or research design.

Research Question 2: How reliable and valid are the two readiness assessment instruments in the Australian context?
   1. Reliability assessments by Cronbach’s Alpha for inter-item scores and research-rater consistency.
   2. Participant judgement of favourable face validity
   3. Differences in assessment between communities.
   4. Comparative rank of the four communities against expert opinion.
   5. Correlation and ranking between measures.

Research Question 3: How useful are readiness assessment reports to Australian communities?
   1. Specific information on community characteristics (to guide change).
   2. Links between survey responses and the literature on community factors on readiness to address adolescent substance use.

Statistical tests
The following statistical tests and analyses were undertaken to consider the characteristics of the questionnaire scales as well as provide a basis in which to substantiate information about the communities obtained from other approaches, such as the department staff:
   • Mean
   • Standard Deviation
   • Analysis of Variance (ANOVA)
   • T-Test for Equality of Means
   • Pearson Correlation
   • Cronbach’s Coefficient Alpha Scores
   • Regression of scale summary scores on the additional questions.

Mean, standard deviations and score distributions were examined for trends in data for each scale. Differences between means and associations between variables were tested using one-way Analysis of Variance (ANOVA), paired T-Tests and Pearson correlations.

The mean values represented the central tendency or average readiness scores for each community. The standard deviation values for each scale were reported to provide information about the variation of scores about the mean.
Significance testing used Analysis of Variance (ANOVA). Levine’s Test for Equality of Variance was used to examine significant differences in any of the dimensions or sub-scales. If there was no significant difference in variance on any of the subscales, then T-tests for Equality of Means were used to examine significant differences between pairs of communities on the sub-scales of both questionnaires.

As a preliminary test for scale homogeneity, a ‘Pearson correlation’ matrix was produced to determine whether scale scores were significantly correlated. The numerical index called the coefficient of correlation expresses the degree of magnitude of the relationship between variables. Inspection of correlation matrices revealing low correlations may either indicate scale heterogeneity or poor scale reliability (Green, Lissitz, & Mulaik, 1977).

Cronbach’s coefficient alpha is a measure of a test’s internal consistency and reliability (Cortina, 1993; Green et al., 1977). It is not sufficient to rely on the coefficient alpha to demonstrate test homogeneity as a high alpha may still be obtained when items are heterogeneous, that is “when most of the item variances are determined by several common factors” with no general factor running through the items (Green et al, 1977 p. 831). Coefficient alpha can be used as a “confirmatory measure of uni-dimensionality or as a measure of the strength of a dimension once the existence of a single factor has been determined” (Cortina, 1993, p.103).

Regression analysis is a method for determining the association between a dependent variable and one or more independent variables. In the present study a linear regression analysis was performed of the sub-scales from both questionnaires onto the ‘empowerment’ variable, provided by the additional questions.

**Theme analysis**

Themes were identified descriptively using the immersion/crystallization method outline by Borkan (1999) The immersion/crystallization method consisted of a series of cycles whereby the researcher immersed herself into the text. Reportable interpretations are reached through reflection and intuitive interpretation. The method can be both content and theory driven. For example, empowerment emerged as an important theme for community capacity building in the literature, so the data was explored to identify how much communities felt in control of their own destiny. In contrast the multiple references to professional and organisation skills led to the development of ‘community competencies’ as a theme.
The themes and sub-themes were then collated in a coding framework so that the data could be put together in a new way that linked the themes; in this case to the three major theoretical concepts of ‘community empowerment’, ‘community competence’ and ‘community consciousness’.

3.7 DESCRIPTION OF SURVEY INSTRUMENT 1

3.7.1 Description

Survey Instrument 1, referred to in Chapter 2, was developed by the Tri-Ethnic Center for Prevention Research (TECPR) of the Colorado State University, USA, for their Community Readiness model. It consisted of 32 open-ended items, with a shorter version of 18 questions that is mostly used in follow-up readiness assessments (Appendix 1).

‘Key informants’ are selected and interviewed over the telephone. The ‘key informant interviews’ are part of a staged process of readiness assessment illustrated below (Figure 3.1):

**Figure 3.1:** Staged process of readiness assessment

- Identify the Issue
- Define the Community
- Conduct Key Informant Interviews
- Score to determine readiness level
- Develop strategies/ conduct workshops
- Community Change

A structured coding frame of ‘anchor statements’ is used to generate quantitative measures from the qualitative responses to the open-ended questions. The survey data ranks communities on six dimensions (see next section) to give a readiness score for each dimension as well as a total score. The scoring rates ‘community readiness’ on a continuum from ‘no awareness’ of the problem to ‘high level of community ownership’ (Table 3.3).

The TECPR model includes community development strategies to move the community along the continuum to a higher level of readiness for prevention.
Communities are ranked on the following dimensions:

1. **Community (Prevention) Efforts**: To what extent are there efforts, programmes and policies that address the issue or problem under investigation?

2. **Community Knowledge of the Efforts**: To what extent do community members know about local efforts and the effectiveness of those efforts?

3. **Community Leadership**: To what extent are appointed leaders and influential community members supportive of the issue?

4. **Community Climate**: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

5. **Community Knowledge about the Issue**: To what extent do community members know about the causes of the problem, consequences and local implications?

6. **Community Resources Related to the Issue**: To what extent are local resources—people, time, money, and space etc available to support these efforts?

(Taken from the TECPR Handbook ‘Community Readiness: The Key to Successful Change’, 2003).

To be able to provide a quantitative measure of readiness, the TECPR had engaged community experts to produce a number of descriptive statements referred to as ‘anchor statements’ that ranked each of the six dimensions above on a nine-point scale of readiness (listed below). Anchored rating scales had been used successfully in industrial psychology as a method for weighting decision criteria (Dickenson & Tice, 1977; Hamilton, 1970; Ivancevich, 1980; Jacobs, Kafrey, & Zedeck, 1980; Kavanagh & Duffy, 1978; Porter, Steers, Mowday, & Boulian, 1974; Ronan & Schwartz, 1974; Saal, Downey, & Lahey, 1980; Sechrest, 1968; Smith & Kendall, 1963).

The TECPR descriptive statements were developed by exposing them to review and modification until a reliable ‘anchor statement’ was available for each stage of readiness for each dimension (Appendix 2). Plested (1999) writes that the ‘anchor statement’ method has considerable reliability. There was 100% inter-rater agreement for all but four ‘anchor statements’ and over 80% agreement for those four. Some questions also included a numeric ranking where respondents are asked to rank a problem from 1-10, in addition to the open-ended response. This measure assists with the scoring process. After extensive testing of the model in American communities over the last 8 years, including rural communities, the authors believe
that the ‘anchor statements’ provide an adequate understanding of the community’s stage of readiness for prevention activity (Oetting et al., 1995).

The TECPR identified nine stages of readiness through which communities develop: the higher the stage of development, the greater the degree of readiness. The development of the nine stages emerged from their work with communities. The following table describes the nine stages that are currently in use; and the characteristics of the communities at each stage.

**Table 3-3: Stages of readiness**

<table>
<thead>
<tr>
<th>STAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No Awareness</td>
<td>Issue is not generally recognised by the community or its leaders as a problem (or it may truly not be an issue).</td>
</tr>
<tr>
<td>2. Resistance</td>
<td>At least some community members recognise that it is a problem, but there is little recognition that it might be a local problem.</td>
</tr>
<tr>
<td>3. Vague Awareness</td>
<td>Most feel that there is a local problem, but there is no immediate motivation to do anything about it.</td>
</tr>
<tr>
<td>4. Preplanning</td>
<td>There is clear recognition that something must be done, and there may even be a committee. However, efforts are not focused or detailed.</td>
</tr>
<tr>
<td>5. Preparation</td>
<td>Active leaders begin planning in earnest. Community offers modest support of efforts.</td>
</tr>
<tr>
<td>6. Initiation</td>
<td>Enough information is available to justify efforts. Activities are underway.</td>
</tr>
<tr>
<td>7. Stabilization</td>
<td>Activities are supported by administrators or community decision makers. Staff are trained and experienced.</td>
</tr>
<tr>
<td>8. Confirmation/ Expansion</td>
<td>Standard efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.</td>
</tr>
<tr>
<td>9. High Level of Community Ownership</td>
<td>Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.</td>
</tr>
</tbody>
</table>
3.7.2 Interview protocol and key informants

The Tri-Ethnic Center for Prevention Research uses the following interview protocol:

- Staff identify key informants according to the nature of the problem under investigation (e.g. readiness for alcohol abuse prevention, cancer prevention).

- A trained interviewer conducts the interviews over the telephone. The interviewer types the responses into a word processor as the interviews are being conducted. The interviewer edits and corrects the interview responses at the end of the interview and passes the responses to the scorers. Two senior researchers at TECPR score the interviews.

- TECPR staff feed back the readiness assessment to the community or community group requesting the assessment, face-to-face. (This process often includes technical support in moving to the next stage of readiness).

The TECPR research staff typically conducted four to six interviews in community populations of up to 20,000. They described the technique as a standard procedure in ethnographic interviewing (Trotter, 1991). Their experience had shown that the fourth interview generally added no new information over that already obtained in the first three interviews, but if it did, or if it conflicted with previous interviews, then a fifth interview was conducted, and so on. Up to thirty interviews may be conducted in cases where initial interviews are inconsistent or the population is large (Burnside & Foley, 2002). In a personal communication with Barbara Pleston (2004), she replied: “experience in conducting the ‘community readiness’ interviews in over 400 rural communities over the past five years has shown that only rarely are more than four interviews necessary”. Whilst spending time with the TECPR staff in 2001, the PhD student was advised that as a general guide, once a minimum number of interviews have been conducted, additional interviews are done only until no new information is gleaned. Communities larger than 20,000 are often divided up, usually by postcode (zipcode) and the four or five interviews conducted within the smaller area.

The TECPR community readiness model generally targets key informants in leadership positions. In their studies on adolescent substance use, for example, leaders would be selected from health, education, justice, local government and other key community organisations involved with young people. The interviews take on
average half an hour to complete but the scheduling and call-backs could take several weeks before an interview was conducted.

Whilst the TECPR continues to follow the described method in their readiness assessment surveys their ‘Community Readiness Handbook’ (instruction manual) does not specify who should conduct the interviews in a community and who should score the responses. The decision is left to the community using the process.

In the present study ten key informants from each community were asked the TECPR questionnaire. The respondents were ten of the fifteen nominated from Survey Instrument 2 (refer 3.9.2). The larger number was a way of assessing whether the procedure of using a small number of key informants as indicated by the TECPR authors yielded reliable information in the Australian context. In assessing the interviews, readiness ranking was analysed after five interviews and then checked against the results after ten interviews. This is discussed in Chapter 4.

3.7.3 Collection and coding of data

The authors of the TECPR readiness survey recommend two or more ‘scorers’ who discuss the survey responses in order to obtain a consensus on the scores and to assign a stage of readiness. The nine ‘anchor statements’ for each dimension are given a numbered rating from 1 to 9, with one being the lowest level of readiness and nine the highest. The scorers give a numerical rating (1-9) from each of the ‘anchor statements’ marking the position at or between the ‘anchor statements’ that best describe the community, for each dimension. After the scorers have independently scored each interview, they are paired with another to go through their respective scores until they arrive at a consensual score for each dimension from every respondent. This method provides readiness scores for each dimension as well as a total score for the community. The final assignment to a particular stage of readiness is not only based on the average ratings of the dimensions, but also on the scorer’s expert judgement based on all the interview information and the scores on the anchored rating scales.

For the present study the interviews were scored by pairs of department staff who had been recruited for this stage of the study, and trained by the PhD student in the scoring method.

3.7.4 Analytic strategy

Although the questions were clustered under dimensions such as ‘Leadership’ and ‘Community Climate’, the scorers were able to make a judgment that a response in
any part of the questionnaire could relate to a particular dimension. To give an example:

Section D: Community Climate
Q9. What is the community’s attitude about adolescent substance use?

Response recorded:
“I think generally speaking it is positive. But again it flares from time to time depending on their attitudes; the media controls a lot of it too. But generally speaking I think it is fairly positive”. What do you mean by that? (Interviewer) “Well they don’t think that it is out of control; that it is normal adolescent behaviour, without any really bad consequences and that most of their kids whilst experimenting, that there is no real danger or violent outcomes”.

In this example the first part of the response clearly relates to ‘Community Climate’, but the scorer thought the second part of the response related to the dimension ‘Knowledge about the Problem’. Once the scorer has gone through the entire interview and marked how the responses related to the dimensions, they then ran through the interview a second time and ranked the responses against the ‘anchor statements’ for the respective dimension. So in the example given, the scorer may have placed the first statement against the ‘anchor statement’; “The prevailing attitude is that it is an accepted part of community life. That it is just the way things are”, giving a readiness score of 1.

The second statement would have been compared to the ‘anchor statements’ under ‘Knowledge about the Problem’, which might have been “Some community members recognize the sign and symptoms of the issue, but information is lacking”, giving a readiness score of 4.

Themes from the survey responses for the present study were analysed (refer 3.5) to identify community characteristics that matched the contemporary research discussed in Chapter 2, as well as to identify any new themes not recorded in existing studies. The anecdotal responses would also illustrate how specific community characteristics could be used to guide community change at the local level.

3.7.5 Follow up with the community
One of the strengths of this assessment model from a practitioner level is that once a judgement has been made regarding the communities’ readiness level, the model
incorporates recommended strategies and activities that communities can implement in order to elevate their readiness for each dimension.

In each case, the aim of the activities or strategies reflects the readiness stage; where there is no awareness, the aim is to raise awareness, and suggested activities centre on making one-to-one contact with community leaders and presenting information to key members. Where a community may be in the “preplanning” stage, activities may be centred on conducting local focus groups to discuss the issues, to increase knowledge of possible activities through information provided directly to leaders and community, and to review existing efforts. In the initiation stage, there may be in-service training, applications for funding, and identification of service gaps.

The authors indicate that the link between the activities and their readiness stages is not highly developed in the model. However this is not necessarily a problem, as it encourages an active process with the community in determining the best activities for a particular community.

3.7.6 Comments on the instrument

Whilst, the instrument had been used to assess readiness in a wide range of community projects, in the USA and abroad, it had received some criticism of its measurement approach. The criticism included:

- that the instrument was not developed using psychometric principles,
- that the use of the anchored rating scale technique gives too much discretion in scoring the responses,
- that the model relies on a small number of key informants to represent the views of the community,
- that the process requires that the interviewer is skilled in engaging the respondent,
- that it has not been externally validated to see if it does measure readiness, and
- that it takes too long to recruit respondents and run the interviews (Beebe et al., 2001)

When questioned on this, the TECPR authors re-stated their confidence in the reliability and validity criteria of their instrument;

“The ‘community readiness’ scales themselves have high face validity. The scoring is done using anchored rating scales, the anchors
of which also have high face validity. The validity of the ‘community readiness’ scores is further strengthened by the high inter-rater reliability measures. These measures tell us how similar the two raters were in their initial evaluation of the dimensions of readiness. A higher reliability measure is better, since it indicates that the scorers were consistent in their ratings and thus “on the same page”. The reliability measures range form 0 to 1, with 1 being perfect reliability. The reliability measure for this instrument is .92.” (E-mail communication, Plested, 2004)

These administrative and methodological features were considered during the process of conducting the present study and will be discussed in the results chapter.

Finally although the TECPR generally uses its shorter version in follow up surveys, it was felt that this version would provide an adequate measure of readiness for the present study. Importantly it took much less time to complete, a factor when participants were being asked to complete two lengthy telephone interviews.

The following table summarises the changes in TECPR survey protocol for the present study that has been described in the previous section.

Table 3-4: Interview schedule comparison between TECPR and present study

<table>
<thead>
<tr>
<th>Method</th>
<th>TECPR – USA</th>
<th>TECPR – adapted for the present study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Issue identified by community.</td>
<td>Community issue nominated by PhD student</td>
</tr>
<tr>
<td>2.</td>
<td>Nominate 5 ‘key leaders’ relative to the issue</td>
<td>Ten community leaders and others identified; assisted using snowball technique</td>
</tr>
<tr>
<td>3.</td>
<td>Trained staff conduct interviews and enter responses into computer at the time</td>
<td>PhD student and research assistant conduct interviews. Short version used (18 questions)</td>
</tr>
<tr>
<td>4.</td>
<td>Research staff score surveys to determine readiness level</td>
<td>Four research assistants score surveys to provide readiness level</td>
</tr>
<tr>
<td>5.</td>
<td>Feedback to community. Develop strategies to introduce change</td>
<td>Letter sent to respondents with preliminary findings and invitation to a formal presentation of results. No further contact with communities related to the study</td>
</tr>
</tbody>
</table>
3.8 DESCRIPTION OF SURVEY INSTRUMENT 2

3.8.1 Description

The Social Development Research Group (SDRG) of the University of Washington, USA, had developed a survey to assess community resources and readiness as a compliment to their ‘Communities That Care’ (CTC) model. This instrument was used as the second survey questionnaire for the present study.

The SDRG questionnaire included 273 items with a range of responses options. The questionnaire included some branching of the questions, so participants answered approximately 164 questions on average. Most response options were structured and included four-point response options (e.g. Strongly Agree, Somewhat Agree, Somewhat Disagree and Strongly Disagree) and ‘Yes’ or ‘No’ answers. In addition, the interviewer had the option of recording a ‘Don’t Know’ answer or ‘Refused’ (to answer). These last two responses were not offered to the respondent as an option when asked the question. There were a small number of open-ended items such as: “Could you describe to me the steps your community used to develop its prevention plan?”

The SDRG instrument had been developed from previous quantitative community readiness survey instruments. The SDRG had selected a catalogue of items from prior studies that they felt represented the constructs that were relevant to the resource and readiness constructs emphasised in the CTC model, and that could be assessed by community members (Arthur et al., 1999). Wherever possible and when indicated by prior analyses of psychometric properties, they maintained intact scales from pre-existing surveys. The SDRG pre-tested the questionnaire with a range of participants and then piloted it with a larger sample. The SDRG instrument was used in the present study without modifying items except for some language modification to suit the Australian context.

The questionnaire had been developed for use using a Computer Assisted Telephone Interview programme, known as C.A.T.I. As this technology was not available through the department, the questionnaire was adapted for pen and paper response (Appendix 3). To be able to respond to the branching in the questionnaire, a ‘prompt’ sheet was developed for the interviewers to be able to guide the respondent to another section of the questionnaire based on responses to certain questions (Appendix 4).
The questionnaire was developed to assess two areas of community function; the attitudes within a community and the structure, processes and expertise of organisations that facilitate change within a community. As with the TECPR, the SDRG identified a number of dimensions that have been listed below. Each dimension is illustrated by an example statement from the survey (in italics);

Attitudinal dimensions:

1. Attachment (to the community): ‘Most people in the community think of it as their home, the place they belong, rather than just a place to live’.
2. Disorganisation (perceived problems): ‘I would like you to tell me how much you feel [substance use, crime, gangs] is a problem in the community’.
3. Community Norms (acceptable behaviour): ‘Adults in the community think the use of alcohol is a normal part of growing up’.
4. Community Support for Prevention: ‘Most people in the community would pay more in taxes to support youth prevention programs’.
5. Ownership (of the problem): ‘Most people in the community believe that preventing drug abuse is everyone’s responsibility’.

Organisational dimensions:

1. Barriers (to prevention activity): ‘How much did each of the following factors pose barriers to prevention-related activity in your community over the past year’? (A loss of key players, lack of leadership, lack of support in the community, lack of coordination).
2. Collaboration (between organisations): ‘Community agencies and organisations work together to solve community problems’.
3. Conflict (within the community): ‘There is a lot of conflict between groups in the community’.
4. Enforcement (of illegal behaviour): ‘If a kid was caught drinking alcohol in the community, do you think he or she would be arrested’?
5. Leader Support for Prevention: ‘Community leaders are knowledgeable about local drug abuse prevention efforts’
6. Leadership (capabilities): ‘Community leaders are able to obtain the necessary resources for community initiatives’

The SDRG assessment method was distinct from that of the TECPR in that assessments were not necessarily linked to recommendations for community building strategies. As the SDRG viewed CTC as a tool to build readiness for the prevention of problematic adolescent behaviour, the assessments carried implications for community building within the CTC training and consulting framework.
This questionnaire, as with the TECPR questionnaire was principally developed to measure readiness for preventing substance abuse, but has since been used to measure other issues of concern.

3.8.2 Interview protocol and key informants

In distinction to the small number of interviews required by the TECPR process, the SDRG recommended that 15 interviews be conducted in each community with at least ten key ‘positional’ leaders (listed below). ‘Positional’ leaders hold a professional role in the planning and decision-making that affects young people in the community. Arthur and his colleagues suggested including others in surveys “who are knowledgeable about the issue”, as their views give an equally important dimension:

“The key objectives for conducting a readiness assessment are to determine 1) whether the population being assessed sees the need for and supports prevention planning and implementation in their community and, 2) key leaders within the community will provide sufficient leadership and resources to ensure a successful prevention effort” (Arthur et al., 1999 p.47)

Five additional people were therefore invited to participate by asking those interviewed whom they considered informed on the issue of adolescent substance abuse

The work context for the ‘positional’ leaders described in the SDRG survey protocol is listed; the bracketed terms by the side of some of them are the terms for the Australian equivalent.

‘Positional leaders’ interviewed (SDRG)

1. Civic (local government - e.g. councillor or youth worker)
2. Business (e.g. small business owner)
3. Law Enforcement (police)
4. Human Services (health and welfare)
5. Judiciary (justice - e.g. government department)
6. Schools
7. Media (journalist or newspaper editor)
8. Faith organisations (church organisations - e.g. minister or youth worker)
9. Recreation organisations (youth organisations or youth peak body)
10. Community Coalition (community groups and committees)
As with the TECPR interview protocol, the key informants are contacted by letter initially and then SDRG staff follow up with a phone call to set the interview date. The SDRG uses the ‘Total Design Method’ (Dillman, 1978) for its postal surveys which recommends multiple personal contacts with potential participants as a way of increasing the response rate.

For the present study, the participants were contacted using the ‘snowball’ technique. This technique is commonly used to identify key informants within a community (Rice & Ezzy, 1999). In the present study, CTC staff provided initial names and these people were contacted and asked to provide further names of relevant professionals in their community.

When the list of fifteen people was completed, each was sent a letter that explained the study and their rights as participants (Appendix 5) and a ‘Response Card’ (Appendix 6) that listed the response options for the SDRG questions used during the interview. Those that declined to be interviewed were mostly those that a) did not have the time or b) felt that they were not the right person to ask about their community. Most were happy to suggest others in their community.

The PhD student and the research assistant that were to conduct the interviews contacted the participants to provide a personalised approach to the recruitment process.

3.8.3 Collection and coding of data

All fifteen interviews were conducted over the telephone. Responses were entered into a booklet of questions that were coded for each interview. The interviewers entered a tick into the relevant box next to the question. At the end of the interview, the survey was checked for completeness before being entered into a database, set up for the study.

The SDRG responses were formed into scales using the syntax developed by the authors within Statistical Program for Social Sciences (SPSS) for Windows statistical software (Carver & Nash, 2005).

3.8.4 Analytic strategy

The data was analysed using standard statistical test described in 3.5.3 ‘Statistical tests and analysis’.
Consistent with the SDRG syntax, the “Don’t Know” responses were listed as missing data in the findings. This has potential implication for the final results that is raised in the next chapter.

The following table summarises the changes in SDRG survey protocol for the present study that has been described in the previous section.

**Table 3-5:** Interview schedule – comparison of methods between the SDRG and the present study

<table>
<thead>
<tr>
<th>Method</th>
<th>SDRG - USA</th>
<th>SDRG - adapted for this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify community issue</td>
<td>Community issue nominated by PhD student</td>
</tr>
<tr>
<td>2.</td>
<td>Nominate 10 “positional leaders”, and 5 others that are knowledgeable about the issue</td>
<td>Ten community leaders and 5 others identified (15); assisted by using snowball technique</td>
</tr>
<tr>
<td>3.</td>
<td>Trained staff conduct interviews using CATI data collection method</td>
<td>PhD student and research assistant conduct interviews. Pen and paper used to record responses</td>
</tr>
<tr>
<td>4.</td>
<td>Statistician codes and analyses data for interpretation by SDRG staff</td>
<td>Assistant entered survey responses from paper to computer. Data analysed using SPSS</td>
</tr>
<tr>
<td>5.</td>
<td>Feedback incorporated into CTC intervention</td>
<td>Letter sent to respondents with preliminary findings and inviting a formal presentation of results.</td>
</tr>
<tr>
<td>6.</td>
<td>Survey adapted for future use in Australia</td>
<td></td>
</tr>
</tbody>
</table>
3.9 ADDITIONAL QUESTIONS ON STATE AND COMMUNITY ENGAGEMENT

‘Power does not lie in the hands of community leaders but in government policies and the structures of central and local government’ (Purdue et al., 2000 p.44).

Four questions on state government involvement in local prevention activity and one on local capacity for prevention were developed by the PhD student and her supervisor for inclusion at the end of the TECPR interview (listed below). The questions were experimental questions that had not been validated but carried high face validity.

The initial rationale for the inclusion of these questions was based on the importance of the community perception of relationships with the state government. Although state governments were responsible for undertaking community drug and alcohol prevention activity through drug policy and funding, government departments were not perceived as community-focused in their application of policy (Phillips, 2000), nor necessarily supporting local community groups to implement changes as befitting local need (Rowling et al., 2002). The first four additional questions were therefore included to try and gauge from the respondents to what extent state government engaged with, and responded to, the four regional communities in the planning and initiation of prevention activity. Examination of this domain would hopefully contribute to the understanding of state and community engagement with community empowerment (Hamilton et al., 1998).

The process could also potentially provide an additional means of assessing the four communities; and evaluating the TECPR and SDRG questionnaires.

The fifth question was included to gauge the community’s sense of capacity (competence) and notion of empowerment to make local changes.
Additional questions asked of the TECPR participants:

1. Are there state government mechanisms to ensure input from your local community into planning decisions?
2. Of the prevention programs that you are aware of, have they mostly been initiated by the community or by state government?
3. To what extent do state government prevention initiatives fit local priorities?
4. Does state government provide financial support for prevention planning that has been initiated locally? Can you provide examples?
5. If your community wanted to introduce a new prevention program, do you think it would be successful in doing so?

The interviews were recorded and noted by the interviewer at the time the TECPR questions were being asked. A total of thirty-six (out of forty) answered these questions. The responses however, were not scored as with the TECPR responses but analysed for content and themes. Themes were elicited by searching the responses to the questions for recurring ideas, topics and experiences that showed patterns, similarities and differences amongst those interviewed (Kellehear, 1993). This method of data analysis allowed a descriptive assessment of the views expressed which has been written up in the next chapter.

Themes were also coded across the first five items to identify agreement that the local community had some support and experience to initiate prevention programmes. As the responses across these items showed a high level of consistency (alpha= 0.55), scores were summed to form a scale measuring perceived community control. The process would ideally establish which TECPR and SDRG subscales predicted this perception.
3.10 SELECTION OF COMMUNITIES

The reason for selecting the four communities involved in the study was a pragmatic one. The four communities were known to the department through the ‘Communities That Care’ (CTC) initiative described later in this section, and they were happy to be involved in a readiness assessment. The limited resources available for the doctoral study necessitated an easily contained context, which could be provided through working with these four communities that had existing links to the department. In the early days of setting up the study the low number of communities and therefore respondents was regarded as a potential limitation that would limit the generalisability. This problem was resolved by deciding that the study would function as a feasibility study that would psychometrically examine and compare the two instruments rather than seeking generalisable population estimates in the Australian context.

In addition, the department was keen to gain a clearer understanding of the readiness level of the four communities as the apparent low level with some was impacting on their ability to respond to the CTC intervention (Feinberg et al., 2004; Hawkins et al., 2002). This increased the prospect there would be a useful benefit to the department as well as the communities in conducting these assessments.

Community profiles.
The four communities in this study, two in Victoria and two in Western Australia were classified as ‘large rural centres’ (urban centres population 25,000-99,000) in the ‘Rural Zone’ category in the Commonwealth Department of Health and Aged Care (2000a). The rural, remote and metropolitan areas (RRMA) classification was developed by the Commonwealth Department of Primary Industries and Energy, and the Commonwealth Department of Human Services and Health in 1994, based primarily on population numbers and an index of remoteness.

There were some similar geographical features across the four communities; two of the communities, A and C were coastal communities, whilst B and D were inland communities. Three of the four were within 150 kilometres of their state capital; only Community D lay about 600 kilometres away. Community A was the only community that included four Local Government Areas (LGA), although three were small municipalities that often joined with the fourth for such projects. Communities A, C and D had populations of approximately 25,000 with Community B a larger population of 65,000. All four communities were defined by their Local Government
Area (LGA) rather than their definition of community identity. In Australia, Local Government Areas are defined by state government legislation.

Three of the four communities included distinct aboriginal communities although their representation was not reflected in the interviews. Community A and C could probably be described as newer communities compared to Communities B and D which had been established during the gold mining boom of the mid-nineteenth century.

The communities were not identified in the present study to avoid findings being used to criticise lower readiness communities. Identifying communities was not considered necessary for the present purpose.

Outline of ‘Communities That Care’

Three of the four regional communities involved in this study had begun to implement the community intervention called ‘Communities That Care’ (CTC). The fourth was considering implementing the intervention.

CTC is a community, outcomes-based, planning framework and service development strategy that is adopted by local communities to strengthen local policy, programme and community strategies for prevention of youth problems. Research on the predictors of health and behaviour problems for adolescents and the risk and protective factors influencing these problems underpin the strategy (Hawkins et al., 1992).

Community organisations have implemented CTC to modify the impact of risk and through this approach minimise the involvement of young people in drug and alcohol abuse, risky sexual behaviour, anti-social behaviour, school dropout and violence. Communities establish the framework over three years as a five-stage process and apply the tools of risk-focussed prevention science. The process involves initiating key leaders, agency and community involvement in a community-led strategy to improve the planning, program development and evaluation of the impact of prevention efforts for children and young people. The major goal of the process is to establish a ‘prevention services system’ for strengthening the well-being of young people and the wider community (Fiske, 2000).

The CTC strategy was developed in the USA, where research work suggested that strategic community mobilisation, that ensures coordinated implementation of evidence-based health promotion and prevention activity, holds promise for reducing the prevalence of adolescent health and social problems. The research
work indicated however, the need for further study to understand how community organisation processes can achieve this outcome.

3.11 STUDY PROCEDURE

The following ten stages made up the procedure for the present study. Each stage is outlined below:

1. Search for instruments
2. Pilot test instruments
3. Development of additional questions
4. Selection of communities
5. CTC staff rank communities
6. Recruitment of study participants
7. Administration of survey
8. Data handling, training and coding
9. Feedback to communities
10. Modification for future use

The study was conducted under the guidance of a research team investigating the implementation of CTC (refer 3.10). A small reference group oversaw the implementation phase of the study. They were the PhD student, her supervisors, a social psychologist and an epidemiologist, the research assistant who was to interview two of the communities and the CTC lead trainer, who was to disseminate the findings from the study to those communities. This group met monthly to discuss the implementation process and progress.

At a later stage four department research assistants were engaged to score the TECPR surveys. The CTC research programme had received funding from the Victorian Health Promotion Foundation in Victoria, which assisted with the cost of the research assistants.

The study was conducted under the auspice of the Department of Paediatrics at the University of Melbourne. Ethics approval was granted through the University.
Stage 1: Search for readiness instruments

The PhD student supplemented the literature review procedure by visiting research centres in the USA and England that were known to work with communities in regard to capacity building and readiness (refer Ch.2). Following this literature search and study tour, the two readiness questionnaires were selected for the present study. They were selected as they had undergone considerable development and refinement and were therefore considered the most relevant for trial in Australia. The opportunity to spend time with those that had developed the questionnaires was invaluable to the process of selecting the instruments.

Stage 2: Pilot test of USA survey instruments

The questionnaires were examined and the language modified where necessary to ensure suitability to the Australian context. The survey protocol adaptations described in table 3.4 and 3.5 were incorporated into the study design.

Six people known to the PhD student were interviewed in order to pre-pilot the use of the two questionnaires as well as provide an opportunity to practice asking the questions. The interviews were administered over the telephone to mimic the intended survey context. Administration of the questionnaire and consultation took approximately one hour for each respondent. The comments and suggestions regarding the questionnaires were documented and considered by the PhD student and the study supervisors as a guide for final modification. It was decided that the questionnaires did not require any content changes following the test.

The original SDRG questionnaire had been developed for computer recording of the responses (Computer Assisted Telephone Interviewing). As this facility was not available, the questionnaire was adapted for pen and paper use (refer 3.9).

The authors of the TECPR questionnaire had developed a shorter version of their 32-item questionnaire that had eighteen questions. This was trialled during the test and appeared adequate in the readiness information that it provided. As the shorter questionnaire took between 40-50 minutes to complete, it was felt that the longer survey would take more time than would be feasible to request of professional volunteers in the Australian context.

Stage 3: The development of additional questions on state government and community engagement.
Chapter 2 raised how ‘community empowerment’ is an important construct for ‘community readiness’. Interest in assessment of this construct followed the PhD student’s visit to the University of the West of England where the Cities Research Centre had conducted extensive research into the role and relationship of government and communities in regard to community capacity building.

Five additional questions were developed to attempt to gain a better understanding of the role and relationship of state government with communities on prevention activity (refer 3.8.).

**Stage 4: Selection of communities**

Refer to 3.10

**Stage 5: CTC staff asked to rank the four communities on readiness.**

In an effort to provide independent criteria with which to assess readiness, the PhD student asked the CTC staff that had been working with the four selected communities to rank each community for readiness, from the most ready to the least ready. Their responses were based on their on-going relationship and extensive interaction over the past 18 months with the communities through CTC.

Three out of four staff members independently ranked all four communities in the same order and this order is used to plot the results in the next chapter. The fourth staff member only rated ‘the most ready’ community the same as the others.

**Stage 6: Recruitment of study participants**

The lead trainer advised those involved with the CTC intervention about the study in order to seek their participation. On agreeing, the CTC coordinators were asked to suggest ‘key informants’ for Stage 7 of the research.

Key informants were invited from health, welfare, education, church, justice, media, business, recreation, local government and state government sectors in line with SDRG and TECPR guidelines. Participants were matched in each community by the type of organisation only, not their leadership status. So in one community it might be the youth worker who responded from the youth agency, but in another community it might be the manager who responded from the youth organisation.

Contact names were initially sought from the CTC coordinators who were familiar with community organisations and very often the staff that worked in them. Those
contacted were asked to identify additional people that they felt should be included in the study using the ‘snowball technique’ described in 3.4. This was either done at the time of setting up the interview or following the interview. Survey Instrument 2 (SDRG) has a section at the end that specifically asks for additional names of people that might want to be included in such a survey.

In each community, fifteen individuals were recruited for the SDRG interview; of those, ten were also asked to complete the TECPR questionnaire including the additional questions. In total, 60 individuals were recruited and 100 interviews were conducted. As a refusal rate around 10% was anticipated, replacement participants were recruited where this occurred.

Letters were sent to those who had been suggested, inviting their participation in the study (Appendix 5). They were also sent information about the study as well as the ‘Response Options Card’ used in the SDRG survey. (Appendix 6). They were then contacted shortly after by telephone to seek their verbal consent and set up the interview appointment.

**Stage 7: Administration of the survey Instruments and the additional questions.**

The PhD student and the research assistant conducted the surveys over the telephone. One hour was scheduled for each interview at the respondent’s convenience, which included evening calls. For the 40 participants that were selected to answer both surveys, this involved scheduling two one-hour appointments. Permission was sought at the time of interview to tape-record the interviews.

Coding noted the respondent’s position and organisation to allow for follow up in future surveys.

As there was some concern that there may be interviewer and order effects, the survey type (TECPR V SDRG) was alternated based on random assignment. The assignment resulted in the surveys being conducted in the following order; Interviewer 1, the PhD student, interviewed Community A and C. Interviewer 2, the research assistant, Community B and D, with Community A and C being asked the SDRG questions first.

Community B and C were asked the TECPR questions first (Table 3.6)
Table 3-6: Order of interviews

<table>
<thead>
<tr>
<th>Community</th>
<th>First Interview</th>
<th>Second Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community A</td>
<td>SDRG</td>
<td>TECPR</td>
</tr>
<tr>
<td>Community B</td>
<td>TECPR</td>
<td>SDRG</td>
</tr>
<tr>
<td>Community C</td>
<td>SDRG</td>
<td>TECPR</td>
</tr>
<tr>
<td>Community D</td>
<td>TECPR</td>
<td>SDRG</td>
</tr>
</tbody>
</table>

Stage 8: Data handling and coding.

As previously mentioned survey coding was completed during the SDRG interviews.

As neither the PhD student nor the research assistant could ‘touch-type’, notes were taken during the TECPR interviews. Headsets were used to make note-taking easier. Each interviewer typed up the notes after the interview. These notes were backed up onto a computer as well as downloaded onto a floppy disk for safe storage, with the taped interviews. All the TECPR interviews were recorded using an audiocassette machine so that they could be checked for accuracy, as well as transcribed later.

The TECPR responses for each community were scored by pairs of department staff that were trained by the PhD student. The pairing of scorers was alternated using random selection to reduce bias, and included both males and females. The scorers were not involved in the interviews.

Ten of the forty interviews were transcribed by an audio typist to see how this compared with scoring from the notes taken at the time of interview. The taped interviews were randomly selected for transcription. Where there was a poor recording as occurred in some of the interviews, another interview was selected for recording.

Three paper copies of the TECPR interviews were printed; one for verification against the audiotapes, one for use in the scoring process and the third to be stored with the original notes, tapes and disks.

The PhD student checked every annotated and transcribed interview against the tapes for accuracy and completeness. The transcribed interviews had some word omissions due to indistinct annunciation or a recording error. In these cases the PhD
student reviewed the relevant section of the tape and added any words that were comprehensible.

The SDRG questionnaire was mostly made up of questions with defined response options. The interviewers entered a tick into the relevant box next to the question. At the end of the interview, the survey was checked for completeness before being entered electronically into a database of responses set up for the study. The SDRG responses were formed into scales using the syntax developed by the authors.

Responses to both questionnaires were reviewed to search for themes that were not identified in the USA studies.

The responses to the additional questions were clustered into themes that emerged from the questions and also formed into scores as described in section 3.8.

**Stage 9: Feedback to communities**

The readiness scores and overall assessment of readiness, was reported back to each participant by letter. The PhD student offered to meet with community groups to present the findings but the offer was not taken up. The results and feedback process were intended to test the reporting process and build capacity, by guiding community coalitions in their prevention planning, and allocation of resources, to address adolescent substance abuse.

**Stage 10: Review of data collection process and the readiness instruments for use in the CTC and other community ‘change’ projects.**

The data collection process was reviewed for effectiveness, efficiency and cost.

### 3.12 CONCLUSION OF CHAPTER

The PhD student had consulted several academics as well as the literature about the methodology for the study. The general view was that a study that combined both quantitative and qualitative methods made for a stronger PhD study because of the benefit from the ‘triangulation’ of data. In commencing the implementation phase of the project, the PhD student felt confident and comfortable with the study design and the methodological approach that had been selected.

Two questionnaires were to be used; one that involved a qualitative method that could be easily used by community groups yet provide a numeric measure; the other a quantitative method that would satisfy the empirical scientists and the
department; and demonstrate feasibility for future use in Australian studies. As the
two measures were designed to collect similar information, described in the sections
3.7 and 3.9, comparison of results from the two would possibly enhance
understanding of the reliability and validity of each instrument.

The additional questions were primarily included to assess the level of state and
community interaction for prevention but provided an additional means by which to
asses the utility of the two USA readiness questionnaires.

The surveys were to be conducted over the telephone. Face to face interviews
through focus groups or an action research method were considered, but rejected
as less appropriate given the project time constraints and the research question
being investigated.

The long and strong collegial and research relationships between the USA and
Australia had led to the sharing of research approaches on many topics and in
many contexts including the community readiness assessment models used for the
present study. Yet community research by the nature of its context is grounded in
different cultures, policy and practices, so it was considered appropriate to
investigate how the American instruments would perform in the Australian context.
The TECPR model had been used by others in the USA and in countries outside of the
USA, but not in Australia. Modified versions of the SDRG instrument had been used by
other researchers, but not outside of the USA.

In addition, the authors of the two questionnaires had developed their models from
different theoretical bases; the TECPR from Psychological Readiness, Social Action
Theory and Diffusion Theory; the SDRG from Prevention Science Theory. The
community development conceptual models that underpinned the TECR model
were commonly understood and used in Australia, but less so those of Prevention
Science.

The survey instruments had not been used in Australia prior to this study and the
process of data collection had been altered from that used by their USA authors. For
these reasons, examination of the process of data collection, as well as the results
from the study were intended to be analysed to establish the feasibility, reliability,
validity and utility in the Australian context. These will be discussed in the next
chapter.
CHAPTER 4: PROCEDURE AND RESULTS

4.1 INTRODUCTION TO THE CHAPTER

The purpose of this chapter is to report on the procedure and the results from the two surveys used to investigate community readiness, and examine the themes from the interviews to build understanding of community readiness factors. Given the study investigates methodological feasibility, the reporting of the procedure and results and some preliminary discussion have been integrated in the sections reporting on the three research questions:

1. Is readiness assessment feasible in the Australian context?
2. How reliable and valid are the two readiness assessment instruments in the Australian context?
3. How useful are readiness assessments reports to Australian communities?

The table (Table 4.1) noting the hypotheses for each research question in the last chapter is listed again to remind the reader how the questions and criteria for their assessment have been framed in the present study.

The first section in this chapter includes data relevant to key informant profiles, response rates and participant views on the survey instruments and the interview process.

The next section summarises the readiness scores for the four communities and the statistical data obtained from the two instruments, for their overall reliability characteristics and validity to the research context. The two instruments were compared for their similarities and differences in their overall ranking of the readiness scores and the inter-relationship between their sub-scales. The association between the readiness scales and the additional questions on state and community engagement is also illustrated in this section.

The last section, 4.4, illustrates some of the qualitative responses from the TECPR interviews and the additional questions on state government and community engagement, to provide a basis for understanding how community factors relate to readiness for the prevention of adolescent substance abuse and the utility of this process to communities in guiding community change.
Table 4-1: Hypotheses for each research question

<table>
<thead>
<tr>
<th>Q1: Is readiness assessment feasible in the Australian context?</th>
<th>Q2: How reliable and valid are the two readiness assessment instruments in the Australian context?</th>
<th>Q3: How useful are readiness assessment reports to Australian communities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1.1: There will be at least an 80% response rate (ideal response rate for questionnaires)</td>
<td>H2.1: Readiness assessment scores will be internally reliable.</td>
<td>H3.1: Assessment reports will provide specific information on community characteristics to guide community change</td>
</tr>
<tr>
<td>H1.2: Surveys can be completed in under 40 minutes (matched to USA tests)</td>
<td>H2.2: Stakeholder evaluative comments will indicate favourable face validity</td>
<td>H3.2: Assessment will provide a basis for understanding how community dynamics relate the prevention of adolescent substance abuse.</td>
</tr>
<tr>
<td>H1.3: Stakeholder evaluation of the questionnaires and survey process will be favourable</td>
<td>H2.3: Assessments will identify significant differences between communities (discriminant validity)</td>
<td>H3.3: Stakeholder evaluation of readiness assessments models and their assessment reports will be favourable</td>
</tr>
<tr>
<td>H1.4: Few modifications will be required to the questionnaires and assessment methodology</td>
<td>H2.4: Assessments will match the ranking of experts (criterion validity)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H2.5: The instruments will correlate and provide similar rankings (construct validity)</td>
<td></td>
</tr>
</tbody>
</table>

Note:  
H = Hypothesis  
Q = Question
4.2 IS READINESS ASSESSMENT FEASIBLE IN THE AUSTRALIAN CONTEXT?

4.2.1 Description of key informants

Sixty-one professionals from the range of community roles nominated responded to the surveys; fifteen from each community answered the SDRG survey, ten of whom were asked the TECPR survey. In one community however, the two surveys were answered by two different people from the same organisation rather than the one, giving sixteen key informants instead of fifteen. This key informant’s views were considered valuable despite only having time to answer one survey. Rather than seek an alternative key informant a colleague with similar professional background was nominated to answer the second survey (TECPR).

It had been intended initially to talk to the most senior staff within each organisation, as these are the people that have the power to make decisions and allocate resources; material, financial and human, that might have an influence over adolescent substance use. In practice, organisational heads often passed on the interview request to a subordinate staff member, stating that they would know more about what was happening in relation to the issue under investigation. The length of time required for the interviews (2 hours) also appeared to influence their deferring the interview to others within the organisation (Arthur et al., 1999; Kumpfer et al., 1994).

This was not the case with all organisations, however, so there was a mix of key informants: from the management level as well as the programme level. Those at a more senior level within the organisation however, appeared to have a broader perspective on the problem in relationship to government policy and system issues.

Thirty (50%) of those interviewed held managerial positions, the reminder were service providers. There were twenty-seven men and thirty-four women interviewed. The majority were in the 41-50 age range (n=26), followed by 31-40 years (n=15), 19-30 years (n=13) and the lowest number in the 51-60 year range (n=7). The key informants were all of European or Anglo-Saxon descent. None of those interviewed identified as being of Australian aboriginal background. Four of the key informants did not complete high school, nine completed high school and the remainder went on to some form of further education; from college trade courses to higher degrees.

Most job roles were successfully matched in each community. The Department of Juvenile Justice in one state would not permit an interview with a staff member
without approval from their ethics department. As this policy was introduced at the
time of the interview schedule there was insufficient time to obtain approval. This
only affected one community; and an alternative key informant from the youth
sector was recruited to the study. Some key informants were employed by
government departments based in the community, as opposed to non-government
organisations. Their responses appeared generally more favourable toward
government activity on youth substance abuse.

The length of time employed in the position varied from 2 weeks to 36 years. The
mean length of time employed across all the key informants was 6.5 years. Most of
the key informants reported that they had been involved with the issue of
adolescent substance use for many years, some all their working lives. Overall key
informants were knowledgeable about their community, possibly as a result of living
and working in the same place over a number of years. Many answered questions
not only from the perspective of their professional role but also from their perspective
as a citizen of that community and for some, as a parent of an adolescent.

One person asked to complete the SDRG survey by hand rather than through
telephone interview, so that she could return to the survey when it suited her busy
schedule. The key informant answered more questions than required, as branching
instructions were not laid out clearly in the paper version of the questionnaire.

The ‘snowball’ technique appeared to generate an appropriate mix of key
informants for the present study.

4.2.2 Recruitment and scheduling the interviews

Although 100 surveys were completed there were some interviewer and community
effects that influenced recruitment for the study.

Interviewer 1 experienced a refusal rate of 35%, Interviewer 2, 12%, giving a mean
response rate of 77%, very close to the 80% anticipated in Hypothesis 1. Interviewer 2
experienced an interview re-schedule rate of 26% (i.e. key informants called to
change the interview time) that was not experienced by Interviewer 1. This possibly
reflected differences in interviewer style. Interviewer 1 having worked in the
community sector reported being attuned to the work demands in the sector,
accepted refusals more readily, but set-up realistic interview times. However, it is also
possible that these differences may represent coincidental and random fluctuation
(Table 4.2).
Table 4-2: Interview scheduling

<table>
<thead>
<tr>
<th></th>
<th>Interviewer 1</th>
<th>Interviewer 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of people interviewed</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Total individuals contacted</td>
<td>46</td>
<td>34</td>
</tr>
<tr>
<td>Declined to be interviewed</td>
<td>16 (34.7%)</td>
<td>4 (11.7%)</td>
</tr>
<tr>
<td>Total number of interviews</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Total interviews scheduled</td>
<td>50</td>
<td>68</td>
</tr>
<tr>
<td>Interviews re-scheduled</td>
<td>None</td>
<td>18 (26.4%)</td>
</tr>
<tr>
<td>1st contact call</td>
<td>10/5/02</td>
<td>10/5/02</td>
</tr>
<tr>
<td>1st interview</td>
<td>25/5/02</td>
<td>29/5/02</td>
</tr>
<tr>
<td>50th (final) interview</td>
<td>13/1/03</td>
<td>2/9/02</td>
</tr>
<tr>
<td>Time from first contact to final interview</td>
<td>34 weeks</td>
<td>16 weeks</td>
</tr>
</tbody>
</table>

The authors for the TECPR survey reported that the length of time from first contact to completion of interviews for a single community with five key informants was five weeks (Plested et al., 1999). Table 4.2 shows that the completion time for Interviewer 2 was three months, consistent with TECPR timing, but eight months for Interviewer 1. Interviewer 1 returned to full time work in August 2002, so interviews were scheduled so that only one was conducted during a working day. In addition, in one community it took a long time to find key informants that were prepared to be interviewed. This community was shown to be “least ready” at the conclusion of the study. This is discussed further in the next chapter.

4.2.3 Conducting the interviews

The interviews took much longer to complete in the Australian trial than indicated by the authors (Table 4.3). The TECPR suggested 30 minutes and the SDRG 40 minutes yet the longest TECPR survey took 80 minutes and the longest SDRG survey took 109 minutes. This was mostly due to the length of the answers, as many were quite vocal in their concern over the issue of adolescent substance use. This was much more evident with the open-ended questions (TECPR). As the interviewers gained
experience however, they became more practiced at moving the questions on when information was being repeated, or sufficient had been said to gain an understanding of the key informants view. The ordering of questionnaires did not appear to influence the length of time required to complete an interview schedule.

**Table 4-3: Time taken to set up and conduct interviews**

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Time</th>
<th>Interviewer 1</th>
<th>Interviewer 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDRG (n=30)</strong></td>
<td><strong>Total Time</strong></td>
<td>30.75 hr</td>
<td>33.87 hr</td>
</tr>
<tr>
<td></td>
<td><strong>Longest Interview</strong></td>
<td>100 min.</td>
<td>109 min.</td>
</tr>
<tr>
<td></td>
<td><strong>Shortest Interview</strong></td>
<td>37 min.</td>
<td>36 min.</td>
</tr>
<tr>
<td></td>
<td><strong>Average length</strong></td>
<td>61 min.</td>
<td>67min</td>
</tr>
<tr>
<td><strong>TECPR (n=20)</strong></td>
<td><strong>Total Time</strong></td>
<td>17.35 hr</td>
<td>16.72 hr</td>
</tr>
<tr>
<td></td>
<td><strong>Longest Interview</strong></td>
<td>75 min.</td>
<td>80 min.</td>
</tr>
<tr>
<td></td>
<td><strong>Shortest Interview</strong></td>
<td>17 min.</td>
<td>26 min.</td>
</tr>
<tr>
<td></td>
<td><strong>Average length</strong></td>
<td>69 min.</td>
<td>50 min.</td>
</tr>
<tr>
<td><strong>Total calls made</strong></td>
<td></td>
<td>120</td>
<td>253 calls</td>
</tr>
<tr>
<td><strong>Total time to conduct interviews</strong></td>
<td></td>
<td>48.1hr</td>
<td>50.59 hr</td>
</tr>
</tbody>
</table>

**4.2.4 Participant evaluation of questionnaires and interview process**

In this section a qualitative analysis is reported of key informant reflections on the questionnaires and interview process. Responses were generally biased toward more favourable comments although there was variation with some unfavourable views expressed. The TECPR questions were generally seen to carry greater face validity than the SDRG survey questions.

The SDRG survey’s final question asked key informants whether they would like to comment or ask questions about the survey. “That's my last question. I want to thank you for taking the time to talk with me today. Do you have any questions or
comments about the survey that you would like me to note?” Most chose to respond and were somewhat candid in their views that are listed below. The same was asked at the end of the TECPR survey by the interviewers although this was not a question set up by the authors of the questionnaire.

In the following table (Table 4.4) the responses are sorted into themes that are noted in the left hand column commencing with the responses to the questionnaires. All the responses have been incorporated in this table and are annotated in the right-hand column.

The reader will recall that the SDRG questionnaire consisted of defined response options, whereas the TECPR consisted of a set of open-ended questions. The order of instrument presentation was randomly allocated.
<table>
<thead>
<tr>
<th>Response themes to SDRG survey</th>
<th>Key informants comments: Favourable</th>
<th>Key informant comments: Less favourable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire:</td>
<td>I liked structured survey-made me form an opinion.</td>
<td>Does not allow for the ambiguity that exists in communities.</td>
</tr>
<tr>
<td>Structured versus unstructured format</td>
<td>Appreciated change in answer sets.</td>
<td>Did not like being forced into limited responses-objected to this.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Would have liked to have added to some of my responses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred open-ended responses (TECPR).</td>
</tr>
<tr>
<td>Comments on the questions</td>
<td>Thought provoking.</td>
<td>Some questions seemed like double negatives- needed to ask to be repeated.</td>
</tr>
<tr>
<td></td>
<td>Questioning really good-made me look at what we are doing-helped me focus.</td>
<td>I had to ask for clarification on some of the questions particularly on the language of CTC.</td>
</tr>
<tr>
<td></td>
<td>Fantastic questionnaire- made me question where I could get this information</td>
<td>Concepts of leaders ill defined.</td>
</tr>
<tr>
<td></td>
<td>“Some questions pertinent, others not.”</td>
<td>Some questions a bit ambiguous-not sure whether you meant community or groups within the community-too broad a term.</td>
</tr>
<tr>
<td></td>
<td>Nice and easy to answer.</td>
<td>Many questions too general.</td>
</tr>
<tr>
<td></td>
<td>Fairly in-depth.</td>
<td>“Need to define some words such as children, adolescents, youth, community agencies and community organisation.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some questions a little too technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Terrible-ambiguous questions-too broad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficult to relate to concept of community</td>
</tr>
<tr>
<td>Response themes to SDRG survey</td>
<td>Key informants comments: Favourable</td>
<td>Key informant comments: Less favourable</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Appropriateness to key informant/worker's role</td>
<td>- Really good.</td>
<td>- OK I guess. I wear several hats-some responses not true in some areas.</td>
</tr>
<tr>
<td></td>
<td>- Great questionnaire.</td>
<td>- Difficult to answer for whole community.</td>
</tr>
<tr>
<td></td>
<td>- Made me think about the process being used in the community-its easy to get locked into ones own work.</td>
<td>- Difficult in responding-my opinion or agency’s opinion.</td>
</tr>
<tr>
<td></td>
<td>...</td>
<td>- In not working in the area I could not answer some of the questions</td>
</tr>
<tr>
<td></td>
<td>Makes you think globally.</td>
<td>- Not sure I could answer yes or no with qualification.</td>
</tr>
<tr>
<td></td>
<td>Stimulates thinking</td>
<td>- Some questions beyond my knowledge.</td>
</tr>
<tr>
<td>Relevance to community</td>
<td></td>
<td>- More data needed on key informant to show why they answered the way they did.</td>
</tr>
<tr>
<td>Interview Process</td>
<td>- Went smoothly.</td>
<td>- A bit frustrating because deals with generalisations- do not acknowledge complexity of communities.</td>
</tr>
<tr>
<td></td>
<td>You are a good questioner.</td>
<td>- Many of the questions would be relevant down the track-not now.</td>
</tr>
<tr>
<td></td>
<td>- Not bad overall</td>
<td>- Does not reflect what is happening now.</td>
</tr>
<tr>
<td></td>
<td>Pretty extensive</td>
<td>- Black and white-does not allow for complexity.</td>
</tr>
<tr>
<td></td>
<td>It was helpful getting the written information [about the survey]</td>
<td>- Difficult to refer to community as diverse-I tended to average things out as a result.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Some questions do not reflect the work going on-outcome focused.</td>
</tr>
<tr>
<td>Response themes to SDRG survey</td>
<td>Key informants comments: Favourable</td>
<td>Key informant comments: Less favourable</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Telephone survey versus a written one</td>
<td>Better than a written one—quicker than a written one.</td>
<td>Would have liked questions to read.</td>
</tr>
<tr>
<td>Questionnaire: Structured versus unstructured format</td>
<td>Preferred open-ended responses</td>
<td>Some terms unclear such as ‘efforts’; ‘community’; ‘this issue’ (several key informants)</td>
</tr>
<tr>
<td>Comments on the questions</td>
<td>Open-ended stuff much easier</td>
<td>Focus and scope of questions unclear at time use/non-use of numeric scale inconsistent</td>
</tr>
<tr>
<td>Appropriateness to community/ worker context</td>
<td>Easy to answer as well-placed individual who sits on strategic committees and has a lot of contact with the community.</td>
<td>Others “more in the know than I” should be answering the questions. “I feel like I’m answering for everyone”.</td>
</tr>
<tr>
<td>Interview Process</td>
<td>Liked TECPR survey</td>
<td>Some of the questions were aimed more at those more directly involved in the welfare side of things.</td>
</tr>
<tr>
<td>Telephone survey versus a written one</td>
<td>Better than a written one—quicker than a written one.</td>
<td></td>
</tr>
</tbody>
</table>
The qualitative analysis of the comments following completion of each of the questionnaires did not reveal a consistent preference or consistently-held criticism. The responses to the survey questions and style were mixed: as many people disliked an aspect of the interview as found it a stimulating experience. Participating in a second survey with a different question style satisfied those that did not like the alternative.

Many felt that the SDRG questions did not allow for the detail of the work going on in their community, nor reflected the processes that were in place. The survey asked questions on community activity that was based on outcomes, rather than process. The feeling left by some key informants was that it would appear that their community was doing very little, when in their view this was not the case.

The face validity of some of the questions was considered in this process of analysis in that some questions were not clear when asked first time and required re-asking or re-wording to make sense to the key informant (refer to section ‘Comments on the Questions’ in table above). This occurred more with the SDRG survey questions than the TECPR.

4.3 HOW RELIABLE AND VALID ARE THE TWO READINESS ASSESSMENT INSTRUMENTS IN THE AUSTRALIAN CONTEXT?

The next section compares the overall readiness scores, sub-scale scores, community ranking and statistical data obtained from the two instruments and the additional questions. The results from each instrument are written up separately to provide clarity to the reader.

The four communities had been ordered from highest to lowest (A, B, C, D) according to an initial ranking of readiness based on observations made by department staff, who were working with the communities to establish their CTC training needs (refer 3.11, ‘Stage 5’).

RESULTS: TECPR SURVEY

4.3.1 TECPR readiness scores and community ranking

The semi-structured interview and rating procedure of the TECPR questionnaire provided a system whereby qualitative data could be quantified and hence used to score prevention readiness in communities.
The overall score based on the TECPR questionnaire was similar across the four communities, with scores ranging between 3.99 (Vague Awareness Stage) and 5.22 (Preparation Stage) (Figure 4.1).

**Figure 4.1**: TECPR overall readiness scores

Based on visual observation of Figure 4.1, the readiness ranking for the four communities were different to the department staff rankings; Community B’s score was slightly higher than A, which was not expected; and Community C’s score was the lowest despite apparent commitment from this community to tackle youth problems (evidenced by participation in the CTC initiative).

### 4.3.2 TECPR dimension (sub-scale) scores

The next section compares the results from the TECPR dimension scores for the four communities. The scorers rated the qualitative responses and quantitative ratings made by community members to derive the dimension scores on the TECPR questionnaire (Figure 4.2).
When compared on the TECPR questionnaire the profile of the relative placement of dimension scores were similar across all four communities. The general profile shows that communities scored higher for ‘Community Efforts’ and ‘Leadership’ and lower for ‘Community Climate’ and ‘Community Knowledge of Efforts’. Variation between communities was most evident for the ‘Community Efforts’ with Community B highest, and C lowest.

4.3.3 TECPR comparison of readiness scores after five interviews and after ten interviews

The TECPR had found that approximately five ‘key informants’ are able to give a reliable readiness assessment for a given community. The present study interviewed ten ‘key informants’ as a way of assessing whether assessment changed with a larger pool of responses (Table 4.5)
Table 4-5: Readiness scores for each community after five interviews; and after ten interviews

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Score after 1st five interviews</th>
<th>Score after 10 interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Efforts</td>
<td>5.70</td>
<td>6.32</td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>4.50</td>
<td>4.62</td>
</tr>
<tr>
<td>Leadership</td>
<td>5.00</td>
<td>5.42</td>
</tr>
<tr>
<td>Community Climate</td>
<td>4.15</td>
<td>4.40</td>
</tr>
<tr>
<td>Community Knowledge of Issue</td>
<td>5.35</td>
<td>5.00</td>
</tr>
<tr>
<td>Resources Related to the Issue</td>
<td>4.84</td>
<td>5.02</td>
</tr>
<tr>
<td><strong>Total Readiness Score (p = 0.18)</strong></td>
<td><strong>4.92</strong></td>
<td><strong>5.13</strong></td>
</tr>
<tr>
<td><strong>Community B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Efforts</td>
<td>7.35</td>
<td>7.27</td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>5.24</td>
<td>4.97</td>
</tr>
<tr>
<td>Leadership</td>
<td>5.40</td>
<td>5.25</td>
</tr>
<tr>
<td>Community Climate</td>
<td>4.10</td>
<td>3.90</td>
</tr>
<tr>
<td>Community Knowledge of Issue</td>
<td>4.60</td>
<td>4.75</td>
</tr>
<tr>
<td>Resources Related to the Issue</td>
<td>5.24</td>
<td>5.20</td>
</tr>
<tr>
<td><strong>Total Readiness Score (p = 0.16)</strong></td>
<td><strong>5.32</strong></td>
<td><strong>5.22</strong></td>
</tr>
<tr>
<td><strong>Community C</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Efforts</td>
<td>5.30</td>
<td>4.60</td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>3.84</td>
<td>3.52</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.88</td>
<td>4.57</td>
</tr>
<tr>
<td>Community Climate</td>
<td>2.94</td>
<td>3.27</td>
</tr>
<tr>
<td>Community Knowledge of Issue</td>
<td>4.04</td>
<td>4.02</td>
</tr>
<tr>
<td>Resources Related to the Issue</td>
<td>4.02</td>
<td>3.97</td>
</tr>
<tr>
<td><strong>Total Readiness Score (p = 0.27)</strong></td>
<td><strong>4.17</strong></td>
<td><strong>3.99</strong></td>
</tr>
<tr>
<td><strong>Community D</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Efforts</td>
<td>6.24</td>
<td>6.37</td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>3.28</td>
<td>3.47</td>
</tr>
<tr>
<td>Leadership</td>
<td>5.40</td>
<td>5.42</td>
</tr>
<tr>
<td>Community Climate</td>
<td>2.98</td>
<td>2.95</td>
</tr>
<tr>
<td>Community Knowledge of Issue</td>
<td>3.88</td>
<td>4.12</td>
</tr>
<tr>
<td>Resources Related to the Issue</td>
<td>4.74</td>
<td>4.30</td>
</tr>
<tr>
<td><strong>Total Readiness Score (p = 0.86)</strong></td>
<td><strong>4.42</strong></td>
<td><strong>4.30</strong></td>
</tr>
</tbody>
</table>

Note: none of the scores achieved after five interviews were different at a statistically significant level (p>0.05) relative to the scores after ten interviews.
Whilst there were some differences in the dimension scores after the first five interviews for all communities, the overall readiness score only changed for Community A (higher stage of readiness) and Community C (lower stage of readiness) after ten interviews. A t-test was also conducted to determine if mean readiness scores differed after five or ten interviews. This test showed no significant change after ten interviews in any of the communities. The community rankings remained the same as will be seen later in this chapter. This result suggests that five interviews with key informants in a small community may be sufficient to achieve a reliable readiness measurement.

4.3.4 The scoring process

As the four scorers for this study were new to the TECPR scoring task, they spent on average 40 minutes, scoring independently and from 40-60 minutes arriving at a consensus score. This added significantly to the time, and therefore cost of using this survey instrument. They did become quicker as they became more practiced.

The scorers said that they preferred the transcribed interviews to the interview notes, as it gave them a more personal view on which to base their scoring. However, the scorers felt that using the interviewer notes would suffice to be able to provide a reliable score.

The table below (Table 4.6) illustrates selected examples of the relationship between key informant comments and the TECPR 'anchor statements'. Column 2 gives an example response from each of the four communities on the six dimensions, and column 3 notes the scorer’s assessment of readiness. The examples have been selected to illustrate the range of responses that give a similar readiness rating; as well as to illustrate examples of high and low readiness ratings.
<table>
<thead>
<tr>
<th>TECPR Dimensions</th>
<th>Example of responses from which scorers ranked communities</th>
<th>Score from ‘anchor statement’s and explanatory statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Efforts</td>
<td>“There is a broad network of services that approach this area on a continuum from prevention to intervention” (A)</td>
<td>Score: 6 Efforts (programmes/activities) have been implemented.</td>
</tr>
<tr>
<td></td>
<td>“Local council set up drug policies for the region which includes a preventive component” (B)</td>
<td>Score: 5 Efforts are being planned</td>
</tr>
<tr>
<td></td>
<td>“There is a fair amount going on but it is often reactive work though, little prevention” (C)</td>
<td>Score: 6 Efforts (programmes/activities) have been implemented.</td>
</tr>
<tr>
<td></td>
<td>“There are very few resources” (D)</td>
<td>Score: 3 A few individuals recognize the need to initiate some type of effort, but there is not immediate motivation to do anything.</td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>“Most are aware that something is happening but not to the extent of how much is out there” (A)</td>
<td>Score: 5 Members of the community have basic knowledge about local efforts (e.g., purpose)</td>
</tr>
<tr>
<td></td>
<td>“If you are in certain networks you know that things are happening” (B)</td>
<td>Score: 4 Some members of the community know about local efforts.</td>
</tr>
<tr>
<td></td>
<td>“Younger audience are more aware of what is available” (C)</td>
<td>Score: 4 Some members of the community know about local efforts.</td>
</tr>
<tr>
<td></td>
<td>“There has been a lot of promotion but the broader community chooses not to know” (D)</td>
<td>Score: 2 Community has no knowledge about efforts addressing the issue</td>
</tr>
<tr>
<td>Leadership</td>
<td>“We see them (leaders) at inter-agency forums. It is a chance for them to be seen but also a chance to be part of something” (A)</td>
<td>Score: 5 Leaders are part of a committee or group that addresses the issue</td>
</tr>
<tr>
<td></td>
<td>“It depends on their personal interest and whether it is causing problems for them (electoral)” (B)</td>
<td>Score: 3 Leaders recognize the need to do something about the issue</td>
</tr>
<tr>
<td></td>
<td>“They are doing a lot of youth work, especially some” (C)</td>
<td>Score: 4 Leaders are trying to get something started.</td>
</tr>
<tr>
<td></td>
<td>“We have a close working relationship with a lot of the leaders in the community; there are lots of working parties” (D)</td>
<td>Score: 5 Leaders are part of a committee or group that addresses the issue.</td>
</tr>
<tr>
<td>TECPR Dimensions</td>
<td>Example of responses from which scorers ranked communities</td>
<td>Score from ‘anchor statement’s and explanatory statement</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Community Climate</strong></td>
<td>“The community are quite understanding of a bit of experimentation-they wonder what all the fuss is about” [A]</td>
<td>Score: 1 The prevailing attitude is that it is an accepted part of community life. “It’s just the way things are”</td>
</tr>
<tr>
<td></td>
<td>“They don’t see it as a problem for the whole community” [B]</td>
<td>Score: 3 Community climate is neutral, disinterested or believes that the issue does not affect the community as a whole</td>
</tr>
<tr>
<td></td>
<td>“There is a “it is never going to happen to me” attitude” [C]</td>
<td>Score: 2 The prevailing attitude is: “There is nothing we can do”; or “Only those people do that”</td>
</tr>
<tr>
<td></td>
<td>“Some of the community who have experienced the impact of youth drug use such as burglary and car theft would do anything that addresses these issues” [D]</td>
<td>Score: 4 The attitude in the community is “This is our problem” and they are beginning to reflect modest support for efforts.</td>
</tr>
<tr>
<td><strong>Community Knowledge about the Issue</strong></td>
<td>“Parents may not be aware—not experienced or not exposed to signs and symptoms (of drug use)” [A]</td>
<td>Score: 4 Some community members recognize the signs and symptoms of this issue, but information is lacking.</td>
</tr>
<tr>
<td></td>
<td>“Information is readily available from a number of agencies” [B]</td>
<td>Score: 5 Community members know that the signs and symptoms of this issue occur locally, and general information is available</td>
</tr>
<tr>
<td></td>
<td>“If you need information you can get it” [C]</td>
<td>Score: 5 Community members know that the signs and symptoms of this issue occur locally, and general information is available.</td>
</tr>
<tr>
<td></td>
<td>“If you knew where to go you would be able to find the information, but I don’t think it is readily available. A lot of it is conjecture” [D]</td>
<td>Score: 4 Some community members recognize the signs and symptoms of this issue, but information is lacking.</td>
</tr>
<tr>
<td><strong>Resources Related to the Issue</strong></td>
<td>“The average person would not provide much support at all” [A]</td>
<td>Score: 1 There is no awareness of the need for resources to deal with this issue</td>
</tr>
<tr>
<td></td>
<td>“Some people might see it as more of a government issue and the community contributes to it through tax, rather than individual responsibility” [B]</td>
<td>Score: 3 The community is not sure what it would take, or where the resources should come from to initiate efforts.</td>
</tr>
<tr>
<td></td>
<td>“Volunteers are rare. There should be a lot more. If people were more aware about what is going on then there would be a lot more volunteer activity” [D]</td>
<td>Score: 1 There is no awareness of the need for resources to deal with this issue.</td>
</tr>
<tr>
<td></td>
<td>“There are some wonderful people here who would give up their lounge rooms but others would say “send them to boot camp” [C]</td>
<td>Score: 5 Some members of the community are looking into available resources.</td>
</tr>
</tbody>
</table>
It can be seen from the examples that the ‘anchor statement’ did not always provide a close representation of the response (refer last response above in bold print). The authors refer to this dilemma (Oetting et al., 2001) suggesting that their arrangement allows for the expertise of the scorer to arrive at an appropriate match between the responses and an ‘anchor statement’.

Those scoring the surveys for this study made a number of comments about the ‘anchor statements’ and their appropriateness:

a. More ‘anchor statements’ were needed to enable a closer match with statements from the key informants.

b. ‘Anchor statements’ should have their own clarifying statements, as their meaning might be unclear.

c. Benchmarks were needed so that all scorers viewed responses within similar parameters.

d. It was sometimes hard to find a match between ‘anchor statements’ and key informant’s comments.

e. One scorer thought that ‘anchor statements’ were not on a continuum in some dimensions (PhD student unable to substantiate).

f. Some of the ‘anchor statements’ contained more than one factor that made it difficult to allocate a score unless survey responses included all the factors; such as the following anchor that gives a score of six: ‘A majority of community members know and the issue occurs locally and there is enough information about the issue to justify doing something’. Many key informants said that the majority of community members knew there was a problem giving a score of 6 but information was lacking matching an ‘anchor statement’ with a score of 4: ‘Some community members recognise that this issue occurs locally but information is lacking’

g. The scorer’s held different criteria as to when a key informant might be described as ‘knowledgeable’. 
4.3.5 Inter-rater scoring consistency

As this was the first time that the TECPR had been used in Australia, it was not possible to recruit research assistants experienced in using this method to score the surveys although the authors refer to the “expert judgement” of the scorers in their model. This situation however provided an opportunity to assess how staff new to the task performed, as this might be a likely scenario with community groups wishing to use the questionnaire. Assessing the performance of the scorers was facilitated by an examination of inter-rater variation (Saal et al., 1980).

The table below (Table 4.7) illustrates the final readiness score agreed to by the two scorers for each community (Line 1). Line 2 and 3 show the readiness scores for each community that were derived from independent assessment by each scorer. Their initials sit by their score. Line 4 shows what their mean score would have been had they not arrived at the ‘agreed score’ recommended by the authors of this questionnaire.

Table 4-7: Inter-rater scoring

<table>
<thead>
<tr>
<th>Community</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final agreed score across Dimensions</td>
<td>5.13</td>
<td>5.22</td>
<td>3.99</td>
<td>4.44</td>
</tr>
<tr>
<td>Scorer 1 rating</td>
<td>(HM) 5.36</td>
<td>(HM) 6.02</td>
<td>(RR) 3.88</td>
<td>(HM) 5.82</td>
</tr>
<tr>
<td>Scorer 2 rating</td>
<td>(PD) 4.84</td>
<td>(NB) 4.06</td>
<td>(PD) 4.13</td>
<td>(RR) 3.54</td>
</tr>
<tr>
<td>Difference in scorer ratings</td>
<td>0.52</td>
<td>1.96</td>
<td>0.25</td>
<td>2.28</td>
</tr>
<tr>
<td>Mean of Scorer’s Scores</td>
<td>5.10</td>
<td>5.04</td>
<td>4.0</td>
<td>4.68</td>
</tr>
</tbody>
</table>

Note: Scorer’s initials are bracketed
The difference between the two independent scorers across the four community ratings ranged between 0.25 and 2.28 with the average difference 1.25. It can be seen from the table above that one scorer gives communities a much higher score than given by others; up to 2 units of variation. The authors suggest that the only time that this happens is with “new” scorers who need some guidance through the scoring process with three or four communities. However, they point out that because the consensus process makes the two scorers examine their scores carefully, the final score is a “good” indicator of readiness.

The PhD student, an experienced community and health promotion worker, arrived at similar scores to the final score on going through the responses. This was a welcome finding as it suggests that scorers do not have to be experienced in this method or have a community health background to undertake this task to arrive at a reliable score.

4.3.6 Statistical data obtained from the TECPR questionnaire

This section summarises some of the information that was obtained from the TECPR instrument that was used to examine quantitative data. Statistical analysis was performed using SPSS (SPSS Inc, 2004). Summary statistics included the mean (95% confidence interval) and standard deviation. Analysis of Variance (ANOVA) was used to test for overall differences between the four communities and T-Tests were used to conduct paired comparisons.

Findings are presented in the following sequence:

   a) Total mean for each dimension across the four communities and overall
   b) Standard deviation measures
   c) Statistical significance for ANOVA test of differences between communities
The table below provides the Mean and Standard Deviation values for the six dimensions of the TECPR questionnaire, for the four communities and the aggregated total.

**Table 4-8: TECPR mean and standard deviation for the four communities (N=40)**

<table>
<thead>
<tr>
<th>Community</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Efforts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>6.32</td>
<td>7.27</td>
<td>4.60</td>
<td>6.37</td>
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<tr>
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<td>0.74</td>
<td>0.76</td>
<td>0.91</td>
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</tr>
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<td>Mean</td>
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<td>4.75</td>
<td>4.02</td>
<td>4.12</td>
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<td>0.86</td>
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<td>0.63</td>
<td>0.87</td>
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<td>Mean</td>
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<td>5.22</td>
<td>3.97</td>
<td>4.30</td>
<td>4.63</td>
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<td>1.24</td>
<td>1.16</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mean</td>
<td>5.13</td>
<td>5.22</td>
<td>3.99</td>
<td>4.43</td>
<td>4.69</td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.67</td>
<td>0.70</td>
<td>0.61</td>
<td>0.56</td>
<td>0.80</td>
<td></td>
</tr>
</tbody>
</table>

Note: Letters refer to Community A, B, C and D.

p-value to 2 decimal places.

Shaded cells are discussed in the following text.
The total mean for each community reflected their overall readiness score (refer section 4.3.1). The total mean for each dimension from the four communities ranged from 3.62 (Vague Awareness) for ‘Community Climate’ to 6.14 (Initiation) for ‘Community Efforts’, with 1 being the lowest score and 9 the highest (refer 4.3.2). The mean for each dimension provided important indicators of readiness that could greatly assist community planning for prevention.

Standard deviation values indicate the variation in responses to the community dimensions around the mean. High standard deviation values were seen across three communities for ‘Leadership’ (1.10-1.80) and ‘Resources Related to the Issue’ (1.00-1.27).

Communities evidencing higher and lower variation in some dimensions are discussed with an example for each community given below (indicated by shaded cells in table 4.8):

Community A showed a relatively high standard deviation (SD = 1.17) to the questions asked on ‘Community Knowledge of the Efforts’; not seen in the other communities. It was known that this community encompassed four different areas each with its own local government, which may be why the range of responses was relatively diverse.

Community B reflected a wide range of views in the ‘Leadership’ dimension (SD = 1.80). This diversity of views was also reflected in anecdotal responses; “If there was money attached, they would support anything” to “so the leaders see the welfare and the health of young people as a significant indicator for the community’s wellbeing”

Community C key informants were relatively consistent in their responses to the dimension on ‘Resources Related to the Issue’ agreeing that residents were supportive of young people and that the community was devoted to fundraising and volunteer efforts. The narrow standard deviation of 0.69 appeared to reflect the consistent view, noted in the interview responses. However, they had the lowest readiness score in this dimension (3.9-‘Vague Awareness’). It would appear that there was general agreement that local resources were lacking.

Community D key informants were relatively consistent in their responses related to how effective and supportive their community leaders were (SD = 0.82) while opinions from the other communities relating to this were not consistent.
The TECPR readiness assessment identified significant differences between the four communities evidenced by the low p value (probability) in the total column. The statistically significant differences across the four communities are also indicated by the low p-value in all the dimensions (p < 0.05), except leadership (Table 4.8).

The table below (Table 4.9) shows all of the statistically significant differences between the pairs of communities. Statistically significant differences were noted across all dimensions except ‘Leadership’.

**Table 4-9**: Comparison of TECPR dimension scores for pairs of communities (p-values).

<table>
<thead>
<tr>
<th>Community</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Efforts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.87</td>
<td>0.01</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Knowledge of Efforts</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.02</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.02</td>
<td>0.00</td>
<td>0.89</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Climate</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Knowledge about the Issue</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>B</td>
<td>0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.02</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.02</td>
<td>0.08</td>
<td>0.76</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources related to the Issue</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.03</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.21</td>
<td>0.08</td>
<td>0.48</td>
</tr>
</tbody>
</table>

Note: Statistical significance results are in bold numerals indicated by p< 0.05

The survey had sufficient statistical power to pick up differences between communities indicated by the low probability values highlighted in the dimensions (p<0.05). However not all communities showed statistically significant differences; for example, Community A and D did not differ in the first dimension ‘Community Efforts’ (this may be because they are in the same state and resource allocation is similar), or Community A and B and Communities C and D in ‘Community Knowledge of the Efforts’. Further down in ‘Community Knowledge about the Issue’ and ‘Resources Related to the Issue’ only two out of six paired comparisons showed statistically significant difference in their results.

**Scale correlations**

To examine the inter-relationship of dimension scales on the TECPR questionnaire, a
Pearson correlation matrix was produced for all scales. The table below (Table 4.10) illustrates this matrix for the six dimensions of the TECPR questionnaire. The correlations are based on responses from the forty key informants in this survey.

Table 4-10: Scale correlations for TECPR dimensions (Pearson correlation) (N=40)

<table>
<thead>
<tr>
<th></th>
<th>Community Efforts</th>
<th>Community Knowledge of Efforts</th>
<th>Leadership</th>
<th>Community Climate</th>
<th>Community Knowledge about the Issue</th>
<th>Resources Related to the Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Efforts</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Knowledge of Efforts</td>
<td>0.58**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>0.42**</td>
<td>0.28*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Climate</td>
<td>0.16</td>
<td>0.37*</td>
<td>0.33*</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Knowledge about the Issue</td>
<td>0.41**</td>
<td>0.39*</td>
<td>0.52**</td>
<td>0.66**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Resources Related to the Issue</td>
<td>0.51**</td>
<td>0.50**</td>
<td>0.52**</td>
<td>0.60**</td>
<td>0.67**</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: * = p<0.05 (0.20 - 0.40); ** = p<0.001 (0.40 - 0.70)

Inspection of the correlations between the dimensions shows that four of the fifteen correlations between the dimensions were weakly correlated (0.33-0.37) and ten were moderately correlated (0.41-0.68).

Some of the moderate correlations are expected, such as the one between ‘Community Efforts’ and ‘Community Knowledge of Efforts’; key informants need to know about the efforts in their community to be able to list them or describe them. However this high level of correlation between dimensions suggests that some of the dimension scales may be measuring similar underlying constructs.
RESULTS: SDRG SURVEY

4.3.7 SDRG readiness scores and community ranking

The overall readiness score for each community from the SDRG questionnaire is presented in Figure 4.3. The scores for each community fell within a close range, from 2.57 to 2.77. The visually observed rankings in Figure 4.3 placed Community B higher than Community A (as with the TECPR result), but gave the same ranking as department staff to Community C and D.

Figure 4.3: SDRG overall readiness scores
4.3.8 SDRG sub-scale (dimension) scores

The sub-scale scores (Figure 4.4) for the SDRG questionnaire also fell within narrow ranges across the four communities, consistent with the TECPR dimension scores. The general profile suggested that scores were lowest for 'Leadership' (skills), ‘Barriers’ and ‘Disorganisation’ (problems in the community). The sub-scales ‘Attachment’ and ‘Disorganisation’ showed some variation between communities, with Community D scoring notably lower on these subscales, but highest on ‘Leader Support’ and ‘Collaboration’.

Figure 4.4: SDRG sub-scale scores.

4.3.9 Statistical data from the SDRG questionnaire

The values in the table below (Table 4.11) are derived from statistical analysis of the SDRG sub-scale scores, which were assigned a number; 1, 2, 3 or 4 to indicate agreement levels. As with the TECPR survey responses, means and standard deviations were first examined for trends in data prior to testing for statistical differences between communities using ANOVA.

The table below provides the mean and standard deviation values for the six dimensions of the SDRG questionnaire, for the four communities and the aggregated total.
Table 4-11: Mean and standard deviations for SDRG dimensions

<table>
<thead>
<tr>
<th>SDRG Dimensions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>2.58</td>
<td>2.70</td>
<td>2.88</td>
<td>2.37</td>
<td>2.63</td>
<td>0.08</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.60</td>
<td>0.51</td>
<td>0.43</td>
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<td>0.55</td>
<td></td>
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<tr>
<td>Leadership</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
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<td>2.40</td>
<td>2.31</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
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<td>2.77</td>
<td>0.06</td>
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<td>Community Support</td>
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<td>0.00</td>
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<td>0.54</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Mean</td>
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<td>2.77</td>
<td>2.84</td>
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</tr>
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<td>0.41</td>
<td>0.30</td>
<td>0.56</td>
<td>0.45</td>
<td></td>
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<td></td>
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<td></td>
</tr>
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<td></td>
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<td>2.75</td>
<td>2.59</td>
<td>2.48</td>
<td>2.62</td>
<td>0.53</td>
</tr>
<tr>
<td>Standard Deviation</td>
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<td>0.46</td>
<td>0.41</td>
<td>0.67</td>
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<td>0.24</td>
<td>0.27</td>
<td>0.30</td>
<td></td>
</tr>
</tbody>
</table>

Note (Table 4.11):

Letters refer to Community A, B, C and D.

p-values are based on ANOVA test for difference between communities p-value to 2 decimal places.

The total mean for each community reflected their average readiness score (refer 4.3.7). The total mean for each sub-scale across the four communities ranged from 2.10 to 3.06 (refer 4.3.8).

The narrow range is reflected across the mean differences and standard deviations throughout the survey. These values are much closer in range than those from the TECPR questionnaire, probably as a result of the restricted response options for each question and the list-wise deletion in cases where key informants answered “Don’t
Know”. This is assumed to be the reason, as ten of the fifteen people interviewed in each community were also asked the TECPR questions; where the standard deviation values were much broader.

A statistically significant difference in the community scores is reflected in two out of eleven dimensions: “Attachment” (to the community) and ‘Disorganisation’ (perceived problems in the community). However there was not a statistical significant difference in the total results across the four communities as evidenced by a p-value greater than 0.05.

**Statistics between pairs of communities**

As with the TECPR survey results, the following table presents probabilities for statistical tests (t-tests) between the mean scores for pairs of communities for the SDRG sub-scales where significant variation occurred. No statistically significant differences were found for any community comparison in the sub-scales ‘Barriers’, ‘Community Norms’, ‘Community Support for Prevention’, ‘Enforcement’, ‘Leaders Support for Prevention’ and ‘Leadership’ so they are not shown.
Table 4-12: Statistics between pairs of communities for the SDRG sub-scales where statistically significant variation occurred.

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.31</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.01</td>
<td>0.41</td>
<td>0.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachment</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.29</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disorganisation</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.13</td>
<td>0.53</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.00</td>
<td>0.02</td>
<td>0.01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conflict</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>0.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.14</td>
<td>0.33</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0.32</td>
<td>0.10</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Note: Letters represent Community A, B, C, D
Statistical significance indicated in bold numerals where p<0.05
There was much less variation in SDRG sub-scale scores between communities than was seen for the TECPR dimensions. This is likely to be a consequence of “don’t know” responses being treated as missing, which meant that the final number of valid responses included in the analyses were reduced. This decreased the power of the study for the SDRG survey and made it less sensitive to community differences than the TECPR survey where five out of the six significant dimensions showed significant variation across communities.

**Scale correlations**

The Pearson’s correlation coefficients for the eleven sub-scales of the SDRG questionnaire are presented in Table 4.13. The correlations are based on the results from the sixty key informants in this survey.

**Table 4-13: Scale correlations for SDRG (Pearson correlation) (N=60)**

<table>
<thead>
<tr>
<th></th>
<th>Conflict</th>
<th>Leadership</th>
<th>Leader Support</th>
<th>Collaboration</th>
<th>Community Support</th>
<th>Attachment</th>
<th>Barriers</th>
<th>Ownership</th>
<th>Enforcement</th>
<th>Disorganisation</th>
<th>Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>0.54**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leader Support</td>
<td>0.38*</td>
<td>0.54**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>0.29*</td>
<td>0.44**</td>
<td>0.37*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Support</td>
<td>0.17</td>
<td>0.47**</td>
<td>0.31*</td>
<td>0.22*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment</td>
<td>0.45**</td>
<td>0.40**</td>
<td>0.22*</td>
<td>0.07</td>
<td>0.30*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers</td>
<td>0.34*</td>
<td>0.33*</td>
<td>0.27*</td>
<td>0.46**</td>
<td>0.30*</td>
<td>0.23*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>0.33*</td>
<td>0.49**</td>
<td>0.18</td>
<td>0.26*</td>
<td>0.51**</td>
<td>0.45**</td>
<td>0.37*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enforcement</td>
<td>0.25*</td>
<td>0.29*</td>
<td>0.24*</td>
<td>-0.04</td>
<td>-0.04</td>
<td>0.23*</td>
<td>0.04</td>
<td>0.16</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorganisation</td>
<td>0.37*</td>
<td>0.09</td>
<td>-0.09</td>
<td>-0.29</td>
<td>0.16</td>
<td>0.31*</td>
<td>0.17</td>
<td>0.17</td>
<td>0.21*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Norms</td>
<td>0.03</td>
<td>0.08</td>
<td>-0.05</td>
<td>-0.07</td>
<td>0.23*</td>
<td>0.22*</td>
<td>0.38*</td>
<td>0.23*</td>
<td>0.20*</td>
<td>0.06</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0.68**</td>
<td>0.75***</td>
<td>0.56**</td>
<td>0.46**</td>
<td>0.60**</td>
<td>0.63**</td>
<td>0.67**</td>
<td>0.68**</td>
<td>0.38**</td>
<td>0.38*</td>
<td>0.34*</td>
</tr>
</tbody>
</table>

Note:

* = p<0.05  [0.20 - 0.40]

** = p<0.001 [0.40 - 0.70]
As with the TECPR scale correlations, some correlations might be expected where they addressed similar constructs, such as ‘Ownership’ and ‘Community Support’ or ‘Collaboration’ and ‘Leadership’.

Inspection of the correlations, as with the TECPR correlations showed that twenty-seven of the sub-scales pairs were weakly correlated (signified by the single asterix adjacent to the value) and eighteen were moderately correlated (signified by the double asterix next to the values) from a total of fifty-five. This represented approximately three quarters of the cross correlations. There were six negative correlations such as those between ‘Norms’ and ‘Collaboration and ‘Disorganisation’ and ‘Leader Support’, however none of these were statistically significant.

As with the TECPR scale the high level of moderately correlated sub-scales suggests that the questionnaire could be potentially simplified as many of the scales appear to be measuring similar underlying constructs.
4.3.10 Cronbach’s alpha values

As the SDRG questionnaire had been developed by aggregating the responses to individual items it was possible to calculate Cronbach’s alpha to provide an indicator of the internal consistency of the items contributing to each sub-scale. Table 4.14 below compares the alpha values from the present study with those reported in the USA.

Table 4-14: Internal consistency (Cronbach’s alpha scores) of sub-scales for Australian ratings relative to a USA sample.

<table>
<thead>
<tr>
<th>Sub-scales</th>
<th>Alpha Score – USA</th>
<th>Alpha Scores - Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational Readiness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>a = 0.65</td>
<td>a = 0.63</td>
</tr>
<tr>
<td>Leadership Support</td>
<td>a = 0.79</td>
<td>a = 0.72</td>
</tr>
<tr>
<td>Leadership</td>
<td>a = 0.79</td>
<td>a = 0.66</td>
</tr>
<tr>
<td>Conflict</td>
<td>a = 0.81</td>
<td>a = 0.77</td>
</tr>
<tr>
<td>Barriers</td>
<td>a = 0.71</td>
<td>a = 0.69</td>
</tr>
<tr>
<td>Enforcement</td>
<td>a = 0.67</td>
<td>a = 0.41</td>
</tr>
<tr>
<td><strong>Attitudinal Readiness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorganisation</td>
<td>a = 0.69</td>
<td>a = 0.68</td>
</tr>
<tr>
<td>Attachment</td>
<td>a = 0.60</td>
<td>a = 0.66</td>
</tr>
<tr>
<td>Community Norms</td>
<td>a = 0.87</td>
<td>a = 0.72</td>
</tr>
<tr>
<td>Community Support for</td>
<td>a = 0.65</td>
<td>a = 0.68</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>a = 0.66</td>
<td>a = 0.61</td>
</tr>
</tbody>
</table>

With the exception of ‘Enforcement’, the SDRG sub-scales generally had acceptable levels of internal consistency (above 0.65) for the Australian sample. Although internal consistency scores were generally similar, the USA sample had slightly higher scores relative to the Australian sample on most sub-scales.
4.3.11 Comparison of the two instruments

The two instruments for assessing readiness ranked the communities in a similar order (Table 4.15).

Table 4-15: Community readiness ranking: comparison of CTC staff, TECPR assessment tool after 5 interviews and after 10 interviews and the SDRG assessment tool.

<table>
<thead>
<tr>
<th>Community</th>
<th>CTC Staff</th>
<th>SDRG(a)</th>
<th>TECPR-10 interviews</th>
<th>TECPR-5 interviews(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community A</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community B</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community C</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Community D</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Ranking Score: 1= First, 2= Second, 3= Third, 4= Fourth

(a) Based on observed scores rather than statistical differences. The SDRG instrument was unable to statistically differentiate the communities.

Communities A and B had the same ranking from both instruments. Based on the actual SDRG scores the instrument ranked the Communities C and D the same as the CTC staff, whereas there were no complete matches between the TECPR rankings and the CTC staff. Communities A and B consistently ranked higher than Communities C and D.

The community TECPR readiness ranking was the same after five interviews as ten interviews, which is consistent with the original author’s views as to how many need to be interviewed before information reaches saturation.

Although this finding notes that both instruments ranked the top two communities, it is somewhat inconclusive as a method of triangulation (Denzin & Lincoln, 2000).

The sub-scales and dimensions were also examined for the community that had the greatest number of high scores and those that had the greatest number of low scores and a ranking given on this basis. This is summarised in Table 4.16.
Table 4-16: Sub-scale scores that categorised a given community as highest or lowest for each TECPR dimension or SDRG sub-scale

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Highest Scores</th>
<th>Number of Lowest Scores</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community A</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Community B</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community C</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Community D</td>
<td>4</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

The ranking from this examination gave the communities the same ranking as the TECPR survey.

Although the two instruments covered similar domains, there were some fundamental differences. For example, the SDRG questionnaire asked specific questions about organisational function that was not a specific focus of the TECPR questionnaire. These differences made it impossible to make direct comparisons between the two instruments although an attempt to align the TECPR dimensions with the SDRG sub-scales is presented in Table 4.17.
Table 4.17: Attempted conceptual matching of the TECPR dimensions and the SDRG sub-scales

<table>
<thead>
<tr>
<th>SDRG Sub-Scales</th>
<th>TECPR Dimensions where similar themes to the SDRG sub-scales were mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment</td>
<td>Dimension 1</td>
</tr>
<tr>
<td>Barriers</td>
<td>Dimension 1, 3 and 4.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Dimension 1 and 4</td>
</tr>
<tr>
<td>Community Norms</td>
<td>Dimension 4 and 5</td>
</tr>
<tr>
<td>Community Support for Prevention</td>
<td>Dimension 1, 3, 4 and 5</td>
</tr>
<tr>
<td>Conflict</td>
<td>Not raised during these interviews</td>
</tr>
<tr>
<td>Disorganisation</td>
<td>Dimension 4 and 5</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Not raised during the interviews</td>
</tr>
<tr>
<td>Leader Support for Prevention</td>
<td>Dimension 3</td>
</tr>
<tr>
<td>Leadership</td>
<td>Dimensions 1, 2, 3 and 5</td>
</tr>
<tr>
<td>Ownership</td>
<td>Dimension 4</td>
</tr>
</tbody>
</table>

Key:
Dimension 1 = ‘Community Efforts’
Dimension 2 = ‘Community Knowledge of the Efforts’
Dimension 3 = ‘Leadership’
Dimension 4 = ‘Community Climate’
Dimension 5 = ‘Community Knowledge of the Issue’
Dimension 6 = ‘Resources Related to the Issue’
‘Conflict’ and ‘Enforcement’ responses did not feature in the TECPR interviews and the TECPR domain ‘Resources Related to the Issue’ did not feature in the SDRG interviews.

Correlations between the TECPR dimensions and the SDRG sub-scales were calculated. Table 4.18 shows the correlations between the two survey instruments.
with the TECPR dimensions noted along the top of the table and the SDRG sub-scales noted along the vertical axis.

Table 4-18: (Pearson) scale correlations between TECPR and SDRG (N=60)

<table>
<thead>
<tr>
<th>SDRG</th>
<th>TECPR</th>
<th>Community Efforts</th>
<th>Community Knowledge of Efforts</th>
<th>Leadership</th>
<th>Community Climate</th>
<th>Community Knowledge of Problem</th>
<th>Resources Related to the Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>-0.02</td>
<td>0.01</td>
<td>0.01</td>
<td>-0.14</td>
<td>-0.07</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>0.17</td>
<td>-0.06</td>
<td>0.50**</td>
<td>0.01</td>
<td>0.19</td>
<td>0.32*</td>
<td></td>
</tr>
<tr>
<td>Leader support</td>
<td>0.18</td>
<td>0.04</td>
<td>0.30*</td>
<td>-0.02</td>
<td>0.20*</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>0.20*</td>
<td>-0.13</td>
<td>0.33*</td>
<td>-0.19</td>
<td>-0.00</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>0.20*</td>
<td>0.36*</td>
<td>0.47**</td>
<td>0.13</td>
<td>0.15</td>
<td>0.32*</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment</td>
<td>-0.05</td>
<td>0.30*</td>
<td>0.32*</td>
<td>0.26*</td>
<td>0.19</td>
<td>0.23*</td>
<td></td>
</tr>
<tr>
<td>Barriers</td>
<td>0.01</td>
<td>-0.04</td>
<td>0.16</td>
<td>-0.04</td>
<td>-0.11</td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>-0.03</td>
<td>0.07</td>
<td>0.41**</td>
<td>0.14</td>
<td>0.22*</td>
<td>0.21*</td>
<td></td>
</tr>
<tr>
<td>Enforcement</td>
<td>-0.04</td>
<td>-0.25</td>
<td>0.02</td>
<td>0.20*</td>
<td>0.32*</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Disorganisation</td>
<td>-0.14</td>
<td>0.23*</td>
<td>-0.10</td>
<td>0.38*</td>
<td>0.15</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Norms</td>
<td>-0.21</td>
<td>-0.06</td>
<td>0.10</td>
<td>0.26*</td>
<td>-0.04</td>
<td>0.02</td>
<td></td>
</tr>
</tbody>
</table>

Note:
* = p<0.05  (0.20 - 0.40),
** = p<0.001 (0.40 - 0.70)

The SDRG sub-scales and TECPR dimensions showed nineteen weak correlations signified by the single asterix and three moderately - correlated items as indicated
by the double asterix. The TECPR ‘Leadership’ dimension correlated moderately with three of the SDRG sub-scales and weakly with three others. The TECPR ‘Community Resource’ dimension was also correlated with the SDRG ‘Leadership’, ‘Community Support’, ‘Attachment’ and ‘Ownership’ sub-scales, but only weakly. The only other significant correlation occurred between the TECPR ‘Knowledge of Efforts’ and the SDRG ‘Community Support’, ‘Attachment’ and ‘Disorganisation’. There were twenty-one negative correlations between the TECPR dimensions and the SDRG sub-scales but none reached statistical significance.

RESULTS: ADDITIONAL QUESTIONS ON STATE AND COMMUNITY ENGAGEMENT

The present study incorporated five additional questions asked at the end of the TECPR survey in an attempt to assess the level of state government and community engagement in the prevention of adolescent substance use and the contribution to community empowerment.

A total of thirty-six out of forty TECPR key informants answered the additional questions and the other four key informants were unable to complete them due to time constraints.

4.3.12 Cronbach’s alpha values

By aggregating the responses to the individual items it was possible to calculate Cronbach’s alpha to provide an indicator of the internal consistency of the items that identified agreement that the local community had some support and experience to initiate prevention programmes. The responses across these items showed a moderate level of internal consistency (alpha= 0.55), hence scores were summed to form a scale measuring perceived community control. This variable has been described as the ‘empowerment’ scale in the text that follows.

Mean and standard deviation

Themes were coded across the five questions and then responses indicating agreement with the local empowerment dimension were summed to provide a scale ranging from 0 (agree with none of the questions) to 5 (agreed with all five). The Mean and Standard Deviation for the total empowerment scores was then examined for each community (Table 4.19). An Analysis of Variance (ANOVA) showed no statistically significant difference between the communities.
Table 4.19: Mean & standard deviation for the communities and additional questions

<table>
<thead>
<tr>
<th>Additional Questions</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>1.63</td>
<td>1.46</td>
<td>1.66</td>
<td>1.53</td>
<td>0.65</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.41</td>
<td>0.38</td>
<td>0.33</td>
<td>0.35</td>
<td></td>
</tr>
</tbody>
</table>

Note:
Letters indicate Communities A, B, C, D
Scores range between 0 to 3.
p-value to 2 decimal points

The findings in Table 4.18 revealed generally high levels of endorsement for community empowerment across each of the four communities.

4.3.13 Regression of readiness scale scores on the empowerment scale

A linear regression analysis was conducted between the scores on the ‘empowerment’ scale, provided by the additional questions, and the sub-scales from both of the readiness questionnaires. The results from this analysis suggested that the two readiness instruments contributed different and distinct information to the prediction of community empowerment. The SDRG results predicted 24% of the variance in empowerment responses, the TECPR results predicted 39.1%. Combining both results however gave a much stronger prediction of 53.9% (p= 0.004).

4.3.14 Construct validity

Correlating data from the two instruments with the empowerment scale further strengthened evidence of construct validity for the two readiness instruments. As a whole the readiness scales were both predictive of empowerment, although not all sub-scales.

The correlation coefficients for the sub-scales and total scores as measured by the TECPR instrument are shown in Table 4.20. Three of the six dimensions in the TECPR survey showed statistically significant positive correlations with the empowerment scale: ‘Leadership’ and ‘Resources Related to the Issue’ revealed moderate correlations and ‘Community Efforts’ showed a weak correlation. Higher readiness scores on these three dimensions were associated with higher empowerment scores.
The total readiness score showed a moderate correlation with the empowerment scale.
The correlations between the total and sub-scale scores of readiness from the SDRG survey and the empowerment scale are given in Table 4.21. Four of the eleven SDRG sub-scales show statistically significant positive correlations with the empowerment scale; two moderately (‘Leadership’ and ‘Collaboration’) and two weakly (‘Leadership Support’ and ‘Barriers’). The total readiness score also showed a moderate positive correlation with the empowerment scale.
<table>
<thead>
<tr>
<th>Additional Questions</th>
<th>Pearson Correlation</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>0.22</td>
<td>0.20</td>
</tr>
<tr>
<td>Leadership</td>
<td>0.41**</td>
<td>0.01</td>
</tr>
<tr>
<td>Leadership Support</td>
<td>0.38*</td>
<td>0.02</td>
</tr>
<tr>
<td>Collaboration</td>
<td>0.51**</td>
<td>0.00</td>
</tr>
<tr>
<td>Community Support</td>
<td>0.22</td>
<td>0.20</td>
</tr>
<tr>
<td>Attachment</td>
<td>0.12</td>
<td>0.47</td>
</tr>
<tr>
<td>Barriers</td>
<td>0.34*</td>
<td>0.04</td>
</tr>
<tr>
<td>Ownership</td>
<td>0.27</td>
<td>0.11</td>
</tr>
<tr>
<td>Enforcement</td>
<td>0.07</td>
<td>0.70</td>
</tr>
<tr>
<td>Disorganisation</td>
<td>-0.17</td>
<td>0.33</td>
</tr>
<tr>
<td>Norms</td>
<td>0.10</td>
<td>0.57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.45**</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Note:

N=36.

Statistical significance indicated in bold numerals where p<0.05

* = p<0.05 (0.20 - 0.40)

** = p<0.01 (0.40 - 0.70)
4.4 HOW USEFUL ARE READINESS ASSESSMENT REPORTS TO AUSTRALIAN COMMUNITIES?

The third research question for the present study provided three hypotheses related to the utility of readiness assessments that involved analysis of the qualitative responses from the TECPR survey and the additional questions.

An important hypothesis for community function (H3.1) was that assessment reports would provide “specific information on community characteristics to guide community change at the local level”. Some information relevant to this hypothesis had been described in 4.3.1, the TECPR survey responses were used to deliver a numeric score of readiness for each of the dimensions as well as a total readiness score for each community that could form a useful diagnostic tool for those implementing change within communities.

There was an important second utility with this questionnaire in that the qualitative survey responses could also provide a useful diagnostic tool for community leaders and others, in that they provide detailed information on specific community characteristics. The TECPR authors had already described how the qualitative responses could be used to give an awareness of a problem within communities that were not very aware (in Stages 1-3)-more so than statistical data (Oetting et al., 2001). In the present study it was felt that analysis of the qualitative responses could further prove the capacity of readiness assessment reporting by informing communities:

a) how their community dynamics relate to the prevention of harmful adolescent substance use and,

b) how communities and practitioners may implement strategic change efficiently and effectively.

A second hypothesis (H3.2) suggested that readiness assessment could also contribute to the broader understanding of how community factors relate to readiness for the prevention of harmful adolescent substance use (refer 2.3.4). Analysis of the qualitative responses was considered important to more fully explore the capacity to inform this area. The contemporary literature, described in Chapter 2, highlighted the significance of ‘Community Competence’ ‘Community Consciousness’ and ‘Community Empowerment’ as key factors in facilitating change at the community level. It was therefore considered useful to organise the
contemporary views expressed in the TECPR survey to explore their concordance with these key domains referenced in the scientific literature.

Responses to the additional questions were also analysed to gain a greater insight into the role and relationship between state government and the communities in prevention activity, as well as the community perspective on community empowerment. This analysis is described later in this section.

Finally, theme analysis also contributed to the process of triangulation of data (refer 3.5.2) offering comparison with the information obtained from the readiness scores, the statistical analyses, the ratings from the department staff that worked with the four communities, and the background information described in Chapter 2.

4.4.1 Theme analysis

To provide a concise framework in which to illustrate the interview responses, the themes that emerged have been clustered under the three key domains (Table 4.22) that were considered the core community characteristics related to readiness for the prevention of adolescent substance use and community change efforts: Community Competence, Community Attitude (Conscientiousness), Community Empowerment
Table 4.22: Interview themes clustered under the three domains for community readiness

<table>
<thead>
<tr>
<th>COMMUNITY COMPETENCE</th>
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<tbody>
<tr>
<td>1. Organisational skills</td>
</tr>
<tr>
<td>2. Leaders’ skills and attitude</td>
</tr>
<tr>
<td>3. Workers’ skills and attitude</td>
</tr>
<tr>
<td>4. Promotion of community activity and efforts</td>
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</tbody>
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<table>
<thead>
<tr>
<th>COMMUNITY ATTITUDE (CONSCIENTIOUSNESS)</th>
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<tbody>
<tr>
<td>5. Community climate and ‘norms’</td>
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<tr>
<td>6. Community priorities</td>
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<tr>
<td>7. Attitude to young people; and drug use</td>
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<tr>
<td>8. Culture of drug use</td>
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<td>9. Role of the media</td>
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<tr>
<th>COMMUNITY EMPOWERMENT</th>
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<tbody>
<tr>
<td>10. Who is responsible for addressing the issue?</td>
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<tr>
<td>11. Unclear magnitude of the problem</td>
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<tr>
<td>12. Government policy and practice</td>
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<tr>
<td>13. Access to data</td>
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</tbody>
</table>

Note: The themes are numbered to match the sections that follow.

The three domains were equally well covered during the interviews and demonstrated that the major themes that have been discussed in the academic literature were being actively considered by local community stakeholders. The interview responses revealed a high level of concordance of information and attitudes across the four study communities despite that Community A and D and Community B and C were thousands of kilometres apart. The responses below demonstrate that a diverse range of views were generally elicited in discussing whether the local community was successful in negotiating the underlying challenges inherent in the three domains of community readiness. A sample of the relevant responses is provided below (noted in italics). The bracketed section after the responses includes the letter for the community represented, and the key informant’s work role.
COMMUNITY COMPETENCE

1. Organisational skills

Although organisational readiness was not specifically questioned in the TECPR readiness assessment, as with the SDRG instrument, responses to the TECPR questions included comments about local organisations and their capacity to address the problem of adolescent substance abuse. Responses were heavily focused on organisational collaboration and co-ordination, which were seen as influential factors to the professionals interviewed:

“The agencies in [Community B] are well networked with each other and willing to work together” (B, Coalition).

“I think the strengths are different groups from the community working together to help solve the problem” (B, Media)

Views in the other communities were not so favourable regarding the extent to which coordination was being achieved in their community:

“Agencies don’t necessarily talk together-they don’t necessarily plan and we know they are not evaluating anything” (A, Health),

“There needs to be a pooling of ideas and energies” (D, Health)

“Coordination between groups can certainly be improved” (C, Coalition).

The focus on the requirement to improve organisational collaboration and coordination also included cross-sectoral collaboration such as that between local communities and state government; and the church:

“There is a need to form better partnerships between local government bodies and State government agencies for better resource and personnel allocation, improve effectiveness and reduce duplication when addressing youth issues” (D, Local Government).

“Church committees are somewhat detached from the realities of their local community”, spoken by a church pastor (C, Church)

2. Leader skills and attitude

Two questions on community leadership in the TECPR survey drew out some strong opinions on their role and competencies: “How are the leaders in your community involved in prevention efforts”? and “Would the leadership support additional efforts”? 

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A consistent criticism of community leaders was their lack of consistency and strategic vision in their approach to prevention that appeared to have a number of bases:

“They don’t have a unified approach to dealing with the issues” (D, Coalition)

“They (leaders) all have different viewpoints about what is going on. There is no consensus on issues” (D, Coalition).

“They (leaders) all have different viewpoints about what is going on. There is no consensus on issues” (D, Coalition).

“They don’t have a unified approach to dealing with the issues” (D, Coalition)

“They (leaders) all have different viewpoints about what is going on. There is no consensus on issues” (D, Coalition).

“Their heart is in the right place but they don’t know how to move on” (C, Welfare).

“Generally community has some wonderful community leaders who would love to be involved in something for the community but here is a lack of understanding of community issues” (C, Local Government)

This lack of consistency and vision in the leadership appeared to be founded on a lack of knowledge and understanding of prevention and appropriate strategies:

“People don’t understand prevention and how beneficial it is. They will spend however many hundreds of dollars to get a very good close-circuit television in our CBD and pay people to watch them [potential youth offenders] 24 hours a day so we get to know what is going on, yet ask them to go and support having a young person’s venue in town where we can have a health clinic and maybe information, they actually won’t support that” (A, Health).

“I don’t see a lot of it (prevention) except the police” (C, Media).

Leaders were accused of avoiding addressing youth substance use:

“They just push it away to the side sometimes”. (B, Media)

“There was a major problem of heroin use in one of the shopping malls and instead of really getting to the crux of the problem and getting to the kids, all they did was just close off the area where they were going so they just went elsewhere” (B, Media).

“What they have done is send out of the council their social policy guy along who really has to act within the constraints of council and cannot move very far and I haven’t seen any councillors there for ages” (A, Church)

The presence of other significant health and social issues in the community was seen as a major factor influencing the response from community leaders:

“They are juggling many balls—accommodation is a bigger issue—also parenting” (A, Health).

“The Police Department often wants stations to have youth officers—but it is like an elective—when it comes to the crunch it is what has to give” and, “If we devoted everything to youth we couldn’t do anything else” (C, Police)
A number of the responses referred to leaders’ particular interests influencing their approach, and the resulting lack of support for alcohol and drug prevention in young people:

“Leaders in the wider community-it depends on their own personal interest and whether it is causing problems for them - an electoral issue” (B, Welfare).

“If there was money attached, they would support anything” (B, Welfare).

“If they see it as a benefit to reduce crime” (C, Youth Organisation)

There were favourable comments for community leader skills (almost all from Community D which had the highest readiness result for this domain):

“One of the things about (Community D) is I suppose our leadership is quite varied and diverse which is not necessarily seen in other communities…they do quite a good job in getting others involved as well” (D, School).

“The strength is that the councillors are very qualified and very approachable and very adolescent friendly” (D, School).

“There are leaders in our community who are quite good at knowing where to get funding for certain projects”. (D, School) and “Local state politicians know a fair bit of what is happening in a particular suburb; and are good at applying some pressure to government bodies to access funding” (D, Local Government).

“The leaders from indigenous organisations are also working towards addressing drug related issues” (D, Local Government)

Leaders were viewed as key people to drive a cause or redress a problem in communities but the formally appointed leaders (‘positional’ leaders) were regarded as less active in this role than the ‘reputational’ leaders (those who informally serve the community) to tackle youth substance abuse:

“They are reactive not proactive; they are not instigators” (A, Law Enforcement).

“The community is not waiting for the lead of the traditional drug and alcohol agencies…people are getting on with trying things. Like we helped the Lions have a drug and alcohol night and had 260 people come to it. There are groups out there who want to just try different things” (C, Coalition)

“What we need are champions” (D, Coalition)
3. Worker skills and attitudes

Regional and rural communities often struggle with the fact that most workers described as specialists in their field are mostly based in the cities. Reasons given for this are access to other specialists, being close to colleagues, opportunity for professional support and mentoring, and for those working privately, access to a larger pool of people. Key informants in the present study also referred to lack of drug and alcohol skills and experience in locally-based workers: “There are no drug and alcohol workers in the area - only outreach which is consistent with a lot of services” (C, Welfare).

Their responses encompassed three areas of expertise:
• level of experience,
• specialist roles and,
• knowledge about the community.

Example responses that reflected this included:
“There is a lack of a skill base - there are drug withdrawal beds in the area but nurses are not experienced” (C, Health).
“The people running the services don’t have adequate skills” (D, Welfare).
“They are not specialised enough (drug workers)” (D, Local Government)

In the absence of specialised drug and alcohol workers it was regarded by some that:
“There are not enough specialist youth workers” (C, Local Government) who often have to deal with drug and alcohol issues in their work with young people in the absence of drug and alcohol workers.

A notable lack in worker knowledge was in regard to their knowledge about the community. This information came through statements such as:
“Not many (professional) people have grown up here to understand the community” (C).

This key informant went on to elaborate as to why:
“Not a lot of workers understand the community- young people are leaving school early, so not going to University and returning to work in the area” (C, Welfare).

Despite the lack of specialist skills, key informants often commented favourably about worker’s positive attitude and dedication to their work such as:
“Most of the youth sector is passionate about prevention strategies” (B, Local Government).

Workers were seen to be looking for ways to improve their capacity to deal with the problem:
“We were also looking for better (drug) assessment tools” (C, Coalition).
“Attitudes are often highly conservative but I think you can get around that providing you have got people on the ground… who have got fairly progressive ideas… who are able to make the connections” (A, School).

4. Promotion of community activity and efforts

Historically health services have not used advertising to tell members of the community why they need to use them. Services were mostly provided to deal with physical ailments, or life events such as pregnancy, and it was assumed that the individual would seek out a service when required. Publicly funded health services are not provided with money to promote services and many general doctors do not advertise as this is seen as undermining their colleague’s practice.

A lack of precedence for promoting health and community services, tied in with a lack of organisational expertise in doing so, has meant that community groups and citizens are often unaware of local service provision. This was expressed in the interviews and was considered a notable failing of local organisations:
“Even informally we don’t publish. We don’t have a local newsletter which would be a good way of getting messages out to people within the sector, so even school teachers, we don’t talk about the things we are doing” (A, Health).
“There must be more creative ways to get the message across- JG organized a debate-it got the media involved” (C, Media).

COMMUNITY ATTITUDE (CONSCIENTIOUSNESS)

5. Community climate and ‘norms’

Community value systems such as community norms of acceptable behaviour, standards and expectations of its members are important influences on the community culture and the physical and social environment in regard to substance use and misuse.

One community in the present study experienced particular difficulties with its drinking culture:
“Ethos is that we are hard workers, hard players and hard drinkers” (D, Health).
“Visiting friends and drinking and smoking with them is the norm” (D, Media)

This culture was seen as part of the history of the town where the pub had been and still was an integral part of community life:

“.its history as a man’s town, a mining town, with a pub on every corner” (D, Health)

“There are a number of hotels operating in a small community. A lot of them are open 24 hours a day. Blokes come off the night shift and go to the pub for breakfast and start drinking then” (D, Justice).

It was the same situation for the young people in that community:

“The pub is seen as the meeting place: a lot of the social life of young people revolves around the pub and sports clubs. Alcohol and drugs come into that” (D, Justice).

The transience of the population was seen as another significant factor in this community: “One of the problems is the transition of the population” (D, Coalition).

Whilst transience meant people kept coming it also meant that many did not see it as their community:

“The big issues is that a lot of people do not own (Community D) as their community, they are here short term and do not make that much commitment. They do not see it as home, a permanent place. So there is indifference amongst quite a few people. They do not tackle such an active role in town.” (D, Health)

“A lot of people are transient and they come here for one thing on their mind-they are involved in that and don’t really take part in the actual community” (D, Police).

6. Community priorities

Most people interviewed described how young people were low on the priority list in terms of resource allocation, volunteer time and overall consideration of their needs:

“The community is very focused on older people. Young people get lost down here in the community sense” (C, Coalition).

“There are some good people down here but they are not involved with young people” (C, Welfare).

“Good stuff happens but not with young people. (C, Welfare).

This view was compounded when the question referred to young people who might be using drugs, regarded as an undesirable behaviour by many:

“You would never ever find a commitment by the newspaper or anybody else to spend that amount of time or money on the prevention of drug addiction or abuse” (B, Business).
Not all key informants held negative views about their communities’ attitude to
young people:
“‘The community would tend to support anything that improved things for youth” [D, Youth Organisation]
“The strength of ‘Stuffest’ [youth festival] has been the ownership by the young
people” [B, Youth Organisation]

7. Attitude to young people; and drug use

When asked the TECPR question under ‘Community Climate’; “What is the
community’s attitude about adolescent substance use”? responses also included
opinions about adolescents as a group, such as:
“There is a lack of tolerance for the developmental needs or behaviour of
adolescents-because they are a bit noisy, a bit moody, people may see it as a drug
problem not a developmental phase” [A, Coalition]; and opinions about those that
used drugs whatever their age:
“My mother and her friends would think that someone who wore a beanie might
take drugs” [A, Media.]
“I see that some of our community leaders being fairly punitive minded in terms of
kids doing drugs or whatever…” [D, School].

Views ranged from the notion that every young person might be a drug user:
“The public also think that every young person is involved in heroin, ecstasy and a
range of other drugs, where the reality is there is little heroin… the perception is that
things are way over the top” [C, Coalition], to a level of disbelief that young people
could possibly be involved in this behaviour;
“It’s also one of those hidden things that people don’t want to talk about, because
we are talking about drugs and young people. People would rather believe that it
doesn’t happen” [D, Welfare].

Some key informants, notably youth and welfare workers, explained there were too
few recreational venues for young people:
“There is not a lot of recreation in the community but plenty of places to go and
smoke dope or drink” [C, Welfare.] Their visibility in outdoor spaces made it easy to
attract attention:
“A group of residents have gotten together and wanted a highly trained security
guard for Saturday nights as they are worried about kids drinking in parks around
their house” [C, Coalition].
8. Culture of drug use

One of the striking themes that emerged from the interviews was the acceptance of drug use, notably alcohol, by the parents of teenagers. The reasons varied; for some it was seen as part of adolescent development:

“This is just normal that they have (used drugs) because the parents used drugs as a teenager” (A, Health):

“That I did it and got through it (drug use)” (B, Coalition).

Many parents were still using drugs at home, being described as the teenagers of the 60’s:

“In more established areas like [Community C] there is an acceptance by parents of drug use and alcohol use. We have had feedback from the police that this is the response that they get when they take a 13 year old home at 3am and the parents are not concerned about police involvement or drug use” (C, Local Government)

This attitude makes it additionally difficult for health workers to address substance use with young people:

“If you try and work on the young person, its hopeless when the substances are freely used at home” (C, Coalition).

“Adults use a whole lot of things given out by doctors and I think a whole lot of those people end up misusing them. So kids have got a mixed message” (B, Welfare).

“Older brothers and sisters are often drinking” (C, School).

Key informants did not feel that parents were intending harm; as some thought that they were ignorant of what harm could be done:

“Their perception of the risks is quite low” (A, Health) but that the parents saw positives to this approach:

“Parents often buy alcohol-they say “this is the way things are” they feel close to the kids” (C, School).

One key informant went so far as to say that parents were happy to support alcohol use particularly and some cannabis if it meant that their teenager stayed away from intravenous drug use:

“Drugs are seen as not allowable, yet it is only certain types of drugs” (C, Local Government)

Although drugs overall were considered taboo:

“For youth all drugs are out” (C, Youth Organisation), there appeared to be a tolerance in some schools:
“There is an acceptable drug use (I shouldn’t say that) that is less noticed and commented on... and schools hide it” (B, Welfare). This key informant went to qualify this statement by adding that if schools were to tackle the problem in the school and in doing so advertise that drugs existed in their school, then this may impact on school enrolments and its future viability.

9. Role of the media

Opinions about the role of the media in addressing the problem of adolescent substance use, particularly the newspaper, were mixed; from favourable to unhelpful:
“The media is a leader in the community and it has had an influence; it’s been supportive of prevention efforts” (B, Coalition).
“The way the media gets involved to promote initiatives and programmes” (D, Local Government)
“The media like to latch on to bad news stories that reinforces poor perceptions” (C, Health)
“Because media often sensationalises certain instances, community concern is not realistic” (D, Local Government)
“I am not sure that media coverage expresses reality or a general position but creates its own reality as people become concerned (e.g. they do not want to go out at night in these parts)” (C, Local Government).

Responses from media interviews however revealed a good understanding of adolescent substance use and the community dynamics in regard to the issue.

COMMUNITY EMPOWERMENT

10. Who is responsible for addressing the issue of adolescent substance abuse?

Views on responsibility were mostly voiced in response to one of the questions on ‘Community Efforts’: What are the weaknesses of these efforts? The range of responses moved from individual responsibility to a community responsibility:
“People are bound by the organisations they work for and don’t see it as their role... they may say this is a health department issue or an education department issue” (A, Welfare).
“Rather than everyone looking broadly and trying to work together-often through lack of funds and resources-they don’t feel that it is their area to be pouring resources into” (A, Schools).
Some key informants gave reasons about why this might be the case:

“The problem lies at the structural and service provision level where these groups have tunnel vision. They are often under-funded financially so want to focus on core business” (A, Coalition).

“Schools are very aware of issues but teachers are a bit jaded in responding to social issues” (C, Local Government).

“One of the problems is that if one of the people motivated to run a programme leaves town, the programmes often will fall” (D, Coalition)

Some saw organisations as failing their communities. Example comments included:

“The hospital has been corporatised, which means it is moving away from putting the community first- it is left up to the community to fill the gap” (C, Media)

“Agencies need to be more accountable and available” (D, Police)

Key informants could identify financial and policy restraints but talked of attitude being the main barrier to taking responsibility:

“Attitude that ‘if it doesn’t happen in my backyard, I don’t want to know about it’ (D, Police)

“I have not put in many barriers but ignorance is one and not wanting to own the problem” (B, School)

“Often community leaders don’t want to know. If a school is having a problem, there is no way they’ll advertise the fact. They have to protect themselves” (B, Local Government).

There were those however who looked more favourably at the situation, with a view that attitudes might change:

“It is the growing need for a community to take a collective responsibility” (B, School)

“A very community-minded community” (C, Business)

“There are others who are aware of what is happening, but they don’t have a strong voice at the moment” (D, Welfare)

11. Unclear magnitude of the problem

In the absence of comprehensive data, especially local data, the four communities could only hazard a guess as to the extent and nature of the problem:

“There is a community perception that drug use is higher than reality” (C, Health)

“The adult drug use in the community seems rather high” (D, School).

“Nicotine is used a lot. We don’t really see the heavy stuff in schools” (C, School)

“There is a high usage of drugs especially illicit in the community here (D, Police) and
new drugs are being introduced:
“Recently we were called out to a chroming situation-this was new” (C, Police)
“Adolescents are getting started on different sort of drugs to 10 - 12 years ago” (D, Police)

Not only is the level of drug use perceived to be high in communities, but the associated problems that come with this:
“The problem appears too big, not just for the wider community but for the leadership” (B, Coalition).
“Certainly there is concern or fear that with alcohol and illicit drugs that violence will occur” (C, Local Government).
“We certainly have some significant issues regarding alcohol abuse by young people that we have seen in our communities, parties that the police cannot attend because the numbers are too big. We have seen zero tolerance brought into a community like (C) with massive police presence due to young people out on the streets getting drunk ambushing coaches, smashing windows and significant problems” (C, Coalition).

Whilst information for the general public was considered to be adequate, many would be unaware of the nature of the problem. The workers interviewed thought that whilst some parents might be aware of the effects of drugs:
“‘Users’ with children are more aware of what to look for-‘users’ are now having children…others were largely ignorant of what to look out for” (C, Welfare).

12. Government policy and practice

Government policy, particularly State government was seen to have a direct impact on the drug situation in communities:
“The government held a community drug summit when they came in two years ago but they have not acted on it…” (A, Coalition).
“A lot of damage was done in this area with the State government’s compulsory competitive tendering and a number of agencies who prior to 1995 worked closely together, with the very nature of how funding went, became combatant and a lot of that has not disappeared” (C, Coalition).

Some of the impact was attributed to the fact that governments operate on such short timelines, which were incompatible with prevention planning and activity:
“I think that the major thing with that is that prevention strategies to me are quite possible five to ten year projects and we suffer from government both at federal, state and the local level that has short term thinking…and sometimes community
leaders are not around long enough to really become part of a prevention campaign” (B, Business).

“There is a lack of a single focus-if you try and address too many things at once you will not address any one of them well” (C, Coalition).

“Funding has been so piecemeal and ad-hoc” (C, Coalition).

“There aren’t enough programmes that focus on the kids that don’t turn up to school” (D, Coalition)

13. Access to data

Many key informants voiced their frustration at the lack of information about their community that might assist them in their work:

“There is data but I don’t think it is available” (D, Youth Organisation).

“Some data is available through the agencies, but it would be very hard for wider community members to access it. The agencies need to look at this.” (D, Police).

“Data gathered on the problems in the community needs to be available” (D, Police)

Even when information existed it was often not available to the wider community:

“We wanted to access the data collected last year in the youth surveys so we know more about what we are doing, but we’ve been told that it’s embargoed, because the survey isn’t completed” (D, Police) or it was in a form that was not easy to use, as this key informant indicated:

“There is difficulty accessing information in a format that is user-friendly from the department (Department of Human Services)” (B, Coalition).

Whilst this was frustrating to workers, they had developed others way of obtaining information:

“Workers get around this by using other methods to gather information”.

“We get information from the Police-unofficial data- but there is stuff the police cannot release” (C, Health).

“There is certainly anecdotal evidence from workers” (B, Coalition)

However, some key informants noted that whilst information was available to the general community:

“People only tend to get interested when it is an issue for them” (A, School).

“While the information can be out there and being circulated, like many other things, it is not until you are being confronted with an issue or particular event that you would actually need to seek that information”(C, Coalition)
The data analysis process also provided insights as to which professionals provided
the more meaningful information about their communities. Whilst there were
comments from all of the nominated work areas; health, welfare, schools and the
coalition workers provided the bulk of the qualitative comments.

4.4.2 Responses to the additional questions on community
empowerment

The role of State government in Australian drug policy and practice was raised in
Chapter 2. Whilst there are other important groups and organisations in the non-
government sector such as welfare, community health and the church that also
play a significant role in addressing the issue, State government has the key role in
influencing and developing policy, as well as being a major provider of programme
funds in these Australian states.

As stated in Chapter 3, a set of additional questions were asked after the TECPR
questions in an attempt to gauge how community groups viewed the role and
acknowledgement of State government at the local level and how this contributed
to community empowerment. All key informants asked the TECPR questions were
asked the additional questions. Due to time constraints only 36 out of the 40 possible
key informants answered these questions.

In what follows a more detailed account of the responses to these questions is
provided. Responses were coded to reflect agreement with the questions. Pie charts
have been used to illustrate the total quantitative percentage breakdown of
responses from the four communities. The charts are followed by qualitative
examples illustrating the variation and clarification in responses. Communities A and
D are in the same state as are communities B and C.

The information provided in this section further illustrates the reporting detail
achievable through the readiness assessment questioning. In overview, responses to
this section confirm the conclusion outlined in Section 4.3.13 that key informants
generally agreed that State government empowered local communities to develop
and deliver prevention programs. The qualitative findings are summarised to
elaborate the variation evident amongst key informants.

The five questions asked were:

1. Are there state government mechanisms to ensure input from your local
   community into planning?
2. Of the prevention programmes that you are aware, have they mostly been initiated by the community or by state government?

3. To what extent do state government initiatives fit local priorities?

4. Does state government provide financial support for prevention planning that has been initiated locally?

5. If your community wanted to introduce a new prevention programme, do you think it would be successful in doing so?

Q1: Are there state government mechanisms to ensure input from your local community into planning?

![Figure 4.5: Q1 - Total responses (percent) from all four communities (n=36)](image)

Seventy one percent of those responding identified that there were State government mechanisms that ensured community input into their planning decisions. They referred to the different approaches used by government to engage the local community: committees, community consultations, surveys, satisfaction surveys, talking to those in leadership roles, and of course, meetings. Eleven percent did not think that there were mechanisms in place for community consultation. However, these key informants seemed to be basing their responses to this question on the survey issue; that of adolescent substance use. As this specific question had not directly referred to adolescent substance use, it may be that a number of the seventy-one percent were replying more generally about government mechanisms.

They noted that the mechanisms were usually employed by locally-based government departments and gave examples such as the health, mental health, public health and the police sectors: “Input is via locally-based government department offices, the Regional offices or through representation of local Members of Parliament in state government (D).
The level and amount of contact varied across the four communities: “We have at least an annual meeting with the Regional Office (DHS)” (C) to: “There are often public briefing sessions held by different government departments on a wide range of issues- probably two to three a month” (B). Community B had for many years held key ‘marginal’ political seats so politicians and their representatives were frequently seen, particularly near election time: “Obviously there is face to face contact with Members of Parliament-a fairly popular choice in B” (B).

At times community members were invited to represent their community in consultative processes: “There is the occasional request from the department for community representatives to sit on working party” (D). “There are a number of people who have had input into a State government drug action plan” (B). One key informant, a government employee thought that whilst: “There are a lot of opportunities out there for people in the community to have input but only a small number of them take advantage of these opportunities” (D). Another noted why this might be the case: “Overall the community is not empowered to participate...I do not think the state or local government sets out to skill up people to participate” (B). One key informant thought that responding to such requests had little benefit as: “Local organisations are canvassed for input I don’t think it makes any difference, as State government seems to do what it wants anyway”. (D).

Some described these efforts as “tokenistic”: “Look they say they do but what they do is fly in people, well not fly in but come down for a day and do a consultation run around and then go away” (A). A number of key informants mentioned that ‘grass-roots’ workers were rarely consulted: “The Office for Youth has just completed the Victorian Youth Strategy but I do not know of anyone in the industry who has actually had any input- yet that Strategy is going to provide our services for the next ten years” (C). Where consultations did occur some thought that the approaches used were unproductive: “They tend to have very formalised processes-ones that don’t engage and connect well with the community and tend to try and get responses from community heads” (C).

However, there was one government organisation that received very positive comments from those that were aware of its existence and function. The department’s model was one that appealed in that it provided a direct communication link between the community and Cabinet, through a tiered structure: “The Safer W.A. committee is about the only direct link to encourage that to happen” (input from the local community into government planning decisions). “So, there is a direct channel right up the chain, which is excellent. It’s been really
good. I think it’s quite unique. I don’t think the other states have anything quite like it” (A).

Q2: Of the prevention programmes that you are aware, have they mostly been initiated by the community or by state government?

![Figure 4.6: Q2 - Total responses (percent) from all four communities (n=36)](image)

Over half of the key informants (54%) thought that the prevention programmes that they were aware of had been initiated by the community: “Most initiatives are implemented as the result of local agencies responding to community issues” (D), although this might be: “initiated by individuals within agencies” (D). This was an interesting finding considering that State government in both states is responsible for policy and services in relation to adolescent substance use. A quarter of the key informants thought that State government had initiated local programmes: “State government agencies are the drivers of the majority of initiatives in the communities” (D) and about one fifth thought a combination of the two: “I do not think that the local community would be responsible for more than 5-10% (A).

The responses to this question also revealed that the study key informants did not simplistically view the drivers for local activity. They understood how the mechanisms of government fed into what communities desired and visa versa: “State government may respond with funding but (efforts are) initiated by the local community” (C). The key informants appeared to understand the strengths and weaknesses of this inter-play between government and communities: “Mostly by the community, often following on from State government suggestions and initiatives” (B) and “Local people come up with the idea, state gets the funds” (A). “There might be something that the State government is doing in Melbourne and they will tinker with it slightly and change the focus a little bit but adopt the same idea in B”. (B)
As the study was conducted in regional communities that housed a number of government departments, the government employees often lived locally and were regarded as community members: “State government workers in the local community are community members - they are based in A, not the city” (A). These government departments were often seen as local organisations, an ideal situation: “Knowing someone in a government department helps. Knowing when amounts become available from time to time, by seeing contacts in head office, is how it tends to happen at this level”. This situation did have some tensions: “A number of these people (public servants) have initiated the programmes so there is a bit of tension as to who claims (the credit)” (B).

Locally driven initiatives were considered to work better: “What has been initiated locally is good. It fits the need better than something that has been brought in” (A).

Not everyone was positive about initiating prevention activity: “I don’t know of any State government prevention initiative” (D) and “The community is not used to getting together to get things going” (B).

**Q3: To what extent do state government initiatives fit local priorities?**

![Figure 4.7](image)

**Figure 4.7: Q3 - Total responses (percent) from all four communities (n=36)**

Compared with the first two questions on state and community engagement, this question on how state government priorities matched local priorities, evoked many more ‘Don’t Know’ responses; just under a third. About a quarter thought that the priorities ‘Do not fit’ and nearly a half that the priorities did ‘Fit’.

As with the responses to Question 2, key informants described the interplay between State government and community when it came to ensuring that priorities were met. Many commented that although State government might be seen to be the driver in terms of initiating new activities or directing interventions, that communities held
the capacity to tailor how this might be achieved: “State initiatives allow modification to fit local priorities” (A). They were clear that priorities differed: “Priorities vary between state and local” (C) although both State and community were in agreement on risk factors: “Reasonable fit-identifying risk factors” and “They fit quite highly especially with identified risk factors” (A).

A key informant from Community B pointed out that the priorities were similar but there was not necessarily agreement on how the priorities were being addressed: “The issues are similar but state leaders need to look at the different ways to address these issues” (B).

Community C felt that regardless of what state government was attempting to introduce, they had the power to refuse if something did not fit their priorities: “If something lacks local relevance it gets little support and gets diverted elsewhere”; “If guidelines fitted the community would grab and run with it” and “We wouldn’t take it up if it did not fit”. However whilst communities might want to refuse State government approaches for prevention, they might not always have a choice as: “There are not always resources for local priorities” (C) and “State government is a major source of funding”.

With some responses there was a level of cynicism about state government’s approach to priority setting: “If they fit, more through luck than good management”, “Initiatives based on vote winning rather than evidence” (A) and “I have not seen any government committed to a long-term approach and prevention” (B). Others were more sympathetic: “They generally tend to take regional views strongly into consideration when they are developing any new policies” (B). Question 2 responses talked of the benefit of state government public servants living and working locally. The benefit of this situation was also noted in this set of responses: “There are key leaders in the community that can ensure programmes are effective” (B). “I think there have been a couple of cases – the Drug Action Strategy Plan is one where the local members have been kept in the loop because they are important from a resourcing and involvement point of view” (C).

One key informant in Community D described how State government tried to ensure local relevance: “There is an attempt to-but it is difficult when they [community] don’t really know what the priorities are” (D). A couple of key informants (from different states), provided some insight as to why communities might not know what are the priorities, and this related to the availability of local data: “Previously this has
been based on guesswork or perception of the people around the table at the agency and community level” (D).

Interventions such as CTC were ensuring that communities had relevant local data about young peoples’ behaviours and health issues through the application of school surveys. Key informants to the TECPR questions also talked about the importance of local data to inform local efforts. Possessing such information would put communities in a much stronger position to determine priorities on youth health issues such as substance use. Whilst this was seen as important, one key informant thought it would create tension with state government: “the local research will cause problems with State government because it will be very much what we want to target” (A).

Overall key informants felt that community efforts that had arisen out of local priorities were more likely to be appropriate and to succeed: “State does not have the same outcomes but if they do it takes longer-often more sterile” (A): “Many State government initiatives do not address the underlying issues in rural communities” (B).

Q4: Does state government provide financial support for prevention planning that has been initiated locally?

![Figure 4.8: Q 4 – Total responses (percent) from all four communities (n=35)](image)

Nearly three quarters of the key informants thought that State government provided financial support for prevention planning that had been initiated locally. Many gave examples of local programmes such as: “Investing in Our Youth” (CTC) (A), “Drug Strategy” (B), “Safer City Centre” (C), and the “Drug Action Group” (D). Funding had been provided through two key government sources; directly from Treasury as part of government programme planning and through some notable funds that were run by State government. The process might be through ‘tendering’ (of services): “Yes
via the tendering process” (D) or through direct application to the fund: “Drug Information and Counselling Service were initiated locally to meet local need; they applied for state funding” (A). Some examples of funds used were: “VEDF Drug Fund”, “Vic Safe” and the “Community Support Fund”. Again, local members of parliament were seen as important to influencing state government: “Through active involvement of local MPs” (C)

Some viewed the allocation of funds favourably: “The Local Drug Action Group receives funding from the state government level this is distributed in response to decisions made by the Management Committee, which has local youth, family and wider community representation” (D). Others less favourably: “They make judgments on the applications (for funding)...it is almost saying, “Your community does not really know what it wants. We know what you want!”. We have arguments about this all the time” (D) and: “You have to put submissions forward and they have to be assessed and all that sort of thing happens, which can be frustrating” “Often, when it gets down to the people assessing these submissions, they are not aware of the community need, not directly aware so they make judgements on the applications and that can be very frustrating for the communities” (C)

Some of the other frustrations with government funding talked about the limitation of ‘seeding’ grants: “There is still an issue I think with the concept of seeding grants because seeding grants create expectations and governments don’t want to get themselves locked into ongoing recurrent funding and yet if they put in a seeding grant there should be a targeted lifetime which is more than 12 months” (C)

Somebody in Community A thought very little was allocated to prevention by state government: “About 1-3% is spent on prevention by the state” (A). Where money was allocated, there was a view that it always went to the same organisations without consideration of what was being achieved: “I think one of the problems in the drug and alcohol areas itself is that it has been a closed shop for the past 8 years to existing providers ....has all gone to the existing providers and yet there has been no assessment as to whether or not those existing providers are delivering the goods” (C)
**Q5:** If your community wanted to introduce a new prevention programme, do you think it would be successful in doing so?

![Figure 4.9](image_url)

**Figure 4.9:** Q5 – Total responses (percent) from all four communities (n=35)

This last question, unlike the first four did not ask about any community relationship with state government but was included to ascertain how confident the key informants felt about their communities’ capacity to make changes. It can be seen from Figure 4.13 that 65% thought their community would be successful in introducing a new prevention programme. About a third (32%) thought they might be and only 3% did not think that success could be achieved.

The responses focussed overwhelmingly on the quality of the workers in the community to achieve such goals - most through their dedication to their work. There were some comments about the need for people with skills, to write applications for example: “Provided someone can get the funds and write applications well; a couple of people have done things and have the skills to do more” (A).

Another community resource was the collaboration that supported initiatives: “I think we would be more successful now than two years ago, because of the cooperation between all of the agencies...each one would submit a letter of support in with the application and it would be a genuine letter of support. I don’t think a community can have anything stronger than that to sway the powers that be to successfully assess an application for funding” (D) and: “At the moment everyone seems to be working together” (A) “There is trust-good networking” (C). Those that responded favourably to this question conveyed their response with a sense of pride: “In this community people are passionate and committed. “There is a lot that they can be proud of-they are good at plugging people in”(C) “Yes- a great group-a dedicated group of professionals- and very good”.
The CTC initiative in Community A received a particularly favourable response from a number of key informants: “Yes, [the CTC coalition]... has a whole stack it wants to put in place”; “It has the right approach - evidence based, collaborative, support, feasible, needs identified”; “Young people work well with them - the sort of people that can get things up and running”\(^{(A)}\)

Community B had only one key informant of the ten that were interviewed that felt confident; and this was due to the political benefit of being a marginal electorate. This community however was ranked second on readiness to implement change with the SDRG and TECPR surveys.

Some of the key informants were employed by a government department as opposed to a non-government organisation. Their responses appeared generally more favourable toward government activity on youth substance abuse: “Based on past experience - we have the capacity to do something well” \(^{(C)}\). It would appear that their responses were more favourable because they had a more intimate knowledge of government policy and practice through closer communication in the workplace.
4.5 FEEDBACK OF READINESS ASSESSMENT REPORTS TO COMMUNITIES

Initially the CTC lead trainer involved with the study communities through the intervention was to give feedback on the readiness information obtained through the study. This seemed ideal as she already had a working relationship with a number of those interviewed, and could tie in the readiness information with the technical support that she was providing through the CTC local coordinators. Unfortunately, she left the position shortly after the data collection commenced and was not replaced. This limited the ability of the present study to obtain participant feedback regarding the value of the readiness assessment reports.

To gauge participant interest in obtaining readiness assessment feedback the PhD student wrote to each participant at the end of the data collection phase when some preliminary data on readiness was available. The letter (Appendix 7) gave the participants some general insights into their community readiness, as well as asked their advice on how this information might be relayed back to their community and or interested groups working in this area.

Responses suggested a low level of interest in the readiness assessment reports. Two people responded from the 60 interviewees contacted; one asked that a briefing session be given to the study participants from their community and the other, from a different community, said they would appreciate further information after they had concluded their ‘Drug Strategy’ plan, a recent requirement of Victorian Local Government.

The latter did not call back, and it was explained to the former that giving detailed information to just the study participants would disclose who they were and what they might have said; which was contrary to the ethics agreement. The ideal group would be one that was already working to address adolescent problems in the community that may include some of those interviewed, as they would be able to use the information to assist in their task. Unfortunately this feedback session did not eventuate.

The following is a summary of the favourable and less favourable community readiness findings from all four communities. Findings specific to each community were relayed in the feedback letters to the key informants (example Appendix 7). Reference is made to the TECPR interview responses described in section 4.4 to illustrate the community readiness findings. The specific responses were not included.
Readiness information was similar across the four communities (refer 4.3.2) but community characteristics varied. There were a number of favourable findings.

Readiness findings reflected that there was general information about adolescent substance use and abuse in the communities (refer section 11) although most was not based on formally collected data (refer section 13). All four communities were engaged in a level of planning (refer 4.4.2 Q5) to address the problem although efforts were not necessarily co-ordinated or detailed (refer section 1). Although community leaders were described as holding differing views on adolescent substance use, overall they were seen as supportive through their involvement, and allocation of resources (refer section 2). In particular police in Community C were noted for their genuine concern and efforts, and leaders in Community D for their effectiveness in harnessing resources (refer section 2). Resources, such as people, money and time were being actively sought or had been committed (refer section 2 and 4.4.2 Q5) and the community climate offered modest support for the efforts to prevent adolescent substance abuse (refer section 6).

The interview responses however reflected that in the four communities the readiness level varied across domains and that the lack of readiness in some domains could have implications for the overall effectiveness of their community efforts.

Less favourable readiness findings showed that community members were not well informed about adolescent substance abuse, nor were they very aware of the work that was being done to address the issue compared with those that had professional roles in relation to young people (refer section 6). Attitudes to adolescent substance abuse ranged from those that believed the problem was significant and wanted a hard line taken, to those that were described as tolerant, accepting that alcohol and tobacco were widely used in this community, to those who chose to ignore that this might be a local problem. Community members, according to those interviewed, considered ‘hard’/illicit drugs a bigger concern than alcohol or tobacco use (refer section 7). Alcohol, tobacco and to some extent marijuana use, were seen as part of the risk-taking behaviour that occurred as a normal part of growing up. Drug use, particularly alcohol was condoned by many parents in the community (refer section 8). Community D had particular challenges as it was described as a hard working rural town with a long history of pubs and clubs forming the core of
social life. Drugs were affordable by many and they were easily available in the community (refer section 5). Communities A and C talked about the fear that existed in the community because of drug use and to some extent a generalised fear of teenagers - an inability to understand their behaviour (refer section 7 & 11).

Although there were community groups in all four communities committed in principle to addressing adolescent substance use, they were limited in their capacity to do so (refer section 1 & 3). Reasons provided were limitations imposed by government funding arrangements, short time-frames in government policy and funding and instability due to change of government. A commonly expressed view was that agencies were not good at collaborating or communicating their efforts, in part attributed to the ‘competitive’ approach utilised by government to fund services in the past that still held sway (refer section 12). The church in Community C was seen as doing a lot for young people, but detached from other community efforts. Other reasons included the lack of staffing expertise, and that prevention was not part of their funded role (refer section 3 & 10). The lack of community information about adolescent substance abuse and limited access to local and state-wide data was a notable limitation (refer section 11 & 13) as well as the lack of resources to evaluate activity (refer 4.4.2 Q4).

Leaders were described in the literature as critical to effective community action (refer 2.3.4) but key informants in the four communities described their leaders as reactive rather than instigators of change; and adolescent substance use was not regarded as a priority issue. They were also described as having a different view of prevention, such as placing monitoring cameras in the high street rather than putting money into a youth programme. Others were seen as showing political self-interest in the issue only reacting when it was raised in the media or resulted in anti-social behaviour, such as vandalism or violence in their community (refer section 2). Overall there was a sense that although “their hearts were in the right place”, community leaders lacked an adequate understanding of the issue and as a result did not know what to do to address the problem.

Worker capacity to address adolescent substance use was limited by a lack of drug and alcohol skills and Community C only had access to outreach workers. Whilst outreach workers provided a service that was welcomed there was a high level of transition and these workers were less aware of local culture and knowledge. Likewise tertiary educated young people often did not return to their community, further reducing the pool of professionals with local knowledge (refer section 3).
Media sources were considered knowledgeable on youth issues but many key informants referred to the sensationalising of youth issues by the media that was often unhelpful and unproductive (refer section 9). Likewise community organisations made poor use of the media to promote or publicise the good work that was being undertaken in their communities (refer section 4).

Key informants from Communities C & D noted fewer resources were committed to young people such as volunteers, fundraising and community action. In Community D, reasons included the transient population that did not see the town as their community; a down-turn in business; and parents working long hours. It was also attributed to lack of understanding of issues related to young people (refer section 5). Community C was described as a community more focussed on its older citizens that formed a larger proportion of the population (refer section 6).
4.6 CONCLUSION TO THE CHAPTER

The present study was the first to attempt to establish the feasibility, reliability, validity and utility of the TECPR and SDRG instruments in the Australian setting. The chapter set out to provide the reader with a coherent set of results from the present study that demonstrated how the information collected related to the research objectives outlined under the three research questions. The hypotheses listed in Table 4.1 were used to guide the assessment and analyses of the results to determine whether the hypotheses had been upheld or rejected. In the sections that followed broad conclusions were drawn from the results. The next chapter will discuss these results in more detail.

Despite it being a relatively small study the two survey instruments independently and collectively provided a great deal of potentially useful information for drawing conclusions about community readiness and its assessment. The results from this pilot study generally supported the feasibility of collecting readiness assessment data and provided some interesting insights into community function and the usefulness of readiness assessment to communities in their prevention work.

Results from the statistical analysis revealed that readiness assessment is feasible using either of the two instruments. A detailed account of the administration and analysis time and participant experience was presented to indicate aspects of the methodology that may be refined in future studies.

The comparison of results from the two community readiness survey instruments suggested some advantages for the TECPR instrument in its slightly higher face validity to key informants and its ability to significantly discriminate the total readiness scores for the four communities. Analysis revealed some associations between the two readiness assessment methods; supporting the view that they were assessing some common underlying dimensions but also that they each provided some unique information. Analysis of the additional questions related to community empowerment suggested that the two assessment methods each contributed unique information in predicting local perceptions of community empowerment.

The qualitative responses from the four communities provided an opportunity to gain a greater insight into the diversity of perspectives relevant to community factors that support or hinder the prevention of youth substance abuse at the community level. As with the quantitative findings there were many similarities across the four communities. Whilst the qualitative responses showed interesting variation, they
could be coherently organised to map against the major domains of community competence, community consciousness and community empowerment that have been referenced in the scientific literature described in Chapter 2.

The qualitative responses also demonstrated the capacity of readiness assessment reporting to provide detailed and specific information on community characteristics (e.g. a culture of pub life) and community dynamics (e.g. older people hold greater priority with community leaders). This more detailed level of information would likely prove valuable to community leaders and others that are considering community change.

The data analysis process also provided insights as to which professionals provided the more meaningful information about their communities. Whilst there were comments from all of the nominated work areas; health, welfare, schools and the coalition workers provided the bulk of the qualitative comments. This finding suggests that they could be usefully identified as key informants in future studies on this issue.

A final step in the present analysis of feasibility of readiness assessment involved an effort to obtain evaluative feedback from community participants regarding the resultant readiness assessment reports, but participants generally failed to engage with the process.

The next chapter will examine the results more systematically against the hypotheses. The limitations are considered prior to drawing conclusions and considering recommendations.
CHAPTER 5: DISCUSSION AND CONCLUSIONS

5.1 INTRODUCTION TO THE CHAPTER

A primary task of this study was to pilot the application and usefulness of two American readiness instruments in Australian communities. The instruments might ultimately provide a systematic and reliable way of assessing community readiness to address adolescent substance abuse. Study findings would also ideally contribute to the understanding of community factors influencing change.

Whilst many questions about communities and adolescent substance use were considered during the design and implementation phase of the present study, the three key research questions crystallised from the literature and instrument review that were described in Chapter 3, guided the reporting of results in Chapter 4. The purpose of the present chapter therefore, is to respond to the aim of the study by synthesising what has been learnt from the results in attempting to answer the research questions. The implications of the findings as well as the relevance of this study to current theory and practice will be discussed in three sections headed by the research questions:

1. Is readiness assessment feasible in the Australian context?
2. How reliable and valid are the two readiness assessment approaches in the Australian context?
3. How useful are readiness assessment reports to Australian communities?

A number of methodological considerations arose in the conduct of this study relating to the application of the instruments as research tools and these will be discussed in this chapter. The discussion will also identify the strengths and limitations of the study.
5.2 KEY FINDINGS IN THE CONTEXT OF THE RESEARCH QUESTIONS

This was the first study to assess the feasibility of the TECPR and SDRG instruments for their use and application in measuring community readiness in the Australian context. It was also the first study to compare the two instruments.

The health promotion and public health literature highlighted in Chapter 2 reflected the increasing recognition that the success of population-based interventions depend in large part on the effective application of community organisation theory and principles, including readiness for change (Bracht & Kingsbury, 1990; Glanz et al., 1997a). To do so however requires a level of understanding of how these principles can be applied at the local level.

Broadly, the results indicated that readiness assessment is feasible using either of the two instruments although it can be seen from the following table that a number of the hypotheses set up to guide the study design (refer 3.2) were not upheld or only partly upheld by the results. The basis of these judgements regarding each of the hypotheses will be elaborated in this chapter.
### Table 5-1: Conclusions regarding the hypotheses for each research question

<table>
<thead>
<tr>
<th>Q1: Is readiness assessment feasible in the Australian context?</th>
<th>Q2: How reliable and valid are the two readiness assessment instruments in the Australian context?</th>
<th>Q3: How useful are these readiness assessment reports to Australian communities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1.1: UPHELD There will be at least an 80% response rate (ideal response rate for questionnaires)</td>
<td>H2.1: UPHELD Readiness assessment scores will be internally reliable.</td>
<td>H3.1: UPHELD Assessments will provide specific information on community characteristics to guide community change</td>
</tr>
<tr>
<td>H1.2: NOT UPHELD Surveys can be completed in under 40 minutes (matched to USA samples)</td>
<td>H2.2: MOSTLY UPHELD Stakeholder evaluative comments will indicate favourable face validity</td>
<td>H3.2: UPHELD Assessment will provide a basis for understanding how community dynamics relate to the prevention of adolescent substance abuse</td>
</tr>
<tr>
<td>H1.3: MOSTLY UPHELD Stakeholder evaluation of the questionnaires and survey process will be favourable</td>
<td>H2.3: MOSTLY UPHELD Assessments will identify significant differences between communities (discriminant validity)</td>
<td>H3.3: NOT UPHELD Stakeholder evaluation of readiness assessment models and their assessment reports will be favourable.</td>
</tr>
<tr>
<td>H1.4: PARTLY UPHELD Few modifications will be required to the questionnaires and assessment methodology.</td>
<td>H2.4: PARTLY UPHELD Assessments will match the ranking of experts (criterion validity)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H2.5: PARTLY UPHELD The instruments scales will correlate and provide similar rankings (construct validity)</td>
<td></td>
</tr>
</tbody>
</table>

Note: H = Hypothesis, Q = Question
5.2.1 Is readiness assessment feasible using the two instruments in the Australian context?

H1.1: UPHLED. There will be at least an 80% response rate.

The mean response rate of 77% was considered very close to the 80% anticipated (refer 4.2.2). The variation between interviewers also revealed that at least one interviewer was able to achieve the 80% response rate. This interviewer achieved an 88% response rate, supporting the capacity to achieve response rates of 80%.

Overall 26% of the key informants re-scheduled an interview appointment and 23% declined to be interviewed. Altogether 373 calls were made to interview 100 people. Whilst the full complement of key informants can be achieved through the snowball technique, hence Hypothesis 1.1 being upheld, the cost compared to postal surveys may limit using this approach in larger studies (Arthur et al., 1999; Sarantakos, 1993). The department has since conducted a small study that tested the feasibility of a postal survey of the SDRG questionnaire, for the reasons of cost and time associated with a telephone interview, but response rates were low (Williams, 2008).

Recruitment and scheduling the interviews

The present study found a number of notable findings in the process of recruiting key informants.

It took 34 weeks for Interviewer 1, and 16 weeks for Interviewer 2, to recruit 30 study participants (refer 4.2.2) using the snowball recruitment technique (Arthur et al., 1999; Beebe et al., 2001; Sarantakos, 1993). The initial contact by phone and follow-up calls to others that had been suggested as knowledgeable in the area, was straightforward, but explaining the study and finding two hours of someone’s time took much longer. The people that declined to take part were not systematically asked for a reason. The following were assumed to be some of the reasons from the conversation that ensued; some were too busy to allocate two hours to interviews, some felt that they were not well qualified to answer, and others said that they did not work in this area. The participants that were familiar with the CTC model in their communities were aware of the department’s involvement, from whence the PhD student had sent initial letters of invitation. This made it much simpler to recruit some, but for those that were not supportive of CTC, the contrary was the case; they needed to be convinced that a readiness survey was a good idea.

One participant however was so against CTC that she was delighted to be asked so she could make sure her views were heard. Another, also involved with CTC, was
clearly offended that there might be a thought that the CTC coalition might not be ready and therefore did not see the relevance of the survey (Arthur, 1999; Arthur et al., 1999; Maxwell et al., 1987).

Readiness of these four communities was also reflected in the process of recruitment; the higher rate of refusal occurred in the community that was measured as “least ready” in the present study (Haglund et al., 1990). The recruitment process took longer with each refusal, as the pool of people identified as possible key informant on this topic, appeared limited.

**Key informants**

The present study found that there were a number of notable findings in the process of interviewing or attempting to interview community leaders (refer 4.2.1).

As noted in Chapter 3, the present study targeted ten ‘positional leaders’ from nominated sectors in each community for both surveys and five others, using the ‘snowball’ technique, for the SDRG survey. Only half those interviewed for the present study were ‘positional leaders’, less than the two thirds suggested by SDRG.

Consistent with Viswanath and Finnegan’s (1995) findings, the present study revealed that when heads of organisations were contacted they often deferred to staff that they felt knew more about adolescent substance abuse. The length of time required for the interviews (2 hours) also appeared to influence their deferring the interview to others within the organisation (Arthur et al., 1999; Harachi et al., 1992; Kumpfer et al., 1994). Two leaders agreed to be interviewed with the agreement that they could attend to other matters at the same time. One director was interviewed by mobile phone on her way to a meeting. This process extended the interview time but provided both the interviewer and key informant supported this approach, an interview was able to proceed.

Consistent with a number of other studies, those interviewed in senior positions were generally more knowledgeable about broader policy and system issues on the subject of adolescent substance use and prevention (Hyman & Sheatsley, 1947; Mostellar & Moynihan, 1972; Plested et al., 1999; Prestby & Wandersman, 1985; Rich, 1980), compared to the worker, who might reveal more about day-to-day practice; and local issues. Most key informants were knowledgeable about adolescent substance use and described being aware for much of their professional life.

It would have been interesting to have interviewed the organisational heads that said they did not know much about adolescent substance use, who deferred to
another person in their organisation. This may have shown that they knew more than they thought about the issue, or that in fact their lack of insight and knowledge was of consequence to effective prevention efforts in the community (Butterfoss et al., 1993; Fawcett et al., 1993; Goodman et al., 1996; Kumpfer et al., 1993; McHugh et al., 2004; Viswanath & Finnegan, 1995).

Government departments based in the community, as opposed to non-government organisations, employed some of the key informants. The responses from these key informants generally appeared more favourable toward government activity on youth substance abuse. Although this feature was not included in the formal analysis of the study, the responses showed a trend such that participants employed within government appeared more favourable because they had a more intimate knowledge of government policy and practice through closer communication in the workplace (Ettema et al., 1983; Fredin, Monett, & Kosicki, 1994; Slater et al., 2005; Zanpour & Fellow, 1992).

Despite a lower number of community leaders than desired, the snowball technique appeared to generate a mix of key informants who were knowledgeable about the issue and their community. The interview process appeared to provide an effective method for engaging key informants in the research process (Atkinson & Flint, 2001). The professional domains targeted in this study, were those suggested by the authors of both questionnaires and they appeared appropriate for a health-focused investigation of readiness (Arthur et al., 1999).

The key informants were overall very knowledgeable about their community, probably as a result of living and working in the same place over a number of years (Arthur et al., 1999). Many answered questions not only from the perspective of their professional role but also from their perspective as a citizen of that community and for some, as a parent of an adolescent. It will be interesting in future studies to compare metropolitan with rural key informants for their level of community knowledge.
H1.2: NOT UPHELD. Surveys can be completed in under 40 minutes.

On average both surveys took around 60 minutes to complete with the longest TECPR survey taking 80 minutes and the longest SDRG survey 109 minutes. Factors emerged in the process of conducting the interviews that led to variation in the length of time required (refer 4.2.3).

Telephone surveys rely on the ability of the interviewer to engage the participants and facilitate a supportive interview (Beebe et al., 2001; Lewis, Jones, & Ruck, 2005) that is not required with postal surveys. The interviewer is also required to manage the interview process. Completion of the interviews took approximately a third (SDRG) to double (TECPR) more time than indicated by the authors. In part, this was due to the lengthy and passionate responses the subject under discussion aroused, the open-ended nature of the TECPR survey, and the lack of experience of the interviewers to manage the response timing. The SDRG survey, despite its defined response options, attracted a lot of additional comment from key informants, as they wanted to explain their answer. The additional explanation was often relevant and included new information but there were negative consequences associated with lengthened interviews. The key informant and interviewer would tire after a period, or run out of time, and as a result, a small number of surveys were not completed. With interviews taking twice as long as planned, interviewer and telephone costs were doubled. However, as with the scorers, the interviewers improved with practice and established methods of ensuring the interviews were kept to appropriate time limits.

Both questionnaires required an explanatory preamble for the interviewer that not only introduced the survey and its purpose but also advised the key informant that short answers would suffice. Although it was likely that interviews could be achieved in a shorter time with practice, Hypothesis 1.2 was not upheld in the present study.

The adapted SDRG survey (translated from computer-administered to pen and paper) required careful interviewing to follow the branching of questions at key stages in the survey. Whilst a tool had been developed to assist the interviewer with the branching, skills were required to maintain an engagement with the key informant whilst attending to the branching checklist (Beebe et al., 2001; Lewis et al., 2005). The observation that a complex interview process may threaten engagement requires consideration in future studies that use the pen and paper SDRG questionnaire.
H1.3: MOSTLY UPHELD. Stakeholder evaluation of the questionnaires and survey process will be favourable

Qualitative analysis revealed that key informant evaluative comments on the instruments mostly reflected approval, however there was considerable variation with many unfavourable comments.

All the participants were asked how they had found responding to the two questionnaires (refer 4.2.4). Most liked to be able to express their views fully to the open-ended questions of the TECPR questionnaire but also appreciated that the SDRG questionnaire pushed them to be precise on their view about a particular point. Although the order of the instrument presentation was randomly allocated, the interview flowed much better when the TECPR questionnaire was asked first, allowing key informants to say whatever they wanted too, before ‘pinning them down’ to limited response options in the SDRG survey. When the SDRG survey was asked first however, the key informants felt frustrated that their response options were limited (Minichiello et al., 1990). The ordering of questionnaires did not appear to influence the length of time required to complete an interview schedule.

Disappointment was expressed that the SDRG survey did not allow for the complexity of community: “A bit frustrating because it deals with generalisations - does not acknowledge the complexity of communities”, or the work that was currently underway: “some questions do not reflect the work going on - too outcome focussed” and “does not reflect what is happening now”.

The different theoretical bases of the two instruments (refer 3.4.2), community development and prevention science, did not appear to result in markedly different key informant evaluations in the present study (Blaikie, 1991). Both produced very similar readiness rankings. Although the assessment rankings were similar there were important theoretical differences that resulted in different domains being assessed. Such differences would probably emerge as relevant in the later phases of their application when the TECPR adopts community development strategies to address the issue of concern (refer 3.7.5); and the SDRG model (refer 3.8.1) trains community groups to adopt a planning approach using evidence-based prevention strategies through the CTC process (Fiske, 2000).

From one perspective it may be surprising that stakeholder evaluations of the readiness instruments were generally favourable. The instruments were developed in the United States policy and practice context that is distinctive relative to Australia in regard to drug and alcohol intervention philosophies. In the United States an
‘abstinence’ approach is emphasised while Australian policies emphasise the ‘harm-minimisation approach’ (Beyers et al., 2005). This very important conceptual distinction did not appear to create a barrier to the questionnaire’s relevance in the study. There was only one question that was obviously not relevant to Australian communities. This question asked about young people being ‘cautioned’ for smoking in public, a behaviour that is illegal in some states of the USA. The fact that young people are not typically cautioned in Australia did not appear to impact on the relevance of the questions to the participants. Many thought young people would be or should be cautioned by their parents or teachers if found smoking.

The face validity of some of the questions was queried in this study (refer 4.2.4) with a lack of clarity of meaning being observed for some of the questions. This finding may indicate areas that may require some adaptation in future studies. This is commented on further in the next section.

Overall the participant response to the survey instruments and processes were favourable allowing the Hypothesis 1.3 to be ‘mostly upheld’.

**H1.4: PARTLY UPHELD. Few modifications will be required to the questionnaires and assessment methodology.**

In overview, each of the survey instruments were able to be implemented with few modifications. However, there were a number of challenges in the feasibility testing and instrument modification undertaken in the present study that provide directions for future improvement. The sections that follow outline issues relevant to training, scoring and data processing.

The level of training provided to scorers in the present trial may have been less than optimal. Experienced TECPR researchers score the questionnaire responses when they are conducting a community assessment, although the TECPR trains a range of health professionals to conduct and analyse survey data independently in other settings. As the TECPR authors refer to the ‘expert judgement’ (Oetting et al., 1995; Plested et al., 1999) of the scorer, the PhD student had to estimate how much community experience would be necessary to enable the scoring process to be accurately completed. The present study provides some basis to assess how much experience scorers require. Only two of the four research assistants that were engaged to score the interviews had any community experience and this was minimal. The inter-rater scoring table (refer 4.3.5) showed that community experience was not vital to the scoring process. Previous studies have suggested,
however, that detailed training is key to an accurate, efficient and expedient assessment (Arthur, 1999; Plested et al., 1999).

The research assistants engaged to score the interviews were given one formal training session on the scoring process before proceeding (the PhD student was available to answer questions and go over any concerns). Initially the scorers took approximately 80 - 100 minutes to score each survey, which was unduly time consuming and therefore costly. The scorers listed a number of features of the ‘anchor statement’ scoring process that contributed to the time taken to score the interviews (refer 4.3.4). Whilst a satisfactory outcome was achieved in the scoring process (refer 4.3.5), the length of the process suggests that more than one training session is required (Plested, 2004).

Experience with the present study also introduced recommendations for improving the data analysis steps. The scorers for the present study proposed that scoring would be easier and quicker (and therefore less costly) if the ‘anchor statement’s were more specifically tailored to the issue being assessed. The Center for Prevention Research at De Paul University in Illinois, referred to in Chapter 2, adapted the TECPR ‘anchor statement’s so that they responded specifically to the issue being assessed (youth tobacco use). The De Paul investigators felt that this provided a much more accurate picture of what was happening in response to the issue and made scoring easier (Pokorny, 2001).

Using a paper based version of the SDRG survey, rather than using CATI, compromised efficiency. Several data processing steps were required before the data could be interpreted (refer 3.8.3); the survey responses were completed by the interviewers, entered into a database by experienced data entry personnel, checked for accuracy by the PhD student, and then imported into SPSS for manipulation and final analysis. The use of CATI technology in future studies would minimise the multiple handling of data, significantly reducing the time taken for data entry and the likelihood of errors; although few were detected in the present study.

Future studies in this area could benefit by increasing opportunities to capture respondent comments and feedback. The open-ended questions of the TECPR questionnaire elicited a lot of information about the community that was recorded and qualitatively analysed to assess readiness in the present study. This information was additionally utilised in the feedback process to communities (refer 3.7.5). Although key informants added comments to their choice of response when completing the SDRG survey, this information was not recorded, because of the
closed question structure of the instrument (Roberts, 1988). Community feedback from the SDRG instrument would therefore be limited to numeric profiles unless it is modified to record and collate comments.

Few modifications were recommended from the initial pilot testing of the instruments, although a number of participants commented on the length of the SDRG interview. Following the present study department researchers have attempted to shorten the SDRG instrument (Williams et al, 2007) retaining only the items with the highest alpha scores. No other modifications appeared to be required for future use of the two instruments. The need to modify the SDRG survey indicated, however, that Hypothesis 1.4 had only been “partly upheld”. Whilst the interview process involving two surveys was lengthy for the participants, it is likely that only one of the surveys would be used in future work.

5.2.2 How reliable and valid are the two readiness assessment instruments in the Australian context?

This was a mixed methods study that included quantitative statistical analysis and also qualitative analysis examine the reliability and validity of the instruments in the Australian context. As the two instruments asked questions about different domains (refer 4.3.11) it was not possible to make a direct comparison but in general they both satisfied the reliability criteria developed for the present study.

**H2.1: UPHELD. Readiness assessment scores will be internally reliable.**

Hypothesis H2.1 was upheld based on the following reliability findings in the present study. The results showed that ratings for two relatively inexperienced scorers of the TECPR were reliable with average differences judged to be within an acceptable range for a pilot study of 1.25 scale points (Table 4.7). Inspection of Pearson correlations between the TECPR dimensions also showed evidence of appropriate internal reliability with four of the fifteen correlations between the dimensions weakly correlated (0.33-0.37) and ten moderately correlated (0.41-0.68) (Table 4.10).

Inspection of the Cronbach’s alpha scores for the SDRG survey showed levels of internal consistency for the dimensions were acceptable relative to those reported in the US, albeit slightly lower (Table 4.14). Correlations between the SDRG dimensions also demonstrated appropriate internal reliability with 27 of 54 associations weakly correlated and 18 moderately correlated (Table 4.13).

Analyses in the present study provided a range of specific observations relevant to the assessment of internal reliability. As the SDRG questionnaire had been
developed by aggregating the responses to individual items, it was possible to calculate Cronbach’s alpha scores to provide an indicator of internal consistency of the items contributing to each subscale (refer 4.3.10). All but one subscale achieved an Alpha score higher than 0.65 in the Australian context and all values were similar to those achieved in the USA. The lower alpha score (0.41) with ‘Enforcement’ would be anticipated as Australia does not have the same laws and regulations about the prohibition and regulation of alcohol and tobacco as in the USA (refer 2.4.2). The strength of the Alpha scores has been a promising finding for the reliability of this instrument in the Australian context.

Pearson correlation analyses offered the opportunity to explore scale interrelationships and suggested that scales within each instrument were measuring aspects of a common underlying domain, while each scale also appeared to measure some unique dimensions. Some of the moderate correlations between the dimensions were logical; for example for the TECPR survey the ‘Community Efforts’ and ‘Community Knowledge of the Efforts’ domains were moderately correlated. This appeared logical in that key informants need to be knowledgeable about the efforts in their community to be able to evaluate them (Table 4.10) and hence, a moderate correlation might therefore be assumed. The high number of moderately correlated scales (p > 0.50) however suggested that the dimensions were not well differentiated. This finding was less than optimal as it suggests the instrument may be longer than necessary and assessments may lack specificity. To give an example of the lack of specificity communities could not confidently predict whether a low readiness score for the TECPR ‘Community Climate’ domain was as a result of ‘Community Resources Related to the Issue’ or ‘Community Knowledge about the Issue’. This lack of specificity within the instrument dimensions may somewhat limit its function as planning tool.

A novel feature of the present study was the comparison of scales across instruments. The high number of moderate correlations between scales across surveys suggested the dimensions are measuring some common underlying constructs in each survey. This finding supports the utility of either instrument as a means of measuring aspects of community readiness (Table 4.18).

In the next sections the hypotheses underpinning the validity criteria for the two instruments are considered. These hypotheses were mostly upheld.
H2.2: MOSTLY UPHELD. Stakeholder evaluative comments will indicate favourable face validity.

Based on the finding of the qualitative analysis reported in 4.2.4, Hypothesis 2.2 was mostly, but not completely upheld.

The authors of the TECPR questionnaire describe a high level of ‘face validity’ to their questions i.e. the questions come across as pertinent and relevant to the situation that is being investigated (Plested, 2004). The findings for the present study showed that there were a small number of questions in both instruments where the lack of clarity of meaning diminished the face validity; more so with the SDRG survey. This finding posed a couple of interesting questions for the PhD student at the time:

- Would community leaders want to use a survey instrument where it was felt some of the questions were unclear or imprecise as with the TECPR questionnaire?
- Is face validity important in a questionnaire where there are good alpha scores as with the SDRG questionnaire?

In relation to the first question, the TECPR survey method has since been used in other studies (Lewis, 2005; Swinburn, 2005) and the face validity has not presented as a problem (refer 5.2.3). In relation to the second it remains ideal in a community process that face validity should be clear along with strong alpha scores (Toumbourou, 2007).

H2.3: MOSTLY UPHELD. Assessments will identify significant differences between communities (discriminant validity)

This hypothesis was partly supported as the TECPR survey identified significant community differences for the total score and across most dimensions (Table 4.7) while the SDRG survey found differences on only a minority of dimensions (Table 4.10).

The statistical significance of the results was examined by comparing across the four communities as well as comparing between pairs of communities. When comparing across the communities the TECPR instrument showed a statistically significant difference in the results of five out of six dimensions (Table 4.8). When comparing between community pairs significant differences were found between sixteen of the thirty six comparisons (Table 4.9).
In contrast the comparison across communities using the SDRG survey only showed statistically significant difference in the results for two of the eleven comparisons (Table 4.11). Nine of the sixty-six domains comparisons for pairs of communities were significant (Table 4.12). This suggests that the SDRG survey is much less sensitive to community differences. Neither survey provided a statistically significant difference (p-value) in the results for leadership suggesting that community leadership features are similar across the four communities.

Despite strong Alpha scores from the SDRG instrument, the lack of differentiation between communities, demonstrated by the p-value, may be a limitation of the instrument. It was apparent that the analytic sample was low for this instrument due to the list-wise deletion in cases where key informants answered “Don’t Know” (refer 4.3.9). The procedure, as advised by the test developers, was to code these responses as missing which led to the scale response for the subject being treated as missing. The coding of “Don’t Know” responses in this questionnaire is being considered for revision in future use; the response options may need expansion to cover “I know nothing about this and therefore cannot comment” or “I am not sure” (Williams, 2008).

The two instruments gave total mean readiness scores for each community in the mid range (refer 4.3.6 and 4.3.9). The mean scores on the sub-scales indicated that all four communities were consistently placed within the mid range for the ‘Leadership’ dimension by both the TECPR and SDRG instruments. A notable result with respect to the interview responses was the high level of similarity in knowledge and attitudes amongst the key informants despite the fact that Communities A and D, and Communities B and C, are thousands of kilometres apart (refer 4.4.1).

The value in these sub-scale profiles lies in their ability to provide diagnostic assessments of the strengths and weaknesses of a community that have practical applications in guiding community enhancement interventions (Thompson & Kinne, 1990; Weiss, 1972). To give an example using the SDRG results (refer 4.3.8), Community D had a ‘Leadership Support’ and ‘Collaboration’ profile equivalent to the communities that were most ready in the present study, but had low score for ‘Barriers’ (to prevention) and ‘Disorganisation’ (problems in the community). The TECPR results (refer 4.3.2) for Community D also reflected a similar profile with low score for ‘Community Climate’ (2.92-‘Resistance’) and ‘Community Knowledge of the Efforts’ (3.47- ‘Vague Awareness’) but higher scores for ‘Leadership’ (5.42-‘Preparation’) and ‘Community Efforts’ (6.37- ‘Initiation’). This information could be used to guide planners, community leaders and others in Community D to address the domains with the lowest
readiness scores, in the knowledge that there is likely to be good support from the leadership, and adequate collaboration to drive change.

Another example reflected in the sub-scale profile is the much lower score for ‘Community Knowledge of the Efforts’ compared to ‘Community Efforts’ (TECPR) for all four communities. Community leaders and others working on the problem of adolescent substance abuse can interpret from this information that whilst their community has a number of programmes to address the problem, most people in the community do not know about them (Kumpfer et al., 1997). This is further reflected in the low score for ‘Community Climate’. The TECPR recommends using the examples from the community responses to indicate where change might occur; in this case, this might include responses that described the inadequacies of promoting services and successful initiatives such as “even informally we don’t publish…we don’t have a local newsletter which would be a good way of getting messages out to people within the sector…even as school teachers we don’t talk about the things we are doing”. The responses can assist with strategy development in communities.

There were three features of the TECPR scoring process that have relevance to assessing community differences that were under closer scrutiny in the present study, in part as a result of Beebe’s (2001) criticism (refer 3.7.6), but also to examine the utility of the instrument. The three scoring features were; 1) the claim that a valid score can be obtained after only five people have been interviewed, 2) the ‘anchor statement’ method of assessing community readiness responses, and 3) the inter-rater variation between scorers and with those new to scoring survey responses:

1) The TECPR recommend in their model that generally no more than five interviews need be completed in smaller communities (<10,000 population) before information starts to be repeated in interviews. In the present study the dimension scores were examined after five interviews and compared with the results from the ten interviews for each community (refer 4.3.3).

The present study provided one of the first opportunities to formally evaluate the effect on TECPR scores of varying interview completion numbers. The findings supported the TECPR method in that there were no significant differences in the dimension scores with five versus ten interviews across the four communities.

There was however interesting variation within this overall observation of no difference. Community A and D’s dimension scores were mostly higher at ten interviews but Community B and C’s were mostly lower. Although the overall scores
did not differ at a statistically significant level, the small differences may have meaningful practical interpretations within the TECPR method. Community A would have ranked at the ‘Pre-Planning’ stage after five interviews rather than the higher ‘Preparation’ stage at ten interviews, and Community C at the ‘Pre-Planning’ stage rather than the lower stage of ‘Vague Awareness’ at ten interviews, using the TECPR readiness ranking. In view of the fact that there was some variation between results after five compared with ten interviews, it would have been informative to continue to interview members of the community until a stable result had been reached (Burnside & Foley, 2002).

There were two important factors to bear in mind when considering the above result, in regard to the overall study design; a) the ‘communities’ interviewed were defined by their Local Government Area (LGA) and not by the community members perceptions of their boundaries and, b) three communities consisted of populations of up to 25,000 people, and one of up to 65,000 people, much larger than the suggested unit of assessment by the TECPR. A limitation in the present study that future studies or readiness assessments of communities will need to consider is how community boundaries might be circumscribed to give a) confidence in the results and b) meaning to the communities that are working with the assessments (Freudenberg & others, 1995; Green & Kreuter, 2001; Mayer et al., 1998; McLeroy et al., 2003; Minkler & Wallerstein, 1997; Purdue et al., 2000). However, the small number of key informants required within a given community to provide a result on the TECPR holds merit for the practical use of this survey, as time and cost can be kept to a minimum.

2) The ‘anchor statement’ method of rating community readiness had received criticism for giving too much discretion to scorers in their scoring of responses (Beebe et al., 2001; Smith & Kendall, 1963). The scores are dependent on individual opinion, and individual scorers might vary from community to community. Additionally, the scorers engaged for the present study were inexperienced in the scoring method and were limited in their experience of community. The range of comments expressed by the scorers about the ‘anchor statement’s (refer 4.3.4) indicated their lack of familiarity with their meaning and application. This can be resolved with more comprehensive training and the opportunity to score surveys with more experienced staff in the first instance (Plested, 2004).

3) The inter-rater scoring consistency shown in Table 4.7 indicated that the consensus approach achieved a reliable score despite an average one-point variation between the individual scorer results. The reliability of the final score was further
enhanced by an independent assessment from the PhD student who, as well as being an experienced community health worker, was extremely familiar with the scoring method and the interview responses. The results from this examination tended to confirm to the PhD student that the inexperienced scorers with limited knowledge of community had achieved reasonable final scores for each community.

In overview, the findings suggested that readiness assessments can be confidently conducted in Australian communities where there is limited research or community expertise. There may be an added advantage of the TECPR method in that it enabled significant distinctions to be made between communities using a relatively efficient method.

**H2.4: PARTLY UPHELD. Assessments will match the ranking of experts (criterion validity)**

The criteria for assessing validity in the present study was the surveys’ readiness ranking compared to that of expert opinion, in this case, the department staff that had a close working knowledge of the four CTC communities. However, only the SDRG survey matched the ranking of the department staff for the two communities with the highest level of readiness (Table 4.15). As a predictive measure this result is inconclusive resulting in Hypothesis 2.4 only being partly upheld.

The two questionnaires provided similar readiness profiles for the four communities although the community ranking varied between the two. Both surveys agreed with the CTC staff expert rankings in giving communities A and B a higher ranking than communities C and D (refer 4.3.11). The SDRG survey ranked the communities C and D the same as the CTC staff, whereas there were no absolute matches between CTC staff and TECPR ranking.

Although this finding notes that both instruments ranked the top two communities, it is somewhat inconclusive as a method of triangulation (Denzin & Lincoln, 2000) where different perspectives are sought to further clarify a phenomenon (refer 3.5.2).

**H2.5: PARTLY UPHELD. The instruments will correlate and provide similar rankings (construct validity).**

This hypothesis was partly upheld because Pearson correlation comparing the dimension scores between the two survey instruments showed a number were...
significantly correlated (Table 4.18). The hypothesis was not fully upheld due to the divergence in the community rankings from the two instruments.

The low number of moderate correlations between the two methods of assessment suggested that they measure many distinct dimensions. This finding somewhat supports the use of both questionnaires in future surveys to give a more comprehensive community profile (Denzin & Lincoln, 2000). However, the length of time to conduct the two interviews would be a barrier to adopting such a comprehensive approach.

The high number of correlated items in each instrument does suggest that they are probably longer and more detailed than they need be to achieve efficient information collection. Since the present study, the SDRG instrument has been shortened considerably to include only the questions that most efficiently contribute to the alpha scales. The shortened version of the TECPR instrument was used in the present study yet results suggest that an even shorter questionnaire may be feasible.

**Triangulation of data**

The process of cross-checking data in this study through the use of a number of validated triangulation strategies (refer 3.4.2) was helpful in building confidence in the construct validity of the results (Lincoln & Guba, 1985).

‘Member–checking’, one of the strategies, was initially considered with the use of focus groups and the feedback stage to the communities. Focus groups were excluded due to constraints in the limited size of the present study and the face-to-face feedback did not occur as a consequence of staff changes. A summary letter (Appendix 7) was the only contact made with key informants following the survey; therefore, limiting the opportunity to hear whether the study results matched their perception of readiness and the usefulness of this to their communities (Gielen & McDonald, 1997). The opportunity to gain feedback could have provided additional information that contributed to the validity of the data in the Australian setting. Had the readiness assessments been instigated by the communities then the application of the findings would have rested with the community groups involved increasing the likelihood of feedback with the present study and potentially contributing to their ‘empowerment’ to make changes (Laverack & Wallerstein, 2001; Mayer et al., 1998).

The construct being assessed by the surveys are confused in some areas between the assessment of attitudes and the quantification of resource levels. The two surveys have been described primarily as attitudinal surveys by their authors and for most of the dimensions being assessed this is an appropriate description, for example
'Community Climate' (TECPR) and 'Community Norms' (SDRG). The dimension 'Community Efforts' in the TECPR instrument also generated attitudinal responses such as the strengths and weaknesses of local efforts, but also included questions that required estimates of resources - for example “What efforts are present in your community to address substance abuse?” For the purpose of triangulation, the present study may have been strengthened by an independent audit of programmes and resources that could have provided an additional measure to ascertain whether the discrepancies seen in the number of programmes and resources across the four communities was a consequence of workers knowledge of those efforts or because governments were funding communities differently.

The use of the two approaches was combined productively (Maxwell et al., 1987) to deliver a number of positive outcomes (Steckler et al., 1992):

- The results from the two surveys provided a richness of information that would not have been achieved using a single questionnaire as the two instruments illustrated different community dimensions (Denzin & Lincoln, 2000).
- The two survey styles complemented each other in that the TECPR “warmed up” the key informant though an open discussion of the issue but the SDRG survey “pinned down” key informants to specific answers to questions, providing information that may not have been delivered from one source.
- The two questionnaires made provision for the preferences of key informants in the type of questioning style leading to a general satisfaction with the process from participants (Minichiello et al., 1990).

5.2.3 How useful are these readiness assessment reports to Australian communities?

The two different approaches to measuring readiness offered by the TECPR and SDRG instruments would suit a number of research scenarios providing a choice for communities and researchers wanting to assess readiness, knowing that either would deliver similar findings and that both were reliable and valid in the Australian context.

Theme analysis from comments in response to the TECPR survey served to provide a more comprehensive profile of the variation in community responses beyond the specific quantitative measure of readiness. Understanding both specific scores and detailing variation could be useful to Australian communities considering making changes in that:

- Assessments could provide specific information on community characteristics to guide community change at the local level.
• Assessments could provide a basis for further understanding how community factors related to the prevention of adolescent substance abuse.

**H3.1: UPHELD. Assessments will provide specific information on community characteristics to guide community change**

This hypothesis was judged to be upheld to the extent that both the readiness assessment methods yielded meaningful quantitative and qualitative data relevant to specific and theoretically important dimensions.

One of the perceived strengths of the assessments was that communities could utilise the results for the individual dimensions as a way of deciding where to give priority to their efforts in the community. The TECPR model was designed with this in mind so that a community readiness assessment “could provide a basis for understanding how community factors related to prevention capacity and in doing so assist communities to move to a higher stage of readiness, through the use of targeted community development strategies” ([Oetting et al., 1995](#)). The overall mean and standard deviation scores provide one indicator of readiness but the ability to refer to specific community characteristics through the different dimension assessed not only provided more meaningful results but also provided the opportunity to tailor planning and strategies to specific information about the community. Strategies could be much more targeted as a result with a greater likelihood of achieving project aims and maximising the use of limited human and financial resources ([Thompson & Kinne, 1990; Weiss, 1998; Weiss, 1972](#)).

For example, ‘Community Efforts’ and ‘Leadership’ scored reasonably well in Communities A, B and D but ‘Community Climate’ and ‘Community Knowledge about the Efforts’ scored less well. Community leaders were therefore well placed in those communities to increase community support for prevention by building community awareness and knowledge about adolescent substance abuse, as well as providing information on programs and services in the community.

The SDRG survey readiness results from each dimension (sub-scales) could also be used to guide planning and strategy development; but without the opportunity to examine the specific characteristics of the community in the same way.

The TECPR survey instrument has been used in other community assessments since the conclusion of this study ([Lewis et al., 2005; Swinburn, 2005](#)). The researcher in one study found that the link between the readiness stages and activities or strategies was not highly developed in the model so there was a dependence on the skill of
the community development worker to make professional judgments about the kinds of activities that were feasible and likely to be successful, consistent with the TECPR model (refer 3.7.5). However, they found that the results of the initial interview provided a guide for the design of further interventions as well as confirmation of the interventions that had already been chosen: “the community readiness interviews provided an important process and monitoring role over and beyond its usefulness as a guide to activities”. They also found that the readiness assessment could increase readiness to change by building an awareness of the limitations within a community (Hawkins et al., 2002).

The capacity of the specific TECPR scores to provide recommendations for community change appeared an important strength. This advantage may suggest some superiority relative to the SDRG tool in providing greater detail as to specific actions to improve community readiness characteristics.

**H3.2: UPHELD. Assessment will provide a basis for understanding how community dynamics related to the prevention of adolescent substance abuse**

This hypothesis was judged to be upheld to the extent that both the readiness assessment methods yielded meaningful findings that could be theoretically linked to community characteristics that influence adolescent substance abuse (refer 4.4.1). Additionally, a regression analysis supported the validity of each of the readiness assessment methods by demonstrating that responses predicted scores on a set of questions designed to measure community empowerment to address adolescent substance abuse (refer 4.3.13).

There were a number of themes that emerged from the qualitative analysis of the TECPR interviews described in 4.4.1 that demonstrated an integration of the present findings with the previous research. The themes were aligned with the three key factors for community change described in Chapter 2; ‘community competence’, ‘community attitude’ (‘conscientiousness’) and ‘community empowerment’, in an attempt to expand the understanding of these concepts in regard to the prevention of adolescent substance use. Analysing the themes was key to understanding the critical components of community dynamics that related to community capacity and change theory. The findings supported the view that the three factors were relevant to community conceptualisation relevant to the prevention of adolescent substance use in the four Australian communities.
In the sections that follow the three factors are used to discuss the results from the present study in relation to the existing readiness literature. The following discussion integrates findings from both the quantitative and qualitative results.

**Community competence**

The major themes from the survey responses aligned to community competence focussed on evaluating organisational, leader and worker skills and capacity to respond to the issue of adolescent substance use.

The majority of the key informants appeared knowledgeable in their evaluations of the issues related to competence. An important gap was that many did not know where to source relevant data on adolescent substance use and they did not know whether community efforts had been evaluated (discussed later). There appeared to be no particular pattern of which type of respondent was informed on issues related to competence. However, a core group from health, welfare, schools and the CTC coalitions provided the bulk of the information relevant to areas of competence such as technical information on substance use rates and evaluation.

This observation was consistent with the authors of both surveys (Arthur et al., 1999; Oetting et al., 1995). This finding reinforces that the respondents from these sectors would be appropriate key informants for future studies on this topic.

Key informants were often expressive in describing the encumbrances that hindered or helped competent prevention efforts on adolescent substance abuse in their community (Freire, 1973; Laverack & Wallerstein, 2001). Commonly referenced were the differing attitudes held between groups within the community such as between community leaders, professional staff and the general community, that undermined community capacity to arrive at a common planning and intervention approach (Roski et al., 1997). Most described ‘systemic’ encumbrances such as lack of local data on the issue (Cummings et al., 1995; Salvaris, 2001). However, failures in organisational competence were commonly referenced. Comments in this regard included a competitive tendering approach to funding that undermined collaborative effort, poor communication across the sectors including government, and the limitation imposed on workable initiatives by the short government funding time-frames (Arthur & Blitz, 2000). They also spoke of the lack of specialised professional skills and knowledge within the community that was seen to reduce local competence to deal with the problem (Ettema et al., 1983; Gaziano, 1988; Viswanath & Finnegan, 1995). Their comments on knowledge not only referred to the professional knowledge required but also knowledge about the community’s culture that influenced how problems were addressed (Green & Kreuter, 2001). Responses
also included important insights into workable solutions to the identified problems (Braithwaite & Lythcott, 1989; Cottrell, 1983), a significant indicator of ‘community competence’ (Freudenberg & others, 1995; Green & Kreuter, 2001; Minkler & Wallerstein, 1997).

Opinions about the professional attributes (skills and knowledge) of both workers and leaders came out strongly in the TECPR survey under ‘Community Efforts’ and ‘Leadership’. This included the importance placed on a worker or leader who might “champion” (advocate passionately) a health issue such as adolescent substance use to influence change in the community (Hawkins et al., 2002; Pentz, 2000). Whilst worker skills were critical in small communities with limited resources, particularly drug and alcohol expertise, it was the knowledge and skill of community leaders that was considered key to achieving successful outcomes (Butterfoss et al., 1993; Fawcett et al., 1993; Goodman et al., 1996; Kumpfer et al., 1993; McHugh et al., 2004).

The SDRG survey differentiated between leader support and leader competence but both surveys revealed that whilst many leaders might be seen as supportive, not many were seen as competent to deal with the issue for a range of reasons (Morrissey et al., 1997). Overall leaders were seen as reactive, not proactive, they lacked vision as a result of limited insight and understanding of the nature of the problem and how to address it effectively. The (perceived) lack of action of many leaders was often attributed to the fact that adolescent substance use was not regarded as a priority issue in all four communities (Bell, 1994; Morrissey et al., 1997; Scrutchins & Solomon, 1996).

Organisations were seen as limited by their prescribed function in the community, often by their funding arrangements (Arthur & Blitz, 2000). Responses focussed heavily on the lack of meaningful coordination, communication and collaboration that came as a result of organisations working within tight boundaries with no mandate to take responsibility for activity or health issues that sat outside these boundaries. The competitive tendering approach to the selection of service providers by government in the past was seen as a mechanism that had divided organisations and that still undermined collaborative practice. If organisations could not, or would not take responsibility for health issues in the broader community, key informants queried who was responsible. In their view, it was often left to individuals to attempt to drive change within communities (Hawkins et al., 2002; Pentz, 2000).

The promotion of organisational and community efforts through the media and other conduits was also included under the domain of ‘Community Competence’.
In general, key informants felt that community organisations did not do a good job in promoting their work and services so that many in the community were not aware of resources and information on adolescent substance use. This was further reflected in the gap in the readiness profile between the scores for ‘Community Efforts’ and the scores for ‘Community Knowledge of the Efforts’. High readiness scores for ‘Community Efforts’ would be expected in Australia as all levels of government have directed significant resources to addressing substance use. The lower readiness scores for ‘Community Knowledge of these Efforts’, however, suggest that this information is not being adequately communicated in communities (Kumpfer et al., 1994; Viswanath & Finnegan, 1995; Wright, 1994).

The present study suggests that the following strategies would be helpful to facilitate community change efforts by enhancing community competence for the prevention of adolescent substance use:

- Leadership training on adolescent substance use and prevention; and support from state government to drive change locally.
- Mobilisation of community organisations through state government policy to take responsibility for the prevention of adolescent substance use.
- Building community awareness of the problem, information on local resources and better use of the media.

**Community attitude (conscientiousness)**

The two survey instruments were developed principally as ‘attitudinal surveys’. Their questions therefore teased out a wide range of opinions on the domains under investigation as well as a number of themes on associated topics such as community priorities and norms, adolescents, drug use and the media. The responses also served to highlight the key informant’s level of awareness of, and concern about the problem.

Key informants were alerted at the beginning of the survey that the questions related to alcohol, tobacco and other drugs including cannabis and illicit drugs. The attitudes expressed varied dependent on the drug type being referenced.

The responses highlighted the high level of acceptance of alcohol as part of the social and recreational context for many Australians including adolescents (Beyers et al., 2005; Fitzpatrick & Gerard, 1993; Goodstadt, 1989; Roski et al., 1997; Rothe, 2005; Semlitz & Gold, 1986). This appeared to be grounded in the cultural tradition for one community (Graham et al., 2006; Haglund et al., 1990), perceived as a drug of lesser risk than other drugs by parents and young people (Crouter, Bumpus, Davis, &
McHale, 2005; Graham et al., 2006; Miller et al., 2006; Nelson et al., 1999; O’Neal, 1993; Yang et al., 2006; Young & Zimmerman, 1998) and as an accepted part of adolescent development (Bonomo, 2004; Hawkins et al., 1992; Kosterman et al., 2000). Many described how parents or older siblings were often drug users (or had been during their adolescence). This generated an acceptance that their children would also experiment with drugs - namely alcohol, tobacco and cannabis (Barnes et al., 2000; Biglan et al., 1996; Hawkins et al., 1992; Stanhope, 1978). There appeared to be a general view among key informants that parents often purchased alcohol for their underage teenagers, particularly for parties (Graham et al., 2006; Jones-Webb et al., 1997; Wagenaar et al., 1993; Wagenaar et al., 1996); and were seen to actively support alcohol use as a way of preventing illicit drug use – particularly intravenous drug use (Shanahan & Hewitt, 1999). Tobacco was considered a drug of concern but the responses suggested that its use whether experimental or habitual was to be expected; the view that it is part of adolescence to try cigarettes (Perry et al., 1996).

The use of illegal drugs was considered unacceptable by the key informants and communities (Australian Institute of Health and Welfare, 2005b), yet they described how little was known about the effect of these drugs and that the perception of level of use was often exaggerated (O’Neal, 1993; Yang et al., 2006; Young & Zimmerman, 1998). The media appeared to have a role in influencing this view with many describing how local newspapers often focussed on the problematic behaviours of adolescence such as drug use (Glanz & Young, 1996; Slovic et al., 1981; Weinstein, 1984). This acceptance of some drug use (principally alcohol and tobacco) as either a ‘community norm’ or an ‘adolescent norm’ (Australian Institute of Health and Welfare, 2005b) combined with an exaggerated concern about illegal drug use, added to the challenges for health workers in addressing adolescent substance use.

Young people’s issues were generally not a high priority in the four communities although a number of individual workers and leaders were aware of the importance of building health promotion and prevention activity in the community for them. Young people who were regarded as drug users, as with other drug users, were considered very low on the list of priorities.

The lack of connection to the community came out very strongly in the responses from one community where there had been a long history of a transient population. The brief connection to the community as a result of the transience appeared to directly influence the desire to become involved in making improvements or
changes (Hamilton et al., 1998; Sarason, 1974). A second community dealt with a different type of transience during the holiday season when outsiders migrated in for a short period; with the more problematic drug use that resulted in anti-social behaviour occurring at this time.

In order to enhance community attitudes supportive of the prevention of adolescent substance use, the present study suggests that the following would help to facilitate community change efforts:

- Improved access to community data and information on adolescent substance use and its consequences
- Building connection to community through community engagement strategies
- Influencing more positive community norms through policy, media and direct engagement.

**Community empowerment**

In Chapter 2, it was stressed that the most effective vehicle for health promotion activity whether directed at policy, environmental change, institutional change, or personal skills and development, was the empowerment of communities, their ownership and control of their own endeavours and destinies (Green & Raeburn, 1988; World Health Organisation, 1986).

Whilst the research literature highlighted a number of the important components of community empowerment such as ownership and control (Israel et al., 1994; Lew et al., 2001; Schultz, Israel, Zimmerman, & Checkoway, 1994), equity (Biegel, 1984; Katz, 1984), the ability to solve problems (Braithwaite & Lythcott, 1989; Cottrell, 1983), political competence and self determination (Florin et al., 1990; Kieffer, 1984), the themes that emerged from the SDRG and TECPR interviews highlighted a) the point of responsibility for dealing with adolescent drug use in communities, b) government policy and practice and c) access to meaningful data to better understand the nature of the problem locally. Consideration of empowerment linked to considerations of local competence.

‘Community mobilisation’ through the development of coalitions has been described as an important component of local empowerment and is central to the structure and function of community health promotion and disease prevention projects (Bracht & Gleason, 1990; Pentz et al., 1989; Thompson et al., 1990-1991). Community mobilisation has been shown to be effective in reducing tobacco use (Lichtenstein et al., 1991; Thompson et al., 1990-1991) and alcohol and other drug
abuse (Johnson & Pandina, 1991; Pentz et al., 1989) in (Mansergh et al., 1996). Yet the present study suggested that no one group or component of the service sector appeared to have overall responsibility for mobilising prevention responses to address adolescent substance use in communities; and the lack of clarity on this issue was reflected in many responses. Chapter 2 described how current drug and alcohol policy and provision is governed by the three tiers of government and a number of specialist bodies in Australia, yet many initiatives are devolved to communities to implement (Giesbrecht & Haydon, 2006; Phillips, 2000).

In general, responses to the specific empowerment questions suggested that key informants considered they were given responsibility and capacity to make local decisions relating to prevention. Question 1 dealt with state government mechanisms to ensure community input into (drug prevention) planning. Results showed that despite the majority of key informants saying that there were mechanisms in place, the various mechanisms were viewed as ‘ad hoc’, limited to certain groups or individuals, poorly promoted and rarely consistent across the two states (Bracht & Gleason, 1990). This lack of meaningful engagement with the community by government was described by some as ‘tokenistic’, leaving power largely in the hands of government departments (Green & Raeburn, 1990; Purdue et al., 2000).

Whilst the arrangements described may have led to productive outcomes, not established in the present study, there are important implications for communities and government bodies in ensuring that there are transparent structures and processes in place to support the effectiveness of communities to prevent adolescent substance abuse (Department of Victorian Communities, 2004; Gielen & McDonald, 1997; Goodman et al., 1998; Norton et al., 2002; Purdue et al., 2000; Toumbourou, Jones, & Williams, 2003). These structures could also provide a forum for the effective communication and collaboration between the various professionals required to address the problem including community representatives, government departments, technical experts and outside agents such as researchers and philanthropic groups (Peterson & Reid, 2003).

The extent of state government commitment to supporting and partnering with communities through local government needs to be explicitly defined in government policy including devolving responsibility to communities with an acceptance that mistakes will be made and that there are no quick fixes. Such action should stem from national policies that include setting parameters and guidelines but not dictating specific steps and strategies for local goals in reducing
risk and harm (Department of Victorian Communities, 2004; Giesbrecht & Haydon, 2006). To achieve this would not only require a commitment from government but would also require that organisations are supported through their service agreements to work more broadly on this issue; as well as providing community members particularly community leaders the support and skills to participate (Aspen Institute for Rural Economic Policy Program, 1996; Green, 1986; Purdue et al., 2000).

In addition to the lack of cross-sector planning structures, there appeared to be no clear provision for community input into drug policy other than Local Governments’ drug and alcohol plans articulated through the Municipal Public Health Plans in Victoria (which were being developed at the time of the study), and Safer W.A. in Western Australia. Since the conclusion of this study and as a result of the Community Drug Summit in Western Australia (Western Australian Department of Health, 2005), two additional bodies have been established in Western Australia to ensure that the State Government receives independent advice from professionals and the broader community; the ‘Community Advisory Council’ and the ‘Local Drug Action Groups’, which is a promising development for advancing local empowerment (Western Australian Department of Health, 2005).

The lack of relevant local data or access to existing data was expressed as a constant source of frustration by workers in all four communities as it not only limited their capacity to tailor efforts to specific community need, but also their ability to critically assess the contextual causes that contribute to the issue (Laverack & Wallerstein, 2001). The lack of useful information was due to a number of identified issues highlighted in Chapter 4; lack of financial resources and skill to collect the information, withholding of data, inadequate interpretation of data and lack of local data (as distinct from state or regional data). Possessing such information would put communities in a much stronger position to determine priorities on youth health issues such as substance use (Harachi, Ayers, Hawkins, Catalano, & Cushing, 1996; Plested et al., 1999).

Similarly, key informants were generally not clear whether community efforts had been evaluated, although most thought not, highlighting the gap between prevention research (evidence-based) (Altman, 1995; Morrissey et al., 1997) and prevention practice (self-evident) (Arthur & Blitz, 2000). Community initiatives require appropriate evaluations as a standardised part of prevention initiatives (Kumpfer, Moskowitz, Whiteside, & Klinzner, 1985) that can a) demonstrate that interventions have an impact, and b) contribute to the development of state and national databases of effective prevention interventions (Giesbrecht & Haydon, 2006).
An important dimension that contributed to the challenge of tackling adolescent substance use in communities, aside from the systemic and policy limitations, focussed on community attitudes (referred to earlier in this section). The overall negative attitude was seen as the main barrier to communities taking responsibility for the problem and giving some priority to this health issue (Beebe et al., 2001; Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004; Fitzpatrick & Gerard, 1993; Logan, Schenck, Leukefeld, Meyers, & Allen, 1999; Puska et al., 1985; Slater et al., 2005). Factors that appear to contribute to the negative attitude toward young people and drug use include the lack of readily available information on the level and nature of drug use by young people (Beyers et al., 2004; Giesbrecht & Haydon, 2006; Kumpfer, Alvarado, & Smith, 2005; Kumpfer & Hopkins, 1993; Kumpfer et al., 1985; Senay, 1991; Slater et al., 2005), the belief that young people use illicit drugs and a general lack of understanding of young people, their development and the risk and protective factors relating to their healthy development.

The responses from the additional empowerment questions also provided some interesting insight into the understanding of ‘community empowerment’. The responses highlighted that whilst state government may initiate policy, provide funds and be seen to be driving drug and alcohol efforts, over 50% of key informants believed that drug prevention efforts were initiated by the community. The communities felt sufficiently “powerful” to adapt or decline state initiatives dependent on whether the initiative fitted community priorities or needs. There appeared to be a sufficient understanding of the complexity of state government approaches by community groups that they felt they could “pick and mix” those that they wished to work with or adapt at the local level. This may be a workable solution to ensuring that action to tackle drug and alcohol issues in the community is appropriate but is unlikely to be resource efficient.

The last of the additional questions moved away from the state and community engagement and tried to gauge the level of confidence that existed in communities to introduce change (Steckler et al., 1993). The majority (65%) of the responses were positive and provided glowing praise for the committed and skilled workers, the cooperation and trust between agencies and the supportive leadership. Some of these responses may have seemed at odds with the deficiencies that participants described in other parts of the survey, but they indicate an overall optimism and “can-do” spirit that is an important characteristic of a healthy and strong community (Kenyon & Black, 2001).
Contribution to research on community empowerment

Five of the empowerment questions were principally developed to examine state government support and interaction with communities relevant to prevention. The responses to these questions were analysed using theme analysis (refer 4.4.2). Comparison of the results using this method provided an additional means of assessing the information gathered from the two USA questionnaires. As coding of the responses from the empowerment questions showed a moderate level of internal consistency (alpha=0.55) the responses were combined to form a quantitative scale, described as the empowerment scale. Regression was used to quantitatively model whether empowerment scores could be predicted from responses to the SDRG and TECPR surveys (refer 4.3.12).

Whilst individually neither instrument was highly predictive of empowerment (TECPR explored 39% and SDRG 24%), the combined results revealed a much stronger prediction of the variance, with the majority of the variance in the empowerment scores (nearly 60%) being explained by responses to the two readiness assessment instruments.

Additional examination of the two surveys using correlation coefficients revealed the sub-scales and dimensions that significantly predicted empowerment scores. These included: leadership, collaboration and resources in both instruments, further supporting the importance of these factors in facilitating community capacity for change. This finding holds important implications for community building and change theory in contributing to understanding of the links between community factors and community empowerment, a gap clearly identified in community research (Bernstein et al., 1994; Fetterman et al., 1996; Goodman et al., 1998; Laverack & Wallerstein, 2001; McLeroy et al., 2003; Mitchell, 2002). This finding also provides clear markers for improving community change strategies directed at community empowerment, by highlighting areas such as leadership development, and enhancing community collaboration. In this context it is important that the contribution of social capital to effective collaboration is better understood through improved measurement.

In order to enhance community empowerment for the prevention of adolescent substance use, the present study suggests that the following would be helpful to facilitating community change efforts:

• Closer collaboration between state government bodies and communities
• Enhanced community participation in the development of policy and community initiatives
• Community leaders being given the support and skills to drive change.

Theme analysis of the responses from the present study has provided a contemporary illustration of how the key community factors for change relate to the prevention of adolescent substance use, giving a greater understanding of the relevance of these factors to community interventions. Importantly, the findings show that not only do the TECPR and SDRG readiness assessment instruments assess community attitude and community skills as indicated by the authors, but the instruments are able to assess community domains relevant to community empowerment. This finding supported the conclusion that Hypothesis 3.2 was upheld.

H3.3: NOT UPHELD. Stakeholder evaluation of readiness assessment models and their assessment reports will be favourable.

In general, this hypothesis was inadequately tested, but based on the limited information available, was not upheld.

An offer to provide face-to-face feedback did not occur as a consequence of staff changes. A summary letter (Appendix 7) was the only contact made with key informants following the survey, limiting the opportunity to hear whether the study results matched local perception of readiness and the usefulness to the community members (Gielen & McDonald, 1997). An offer of an opportunity to gain feedback on the readiness assessment reports was not taken up by key informants. Had it been taken up, this could have provided additional information that contributed to the validity of the data in the Australian setting.

Had the readiness assessments been instigated by the communities then the application of the findings would have rested with the community groups involved, increasing the likelihood of feedback with the present study and potentially contributing to their ‘empowerment’ to make changes (Laverack & Wallerstein, 2001; Mayer et al., 1998).
5.3 THE LIMITATIONS OF THE PRESENT STUDY

There were a number of limitations in the research design that require careful consideration should the present study be replicated in the future:

1. Firstly, the small size of the study, indicated by the number of communities and the number of participants, would only have power to identify the significant findings for large or moderate, but not small effects (Peterson et al., 1992). The study was centred on regional communities, not metropolitan communities, limiting the generalisability of the results to the range of Australian communities. Those participating in the study were considered representative of the four communities but may not be representative of other communities. As this was the first attempt to use these instruments in the Australian context, the study was designed as a feasibility study of the utility of the instruments that could lead to further studies of effectiveness in a broader range of representative communities.

2. As the TECPR survey had not been psychometrically tested in its development, the confidence in the reliability of the quantitative scores derived using this instrument may be limited in some research contexts. The application of a number of approaches to ensure an adequate ‘triangulation of data’ (refer 3.5.2) was the main strategy used in the present study to explore reliability. The correlation findings suggested the scales showed appropriate internal reliability.

3. The study was an ‘investigator-driven’ assessment which conflicted with advocates in the literature who emphasise the benefits of community-initiated change and question the usefulness of investigator-driven assessments for communities (Gielen & McDonald, 1997).

4. The reliance on subjective reports (provided by the key informants) about the issue under investigation is open to both conscious and unconscious distortions that could reduce validity (Beebe et al., 2001; Kaplan et al., 1987; Van Meter, 1990). Arthur (1999) suggested that the problem can be minimised by assuring key informants of the confidentiality of their responses, by collecting data from individuals representing different roles in the communities and from different community organisations; and through validation of the data against data collected independently from other sources - in this case, information from department staff. The multiple key
informants’ perspectives on many of the variables being assessed also allowed comparison of the same variables across key informants. Selection bias was minimised by recruiting key informants from multiple starting points rather than a single chain of referral in each community (Atkinson & Flint, 2001).

5. The two instruments may have been considered an inappropriate basis to compare readiness findings. These instruments have a number of differences; in the theory that underpinned their development, their procedures for data collection, the domains assessed and in the coding and interpretation of the data. In addition, the utilisation of two questionnaires on similar topics would potentially sensitise the key informant to what to expect with the second survey. This sensitising was minimised by varying the order of surveys. Correlation findings generally showed modest but significant findings between responses to the two instruments, suggesting some common dimensions were measured. The regression analysis predicting empowerment scores suggested each instrument also measured many unique components.

6. Feedback and dialogue with the study participants and key stakeholders in the community would have provided an additional check regarding the validity of the assessment report findings in these settings. Unfortunately this was not possible within the resource limitations the study faced.
5.4 CONCLUSION TO THE CHAPTER

Conclusions to Question 1: Is readiness assessment feasible in the Australian context?

This was the first study to assess the feasibility of the TECPR and SDRG instruments for their utility and application in measuring community readiness in the Australian context. As stated earlier readiness assessment appeared feasible using either of the two instruments but there are a number of conclusions from Question 1 that will improve the feasibility of using these survey approaches in the Australian context;

**Conclusion 1:** Careful consideration of the assessment context and comprehensive training will improve feasibility by ensuring that data collection is stream-lined and coding is efficient, minimising costs; as well as not being too onerous for the key informants or research staff.

**Conclusion 2:** The small number of key informants required to achieve a readiness result is favourable for feasibility. In small communities the number of key informants may be limited and it may be time-consuming finding appropriate recruits. Feasibility may also be impacted by community readiness. The four communities assessed in this study were “somewhat ready” indicated by their interest in CTC and this possibly contributed to their willingness to participate in the surveys. It can be surmised that it probably would have been harder to engage communities that were less ready; as well as those communities with a high level of readiness where the assessments may have seemed irrelevant.

**Conclusion 3:** The two survey styles appeared quite acceptable to the key informants, offering a choice for communities dependent on the context and research expertise.

**Conclusion 4:** The snowball technique appeared to generate the right mix of key informants that were knowledgeable about the issue and their community (Rice & Ezzy, 1999), as well as provide an effective method for engaging key informants in the research process. This was supported with careful application of the Dillman Method (1978). The professional domains that were targeted in this study, as suggested by the authors of the questionnaires, appeared appropriate for a health-focussed investigation such as this one.
Conclusions to Question 2: How reliable and valid are the two readiness assessment approaches in the Australian context?

To summarise, this was a small study with some statistical analysis in order to contribute to the examination of the reliability and validity of the instruments in the Australian context. Although the statistical analysis of the two instruments solely consisted of the basic set of tests, it served to increase the confidence in the reliability and validity of the two instruments. As the two instruments asked questions about different domains (refer 4.3.11) it was not possible to make a direct comparison but they both provided some similar readiness information illustrated by the profiles in the four regional communities (refer 4.3.2 and 4.3.8) and some unique information. The two instruments also gave the same ranking to the two communities with the highest level of readiness; but only the SDRG survey matched the ranking of the CTC staff for two of the communities (refer 4.3.11). The analysis did not include a psychometric test of the instruments, in part because of the small sample, but clearly there is scope for further work in this area with a larger sample. The hypotheses relevant to validity testing were either partly or mostly upheld in the present project.

A number of conclusions can be supported about the reliability and validity of the two instruments from the present study:

Conclusion 1: The semi-structured interview and rating procedure used by the TECPR survey provided a system whereby qualitative data can be quantified and hence address a broad range of assessment contexts (refer 3.4.1) (Harrington et al., 1988; Hill et al., 1989; Roche et al., 1991).

Conclusion 2: Use of an Anchor Rating scale (refer 4.3.4) as a ranking method and the Inter-Rater Scoring assessment (refer 4.3.5) delivered a satisfactory result, demonstrating that this method can be reliably used with less experienced scorers to provide a feasible readiness measure in the Australian context.

Conclusion 3: The TECPR instrument would appear to be the more efficient of the two evidenced by the smaller number of key informants required to achieve a valid and reliable readiness result. The advantages of the TECPR instrument included its brevity, fewer redundant dimensions and p-values that demonstrated that the instrument could significantly discriminate between communities (refer 4.3.6).

Conclusion 4: The small number of key informants (refer 4.3.3) for the TECPR survey combined with the ease of scoring makes it an ideal tool for rapid readiness assessments (Donnermeyer et al., 1997) for community groups that lack sophisticated research resources.
Conclusion 5: The fact that readiness results differed slightly within the TECPR dimensions after five and after ten interviews in the present study was probably due to the fact that much larger communities were being assessed than recommended as the unit of assessment by the TECPR authors. This problem can no doubt be alleviated by ensuring that community size is maintained at approximately 10,000 population in future studies.

Conclusion 6: The number of highly correlated items in the dimensions and subscales of the two instruments suggest that both instruments could be simplified, saving on the time and cost in using these surveys. The SDRG survey has since been shortened to include only the items that contribute to the Alpha scores.

Conclusion 7: The Face Validity of both instruments was acceptable but some participants expressed disappointment that the SDRG questionnaire focused on outcomes rather than ongoing community efforts.

Conclusion 8: The low number of moderate correlations between the two methods of assessment (Table 4.18) supports the use of both questionnaires in future surveys to give a more comprehensive community profile (Denzin & Lincoln, 2000). However, the length of time to conduct the two interviews would be a barrier to this approach.

Conclusion 9: The use of a number of 'triangulation' strategies in the conduct of this study increased the confidence in the reliability of the results. It would be recommended that similar strategies be utilised in any future readiness surveys using these instruments, if feasible.

Conclusion 10: The final assessment should be that the tools support the perspective of community workers who have experience and insight concerning community knowledge and organisation characteristics; as has been demonstrated in further use of the TECPR questionnaire (Lewis et al., 2005).

Conclusions to Question 3: How useful are readiness assessment reports to Australian communities?
The survey responses from the present study provided a basis for understanding how community factors related to readiness for the prevention of adolescent substance abuse in four Australian communities. The responses drew out many of the issues in recent literature on this topic, supporting the relevance of the instruments to contemporary reflection and practice; a finding that would also contribute to their utility in the Australian context.
Perhaps of greater utility to community leaders and coalitions addressing adolescent substance abuse (or any other community problem), is that the assessments provided specific information on local community characteristics that could assist greatly in structuring and tailoring the changes that are required. Readiness assessments could therefore be effectively used in a number of community applications such as planning, resource allocation, tendering, risk assessment and evaluation of effectiveness (measurement of change). The utility of the findings to the four communities involved was not established in the present study however, as the feedback stage did not occur (refer 4.5).

The study has demonstrated that both the TECPR and SDRG survey instruments were reliable and valid in the Australian context and were acceptable to the study participants. As the two instruments provided similar information, the suitability of their use will be governed by the research setting and resources available at the time.

As indicated in Chapter 3, the PhD student wanted to ensure that the results of the study would provide community groups with a reliable readiness instrument that could be used in a range of settings, without the need for high-level research expertise. The TECPR has been shown to be a reliable instrument for use in the Australian context with the additional merit that its qualitative approach can be quantitatively analysed. Collecting and rating community readiness can be done in a manner that is not unduly time-consuming and burdensome to ‘researchers’ or participants. Engagement in research in this way can have an empowering effect by assisting with the process of education, and development of community consciousness and of community mobilisation (Gaventa, 1988; Kennedy, 1995).

The TECPR survey instrument has since been used in a further four studies in Victoria, and one cross-nation study, known to the PhD student.

The limitation for communities using survey instruments like the SDRG is that they require research and computer software expertise to enter, code and analyse the data; and this expertise is rarely available in community settings (Parker et al., 2003). However, it has been demonstrated to be a reliable instrument in the Australian context and with some modification, it has since been used by researchers to investigate community readiness in other projects.

The next chapter will present three major conclusions from the present study.
CHAPTER 6: CONCLUSION TO THE THESIS

6.1 INTRODUCTION TO THE CHAPTER

The aim of the study was to expand the understanding of community readiness and its assessment; that could enhance the capacity of communities to address adolescent substance abuse. This was the first study to attempt to measure community readiness to address adolescent substance abuse in Australian regional areas. This final chapter will summarise the study and provide some conclusions on how the findings can contribute to the development of policy and practice in regard to community capacity to address adolescent substance abuse as well as provide some thoughts on further research on community readiness.

6.2 CONTRIBUTION TO COMMUNITY READINESS RESEARCH: What has been learnt about community readiness, the feasibility of readiness assessment and the implication for prevention policy and practice in Australia?

Chapter 1 raised some of the issues and complexities for communities in addressing adolescent substance abuse and the associated harms, as well as explored the author’s motivation for studying this problem. Chapter 2 provided an overview of the scientific literature on the problem of adolescent substance abuse, the role and function of community in society as well as an understanding of how individual behaviour is influenced by the social systems that operate within communities; and community change. Three important characteristics of community function were illustrated, ‘Community Competence’, ‘Community Attitude’ and ‘Community Empowerment’, that are considered essential elements if communities are to be effective in leading change. Chapter 3 defined the three research questions that formed the basis of the investigation, as well as outlined the two survey instruments, the additional questions and the rationale for the selection of the study methodology. Chapter 4 provided an illustration of the findings from the surveys as well as from some specific questions on state government and community engagement. Chapter 5 interpreted the results to draw some conclusions from the research in order to provide some broad conclusions for policy and practice in the sections that follow - Chapter 6.
The present study set out to assess community readiness to address adolescent substance abuse in four Australian local government areas and in doing so examine the validity and utility of two North American readiness instruments and their suitability to the Australian context. The process of assessment also enabled an examination of how well the two instruments were able to assess the three factors considered key to effective community change: community competence; community consciousness; and community empowerment. The present study also included questions to examine the interaction with and support for communities from state government.

As a result, the present study has made a number of contributions to further the understanding of community readiness:

Firstly, the literature in Chapter 2 on community interventions emphasised that an understanding of the social systems within communities, how change occurs within these systems and how system change can influence adolescent behaviour and well-being, is fundamental to effective planning and resource allocation for the prevention of complex community problems such as adolescent substance use. It was stated that readiness assessment could potentially assist a range of stakeholders such as government departments, community groups, organisations and community leaders to better understand these complexities as a way of ensuring successful community interventions.

Secondly, the results of the present feasibility study suggest that readiness can be measured reliably in the Australian context using either of the two instruments. The choice of instrument would depend on the context for the research, the communities involved and the dimensions that are to be examined. The two instruments compared favourably to one another in terms of readiness information sourced.

The TECPR instrument had the potential to elicit detailed information on community characteristics that could be useful in a number of contexts such as planning, strategy development, risk assessment and evaluation in addition to a quantitative measure of readiness. Whilst it took more time than anticipated to conduct the interviews, the results indicated that only around five people needed to be interviewed to achieve a reliable readiness measure for a specific community. The assessment of community readiness using this method would therefore appear to be feasible in the Australian context.
Responses to the scales for the SDRG instrument showed internal consistency comparable to those from USA studies. With some modification to the existing instrument to reduce the number of items to those required to achieve an adequate alpha score, the assessment of community readiness using this method would also appear feasible in the Australian context. The small number of respondents required to achieve a readiness result indicates that overall readiness surveys should not be unduly time-consuming or burdensome to the researcher and respondents.

The results from these survey instruments suggest that there can be a new way of assessing Australian community capacity to make changes that may lead to greater effectiveness and greater cost efficiency both in human and financial resources.

Thirdly, it can also be tentatively concluded from the analysis of responses to community empowerment questions that community members perceive they are empowered as change agents to achieve social and behavioural outcomes, where community readiness is high on relevant dimensions. Findings from the literature review and reflected in the integration of responses to the present study suggest that to achieve community mobilisation for policy change communities need to be competent, conscientious and empowered. The support of, and collaboration with, government departments is vital as it is federal government that drives drug and alcohol policy and state government that funds programmes within communities in Australia. A qualitative examination of responses relevant to state government and community engagement for the prevention of adolescent substance use showed that whilst key informants’ views were mostly positive there is much room for improvement in the state government’s commitment to provide meaningful and productive communication and planning systems with community leaders, key stakeholders and the wider community.

There is scope to examine this important relationship in future community capacity studies.
6.3 FURTHER WORK

Readiness research is still in its infancy. This study was a small feasibility study with the inherent limitations that this brings, described in 5.3. There is scope for further work on this topic to determine whether the results from this study are consistent with results from other communities, particularly metropolitan communities that were not included in the present study.

Important questions remain about community readiness and its assessment; that could also form the basis of further work on this subject. One of the key questions yet to be answered is whether a higher level of readiness indicates that communities will be more effective in their prevention work. At the end of the present study, the student's department received a grant to re-survey the same communities and conduct surveys of adolescent health and wellbeing in the local schools. The results from this study will be able to explore a connection between adolescent reports of well-being and stakeholder reports of community readiness.

Questions were also raised about the community readiness domains that have broader implications for strategic planning in communities:

- Are some domains more important than others?
- Is there a hierarchy of importance or does a combination of domains have more of an influence?
- Is it necessary for all domains to be strengthened to build community capacity for prevention of adolescent substance abuse?
- Can all domains be equally supported by outside agents in a programme context?
- Whilst a regression analysis of the additional questions revealed that some domains in both instruments indicated community empowerment, further testing is required to ensure appropriate validation for future studies.
6.4 FINAL WORD

Three hypothetical questions were raised in the discussion in Chapter 1 that reflected the failure of communities to tackle youth substance abuse. Can those questions now be answered in the conclusion of this study?

1. **Why did the well-intended efforts of the community fail despite significant input from leaders and concerned individuals?**

The community of well-intentioned leaders and health practitioners was not able to address the community’s concern at the time because they were not ready to do so. Little was known about the nature of the problem other than what was being conveyed in the media, which was mostly sensationalism. An assessment of community climate would probably have shown that there was little sympathy to help those with a drug problem and more a desire to remove the problem from their community. Other than the drug and alcohol programmes funded by government (that did not include any prevention programmes), there were few resources in the community devoted to addressing the problem, such as fund-raising, community awareness campaigns and volunteers for initiatives. A readiness assessment in this instance could have assisted in identifying the strengths and weaknesses of the community that would have provided a basis for some strategic planning to address the issue.

2. **Why were these communities resistant to an approach that assisted those in danger from death by overdose?**

The review of the failure of the state government to introduce safe injecting facilities indicated that as a result of the community not being involved in the development of policy at the time and a lack of information on the nature of the problem, the experts that were asked to promote the project were not credible. A readiness assessment may have identified that the community climate was at a different level to that of the appointed experts and the governments; while also revealing a potential lack of knowledge about the problem.

3. **Is there a way of assessing readiness within communities or coalitions ahead of introducing an intervention or change?**

Yes. This study has demonstrated that assessment is feasible and that readiness can be measured reliably. The study suggest that there is merit in considering a community’s level of readiness when serious issues like youth substance abuse need to be tackled, as it allows for a more strategic approach to planning and resource allocation.
6.5 CONCLUSION TO THE CHAPTER

The aim of the present study has been achieved. This study concludes that readiness assessments are feasible and could assist Australian government departments, community groups, organisations and community leaders to better understand the preparedness and characteristics of a community in the prevention of adolescent substance abuse as a way of ensuring successful community interventions.
GLOSSARY

**Alcohol**: classified as a sedative/hypnotic drug. Ethanol is the main psychoactive ingredient in alcoholic beverages.

**Cannabis**: a generic term for the various psychoactive preparations of the marijuana (hemp) plant (Cannabis Sativa).

**Coalition**: collection of individuals representing diverse organisations, factions or constituencies who agree to work together in order to achieve a common goal (Feighery & Rogers, 1989). In Australia, the term inter-sectoralism has been used (Hawkes, 1992). Partnership is another term commonly used in Australia.

**Community**: for the purpose of this study, community is defined as a bounded geographic area characterized by an identifiable population and overlapping health, education and human service systems (Arthur, 1999 #2).

**Community Capacity**: the characteristics of communities that affect their ability to identify, mobilise and address social and health problems and the cultivation and use of transferable knowledge, systems and resources that affect community and individual level changes consistent with population health-related goals and objectives (Goodman et al., 1998).

**Community Development**: refers to the process of facilitating the community's awareness of the factors and forces that affect its health and quality of life, and ultimately helping to empower the community with the skills needed to take control over and improve those conditions. It involves helping communities to identify issues of concern and facilitating their efforts to bring about change in these areas (Hawe, Degeling, & Hall, 1990).

**Community Leaders**: for the purposes of this study, leaders are people who hold appointed senior positions in organisations that can be influential in community change; or are influential community members (Arthur et al., 1999).

**Community Organisation**: defined as the process by which community groups are helped to identify common problems or goals, mobilise resources and in other ways develop and implement strategies for reaching the goals they have collectively set. (Minkler & Wallerstein, 1997).
Community Readiness: is the relative level of acceptance of a program, action or other form of decision-making activity that is locally based (Donnermeyer et al., 1997).

Contingency Theory: postulates that organisational design reflects the degree of complexity of the environment in which the organisation operates (Kaluzy & Hernandez, 1988).

Culture: In the present context, culture refers to community practices, conventions and norms that represent implicit local influences on collective substance use behaviours.

Demand Reduction: policies or programmes designed to reduce consumer demand for drugs (Dietze, Langan, & Thornton, 1998)

Domain: a domain is a field or area of influence (Laverack & Wallerstein, 2001).

Drug: any chemical agent that has the capacity to alter biochemical or physiological processes, tissues or organisms and in this sense usually psychoactive drug (World Health Organisation, 1994).

Empowerment: defined as an enabling process through which individuals or communities take control over their lives and their environment (Rappaport, 1984).

Illicit drug: a drug whose production, sale or possession is prohibited by United Nations Schedules. ‘Illegal drug’ is an alternative term.

Inter-sectoralism: relationship between departments, institutions and interest groups within a locality. These different groups are working together to achieve a common goal. In the USA the term ‘coalition’ is more commonly used.

Licit drug: a drug whose production, sale or possession is not prohibited under United Nations schedules. ‘Legal drug’ is another term.

Phenomenology is the study of “phenomena”: appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience. Phenomenology studies conscious experience as experienced from the subjective or first person point of view (Stanford Encyclopedia of Philosophy, July 2008).

Prevention: “Interventions that occur before the initial onset of a disorder” to prevent the development of disorder (Mrazek & Haggerty, 1994) p 23.
**Protective Factors**: Those factors that “produce resilience to the development of psychological difficulties in the face of adverse risk factors” (Spence & Dadds, 1996) p.5.

**Risk Factors**: “Those characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder” (Mrazek & Haggerty, 1994) p.127.

**Rural and Remote Communities**: The rural, remote and metropolitan areas (RRMA) classification was developed by the Commonwealth Department of Primary Industries and Energy, and the Commonwealth Department of Human Services and Health in 1994, based primarily on population numbers and an index of remoteness. The four communities in this study fall in the ‘large rural centres’ category (urban centres population 25,000-99,000) in the ‘Rural Zone’ (Commonwealth Department of Health and Aged Care, 2000a)

**Substance Use**: self-administration of a psychoactive substance. Use can be controlled, experimental, harmful, hazardous, recreational or safe (Dietze et al., 1998)

**Supply Reduction**: policies or programmes involving law enforcement agencies designed to curtail the manufacture and distribution of illicit drugs (Dietze et al., 1998)
REFERENCES


Department of Sport and Recreation. (1975). 'Life Be In It': Victorian Government.


Health (General Amendment) Act, Parliament of Victoria, 29A (1988).


Plested, B. (2004). Personal communication. Fort Collins, Colorado, USA.


APPENDIX 1: TECPR QUESTIONS
This is the survey used by the Tri Ethnic Center for Prevention Research to assess community readiness.

TECPR
COMMUNITY READINESS QUESTIONNAIRE
SHORT VERSION

COMMUNITY READINESS QUESTIONS
A. EXISTING COMMUNITY EFFORTS

B. COMMUNITY KNOWLEDGE OF THE EFFORTS
1. Using a scale from 1 to 10, how much of a concern is adolescent drug use in the community, with one being not at all and ten being a very large concern. Please explain.

2. Please describe the efforts that are available in your community to address adolescent drug use? How long have they been available?

3. Using a scale from 1 to 10, how aware are people in the community of these efforts, with one being no awareness and ten being very aware? Please explain.

4. What are the strengths of these efforts?

5. What are the weaknesses of these efforts?

C. LEADERSHIP

6. Using a scale from 1 to 10, how much of a concern is adolescent drug use to the leadership, with one being not at all and ten being a very large concern? Please explain.

7. How are the “leaders” in your community involved in prevention efforts? Please explain.

8. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

9. What is the community’s attitude about adolescent drug use?

10. What are the primary obstacles to efforts in your community?

E. COMMUNITY KNOWLEDGE ABOUT THE PROBLEM

11. In your community, what type of information is available about adolescent drug use?

12. How aware are community members about the signs and symptoms of
adolescent drug use? Please explain.

13. Is local data on this issue available in your community?

14. How do people obtain this information in your community?

RESOURCES RELATED TO THE ISSUE

15. Who would a young person using drugs turn to first for help?

16. What is the community's attitude about supporting efforts with people volunteering time, making financial donations, and providing space?

17. Are you aware of any proposals or action plans that have been written to address this issue in your community?

18. Do you know if there is any evaluation of these efforts? If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort, with one being not at all and ten being very sophisticated.
APPENDIX 2: ANCHOR STATEMENTS

The Tri Ethnic Center for Prevention Research assess responses drawing on the following anchor statements.

Dimension A. Existing Community Efforts
0
1. No awareness of the need for efforts to address the issue.
2. No efforts addressing the issue.
3. A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
4. Some community members have met and have begun a discussion of developing community efforts.
5. Efforts (programs/activities) are being planned.
6. Efforts (programs/activities) have been implemented.
7. Efforts (programs/activities) have been running for several years.
8. Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
9. Evaluation plans are routinely used to test effectiveness of many different based on evaluation data.

Dimension B. Community Knowledge of the Efforts
0
1. Community has no knowledge of the need for efforts addressing the issue.
2. Community has no knowledge about efforts addressing the issue.
3. A few members of the community have heard about efforts, but the extent of their knowledge is limited.
4. Some members of the community know about local efforts.
5. Members of the community have basic knowledge about local efforts (e.g., purpose).
6. An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
7. There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
8. There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
9. Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.
Dimension C. Leadership (includes appointed leaders & influential community members)

0
1 Leadership has no recognition of the issue.
2 Leadership believes that this is not an issue in their community.
3 Leader(s) recognize(s) the need to do something regarding the issue.
4 Leader(s) is/are trying to get something started.
5 Leaders are part of a committee or group that addresses this issue.
6 Leaders are active and supportive of the implementation of efforts.
7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
8 Leaders are supportive of expanding/improving efforts through active participation
9 Leaders are continually reviewing evaluation results of the efforts and are modifying

Dimension D. Community Climate

0
1 The prevailing attitude is that it's an accepted part of community life.
   - "It's just the way things are."
2 The prevailing attitude is "There's nothing we can do," or "Only 'those' people do that."
3 Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.
4 The attitude in the community is now beginning to reflect interest in the issue. "We have to do something, but we don't know what to do."
5 The attitude in the community is "This is our problem" and they are beginning to reflect modest support for efforts.
6 The attitude in the community is "This is our responsibility" and is now beginning to reflect modest involvement in efforts.
7 The majority of the community generally supports programs, activities, or policies. "We have taken responsibility."
8 Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. "We need to keep up on this issue and make sure what we are doing is effective"
9 All major segments of the community are highly supportive, community members are actively involved in evaluating and improving efforts and demand accountability.
Dimension E. Community Knowledge about the Issue
0
1 Not viewed as an issue.
2 No knowledge about the issue.
3 A few in the community recognize some signs and symptoms.
4 Some community members recognize the signs and symptoms of this issue, but information is lacking.
5 Community members know that the signs and symptoms of this issue occur locally, and general information is available.
6 A majority of community members know the signs and symptoms of the issue and that it occurs locally and there are local data available.
7 Community members have knowledge of, and access to, detailed information about local prevalence.
8 Community members have knowledge about prevalence, causes, risk factors, and consequences.
9 Community members have detailed information about the issue as well as information about the effectiveness of local programs.

Dimension F. Resources Related to the Issue
(people, money, time, space, etc.)
0
1 There is no awareness of the need for resources to deal with this issue.
2 There are no resources available for dealing with the issue.
3 The community is not sure what it would take, or where the resources would come from, to initiate efforts.
4 The community has individuals, organizations and/or space available that could be used as resources.
5 Some members of the community are looking into the available resources.
6 Resources have been obtained and/or allocated for this issue.
7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.
8 Diversified resources and funds are secured and efforts are expected to be permanent. There is additional support for further efforts.
9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.
APPENDIX 3: SDGR QUESTIONS

These questions replicate those used as part of the SDGR ‘Diffusion’ computer-based survey. A paper booklet was used in the present study. One question booklet was used for each interview to: record the progress of the interview, data collection, and data entry.

Survey Form:
Stephanie Jones – Centre for Adolescent Health – Parkville, Victoria 2002
jones@cryptic.ch.unimelb.edu.au

CONFIDENTIAL INFORMATION

Respondent Code __________

Call/Note: the respondent’s local line

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Initial</th>
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</thead>
<tbody>
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</table>

Processing Sequence

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<th>Researcher’s Initial</th>
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<tr>
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</tr>
<tr>
<td>Interview Abandoned</td>
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<td></td>
<td>8</td>
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<td></td>
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Session Start-Up Questions: Q1 - Q4
Scheduling Questions: Q5 - Q7
Interview Script Introduction Questions: Q8 - Q17
Community Questions: Q18 - Q45c
CTC Branch Questions: Q58 - Q99
Other Prevention Plan Branch Questions: Q101 - Q119
Framework Other Non-specific Questions: Q120 - Q150a
Community Policing Questions: Q151 - Q157g Deleted
Background Questions: Q158 - Q160
Snowball Questions: Q161 - Q162c
Last Respondent Questions Q: Q163
Interviewer Assessment Questions: Q164 - Q166
Response Card
Prompts & "CATI' Check

Notes

Please date and initial your notes

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SESSION START-UP QS: Q1 – Q4

Start here...
Fold out Prompt/Check sheet at back.
Fill in Respondent details and telephone number.
Check equipment: 2x pencils, eraser, clock, recorder, glass of water, tissues, telephone ear piece.
Dial Telephone

Q4: Choose one of the following...

Scheduling Script
Conduct Interview

Continue
Skip to Q8

SCHEDULING QS: Q5 – Q7

Q5: Hello, may I speak with Respondent Name?

Yes 1. Skip to Q6
Not Available 2. Continue

Q5a: When would be a good time to reach Respondent Name?

Make Call/Note on cover
Terminate interview

Q6: (Hello, My name is Interviewer’s Name and I’m calling from the Centre for Adolescent Health in Melbourne. I’m calling to schedule a time to conduct the telephone interview with you about Community. We recently sent you a letter to let you know that we would be calling. Did you receive the letter?

Yes 1. Skip to Q7
No 2. Continue

Q6a: I’m sorry, it was just a brief letter to let you know we would be calling.
Continue

Q7: The purpose of this interview is to learn more about what different communities are doing to address adolescent substance use. (As we mentioned in the letter), the interview should last approximately 50 minutes. When would be the best time for me to call you back to do the interview?

Not Now 1. Terminate Interview
Conduct Interview Now 2. Skip to Q10
INTERVIEW SCRIPT INTRO Q5: Q8 – Q17

Q8. Hello, may I speak with Respondent Name?
   Yes 1 Skip to Q9
   Not Available 2 Continue

Q8a. When would be a good time to reach Respondent Name?
   Make Call/Note on cover
   Terminate Interview

Q9. (Hi,) this is interviewer’s Name calling from the Centre for Adolescent Health. I’m calling to conduct the interview about Community that we scheduled for this time. Is this still a convenient time for you?
   Yes 1 Skip to Q10
   No 2 Continue

Q9a. When would be a good time for me to call you back?
   Make Call/Note on cover
   Terminate Interview

Q10. This interview is completely voluntary and confidential. While portions of this interview may be monitored by my supervisor, all of the information you provide will remain strictly confidential. If I come to any question you prefer not to answer, just let me know and I’ll skip over it. Okay?
   Yes 1 Terminate Interview
   No 2 Turn Off the Tape Recorder

Q11. May I have your permission to record this interview?
   Yes 1
   No 2

RESPONSE

With the letter that we sent, you should have received a blue sheet of paper. This (blue) sheet is a Show Card that we’ll be using throughout the interview. There are 5 response cards on this sheet and each one has different response options. As we go through the interview, I will let you know which response card to use for each question. There will be some questions that do not use a response card and I will just read you the response options. Do you have any questions about using the response cards?

As I mentioned, the purpose of this survey is to learn more about what Community is doing to prevent adolescent substance use, such as alcohol, tobacco, marijuana and other drugs. In this interview, I will be asking a lot of questions about prevention. There are many different prevention activities that a community might engage in. However, for the purposes of this survey, I’d like you to think about the prevention of adolescent substance use when giving your answers. Okay?

Great. First, I’m going to ask a few questions about your background. Next, I’ll ask some general questions about your community. Last, I’ll ask you some specific questions about your community’s efforts to reduce drug use.

Q11a. Note start time on Prompt/Check sheet
Q12  How long have you lived in Community?

<table>
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</tr>
<tr>
<td>Refused</td>
<td>66</td>
</tr>
<tr>
<td>Don't Know</td>
<td>77</td>
</tr>
</tbody>
</table>

Q13  How long have you worked in Community?

<table>
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<tbody>
<tr>
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<td>3 Skip to Q16</td>
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<tr>
<td>Refused</td>
<td>66</td>
</tr>
<tr>
<td>Don't Know</td>
<td>77</td>
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</tbody>
</table>

Q14  Question Deleted

Q15  How long have you been at Organisation?

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<tr>
<th>Years</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Refused</td>
<td>66</td>
</tr>
<tr>
<td>Don't Know</td>
<td>77</td>
</tr>
</tbody>
</table>

Q16  Thinking about your past work and volunteer experiences, would you say that you have worked on issues related to prevention of adolescent drug use?

| Yes | 1 Skip to Q18 |
| No | 2 Skip to Q18 |
| Refused | 66 Skip to Q18 |
| Don't Know | 77 |

Q17  How long have you worked on these issues?

<table>
<thead>
<tr>
<th>Years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refused</td>
<td>66</td>
</tr>
<tr>
<td>Don't Know</td>
<td>77</td>
</tr>
</tbody>
</table>
Q18

Please look at Card A

Next I'd like to ask you some questions about your community, Community. Please tell me how much you agree or disagree with each of these statements?

This is a tight knit community.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don't Know | 7 |

Q19

Community agencies and organizations work together to solve community problems.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don't Know | 7 |

Q20

This community is willing to try new ideas to solve community problems.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don't Know | 7 |

Q21

Most people in Community care a lot about the community.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don't Know | 7 |

Q22

Most people in Community tend to think of it as their home, the place they belong, rather than just a place to live.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don't Know | 7 |
**Q23** Most people in Community feel safe in the community.
- **Strongly Agree** 1
- **Somewhat Agree** 2
- **Somewhat Disagree** 3
- **Strongly Disagree** 5
- **Refused** 6
- **Don't Know** 7

**Q24** It is difficult to get people in Community involved in community activities.
- **Strongly Agree** 1
- **Somewhat Agree** 2
- **Somewhat Disagree** 3
- **Strongly Disagree** 4
- **Refused** 6
- **Don't Know** 7

**Q25** Most people in Community are committed to addressing community issues.
- **Strongly Agree** 1
- **Somewhat Agree** 2
- **Somewhat Disagree** 3
- **Strongly Disagree** 4
- **Refused** 6
- **Don't Know** 7

**Q26** Most people in Community are pretty set in their ways.
- **Strongly Agree** 1
- **Somewhat Agree** 2
- **Somewhat Disagree** 3
- **Strongly Disagree** 4
- **Refused** 6
- **Don't Know** 7

**Q27** Residents across all sectors of the community participate in the decision-making process.
- **Strongly Agree** 1
- **Somewhat Agree** 2
- **Somewhat Disagree** 3
- **Strongly Disagree** 4
- **Refused** 6
- **Don't Know** 7

**Q28** Question Deleted
Q29 Some communities are quite open to change, while others resist it. How would you characterize your community? Would you say...

  Open to change  1
  Somewhat open to change  2
  Somewhat wary of change  3
  Wary of change  4
  Refused  6
  Don’t Know  7

Q30 Please look at Card B.
In this community, how wrong do most adults think it is for adolescents to...

Q30a ...drink alcohol

  Very Wrong  1
  Wrong  2
  A Little Bit Wrong  5
  Not at All Wrong  4
  Refused  6
  Don’t Know  7

Q30b ...smoke cigarettes

  Very Wrong  1
  Wrong  2
  A Little Bit Wrong  3
  Not at All Wrong  4
  Refused  6
  Don’t Know  7

Q30c ...use marijuana

  Very Wrong  1
  Wrong  2
  A Little Bit Wrong  3
  Not at All Wrong  4
  Refused  6
  Don’t Know  7
Q31 Please look at Card A.

Next, I'm going to read a list of statements that may or may not be true about your community. Please tell me how much you agree or disagree with each one.

There is a network of people concerned about children's issues who stay in touch with each other.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don't Know 7

Q32 Generally, people in Community believe it is possible to reduce adolescent drug use through prevention efforts.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don't Know 7

Q33 Generally, people in Community are knowledgeable about local prevention efforts.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don't Know 7

Q34 Community agencies and organizations rarely coordinate their activities.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don't Know 7
Q35 Please look at Carol A.

The next set of questions asks about your opinions of the leaders in your community. Again, for each of the following statements, please tell me how much you agree or disagree.

Q35a …are able to represent all sectors of the community, including cultural and ethnic minority groups

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>1</td>
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<tr>
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<td>Somewhat Disagree</td>
<td>3</td>
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<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>6</td>
</tr>
<tr>
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</table>

Q35b …are able to build consensus across the community

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
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<td>Somewhat Disagree</td>
<td>3</td>
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<tr>
<td>Strongly Disagree</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>6</td>
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<tr>
<td>Don’t Know</td>
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</table>

Q35c …are able to obtain the necessary resources for community initiatives

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
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<td>Strongly Disagree</td>
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</table>

Q35d …are able to manage conflicts between different groups within the community

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
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<td>Refused</td>
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</table>

Q35e …are committed to reducing drug abuse and promoting positive youth development

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Frequency</th>
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Q35f …are knowledgeable about local drug abuse prevention efforts?

<table>
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<tbody>
<tr>
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<td>Refused</td>
<td>6</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>7</td>
</tr>
</tbody>
</table>
Q35g ...believe drug abuse prevention efforts are cost effective.
  Strongly Agree  1
  Somewhat Agree  2
  Somewhat Disagree  3
  Strongly Disagree  4
  Refused  6
  Don't Know  7

Q36 Please look at Carol C.
In the past year, how much has Organization Name collaborated with the following organizations regarding prevention issues?

Q36a ...Community Coalitions
  A Lot  1
  Some  2
  A Little  3
  Not at All  4
  Refused  6
  Don't Know  7

Q36b ...Human service agencies
  A Lot  1
  Some  2
  A Little  3
  Not at All  4
  Refused  6
  Don't Know  7

Q36c ...Schools
  A Lot  1
  Some  2
  A Little  3
  Not at All  4
  Refused  6
  Don't Know  7

Q36d ...Health agencies
  A Lot  1
  Some  2
  A Little  3
  Not at All  4
  Refused  6
  Don't Know  7

Q36e ...Businesses
  A Lot  1
  Some  2
  A Little  3
  Not at All  4
  Refused  6
  Don't Know  7
<table>
<thead>
<tr>
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<th>Description</th>
<th>Response 1</th>
<th>Response 2</th>
<th>Response 3</th>
<th>Response 4</th>
<th>Response 5</th>
<th>Response 6</th>
<th>Response 7</th>
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</thead>
<tbody>
<tr>
<td>Q36f</td>
<td>…local government</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
</tr>
<tr>
<td>Q36g</td>
<td>…Youth recreation programs</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
</tr>
<tr>
<td>Q36h</td>
<td>…Law Enforcement</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
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<tr>
<td>Q36i</td>
<td>…Juvenile justice system</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
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<tr>
<td>Q36j</td>
<td>…Media groups</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
</tr>
<tr>
<td>Q36k</td>
<td>…Religious groups</td>
<td>A Lot</td>
<td>Some</td>
<td>A Little</td>
<td>Not at All</td>
<td>Refused</td>
<td>Don't Know</td>
<td></td>
</tr>
</tbody>
</table>
Q37

Now please look at Card D

I'd like to ask you about some problems that may or may not be present in different communities. For each one, I'd like you to tell me how serious a problem you feel it is in Community.

(The first/next one is...)

Q37a  ...Pollution

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7

Q37b  ...Poverty

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7

Q37c  ...Gangs

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7

Q37d  ...Health problems of older adults

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7

Q37e  ...Poor School quality

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7

Q37f  ...Racism

    Very Serious  1
    Somewhat Serious  2
    Not Very Serious  3
    Not at All Serious  4
    Refused  6
    Don't Know  7
<table>
<thead>
<tr>
<th>Question</th>
<th>Issue</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q37g</td>
<td>Substance abuse</td>
<td>Very Serious 1, Somewhat Serious 2, Not Very Serious 3, Not at All Serious 4, Refused 6, Don’t Know 7</td>
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<tr>
<td>Q37h</td>
<td>Teenage pregnancy</td>
<td>Very Serious 1, Somewhat Serious 2, Not Very Serious 3, Not at All Serious 4, Refused 6, Don’t Know 7</td>
</tr>
<tr>
<td>Q37i</td>
<td>Crime</td>
<td>Very Serious 1, Somewhat Serious 2, Not Very Serious 3, Not at All Serious 4, Refused 6, Don’t Know 7</td>
</tr>
<tr>
<td>Q37j</td>
<td>Mental illness</td>
<td>Very Serious 1, Somewhat Serious 2, Not Very Serious 3, Not at All Serious 4, Refused 6, Don’t Know 7</td>
</tr>
<tr>
<td>Q37k</td>
<td>Poor public transport</td>
<td>Very Serious 1, Somewhat Serious 2, Not Very Serious 3, Not at All Serious 4, Refused 6, Don’t Know 7</td>
</tr>
</tbody>
</table>
Q38 Thinking about the list of problems I just mentioned, I’d like you to rank the top three problems in terms of priority for your community.

Q38a Which one problem do you think should be addressed first?

(I can repeat the list for you if you’d like.)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Refused 66</th>
<th>Skip to Q39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t Know 77</td>
<td>Skip to Q39</td>
<td></td>
</tr>
</tbody>
</table>

1. Pollution
2. Poverty
3. Gangs
4. Health Problems of older adults
5. Poor School quality
6. Racism
7. Substance abuse
8. Teenage pregnancy
9. Crime
10. Mental illness
11. Poor public transportation

Q38b Which problem do you think should be addressed second?

(I can repeat the list for you if you’d like.)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Refused 66</th>
<th>Skip to Q39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t Know 77</td>
<td>Skip to Q39</td>
<td></td>
</tr>
</tbody>
</table>

1. Pollution
2. Poverty
3. Gangs
4. Health Problems of older adults
5. Poor School quality
6. Racism
7. Substance abuse
8. Teenage pregnancy
9. Crime
10. Mental illness
11. Poor public transportation

Q38c Which problem do you think should be addressed third?

(I can repeat the list for you if you’d like.)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Refused 66</th>
<th>Skip to Q39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t Know 77</td>
<td>Skip to Q39</td>
<td></td>
</tr>
</tbody>
</table>

1. Pollution
2. Poverty
3. Gangs
4. Health Problems of older adults
5. Poor School quality
6. Racism
7. Substance abuse
8. Teenage pregnancy
9. Crime
10. Mental illness
11. Poor public transportation
Q39  Now please look at Card A

The next section asks for your opinions about how decisions are made and about how conflicts or problems may be handled in your community. Please tell me how much you agree or disagree with each statement.

(The first/next one is...)  

Q39a  There is a lot of conflict between groups in this community.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q39b  Disagreements in Community prevent problems from being addressed.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q39c  Residents provide little input into our community’s decisions.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q39d  Community conflicts are usually resolved in a manner that is respectful of and satisfactory for the people involved.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q39e  Question Deleted

Q39f  Community has systems in place to help people get involved in the community decision-making process.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7
Q39g  Community problems overwhelm local community groups.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7

Q39h  Though community residents may disagree over ideas, these disagreements do not typically lead to a breakdown in progress.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7

Q39i  What happens in Community is largely a matter of chance.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7

Q40  Still looking at Card A.
   Please tell me how much you agree or disagree with the next few statements.

   In the past two years, my community has been successful at addressing social problems.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7

Q41  My community never seems to be able to accomplish much at all.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7

Q42a  Adults in Community think the use of alcohol is a normal part of growing up.
   Strongly Agree 1
   Somewhat Agree 2
   Somewhat Disagree 3
   Strongly Disagree 4
   Refused 6
   Don’t Know 7
Q42b  Adults in Community think the use of tobacco is a normal part of growing up.

    Strongly Agree    1
    Somewhat Agree    2
    Somewhat Disagree 3
    Strongly Disagree 4
    Refused           6
    Don't Know        7

Q42c  Adults in Community think the use of marijuana is a normal part of growing up.

    Strongly Agree    1
    Somewhat Agree    2
    Somewhat Disagree 3
    Strongly Disagree 4
    Refused           6
    Don't Know        7

Q43  The next few questions ask about substance use regulations in your local community.

Please look at Card E.

How frequently do you think the laws prohibiting alcoholic beverage sales to minors are enforced in your community?

    Very Frequently  1
    Somewhat Frequently  2
    Not Very Frequently  3
    Not At All Frequently  4
    Refused           6
    Don't Know        7

Q44  How frequently do you think the laws prohibiting tobacco sales to minors are enforced in your community?

    Very Frequently  1
    Somewhat Frequently  2
    Not Very Frequently  3
    Not At All Frequently  4
    Refused           6
    Don't Know        7

Q45a  Looking at Card E.

If a young person were caught smoking a cigarette in Community, do you think he or she would be cautioned?

    Definitely    1
    Maybe Depending on the Circumstance  2
    Probably Not   3
    Definitely Not  4
    Refused        6
    Don't Know     7
Q45b  If a young person were caught drinking alcohol in Community, do you think he or she would be cautioned?

- Definitely 1
- Maybe Depending on the Circumstance 2
- Probably Not 3
- Definitely Not 4
- Refused 6
- Don’t Know 7

Q45c  If a young person were caught using marijuana in Community, do you think he or she would be cautioned?

- Definitely 1
- Maybe Depending on the Circumstance 2
- Probably Not 3
- Definitely Not 4
- Refused 6
- Don’t Know 7

Next, I’d like you to think about different approaches for reducing substance abuse among adolescents.

Q46  If you were deciding how to spend money for reducing substance abuse, what percentage would you allocate to each of the following approaches: law enforcement, prevention, and treatment.

Out of 100%, what percentage would you give for …

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Law enforcement</td>
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<tr>
<td>Prevention</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
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</table>

VERIFY TOTAL = 100%

 Refused 66
 Don’t Know 77

Q47  Question Deleted
Q48  Now please look at Card A
The next set of questions asks about the attitudes of people in your community on these issues. How much do you agree or disagree with each of these statements?

Q48a  Most people in Community believe that parents should be the only ones to teach their children about alcohol, tobacco, and other drugs

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q48b  Most people in Community believe that schools need to be active in teaching children about alcohol, tobacco, and other drugs

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q48c  Most people in Community believe that preventing drug abuse is everyone’s responsibility

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q48d  Most people in Community would be willing to pay more in taxes to support youth drug prevention programs

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q48e  Most people in Community think that prevention programs for youth don’t work.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7

Q48f  Most people in Community think there is nothing they can do to prevent drug, alcohol, and tobacco abuse.

- Strongly Agree 1
- Somewhat Agree 2
- Somewhat Disagree 3
- Strongly Disagree 4
- Refused 6
- Don’t Know 7
Q49 There are different factors that may influence adolescent drug use. I’m going to read a list of factors. For each pair, which factor would you say is more important for preventing adolescent drug use? (Would you say... or...)
(If needed: Which factor would you say is more important for preventing adolescent drug use?)

Q49a
1. Self-esteem
2. Of Bonding to adults
3. Refused
4. Don’t Know

Q49b
1. Clear standards for behavior
2. Of Open communication with children
3. Refused
4. Don’t Know

Q49
1. Opportunities For Active Involvement in the classroom
2. Of Information on the effects of drugs
3. Refused
4. Don’t Know

Q49d
1. Holding parents legally accountable
2. Of Developing children’s social skills
3. Refused
4. Don’t Know

Q49e
1. Strict punishment
2. Of Recognizing children for positive behaviors
3. Refused
4. Don’t Know

Q50 Question Deleted

Q51 Now please look at Card C.
Communities select their prevention activities and providers using different criteria. I'm going to read a list of some criteria. For each one, please tell me how much it influenced your community's selection of current prevention activities and providers.

(The first/next one is...)

( Did this influence Community's selection... )

Q51a Analysis of local needs, based on data your community collected

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<th>Code</th>
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<tr>
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<tr>
<td>Some</td>
<td>2</td>
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<tr>
<td>A Little</td>
<td>3</td>
</tr>
<tr>
<td>Not at All</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
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</tr>
<tr>
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Q51b A desire to support existing prevention programs

<table>
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<th>Option</th>
<th>Code</th>
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Q51c Data on risk and protective factors

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Q51d Review of research on effective programs to identify those that might work for your community

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Q51e Funding available for particular programs or activities

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Q51f Data showing that some neighborhoods needed more activities

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Q52 Now I'd like to ask a few questions about your community's overall approach to prevention planning.
Does Community use a specific approach or framework to guide prevention planning?

Yes 1  Continue
No 2  Skip to Q53
Refused 6  Skip to Q53
Don’t Know 7  Skip to Q53

Q52a Would you name or briefly describe this approach or framework?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Refused 6
Don’t Know 7

Q53 Have you heard of the risk and protective focused prevention approach (sometimes called Communities That Care)?

Yes 1  Continue
No 2  Skip to Q54
Refused 6  Skip to Q54
Don’t Know 7  Skip to Q54

Q53a In a sentence or two, can you tell me what that approach is?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Refused 6
Don’t Know 7

Q54 Can you tell me some risk factors, or things that increase the likelihood of substance abuse?

Yes 1  Continue
No 2  Skip to Q55
Refused 6  Skip to Q55
Don’t Know 7  Skip to Q55

Mark response: Check 1
Check 2
Check 3
Check 4
Q54a  Can you please name them for me?  
Specify 1

Refused 6
Don't Know 7

Q55  Can you tell me some protective factors, or things that reduce the likelihood of substance abuse?  
Yes 1  
No 2  
Refused 6  
Don't Know 7  
Continue

Q55a  Can you please name them for me?  
Specify 1

Refused 6
Don't Know 7

Do Check 1

Q56  Have you heard of a prevention planning framework that addresses risk and protective factors?  
Yes 1  
No 2  
Refused 6  
Don't Know 7  
Mark response: Check 2

Do Check 2

Q57  In a sentence or two can you tell me what that framework is?  
Specify 1

Refused 6
Don't Know 7

Do Check 3
Q58 In your opinion, what are the most important steps in implementing the Risk and Protection Focused prevention approach?

Specify 1

Refused 6
Don’t Know 7

Q59 When did you first hear of this prevention approach?

Record Year
Refused 6666
Don’t Know 7777

Q60 How did you first hear about this prevention framework?

Specify 1

Refused 6
Don’t Know 7

Q61 Have you ever been to a training to learn about risk and protective focused prevention?

Yes 1
No 2, Skip to Q62
Refused 6, Skip to Q62
Don’t Know 7, Skip to Q62

Q61a When did you first attend a training? For unknown year enter 7777

Record Year
Refused 6666
Don’t Know 7777

Q61b Who conducted the training?

Specify 1

Refused 6
Don’t Know 7

Q62 Have you ever seen a risk and protective focused prevention manual, kit or curriculum?

Yes 1
No 2, Skip to Q63
Refused 6, Skip to Q63
Don’t Know 7, Skip to Q63
Q62a  What was the name of it?

Specify 1

Refused 6
Don't Know 7

Q63  How easy do you think the risk and protective focused prevention approach is to understand? (Would you say...)

Very easy 1
Easy 2
Difficult 3
Very Difficult 4
Refused 6
Don't Know 7

Q64  Do you support the risk and protective focused prevention approach?

Yes 1
No 2
Refused 6
Don't Know 7

Q65  Does Community use a risk and protective focused framework to prevent adolescent problems?

Yes 1  continue
No 2  skip to Q66d
Refused 6  skip to Q66d
Don't Know 7  skip to Q66d
Q66a  Please look at Card A
How much do you agree with each of the following statements?
(The first/next one is...)  
The risk and protective factor framework is difficult to use.

Strongly Agree  1  
Somewhat Agree  2  
Somewhat Disagree  3  
Strongly Disagree  4  
Refused  6  
Don’t Know  7

Q66b  In general the risk and protective factor framework is more effective in preventing adolescent drug use than our former approach to prevention.

Strongly Agree  1  
Somewhat Agree  2  
Somewhat Disagree  3  
Strongly Disagree  4  
Refused  6  
Don’t Know  7

Q66c  Skip to Q66f

Q66d  Please look at Card A
How much do you agree with each of the following statements?
(The first/next one is...)  
The risk and protective factor framework would be difficult to use.

Strongly Agree  1  
Somewhat Agree  2  
Somewhat Disagree  3  
Strongly Disagree  4  
Refused  6  
Don’t Know  7

Q66e  In general the risk and protective factor framework would be more effective in preventing adolescent drug use than our current approach to prevention.

Strongly Agree  1  
Somewhat Agree  2  
Somewhat Disagree  3  
Strongly Disagree  4  
Refused  6  
Don’t Know  7

Q66f  Methods for assessing the risk and protective factor framework’s impact on prevention programs are readily available.

Strongly Agree  1  
Somewhat Agree  2  
Somewhat Disagree  3  
Strongly Disagree  4  
Refused  6  
Don’t Know  7
Q66g  Methods for assessing the risk and protective factor framework’s impact on adolescent drug use are readily available.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don’t Know | 7 |

Do Check 4

Q67 Did Community make a formal decision to adopt the risk and protective focused prevention framework?

| Yes | 1 |
| No | 2 |
| Refused | 6 |
| Don’t Know | 7 |

Q68 Please look at Card A again. Please indicate how much you agree or disagree with the following statement. Leaders in my community are committed to using the risk and protective focused prevention approach.

| Strongly Agree | 1 |
| Somewhat Agree | 2 |
| Somewhat Disagree | 3 |
| Strongly Disagree | 4 |
| Refused | 6 |
| Don’t Know | 7 |

Q69 Question Deleted

Q70 When did Community first start using this prevention approach?

| Record Year |
| Refused | 6666 |
| Don’t Know | 7777 |

Q71 Was a coalition formed specifically to adopt this prevention approach?

| Yes | 1 | Skip to Q72a |
| No | 2 |
| Refused | 6 |
| Don’t Know | 7 |

Q72 Has an existing coalition chosen to adopt the risk and protective focused prevention approach?

| Yes | 1 |
| No | 2 | Skip to Q73 |
| Refused | 6 | Skip to Q73 |
| Don’t Know | 7 | Skip to Q73 |
Q72a What is the name of the coalition?

Specify 1

Refused 4

Don't Know 7

Q72b In what year was this coalition formed?

Record Year

Refused 6666

Don't Know 7777

Q73 Did your community prioritize risk and protective factors that you wanted to address with prevention activities?

Yes 1

No 2 Skip to Q77

Refused 4 Skip to Q77

Don't Know 7 Skip to Q77

Q73a Which risk and protective factors did you prioritize?

Probe: "Are there any others?", "Can you think of anymore?"

Specify 1

Refused 6

Don't Know 7

Q74 When was the last time your community went through this process?

Record Year

Refused 6666

Don't Know 7777

Q75 How many times has your community gone through this prioritization process?

Record Number

Refused 66

Don't Know 77

Q76 Did your community choose what programs to implement based on this prioritization?

Yes 1 Skip to Q77

No 2

No, but we plan to 3

Refused 6

Don't Know 7
Q76a Which programs did Community choose to implement based on this prioritization?
Probe: "Are there any others?", "Can you think of anymore?"
Specify 1

Q77 Did your community prioritize geographic areas to receive additional prevention services?
Yes 1
No 2  Skip to Q78
No, but we plan to 3  Skip to Q78
Refused 6  Skip to Q78
Don't Know 7  Skip to Q78

Q77a How did your community prioritize this?
Specify 1

Q78 Did Community prioritize specific groups within the community to receive additional prevention services?
Yes 1
No 2  Skip to Q79
No, but we plan to 3  Skip to Q79
Refused 6  Skip to Q79
Don't Know 7  Skip to Q79
Q78a  How did your community prioritize this?  Specify

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Refused  6
Don't Know  7

Q79  Did your community evaluate if programs affect risk and protective factor levels among the individuals participating in these programs?

Yes  1
No  2  Skip to Q81
No, but we plan to  3  Skip to Q81
Refused  6  Skip to Q81
Don't Know  7  Skip to Q81

Q79a  Have prevention programs changed as a result of this evaluation?

Yes  1
No  2
Refused  6
Don't Know  7

Q79b  Has your community made funding decisions based on program evaluations?

Yes  1
No  2
Refused  6
Don't Know  7

Q80  Question Deleted

Q81  Now please look at Card C.

Q81  The following is a list of why some communities choose to adopt the risk and protective focused prevention approach. Please tell me how much each of the following influenced Community's decision to adopt this prevention approach.
(First/Next ...)

Q81a  Because it was mandated by a state agency or agencies?

A Lot  1
Some  2
A Little  3
Not at All  4
Refused  6
Don't Know  7
Q81b Because it seemed to be a good way to coordinate prevention activities?

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q81c Because it is supported by research?

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q81d Because it seemed to be working in other communities

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q81e Because it was of interest to someone in your community?

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q81f The availability of grants or other money tied to this framework or approach

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q82 How compatible with your community’s norms and beliefs is the risk and protective focused prevention framework? Is it ... (read responses)

- Very compatible 1
- Somewhat compatible 2
- Somewhat incompatible 3
- Very incompatible 4
- Refused 6
- Don't Know 7

Q83 Question Deleted
Q84 Over the history of your adoption of this prevention approach, has there been anyone from your community who advocated for its adoption, and was passionate about the approach?

Yes 1
No 2
Self 3
Refused 4
Don't Know 7

Q85 Question Deleted
Q86 Question Deleted
Q87 Question Deleted

Q88 How important do you think community leaders were in influencing others in your community to adopt this prevention approach? Would you say...

Very important 1
Moderately important 2
Somewhat important 3
Not important at all 4
Refused 6
Don't Know 7

Q89 Please look at Card H.
In your estimation, what percent of the prevention service providers in Community have heard about the risk and protective prevention focused approach?

All 1
Most 2
Some 3
None 4
Refused 6
Don't Know 7

Q90 In your estimation, what percent of the prevention service providers in Community use this prevention approach to guide their planning of services and activities?

All 1
Most 2
Some 3
None 4
Refused 6
Don't Know 7

Q91 Now please look at Card G.
How often does Organization use the risk and protective focused approach to guide planning of prevention services and activities?

Almost always 1
Frequently 2
Sometimes 3
Never or almost never 4
Refused 6
Don't Know 7
Q92 How often does Organisation use other approaches in planning of prevention services and activities?

- Almost always 1
- Frequently 2
- Sometimes 3
- Never or almost never 4
- Refused 5
- Don’t Know 6

Q93 Communities adopt the risk and protective focused prevention approach in different ways. Often communities change the framework to suit their needs. Would you say your community has changed the framework:

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 5
- Don’t Know 6

Q93a In a sentence or two, can you tell me how your community has changed the framework?

Specify 1

Q94 Conversely, communities may change through their experiences using this prevention approach. Since you began using this approach, how much would you say your community has changed? Would you say...

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 5
- Don’t Know 6

Q94a In a sentence or two, can you tell me how your community has changed?

Specify 1

Refused 6
Don’t Know 7
Q95 Has adoption of the prevention approach by your community had any unanticipated consequences?
   Yes 1
   No 2_ Skip to Q96
   Refused 6 Skip to Q96
   Don’t Know 7 Skip to Q96

Q95a In a sentence or two could you describe them to me?
   Specify 1

Q96 Certain factors may exist in different communities that help them to use the risk and protective focused prevention approach. In the past year, what factors helped your community to use this approach? (Probe: Were there any other factors?)

Q96a First mention:
   Specify 1

Q96b Second mention:
   Specify 1

Q96c Third mention:
   Specify 1
Q97 What are the most important barriers Community has experienced in implementing this prevention framework? (Probe Were there any other barriers?)

Q97a First mention: Specify 1_.

Q97b Second mention: Specify 1_.

Q97c Third mention: Specify 1_.

Q98 How effective do you think your community’s prevention framework is? Would you say...

Q99 In your opinion, have the results of your community’s prevention framework been...

Q100 Question Deleted
Survey Form – Diffusion Project

OTHER PREVENTION PLAN BRANCH Q5: Q101 – Q119

Q101 Now please look at Card C. The following is a list of why some communities choose to adopt a prevention approach. Please tell me how much each of the following influenced Community’s decision to adopt its prevention approach.
(First/Next …)

Q101a Because it was mandated by a state agency or agencies?
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7

Q101b Because it seemed to be a good way to coordinate prevention activities
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7

Q101c Because it is supported by research?
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7

Q101d Because it seemed to be working in other communities
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7

Q101e Because it was of interest to someone in your community?
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7

Q101f The availability of grants or other money tied to this framework or approach
- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don’t Know 7
Q102  How compatible with your community's norms and beliefs is your community's prevention frame-
work? Is it …
   Very compatible 1
   Somewhat compatible 2
   Somewhat incompatible 3
   Very incompatible 4
   Refused 6
   Don't Know 7

Q103  How does this prevention approach compare to what your community was doing before? Is it…
   A lot better 1
   Somewhat better 2
   About the same 3
   Somewhat worse 4
   A lot worse 5
   Refused 6
   Don't Know 7

Q104  Over the history of your adoption of this prevention approach, has there been anyone from your com-
munity who advocated for its adoption, and was passionate about the approach?
   Yes 1
   No 2
   Self 5
   Refused 6
   Don't Know 7

Q105  Question Deleted
Q106  Question Deleted
Q107  Question Deleted

Q108  How important do you think community leaders were in influencing others in your community to
adopt this prevention approach? Would you say…
   Very important 1
   Moderately important 2
   Somewhat important 3
   Not important at all 4
   Refused 6
   Don't Know 7

Q109  Please look at Card II.
In your estimation, what percent of the prevention service providers in Community have heard about
this prevention approach?
   All 1
   Most 2
   Some 5
   None 6
   Refused 6
   Don't Know 7
Q110  In your estimation, what proportion of the prevention service providers in Community use this prevention approach to guide their planning of services and activities?

- All 1
- Most 2
- Some 3
- None 4
- Refused 6
- Don't Know 7

Q111  Please look at Card G.

How often does Organization use this approach to guide their prevention services and activities?

- Always or almost always 1
- Frequently 2
- Sometimes 3
- Never or almost never 4
- Refused 6
- Don't Know 7

Q112  How often does Organization use other approaches in planning of prevention services and activities?

- Always or almost always 1
- Frequently 2
- Sometimes 3
- Never or almost never 4
- Refused 6
- Don't Know 7

Q113  Please look at Card C...

Communities adopt prevention approaches in different ways. Often communities change the framework to suit their needs. Would you say your community has changed the framework:

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7

Q114  Conversely, communities may change through their experiences using a prevention approach. Since you began using this approach, how much would you say your community has changed?

- A Lot 1
- Some 2
- A Little 3
- Not at All 4
- Refused 6
- Don't Know 7
Q115 Has adoption of this prevention approach by your community had any unanticipated consequences?

Yes 1
No 2  Skip to Q116
Refused 6  Skip to Q116
Don't Know 7  Skip to Q116

Q115a In a sentence or two could you describe them to me?

Refused 6
Don't Know 7

Q116 Certain factors may exist in different communities that help them to use a prevention approach. In the past year, what factors helped your community to use this approach? (PROBE: Were there any other factors?)

Q116a First mention: Specify 1

None 2  Skip to Q117
Refused 6  Skip to Q117
Don't Know 7  Skip to Q117

Q116b Second mention: Specify 1

None 2  Skip to Q117
Refused 6  Skip to Q117
Don't Know 7  Skip to Q117

Q116c Third mention: Specify 1

No other factors 2  Skip to Q117
Refused 6  Skip to Q117
Don't Know 7  Skip to Q117

Q117 What are the most important barriers Community has experienced in implementing this prevention framework? (Probe: Were there any other barriers?)

Q117a First mention: Specify 1

None 2  Skip to Q118
Refused 6  Skip to Q118
Don't Know 7  Skip to Q118
Q117b Second mention: Specify 1

No other barriers 2 Skip to Q118
Refused 6 Skip to Q118
Don't Know 7 Skip to Q118

Q117c Third mention: Specify 1

No other barriers 2 Skip to Q118
Refused 6 Skip to Q118
Don't Know 7 Skip to Q118

Q118 How effective do you think your community’s prevention framework is? Would you say...

Very effective 1
Somewhat effective 2
Somewhat ineffective 3
Very ineffective 4
Refused 6
Don't Know 7

Q119 In your opinion, have the results of your community’s prevention framework been...

Very desirable 1
Somewhat desirable 2
Somewhat undesirable 5
Very undesirable 4
Refused 6
Don't Know 7
FRAMEWORK NON-SPECIFIC QS: Q120 – Q150a

Q120 Has your community written a mission statement for your prevention efforts?

Yes 1
No 2
Refused 6
Don’t Know 7

The next set of questions asks about your opinions of the organizations in your community in terms of how they manage issues related to prevention. Again, for each of the following, please tell me how much you agree or disagree. Please look at Card A.

Q121 There is a network of people concerned about prevention issues who stay in touch with each other.

Strongly Agree 1
Somewhat Agree 2
Somewhat Disagree 3
Strongly Disagree 4
Refused 6
Don’t Know 7

Q122 Community agencies and organizations rarely coordinate prevention activities.

Strongly Agree 1
Somewhat Agree 2
Somewhat Disagree 3
Strongly Disagree 4
Refused 6
Don’t Know 7

Q123 Community agencies and organizations work together to address problems with prevention strategies.

Strongly Agree 1
Somewhat Agree 2
Somewhat Disagree 3
Strongly Disagree 4
Refused 6
Don’t Know 7

Q124 Organizations in Community participate in joint meetings to address prevention issues.

Strongly Agree 1
Somewhat Agree 2
Somewhat Disagree 3
Strongly Disagree 4
Refused 6
Don’t Know 7

Q125 Organizations in Community share information with each other about prevention issues.

Strongly Agree 1
Somewhat Agree 2
Somewhat Disagree 3
Strongly Disagree 4
Refused 6
Q126 Organizations in *Community* coordinate prevention strategies.

- Strongly Agree: 1
- Somewhat Agree: 2
- Somewhat Disagree: 5
- Strongly Disagree: 4
- Refused: 6
- Don't Know: 7

Q127 Organizations in *Community* participate in joint *planning* and *decision making* about prevention issues.

- Strongly Agree: 1
- Somewhat Agree: 2
- Somewhat Disagree: 3
- Strongly Disagree: 4
- Refused: 6
- Don't Know: 7

Q128 Organizations in *Community* share money or personnel when addressing prevention issues.

- Strongly Agree: 1
- Somewhat Agree: 2
- Somewhat Disagree: 3
- Strongly Disagree: 4
- Refused: 6
- Don't Know: 7

Q129 In *Community*, each organization has a clearly defined role in carrying out the community's prevention plan.

- Strongly Agree: 1
- Somewhat Agree: 2
- Somewhat Disagree: 3
- Strongly Disagree: 4
- Refused: 6
- Don't Know: 7

Q130 Are there any coalitions in your community that promote prevention-related activities?

- Yes: 1
- No: 2 (Skip to Q132)
- Refused: 6 (Skip to Q132)
- Don't Know: 7 (Skip to Q132)
Q130a  How many coalitions?

Number of coalitions
Refused 66
Don't Know 77

Q131  Is there one primary coalition focusing on positive youth development and prevention activities in Community?

Yes 1
No 2  Skip to Q1.32
Refused 6  Skip to Q1.32
Don't Know 7  Skip to Q1.32

Q131a  Which coalition?

Primary Coalition
Specify 1

Refused 6
Don't Know 7

Q132  Has your community developed goals for the prevention of substance abuse?

Yes 1
No 2  Skip to Q1.33
Refused 6  Skip to Q1.33
Don't Know 7  Skip to Q1.33

Q132a  Which of the following best describes the goals your community has formulated for the prevention of substance abuse? Would you say...

Community goals have not been discussed 1
Community goals have been discussed but not agreed upon 2
Explicit community goals have been agreed upon 3
Refused 6
Don't Know 7

Q133  Did your community develop an action plan as part of planning to implement programs for substance abuse?

Yes 1  Skip to Q1.34
No 2  Skip to Q1.37
Plan to 3  Continue
Refused 6  Skip to Q1.37
Don't Know 7  Skip to Q1.37

Q133a  When do you plan to do this? Record YYYY for unknown year

Record Year
Refused 6666
Don't Know 7777

CHECK: WAS R ASKED Q133a?
* IF YES, Skip to Q1.37
* IF NO, Continue
Q134  When did your community develop this plan? Record 777 for unknown year.
Record Year:
Refused 666
Don't Know 777

Q135  How clearly articulated is your community's plan to achieve its goals for preventing substance abuse?
Would you say ...

No clear plan is in place 1         Skip to Q137
We have an informal written plan 2
We have a general written plan 3
We have an explicit written plan 4
Refused 6
Don't Know 7

Q136  Could you describe for me the steps your community used to develop its prevention plan?
(PROBE: What were the steps your community took to develop the prevention plan?)
Specify 1

Refused 6
Don't Know 7

Q137  Please look at Card C.
In your community, how much do individuals from diverse ethnic and cultural backgrounds participate in prevention planning and implementation? Do they participate...

A Lot 1
Some 2
A Little 3
Not at All 4
Refused 6
Don't Know 7

Q138  Certain barriers may exist in different communities that prevent them from implementing prevention.
related activities. Thinking over the past year, how much did each of the following factors pose barriers to prevention-related activities in your community.

The (first / next) one is...

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<th>Question</th>
<th>Description</th>
<th>Options</th>
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<tr>
<td>Q138a</td>
<td>Lack of coordination among participating groups</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
</tr>
<tr>
<td>Q138b</td>
<td>Lack of agreement on goals and methods</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
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<tr>
<td>Q138c</td>
<td>Lack of leadership</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
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<tr>
<td>Q138d</td>
<td>A loss of key players</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
</tr>
<tr>
<td>Q138e</td>
<td>Lack of financial resources</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
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<td>Q138f</td>
<td>Lack of human resources</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
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<tr>
<td>Q138g</td>
<td>Lack of support in the community</td>
<td>A Lot 1, Some 2, A Little 3, Not at All 4, Refused 6, Don't Know 7</td>
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Q139  Question Deleted
Q140  Question Deleted
Q141 There are different types of data on adolescent prevention needs that communities may collect. Did your community collect needs assessment data to prioritize prevention needs?

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Q142 Has Community conducted youth or student surveys to assess prevention needs?

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Q142a Which of the following were measured by the surveys?

(The first/next one is...) 

142aa ...substance use

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142ab ...delinquency

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142ac ...risk factors

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142ad ...protective factors or assets

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142ae ...health behavior

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</table>
Q142b  How useful were these data to the community’s prevention efforts? Would you say...

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<tr>
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</tr>
<tr>
<td>Useful</td>
<td>2</td>
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<tr>
<td>Somewhat useful</td>
<td>3</td>
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<td>Not useful</td>
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<td>Refused</td>
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Q142c  When was the last time these data were collected?

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Q142d  How frequently does the community collect this data?

Specify

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</table>

Q143  Has Community conducted focus groups to assess youth prevention needs?

Yes | 1 | Skip to Q 44
No  | 2 |
Refused | 6 | Skip to Q 44
Don’t Know | 7 | Skip to Q 44

Q143a  How useful were these data to the community’s prevention efforts? Would you say...

<p>| | |</p>
<table>
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<tr>
<td>Very useful</td>
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Q143b  When was the last time these data were collected?

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<tr>
<td>Don’t know Year or at all</td>
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Q143c  How frequently does the community collect these data?

Specify

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<tbody>
<tr>
<td>Refused</td>
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<tr>
<td>Don’t Know</td>
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</tbody>
</table>

Mark response: Check 5
Q144 Has Community collected archival social indicators to assess youth prevention needs, (such as juvenile alcohol arrest rates)?

Yes 1
No 2  Skip to Q146
Refused 6  Skip to Q146
Don’t Know 7  Skip to Q146

Mark response: Check 5

Q144a How useful were these data to the community’s prevention efforts? Would you say...

Very useful 7
Useful 2
Somewhat useful 3
Not useful 4
Refused 6
Don’t Know 7

Q144b When was the last time these data were collected?

Record year (YYYY)
Don’t know month 77
Refused 666
Don’t know Year or at all 777

Q145 Selecting the archival social indicators on which to collect data can be a difficult process for a community. How did your community decide which archival indicators to collect data on?

Specify ___

________________________________________

________________________________________

________________________________________

________________________________________

Refused 6
Don’t Know 7

Q146 Question Deleted

Do Check 5

Page 345
Q147a  There are many different ways a community can look at or analyze the data it collects, based on this data, did your community…
Q147a  …Write a report summarizing the problem
Yes 1
No 2
Refused 6
Don’t Know 7

Q147b  …Select new prevention activities to respond to the community’s needs?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147c  …Analyze the data by geographic area or subgroup within the community?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147d  …Prioritize geographic areas to receive additional services?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147e  …Prioritize groups within the community to receive additional services?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147f  …Monitor changes in levels of risk and protection over time?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147g  …Compare your community’s data to regional, state, or national data?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147h  …Monitor changes in assets over time?
Yes 1
No 2
Refused 6
Don’t Know 7

Q147i  …Monitor changes in adolescent drug use over time?
Yes 1
No 2
Refused 6
Don’t Know 7
Q148 Thinking back over the past year, has the level of prevention activities changed in your community?
- Yes 1
- No 2 Skip to Q149
- Refused 6 Skip to Q149
- Don't Know 7 Skip to Q149

Q148a How has it changed? Would you say it has...
- Doubled or more than doubled 1
- Increased somewhat 2
- Decreased somewhat 3
- Been cut in half or more than half 4
- Refused 6
- Don't Know 7

Q148b What brought about this change?
- Specify 1

Q149 Compared to the previous year, has the level of prevention-related funding changed in your community?
- Yes 1
- No 2 Skip to Q150
- Refused 6 Skip to Q150
- Don't Know 7 Skip to Q150

Q149a How has it changed? Would you say it has...
- Doubled or more than doubled 1
- Increased somewhat 2
- Decreased somewhat 3
- Been cut in half or more than half 4
- Refused 6
- Don't Know 7

Q150 Now I’d like you to think back over the past 2 years. During this period, have there been any major events or changes that significantly affected prevention activities in your community?
- Yes 1
- No 2
- Refused 6
- Don't Know 7
Q150a Could you describe them? Specify 1

 Refused 6
 Don’t Know 7

Finally, I have just a few background questions.

Q151 What is your current age? (Read ranges)

 19 - 30 years 1
 31 - 40 years 2
 41 - 50 years 3
 51 - 60 years 4
 Refused 66
 Don’t Know 77

Q152 What is the highest level of education you have obtained? (Read categories if necessary)

 Completed Secondary School 1
 Not used 2
 Not used 3
 Trade School 4
 Bachelor’s Degree 5
 Master’s Degree 6
 Not used 7
 PH.D. 8
 Refused 66
 Don’t Know 77

Q153 Record Gender
**Q154** Thinking about both community leaders and other community members besides yourself, has someone been actively involved in prevention efforts in your community?

Specify

- Nobody else
- Refused
- Don’t Know

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<th>Option</th>
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**Q154a** What is this person’s (name/title)? Probe for correct spelling

First name

Last Name

Title or Position in community

- Refused
- Don’t Know

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**Q154b** What organization does this person work for?

Organisation

- Refused
- Don’t Know

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**Q154c** What is this person’s telephone number?

Phone Number

- Refused
- Don’t Know

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**Q155** Would you say anyone else in your community is knowledgeable about preventing adolescent problems?

Yes

Specify

- Nobody else
- Refused
- Don’t Know

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**Q155a** What is this person’s (name/title)?

First name

Last Name

Title or Position in community

- Refused
- Don’t Know

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**Q155b** What organization does this person work for?

Organisation

- Refused
- Don’t Know

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Q155c  What is this person’s telephone number?

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LAST RESPONDENT Q: Q156

Q156  That’s my last question. I want to thank you for taking the time to talk with me today. Do you have any questions or comments about the survey that you would like me to note?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

| Refused | 6 |
| Don’t Know | 7 |

Enter end time: [ ]
INTERVIEWER ASSESSMENT QUESTIONS: Q157 – Q159

Q157 Please give your estimation of how well the respondent understood the questions:
1. Easily understood questions
2. Understood questions with some explanation
3. Understood questions with much explanation
4. Did not seem to understand many questions

Q158 Please give your rating of how cooperative the respondent was:
1. Friendly, cooperative
2. Generally cooperative
3. Generally uncooperative
4. Uncooperative and hostile

Q159 Please give your estimation of how truthfully the respondent answered the questions:
1. Very truthful
2. Somewhat truthful
3. Not very truthful
4. Not at all truthful
APPENDIX 4: SDGR BRANCHING GUIDE

The SDRG uses a computer-based system which determines prompts and questions based on responses to earlier questions. The underlying logic of the survey was tabulated in this branching guide to enable interviewers to manually determine which questions to ask based on responses to earlier questions.

[Diagram showing branching logic with questions Q52 to Q144 and corresponding options for branching.]
APPENDIX 5: LETTER OF INVITATION

- Initial contact with possible respondents was made by letter.

LETTER OF INVITATION TO PARTICIPATE
STUDY INFORMATION STATEMENT
WHAT ARE YOUR RIGHTS AS A PARTICIPANT
LETTER OF INVITATION TO PARTICIPATE

Dear,

Re: A project to measure community capacity. Can you help?

I write to seek your participation in a study that we are running in your community. The study will assess some ways to measure community capacity in the prevention of adolescent social and behavioural problems. The study is being conducted by the Centre for Adolescent Health with the University of Melbourne’s Department of Paediatrics.

In understanding the different approaches that communities use to help reduce the risk factors that undermine healthy youth development, we hope to contribute the body of knowledge that will assist communities to move forward in their prevention work.

The study comprises two telephone questionnaires, one that uses mainly multiple-choice answers and takes approximately 50 minutes to complete, and the other uses mainly open-ended questions that will take approximately 20 minutes to complete.

I will call you shortly to seek your involvement, and hopefully set the interview times with you. If you are not able be involved in the study I wonder if you would advise me at the time of my call, as to whom I may talk to in your organisation?

The information that you would provide would be pooled with other responses to give an overall impression of your community. Strict confidentiality guidelines apply and your specific responses will remain confidential to the researchers.

At the completion of the project a summary document will be sent to you on request and each community will have the opportunity to hear about the study.

I have enclosed a question response card, an information statement and a notice of your rights as a participant to the study.

If you have any questions, please do not hesitate to contact me at (03) 9345-6681.

I look forward to the opportunity of your participation in this project.

Yours sincerely,

Stephanie Jones

jonesst@cryptic.rch.unimelb.edu.au
INFORMATION STATEMENT
Study to measure community capacity
What is the project about?

- primarily to compare two different ways of measuring communities’ capacity in terms of prevention of adolescent social and behavioural problems
- further, to gain a better understanding of the different approaches that communities use to address the risk factors that undermine adolescent development
- finally, to make the knowledge gained during the course of the project available to Australian communities and community based prevention initiatives.

The interviews are strictly confidential:

- names are not stored with your answers, codes are used
- data will be stored under lock and key
- only the research team has access to the data
- individual level data is not used in analysis, only aggregated data for a whole community.

There are two questionnaires:

1. Questionnaire 1:
   - most of the questions are open ended
   - it will take approximately 50 minutes to complete
   - the questions are about your background, general questions about your community and specific questions about your community’s efforts to reduce the risks that undermine healthy youth development.

2. Questionnaire 2:
   - the interview should last approximately 25 minutes
   - the questions are open-ended
   - permission will be sought to tape record your responses to this questionnaire. This is done to ensure the accuracy of written notes. The responses are assigned numeric values and it is important that we accurately record actual language used for this purpose.

General:

- any questions that you do not wish to comment on can be skipped
- please note that these questionnaires are not tests; there are no right or wrong answers, just your answers.
WHAT ARE YOUR RIGHTS AS A PARTICIPANT?
Study to measure community capacity

Your rights as a participant of this study are to:

1. choose whether or not to take part
2. withdraw from the study at any time
3. ask for any unprocessed data provided by you to be withdrawn
4. have the study fully explained.

You should feel free to ask the researcher any questions about the study.

Other information you should know about being part of the study:

1. Your answers to the questions on this study will be kept private. This is subject to legal requirements.
2. Any information from this study will not reveal your identity.
3. You should have been told what you need to do for this study, and how long it will take.
4. If you do not wish to take part in this study, this will not affect your relationship with the Centre for Adolescent Health.
5. The University of Melbourne’s Ethics Committee has approved this research project.

The person to contact first if you require more information or have any concerns related to the study is:

Stephanie Jones
Principal Investigator

Phone: (03) 9342-7507

If you have any concerns about the study, and would like an independent opinion, please contact the following during business hours:

Executive Officer

Human Research Ethics

University of Melbourne

Parkville, Victoria, 3052

Tel: (03) 8344-7507

Facsimile: (03) 9347-6739
APPENDIX 6:
SDRG RESPONSE CARD

This card was sent to respondents and referred to during the interview.
APPENDIX 7: FEED-BACK LETTER

Centre for Adolescent Health

2, Gatehouse Street,
Parkville,
Victoria, 3052.
14th November 2003

Dear

Re: Completion of study to measure community capacity for youth substance misuse prevention in (Community C)

Last year I contacted you to seek your involvement in a study on community readiness for adolescent substance use prevention. Two surveys, one a semi-structured set of questions, and the other a set of open-ended questions, were used to interview 15 people in the Community C, on adolescent substance use and prevention. The people interviewed came from a range of professional and organisational backgrounds such as health, education, welfare, media, justice and government. That study has now been completed.

I am writing to give you some information from that study, which hopefully will be useful to your prevention or community capacity building work; and to ask your opinion on how I should report this information back to the community as a whole.

Background information

The study was conducted for three reasons:

1. I was interested in how communities could be more effective in addressing issues of concern in their community. This evolved over many years working in the community, but particularly at the time when heroin use was escalating and becoming a major concern for many communities. I made this interest the subject of my PhD.
2. The ‘Community for Youth’ initiative, being run in Community C was interested to know more about community readiness, to assist in its prevention work on a number of adolescent concerns.
3. The Centre for Adolescent Health in Melbourne that has been working with ‘Community for Youth’ was interested in finding out whether the 2 survey instruments used would be useful measures of ‘community readiness’. (This term refers to the range of community and organisational characteristics that are needed in order to establish well-coordinated prevention programs).

The two survey instruments used were developed and tested in the USA for use in communities where there were drug concerns. One of the surveys has since been used to address a number of community health, environmental and social concerns; such as heart disease, diet, water quality, litter, homelessness and violence to give some examples. It has been used in Europe, Africa, USA and now Australia.

These surveys were used, as there were none similar in Australia at the time (or that I could find).

Fifteen people were interviewed. Ten of those interviewed answered both surveys.
Those interviewed were suggested by others in the community for their local knowledge on youth issues and prevention activity. The surveys asked a number of questions that focused on characteristics of the community, such as resources for prevention, community attitudes, adolescent substance use, leadership and organisational function.

The individual responses have been collated into a grouped result to give a readiness profile for the community for 2002/2003. Those interviewed and their individual responses are not identified.

**Collation of the data - how was this done?**

The interviews with open-ended questions were checked for responses that were consistent with statements that sat along a continuum of readiness. Stages of readiness were assessed for:

1. ‘Community Knowledge about the Issue’
2. ‘Community Efforts’ (programs and policies etc.)
3. ‘Community Knowledge about Prevention Efforts’
4. ‘Community Climate’ (supportive)
5. ‘Leadership’ (aware and active)
6. ‘Resources’ (time, money, space etc.)

The readiness scores from the 10 interviews were combined to give a total score to each of the above community characteristics.

The semi-structured interviews were analysed using a statistical method, to provide a community response for a number of readiness characteristics, very similar to the above characteristics. The two surveys have been compared for their responses.

**What we found out about community readiness in your community.**

There is clear recognition by many that there is a local problem, and that something should be done about it. There are identifiable leaders, and there are groups and programs that focus on prevention of youth substance misuse, but at the moment efforts are not coordinated or detailed. There is a lot of discussion and some planning but little action yet to address the problem in the community.

The interviews reflected that in some domains the readiness level was not as progressed as others, which may have implications for the overall effectiveness of prevention efforts.

The readiness assessment showed that the community members were not as abreast of the issues, or very aware of the work that was being done to address adolescent substance use, as those that had professional roles in relation to adolescents, substance use or prevention. Community members, according to those interviewed, consider ‘hard’/illicit drugs a bigger concern than alcohol or tobacco use. Alcohol, tobacco and to some extent marijuana use, was seen as part of the risk-taking that occurs as a normal part of growing up. Parents were described as unaware, or irresponsible in their handling of drug issues. Fear existed in the community about drug use, mostly reflected in the concern about the associated anti-social behaviour.

The community climate suggests that it is motivated by self interest particularly in regard to the anti-social behaviour and violence associated with drug use rather than a deep concern for its younger members. It was described as a community more focussed on its older citizens, who form a larger precentage of the population.
This was reflected in the fewer resources committed to young people such as volunteers, fundraising and community action; and the lack of understanding of issues related to young people.

There was a view that agencies, although committed in principle to addressing adolescent substance use, were limited in their capacity to do so. Worker skills and capacity were commonly noted; such as lack of skills in drug and alcohol work; burn out of existing workers as a result of limited resources. There are no drug and alcohol agencies based in the area. Outreach workers provide a service which was considered a good thing but the workers were less aware of local culture and knowledge. Tertiary educated young people often did not return to their community, further reducing the pool of workers with local knowledge.

A view was commonly expressed that agencies were not good at collaborating or communicating their efforts. Church communities were seen as doing a lot for young people, but detached from the rest of the community.

Government approaches were regarded as not conducive to good prevention efforts, as policy and funding timeframes were often short term. Funding for social health was often piecemeal and ad hoc. Information, such as local and state-wide data was not readily available, nor necessarily shared with community groups, such as police data.

Leaders were described as critical to effective community action but were often seen as reactive rather than instigators of change; people who did not see adolescent substance use as a priority in their community. There was no one ‘champion’ for youth substance misuse prevention but the police were noted for their genuine concern and efforts, and local government for contributing resources. Overall there was a sense that leaders did not know what to do, although their “hearts were in the right place”.

Media sources were very knowledgeable on youth issues but many referred to the sensationalising of youth issues by the media that was often unhelpful and unproductive. Community organisations made poor use of the media to promote or publicise the good work that they were undertaking.

The geography of Community C raised comment in the interviews. The area is a large one, with a sparse population, lying within an hour or two from the metropolis of Melbourne. Those interviewed suggested that its proximity to Melbourne limited the resource opportunities compared with rural areas further from Melbourne, yet the Community C was seen as a rural place. Transport as in all four communities included in the study, was considered to be poor and contributed to many of the youth problems (e.g., young people unable to attend recreation or social activities as no transport, young people unable to get home easily at night after evening functions, young people unable to get to work or job interviews as a result of poor or non-existent transport).

**How can this information be used to further prevention work?**

The model that I have used to measure community readiness uses a scoring system that can be used to monitor change and/or progress towards effective prevention within a community, as well as build community capacity for prevention and intervention.

For example: ‘Community Efforts’ and ‘Leadership’ scored reasonably well in Community C but ‘Community Climate (support)’ and ‘Community Knowledge about the Efforts’ scored less well. Through building community awareness and
knowledge about the issue of adolescent drug use, as well as providing information on programs and services in Community C, there is the opportunity to bring the community along with you, and thus build the overall effectiveness of the prevention work that is being undertaken in your community.

**What next?**

I have attempted in this letter to you to give you an outline of the results of this study. There is a lot more that can be shared, that would hopefully contribute to the prevention work that Community C is already doing.

I would appreciate your thoughts on how this information might be delivered to your community, if you thought this appropriate, whether through a particular coalition, through an open forum, or perhaps through coverage in the local newspaper.

I would like to thank you once again for your contribution to this study. I believe that in time it will be seen as a useful contribution to understanding community readiness, and in doing so, support communities to move forward in their prevention work.

Yours sincerely

Stephanie Jones
THANKS TO:

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Barry Anderson</td>
<td>Communities That Care/ Joseph Rowntree Foundation, UK</td>
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<tr>
<td>Michael Arthur</td>
<td>Social Development Research Group, University Washington, USA</td>
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<tr>
<td>Nadine Bertalli</td>
<td>Centre for Adolescent Health, Melbourne, Australia</td>
</tr>
<tr>
<td>Caryn Blitz</td>
<td>Social Development Research Group, University Washington, USA</td>
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<tr>
<td>Lyndal Bond</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<tr>
<td>Glenn Bowes</td>
<td>Department of Paediatrics, University of Melbourne</td>
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<td>Harry Bryce</td>
<td>Australian College of Health Service Executives</td>
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<tr>
<td>Martha Burnside</td>
<td>Tri-Ethnic Center for Prevention Research, University Colorado, USA</td>
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<td>Linda Byrnes</td>
<td>University Melbourne</td>
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<td>Colleen Carlon</td>
<td>Edith Cowan University, Western Australia</td>
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<td>Richard Catalano</td>
<td>Social Development Research Group, University Washington, USA</td>
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<td>Paul Deany</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<td>Elisabeth Douglas</td>
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<td>Sarah Drew</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<tr>
<td>Ruth Edwards</td>
<td>Tri-Ethnic Center for Prevention Research, University of Colorado, USA</td>
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<tr>
<td>Isaac Epstein</td>
<td>School of Social Work, City University of New York</td>
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<tr>
<td>David Evans</td>
<td>University Melbourne</td>
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<tr>
<td>Gina Fiske</td>
<td>Department of Victorian Communities, Melbourne</td>
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<tr>
<td>Robert Foley</td>
<td>Tri-Ethnic Center for Prevention Research, University of Colorado, USA</td>
</tr>
<tr>
<td>Kimberley Fornero</td>
<td>Division of Community Health and Prevention/Minnesota Institute of Public Health, USA</td>
</tr>
<tr>
<td>Alan France</td>
<td>Centre for the Study of Childhood and Youth, University of Sheffield, UK</td>
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<tr>
<td>Heather Gilbertson</td>
<td>Royal Children's Hospital, Melbourne</td>
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<td>Sara Glover</td>
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<td>John Hargreaves</td>
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<td>Sheryl Hemphill</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<td>Rosalie Holian</td>
<td>School of Management, R.M.I.T., Melbourne</td>
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<td>Peter Horsley</td>
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<td>Pamela Jumper-Thurman</td>
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<td>Helen Keleher</td>
<td>Deakin University, Melbourne</td>
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<td>Mary-Ann La Fazia</td>
<td>Department of Social and Health Services, Washington, USA</td>
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<td>Primrose Letcher</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<td>Virginia Lewis</td>
<td>Australian Institute of Primary Care, La Trobe University, Melbourne</td>
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<tr>
<td>Hamish Malloy</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<tr>
<td>Kami McClure</td>
<td>Institute for Prevention Policy Research, University of Southern California, USA</td>
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<tr>
<td>Martha Morrow</td>
<td>Key Centre for Women's Health, University Melbourne</td>
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<tr>
<td>Catherine Nolan</td>
<td>Dept Education and Early Childhood Development</td>
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<td>Terry Nolan</td>
<td>School of Population Health, University Melbourne</td>
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<td>Craig Olsson</td>
<td>Centre for Adolescent Health, Melbourne</td>
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<td>Barbara Plested</td>
<td>Tri-Ethnic Centre for Prevention Research, University of Colorado, USA</td>
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<td>Steven Pokorny</td>
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<td>Cities Research Centre, University of the West of England, UK</td>
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<td>Celia Robbins</td>
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<td>Murray Stewart</td>
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Author/s: Jones, Stephanie Louise

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