An Overview of Community-Based Prevention

Bonnie Benard
Research Specialist
Prevention Resource Center

Introduction

The clarion call for prevention at the community level has been sounding for many years, in many fields, and by many researchers and practitioners. Perhaps the quotation "prevention is an approach whose time has come," is apt for community-level prevention as well. The time seems right—certainly a sense of urgency appears to be growing in the human service and public policy area—for advocating and facilitating the development of community prevention programs focused on alcohol and other drug abuse and use—as well as the interrelated social problems of school failure/dropping out, teen pregnancy, child sexual abuse, and delinquency/crime. As prevention advocates, policymakers, program planners, and practitioners, we need a shared basic understanding of community prevention: what it is, who is involved, why we should do it, where it came from practically and theoretically, and how to do it.

The purpose of this paper is to help establish this framework by providing a brief overview of community prevention in terms of definition, rationale, historical antecedents and theory bases, program models, and the types of programs now in the field.

Community-Wide Prevention Defined

The topic of this section of the conference is listed as "community-based" prevention. But the term is not only inadequate for describing the community prevention approach—it is also misleading. It suggests that a single prevention activity emanating from a single community group or agency is community prevention. Instead, the term "community-wide" prevention better describes the phenomenon under discussion. Community-wide prevention refers to the systematic application of prevention strategies throughout the community in a sustained, highly integrated approach that simultaneously targets and involves diverse social systems such as families, schools, workplaces, media, governmental institutions, and community organizations. Inherent in this definition are three critical attributes that distinguish community-wide efforts from other prevention efforts.

First, community-wide prevention is *comprehensive*; that is, it targets *multiple systems* (families, schools, workplaces, media, governmental institutions,

Benard, B. (1988). An overview of community-based prevention. *OSAP prevention monograph 3. Prevention research findings: 1988.* DHHS Pub. No. (ADM) 89-1615. Rockville, MD: Department of Health and Human Services, Office for Substance Abuse Prevention, Alcohol, Drug Abuse, and Mental Health Administration, 126-147. In the public domain.

and community organizations) and uses *multiple strategies*. The following five strategies have been identified as the foundation for effective efforts against alcohol and other drug abuse and use—as well as other interrelated social problems:

(1) **Involving and training impactors.** Impactors include significant individuals and role models in the community. Their involvement strengthens the total prevention support system within a community.

(2) **Providing information.** To achieve the greatest impact, information and educational materials must be appropriate to each audience, geared to specific needs, and used in conjunction with all the other strategies.

(3) **Developing life skills.** Life skills promote healthy personal functioning and include, but are not limited to, the following intra- and interpersonal skills: self-awareness, communication techniques, decisionmaking/problem solving, friendship, stress management, assertiveness, resistance/refusal, consumer awareness, and low-risk choicemaking.

(4) **Creating alternatives.** By providing positive and constructive means for addressing feelings of boredom, frustration, pain, and powerlessness; for rite-of-passage marking; and for having fun, health-risk behaviors such as alcohol and other drug abuse and use can be diminished.

(5) **Influencing policy.** Family, school, governmental, community, and media policies—both formal (such as laws and regulations) and informal (such as values and norms)—must provide clear and consistent messages regarding alcohol and other drug use (or sexuality, school achievement, and so forth), and promote social and economic changes that create more opportunities for education, employment, recreation, and self-development.

The matrix in figure 1 is a simple but useful tool in conceptualizing the comprehensiveness of community-wide effort.

An ideal community-wide effort would have each of the squares filled in with the appropriate prevention activity.

Systems / Strategies	Families	Schools	Work places	Media	Government	Community
Involving & Training Impactors						
Providing Information						
Developing Life Skills						
Creating Alternatives						
Influencing Policy						

Figure 1.

A second attribute of community-wide prevention is an emphasis on the *program development process*. While the literature abounds with various planning models, the common, generic ingredients include identification of community leaders and organizational structure; assessment of needs (problem identification); the development of realistic, multiple, and measurable long-term goals and shorter-term objectives; the coordinated implementation of activities and tasks; and program management, evaluation, and replanning.

The third distinct attribute of community-wide prevention is that it is *collaborative*. While implied in the above two attributes, the active participation of representatives of all involved systems—parents, school personnel, youth, local businesses, religious institutions, media, local government, human services, law enforcement, and other community organizations—in the actual program planning and implementation process is essential in carrying out a community-wide prevention effort. The development of a collaborative community base ensures the availability of community resources to support the program as well as community ownership of the program. According to Pentz (1986), previous research suggests that these latter two factors, along with the "sequential use of multiple channels for community program delivery" (i.e., using multiple systems), "determine successful entry, implementation, and institutionalization of a community-based prevention program" (Pentz 1986).

Rationale

Given the above definition and attributes of community-wide prevention, we can see that it does not provide a "quick fix" or "silver bullet" to doing prevention, but, rather, demands a long-term commitment and a high degree of involvement and participation on the part of many people. The practical and logical question then follows, why bother? Why focus on community-wide approaches to alcohol and other drug abuse prevention? According to Cheryl Perry (1986), while "the answers may be obvious to prevention researchers and practitioners, it must be noted that the community prevention approach only recently has emerged and only now is being studied to determine its efficacy."

The rationale for *community-wide* prevention of alcohol and other drug abuse problems (beyond the rationale for prevention itself) is basically twofold. First, from over a decade of prevention research—both correlational and programmatic—the most important conclusion we can make is that the causes of drug abuse and other interrelated social problems are multiple—involving personality, environmental, and behavioral variables—and that prevention efforts focused on a single system and a single strategy will probably fail (Jessor and Jessor 1977; Perry and Jessor 1985). We have witnessed this failure in our almost unilateral, single-strategy/single-system approach to adolescent drug use prevention—providing information in the school classroom. Some researchers, such as Lloyd Johnston (1986), who conducts the National Institute

on Drug Abuse's annual high school-senior survey, claim the decline in prevalence of marijuana and other drug use by adolescents over the last few years is attributable, in part, to these school drug education programs. However, the continued, stabilized, high level of adolescent alcohol problems (especially in the binge drinking category), testifies to the ineffectiveness of these programs in preventing either the onset of alcohol use or problems. Alcohol is the drug that one out of every three Americans says affects the family adversely, according to Gallup polls. In addition, evaluations of numerous alcohol and other drug prevention programs and even of popular alcohol prevention curricula have found no changes in alcohol and other drug use behavior (DiCicco et al. 1984; Mauss et al. 1988; Hopkins et al. 1988; Goodstadt 1986; Hansen 1988).

While it is beyond the scope of this paper to consider the limitations and the possibilities of school-based prevention, a concurrence has existed in the literature for some time that to be effective, school-based prevention should be part of a larger community-wide effort (Hopkins et al. 1988; Pentz 1986; Pentz et al. 1986; Perry 1986; Benard et al. 1987). The recent disappointing evaluation, by Hopkins et al. (1988), of a popular alcohol education curriculum states, "Surely any school-based program hoping to have any appreciable impact will have to be embedded in a *comprehensive, community-wide* prevention effort directed at all the major social influences and institutions that shape our youth."

Other prevention experts claim that as long as alcohol use is encouraged and glamorized in our culture (especially by the media) as the only way to have fun, relax, be cool, or be grownup, adolescent drinking will continue to be a problem. Perry (1986) states, "Drug abuse is social behavior and such behavior is embedded in the larger framework of community norms and social support systems that regulate the occurrence of these behaviors." Similarly, Griffin (1986) cautions: "Current social norms about chemical use are a reflection of the community. The community is a fertile, powerful, and necessary environment for changing norms. If chemical use problems of young people are to be reduced, community-based prevention programs also must challenge adults to reflect on their patterns of chemical use.... Prevention cannot be a task assigned by the community to the school and focused only on youth. It is a shared responsibility."

Ultimately, if we actually hope to impact youthful alcohol and other drug use behavior, we must encourage low-risk choicemaking around alcohol/drugs in all the social systems in our environment—families, schools, workplaces, media, and community.

A second rationale for a community-wide prevention orientation is not alcohol and other drug-specific but, rather, addresses some underlying variables (like societal alienation, loneliness, or lack of purpose) that correlate with various problem behaviors throughout the lifespan. According to this rationale, if we are to prevent the occurrence of problem behaviors like alcohol and other drug

use, school failure/dropping out, teen pregnancy, child sexual abuse, delinquency/crime, and so forth, we must promote and build physically and psychologically healthy communities that *empower* people to have control over their lives.

The social, economic, and technological changes since the late 1940's have played a significant role in our sense of geographical and psychological community. Communities have become more fragmented, resulting in breaks in the naturally occurring *linkages* among the social systems; linkages that provide support and nurturance to individuals and create opportunities for them to participate meaningfully in their community. Protective factor research has studied individuals who succeed in spite of adverse environmental conditions; often, a major contributing factor has been the presence of environmental support from even one social system—one family member, one teacher, one school, and so forth, that facilitated a bonding with that system (Werner and Smith 1982; Rutter 1984).

According to this rationale, community-wide prevention efforts must focus on building collaborative linkages among systems and within systems in our community. The following represent some of the intersystem linkages possible in community-wide efforts:

Family-School
Family-Workplace
Family-Community
Family-Government
Community-University
Community-Government
Community-Social Services
School-Workplace
School-University
School-Social Services
School-Government
School-Community
Workplace-University

According to Rutter (1984), preventive interventions need to address this issue of intersystem linkages. Since human development is, he says, a "question of linkages that happen within you as a person and also in the environment in which you live, ...our hope lies in doing something to alter these linkages, to see that kids who start in a bad environment do not go on having bad environments and develop a sense of impotency." Similarly, Werner and Smith (1982) see that the key to effective prevention efforts is to reinforce within every arena the intrasystem linkages, the "natural social bonds" (between young and old, between siblings, between friends, and so forth), "that give meaning to one's life and a reason for commitment and caring." To neglect these bonds, according to the authors, is to "risk the survival of a culture."

History / Theory Bases

Having defined and established a rationale for community-wide prevention, it seems appropriate to give a simplified summary of some of the historical and theoretical antecedents to this approach.

Historically, for the most part, two fields have focused on the community as an *arena* for preventive interventions: public/community health and mental/community mental health. The former has had a lengthy tradition in community planning agencies, beginning in the 1920's with local health and welfare councils, and progressing through comprehensive health planning agencies in the 1960's and the federally mandated Health Systems Agencies (HSA) in the 1970's (Sofaer 1988); and internationally, with community development programs in nonindustrialized countries during the 1960's and early 1970's. However, according to Sofaer, with the demise of the HSAs last year, "Health planning is now largely limited to individual institutions [businesses] that plan programs for specific health problems and target groups, but these individual institutions are not accountable for their impact on overall community health."

In the field of mental health, interventions in the community also have a tradition in the United States dating to the community psychopathic hospital of the 1890's and developing into the community clinic movement and the citizens' mental hygiene movement of the early 20th century. After World War II, efforts of large State mental health institutions to effectively treat patients failed. This fact, combined with the development of tranquilizing drugs, the therapeutic community, and geographic decentralization of State mental hospitals, set the stage for the emergence in the 1960's of the community mental health center movement. In 1963, President Kennedy proposed a national mental health program to Congress that included the establishment of comprehensive community mental health centers that would provide service to the *total* community, use rational planning in management, and identify stress-inducing aspects in the community (Bloom 1984).

While the recent history of the community mental health movement is beyond the scope of our discussion, it is sufficient to note that for numerous and often complex political reasons, according to Bloom (1984), "The accomplishments of the nearly two decades of the community mental health center movement have fallen far short of the original hopes of most of its vocal proponents...." In the three areas of most concern to the concept of community-wide prevention, "...development of a concern for the total population, development of preventive services, and reduction of community stresses and enhancement of community strengths...," the "...community mental health center program has done most poorly." Today, most community mental health centers provide mainly clinical services. According to a 1983 survey of these centers, "Services reporting the greatest decreases are consultation/education, prevention, and evaluation" (Larsen 1987).

As you can see, both community health and community mental health *settings*, for the most part, have failed to provide "homes" for community-wide prevention efforts. What we see happening in the 1980's, with the withdrawal of Federal impetus and funding for community-wide health and mental health

prevention, is the extension of practice—especially as consultation—in both fields, into other settings: business, industry, human service organizations, and community organizations.

However, while these two areas may have failed to serve as the structures for the practice of community prevention, the two disciplines of public/community health and psychology have furnished research support and theoretical bases validating this approach.

We find a rich, in-depth research and theoretical heritage in the public health subspecialty of community health education. According to Steckler (1985), theory and practice in this field have basically two roots: the community studies literature and the planned change literature. He identifies the former category as including the Lynds' *Middletown* studies of the 1920's and 1930's, Vidich and Bensman's *Small Town in Mass Society*; Warner's *Democracy in Jonesville*; Dollard's *Caste and Class in a Southern Town*; Warren's *Studying Your Community*; Dahl's *Who Governs?*; Hawley and Wirt's *The Search for Community Power*; and Hunter's *Community Power Structure*. He gives as examples of planned change Paul's *Health, Culture, and Community*; Spicer's *Human Problems in Technological Change*; Bennis, Benne, and Chin's *The Planning of Change*; Etzioni's *Social Change*; Goodenough's *Cooperation in Change*; Lippitt's *The Dynamics of Planned Change*; Rothman's *Planning and Organizing for Social Change*; Alinsky's *Rules for Radicals*; and Biddle's *The Community Development Process*.

In the 1970's, the community health literature, reflecting the move away from intervention largely based on the community, began to focus on program planning and evaluation "drawn more from general systems theory, research methodology, health planning, epidemiology, and to a lesser extent, planned change for its conceptual and theoretical foundations" (Steckler 1985).

Looking now at the research and theoretical bases for community-wide prevention in the field of psychology, the Swampscott Conference on the Education of Psychologists for Community Mental Health of 1965 is hailed as the event marking the birth of the subfield of community psychology. "Particularly emphasized as primary concerns for community psychology were prevention and the need to examine social institutions, systems, and settings as determinants of the emotional well-being of individuals" (Felner 1983). Current prevention concepts such as stressful life events and transitions, empowerment, mutual help, social support, community ecology, working in natural settings, and collaboration have emanated from this field.

However, the concept of prevention "has now moved far from the Swampscott Conference and an almost exclusive home in community psychology" (Jason et al. 1983) and is now being incorporated into the practices of developmental, organizational, social, and health psychologists (Albino 1983). Similar to the

trend in community health, these subfields of psychology are being extended into nonclinical settings as well—into business, industry, human service organizations, and the nonprofit community organization sector. With this extension, we see, as in community health, a concomitant emphasis in the literature on program planning and evaluation.

Since the late 1960's and 1970's, the two fields have borrowed back and forth theoretically, with the public health concept of prevention and risk factors being incorporated into psychology, and with numerous psychological concepts and theories—especially from behavioral psychology (such as social learning, social inoculation, contingency management, and so forth)—being infused into public health programming (Elder et al. 1985).

Furthermore, incorporated into this cross fertilization of public health and psychology have been theoretical contributions from other fields, especially from communications research: Rogers' diffusion of innovations theory (1983), McGuire's (1968) communication-persuasion theory, Festinger's (1957) cognitive dissonance theory, Kotler's (1980) social marketing approach, and numerous other concepts and theories of mass communication (Flay 1986).

The end result in the 1980's has been the development of several integrative models for reducing health-compromising behaviors and for promoting health-enhancing behaviors. At the community-wide level, two research-based approaches for alcohol and other drug abuse prevention offer particular promise as models for future prevention programming.

Models

The University of Southern California's (USC) Comprehensive Drug Abuse Program. The USC model, developed by the Institute for Health Promotion and Disease Prevention Research, combines two approaches: a state-of-the-art resistance skills approach to prevention of alcohol and other drug use at the critical middle school transition for youth; and a community organization planning process to involve all systems in the community—family, media, workplaces, local government, and other resources. This model is based on several large-scale, community-wide heart disease prevention programs initiated in the early 1970's—in the United States and elsewhere, that found significant reductions in the risk factors associated with the onset of negative health behavior, the behaviors themselves, and related morbidity and mortality (Johnson and Solis 1983). These programs were characterized by the following:

- Family involvement
- Specific skills
- Intensity (multiple prevention strategies)

- Positive evaluations (especially in smoking cessation and maintenance)
- Continuity (3 to 7 years' duration).

Research on social-psychological models of adolescent smoking prevention, which reduced the incidence of cigarette smoking in adolescents by at least 50 percent, also served as a rationale for the USC model. Additional research found this approach effective in preventing the onset of alcohol and marijuana use (Johnson and Solis 1983).

This 1984 USC model was implemented as Project Star in Kansas City, Missouri, in 15 school districts (conceptualized as the community unit) and began this year as a county-wide Project I-Star in Indianapolis, Indiana. These two projects hold much promise for community-wide prevention programming because they incorporate the following characteristics:

- A state-of-the-art resistance skills program (Hansen 1988)
- An integrated model of community organization (Pentz 1986)
- Long-term intervention (5 to 6 years)
- Ongoing process evaluations and actual *impact* evaluations.

In addition, these two projects meet the three major criteria for community-wide prevention.

First, they are *comprehensive.* They engage multiple systems and strategies. In a sequential manner, these projects begin with a school program and subsequently progress to parent and community organization and health policy programs.

Second, they emphasize the *program development process.* A unique contribution of the USC approach is the integrated community organization/program development model developed by Mary Ann Pentz (1986). Her schema for initiating, implementing, and maintaining a community-wide prevention effort incorporates Rothman's (1979) model of community organization, Green's (1985) model of system-centered community health education, Rogers' innovations-decision process model (1983), and Watzlawick's model of planned change (Pentz 1986). See figure 2.

In the development of Project Star, this planning model was used sequentially as each new system was targeted (trained and involved). The systems were the school, family, media, and health professions, and businesses, workplaces, and community agencies.

Finally, the two projects are *collaborative.* Project Star is an example of a collaborative effort on the part of a university research team, a private-sector business, a nonprofit foundation, a Federal agency, the schools, families, media,

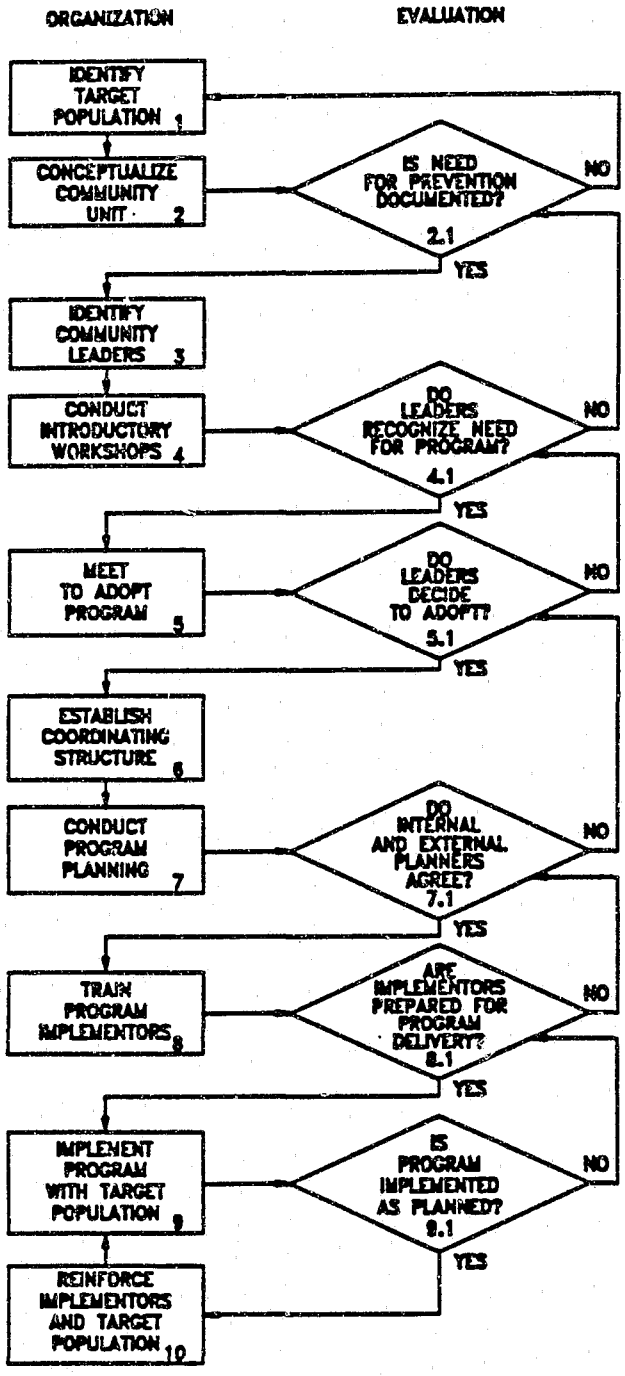

Figure 2. Steps to Community Organization and Evaluation

health-planning organizations, and other community agencies, including a baseball team.

The field of prevention of alcohol and other drug problems can look to this model as an exemplar of well-coordinated, community-wide programming that seeks not only to reduce actual drug use by youth but also to create a community environment that *supports* drug-free lifestyles.

The Minnesota Heart Health Program. The Minnesota Heart Health Program (MHHP) is actually one of the comprehensive community heart disease prevention programs from which the USC model evolved. It is currently under way as part of a 10-year education program in three northern midwestern communities. All of these programs are aimed at changing smoking prevalence, eating patterns, physical activity levels, and hypertension management in the entire community—children, adolescents, adults, and the elderly (NIDA: Perry and Jessor, 1983). To achieve its goals, the MHHP is organized around three major strategies: health behavior campaigns, educational interventions, and community organization programs. Youth are considered a specific target group within the larger program. The three strategies are specifically designed for youth (see figure 3) and are based on Jessors' extensive etiological research on adolescent drug use and other problem behaviors.

Each intervention focuses on one set of risk factors for problem behaviors and has as its goal to "delay the onset, minimize the consequences, and prevent the abuse of drugs as well as promote the adoption of health-enhancing alternatives

Health Behavior Campaigns	Target Group Interventions: Youth	Community-Based Programs
• Kwit Smoking This Year Interviews	• Heart Health Centers	• Community Steering Committee
• Quit and Win	• Hearty Heart and Friends	• Task Force on Smoking
• Dining a la Heart	• Keep It Clean I, II	• Student Health Representatives
• Get Ready for the 21st Century	• Slice-of-Life Health Skills Program	• Peer Leadership Training
• Jog 'n Log		
• Volksmarche		
• T.V. Premiere		

Source: Perry and Jessor 1983.

Figure 3. Minnesota Heart Health Program: Intervention Modalities

to drug use" (Perry 1986). Developing these latter alternatives is achieved through:

- Health behavior campaigns that focus on changing impersonal environmental risk factors (role models in mass media, parent and peer approval of drug use, and opportunities to use drugs) and that use mass media campaigns;
- Educational interventions that focus on changing personality risk factors (tolerance for drug-use behavior and risk-taking or rebelliousness) and that emphasize life-skills training; and
- Community organization interventions that focus on changing risk factors in the more immediate social environment (community role models, parent and peer approval of drug use, and opportunities to use drugs) and that emphasize task force organization, community-initiated projects, peer leadership training, and social policy change.

Besides satisfying the criteria for a community-wide prevention program (i.e., comprehensiveness, emphasis on program development process, and collaboration on the part of a university research team, the National Heart Lung and Blood Institute, and local communities), the MHHP can be expected to serve as an exemplary model in several ways:

- First, it represents an alcohol and other drug abuse prevention effort incorporated into a broader health-promotion effort that considers the concept of health "as including not only the physical domain but the psychological, social, and personal as well" (NIDA: Perry and Jessor 1983). As a consequence, this model emphasizes the strengthening of health-enhancing behaviors (i.e., alternatives) along with the reduction of health-compromising ones.
- Second, MHHP is a community-wide effort focused not only on reducing alcohol and other drug use by youth, but also on building healthy behaviors and reducing unhealthy ones among *all* age groups.

The USC Comprehensive Drug Abuse Prevention Program and the Minnesota Heart Health Program represent research-based models for doing community-wide prevention that hold promise for replication in other communities. Yet, as David Murray, the director of one of the three MHHP sites, warns, replication "will not occur without considerable investment of time and dollars, and it must be remembered that community-based interventions provide no magical solution for health promotion problems. However, the early evidence from MHHP and similar trials suggests that this strategy can help to organize a community around a health promotion issue and to increase the level of preventive activity in the community" (Murray 1986).

The "Field"

Now that we have looked at two models for doing community-wide prevention, I would like to comment briefly on the state of the field. Most of "what is out there" falls short of fulfilling the attributes of community-*wide* prevention in terms of *comprehensiveness* and a *collaborative planning process*. Some would better be referred to as community-*based* programs. However, there are literally hundreds of programs in the prevention field of alcohol and other drug use, teen pregnancy, dropping out, latchkey children, child sexual abuse, and delinquency. They are characterized by a great diversity in the linkages/systems on which they focus; this probably and properly reflects the unique political, social, and economic conditions of their respective communities, which ultimately impact the critical issue of *sponsorship* and impetus for local change. We can categorize these programs according to their system linkages and their sponsorship.

Linkages

Referring to the list of infrasystem linkages listed earlier, I'll make a brief mention of representative programs or issues involved in each linkage.

Family-School. This is a linkage that has received and continues to receive much attention in both research and the public policy area. Involving parents in both the content and structure of the school has been identified as a critical ingredient in the literature on school effectiveness. Also, using the school as a setting for educating parents in the problems of alcohol and other drugs, teen pregnancy, child abuse, and school failure is a major prevention focus. Given the critical role parents and schools play in the development of children and the ease of access and nonstigmatizing nature of the school as a setting, it should come as no surprise that this is a major emphasis. Research programs, like the Perry Preschool Project, Missouri's New Parents as Teachers, the Seattle Social Development Project, and the New Haven Primary Prevention Project, which have actually found reduced levels of problem behaviors (delinquency, teen pregnancy, drug problems, school failure) or in the precursors to these behaviors, have all emphasized the family-school linkage.

Family-Workplace. This linkage is beginning to get more attention, especially in the area of public policy, since the majority of families no longer have a "mom" at home to provide the support and nurturance for either young children or aging parents. We are seeing some efforts in the workplace to provide child care, as well as more flexible and part-time employment schedules (Anonymous 1984). Also, in the area of alcohol and other drug abuse, Employee Assistance Programs (EAPs) are beginning to broaden their scope to include family members as well in their programming. This is an area that should be quite productive in the future as a prevention research and programming focus.

Family-Community Organizations. Building family strength has been a major thrust of numerous community-based organizations involved in the Family Resource Movement. For example, the Ounce of Prevention Fund in Illinois is a "public-private partnership which promotes the well-being of children by working with families and communities to foster good child development" (*Ounce of Prevention Fund Magazine* 1987).

Family-Government. After much neglect at the Federal and State levels, family issues, especially child care, are really at the forefront of policymaking. Until this year's proposed legislation, child-care legislation has not even been discussed nationally since 1971. There just might possibly be a correlation with this neglected issue and the number of at-risk youth.

School-Workplace. A number of issues are involved in this linkage. First, a rising concern has been the need for school-to-work transition and mentorship programs to promote future employment for high-risk youth. Second, local businesses are becoming increasingly involved financially with schools to help ensure an educated, qualified, future workforce. Third, adult (parent) literacy programs in the workplace are increasingly being seen as fundamental to helping break the cycle of illiteracy and school failure that trap a great number of youths.

University-School, -Workplace, -Community. A critical issue in these areas is one of technology transfer—getting research-based prevention models to prevention arenas. Considering that the naturally occurring social systems of the family, school, workplace, and community are increasingly providing the forum for community psychology and community health research, we are beginning to see programs like Project Star that are collaborative community-university efforts.

School-Social Services. This linkage is critical to early intervention dealing with children from dysfunctional families characterized by alcoholism or drug abuse. Programs like the Cambridge and Somerville Program for Alcoholism Rehabilitation and student assistance programs, which set up a referral structure and provide access to treatment resources, are becoming more common.

School-Government. Report after report documenting the very pressing issue of at-risk youth cites the urgent need for enough resources to be allocated at the Federal, State, and local levels to encourage the development of *quality* elementary, middle, junior, and senior high schools that provide both academic and social support. This involves reforms too numerous to mention here.

School-Community. Like the family-school linkage, the necessity of schools and communities collaborating to reduce problem behaviors and create more supportive social environments is clearly established (Killip et al. 1987). As we discussed earlier, years of prevention research have documented the need for

schools and communities to work together. Project Star is a good example of such an effort.

Community-Social Services, -Government Services. What we are looking at ultimately in this linkage is a coordinated system of human services delivery at the local level—be it prevention, early intervention, or treatment. Community task forces, coalitions, networks, collaborations—call them what you will—are the mechanism for achieving this. Washington, D.C.'s task force on health planning for prevention (1985) is a fine example of this attempt at human services coordination.

Sponsoring System

We can also categorize community-based prevention programs according to their sponsoring system (see figure 4).

Levels / Sponsors	National/ Federal	State	Local/ Community
Government			
Professional Organizations/ Associations			
Citizen			
Business/ Foundations			

Figure 4.

Some community-based programs have as their impetus and funding source a *governmental* mandate. For example, Head Start programs and some job training programs have a *Federal* mandate. Soon, we will probably have some form of leave program so people can care for small children or aging parents. In the alcohol and other drug abuse field, the Office for Substance Abuse Prevention has been a key motivator in encouraging the development of community-wide programs with its comprehensive community grants.

State governments, whether at the executive or legislative level, have played perhaps the major role the last few years in initiating programs to address at-risk youth, especially for the problem behaviors of teen pregnancy, alcohol and other drug use, and dropping out/school failure. While a majority of these efforts involve statewide programming mandates (such as Missouri's New Parents as Teachers), some offer matching funds or grants for communities to

develop their own local programs (such as Nebraska's and Colorado's community prevention teams approach). Illinois' community network-building approach is another example of a statewide effort. An extremely positive development has been the creation of State offices of prevention (as in California, Arizona, Virginia) to coordinate State policies that affect community prevention efforts.

At the city government level, we see some exciting community-wide efforts such as Seattle's Kid's Place, a citywide youth empowerment effort. Increasingly, latchkey, drop-out, and alcohol and other drug programs are also being sponsored at the local governmental level (i.e., school district).

Another impetus for community prevention has come from professional organizations and associations. At the national level, we are looking at groups like the National Education Association and Association for Curriculum and Development, both of which sponsor innovative school-community projects; the Children's Defense Fund (including the Adolescent Pregnancy Clearinghouse), which focuses on changing social policy to build more supportive environments for youth; and certainly the National Prevention Network, which hopes to create a national agenda for alcohol and other drug abuse prevention. The list can go on and on: National Association of Chief State School Officers, National Governors' Association, Prevention Task Forces of the American Mental Health Association, the American Psychological Association, and the National Council of Community Mental Health Centers. We even have several examples of coalitions among national groups that have organized around and funded a project to encourage community prevention. The Chemical People Project is a vivid example of this collaboration. Most of these professional organizations have no funding resources; but, they are nonetheless major advocates of social policy change. Their potential for collaborating with other funding systems is great.

Looking across our chart at the State and local level, these professional organizations/associations and their State and local affiliates can—and sometimes do—provide an impetus for prevention at the community level. Statewide coalitions formed around teen pregnancy, AIDS, drop-outs, and so forth, are becoming fairly common phenomena. At the local level, coalitions have been formed by professional organizations and associations along with State human service organizations to promote both health and mental health in their communities. The 1985 Washington, D.C., Mental Illness Prevention Working Group Report documents this comprehensive planning approach. Similarly the Houston-Galveston Health Promotion Consortium (DeFrank and Levenson 1987) and the Brooklyn Teen Pregnancy Network (Canada 1986) exemplify the diverse and numerous local professional coalitions that exist to promote healthy development and prevent health-compromising behaviors at the community level.

Citizen Involvement

While we tend to focus on prevention programs that are evaluated by research teams whose findings are published, there exists a whole genre of citizen-initiated community task forces and parent groups "out there" in places like Mulberry Grove, Illinois, that were initiated and have been maintained by a core group of concerned parents and citizens. Many of these programs have come and gone, losing momentum once they realize prevention is not quick, easy, or cheap. Increasingly, they are joining national organizations like the National Federation of Parents for Drug-Free Youth or the National Coalition of Citizens in Education or, at the State level, organizing affiliations (like the Illinois Drug Education Alliance) or becoming part of statewide governmental initiatives like Colorado's Community Teams for Drug-Free Youth or Illinois' InTouch system. As a consequence, many of these groups have received extensive training in community development and alcohol and other drug abuse prevention. The end result, of course, is that we are seeing an increasing understanding and awareness of prevention as well as increased skills in doing community prevention.

Last, but far from least, is the business/foundation level, where we are witnessing a tremendous growth of interest in, and funding for, both alcohol and other drug abuse prevention and education for at-risk youth at the community level. A Lou Harris poll conducted early in 1987 found that of 1,000 grantmakers surveyed, over half said they had supported alcohol and other drug abuse prevention programs in 1986. The figure was 65 percent for company-sponsored foundations (Fuerst 1988). Similarly, foundations are concerned with funding education programs for at-risk youth because, according to one grantmaker, "As families collapse and child-protective services look less and less attractive, the schools seem to be all there is left...." and also because "Corporations want to ensure a steady flow of well-qualified and educated workers...." (Olson 1988). Instead of making specific or categorical grants, as was often the case in the past, "These foundations are aiming their efforts at sweeping organizational change. The hope is that such initiatives will lead to deeper and more lasting school reform and to system change. Consequently, they are committing sizeable sums of money, often over long periods of time" (Olson 1988). An exciting aspect of these new initiatives, such as the Annie E. Casey Foundation's $50 million "New Futures" program, is that the emphasis is on school-community partnerships that require matching grants from each city and emphasize collaborative planning processes involving "key sectors of the community..." (Olson 1988). With only a little imagination, we can see the tremendous potential of innovative, collaborative funding arrangements for community-wide prevention.

Conclusion

While the majority of programs "out there" in the field address only one or two of the above linkages simultaneously and are not community-wide, the

potential for their becoming comprehensive exists. Through the mechanism of a task force, a coalition, or whatever you choose to call it, representatives from diverse but narrowly focused prevention efforts can engage in a collaborative, long-range, community planning process. According to Cooper (1980), "Collaborative planning, funding, and programming at the Federal, State, and local levels must be accomplished if we are to succeed in prevention."

As prevention professionals and advocates, we must encourage the development of these collaborative efforts to accomplish our goals of actually reducing problem behaviors like alcohol and other drug abuse and of creating environments that support and nurture the development of not only children but also adults, families, and the elderly. The problems of alcohol and other drug abuse, delinquency, child abuse, and teen pregnancy are all rooted in the community (Garbarino 1980; Miller and Ohlin 1985). We will find solutions in the community.

References

Albino, J. Health psychology and primary prevention: Natural allies. In: Felner, R.D.; Jason, L.A.; Moritsugu, J.N.; and Farber, S.S. *Preventive Psychology: Theory, Research, and Practice*. New York: Pergamon Press:221–244, 1983.

Bell, P. Community-based prevention. In: *Proceedings of the National Conference on Alcohol and Drug Abuse Prevention: Sharing Knowledge for Action. (Aug. 3-6, 1986)*. Rockville, Md.: NIDA, 1987.

Benard, B.; Fafoglia, B.; and Perone, J. Knowing what to do—and not to do—reinvigorates drug education. *ASCD Curriculum Update*, Feb. 1987.

Canada, M. Adolescent pregnancy: Networking and the interdisciplinary approach. *Journal of Community Health* II(1):58–62, Spring 1986.

Cooper, S. Implementing prevention programs: A community mental health center director's point of view. In: Price, R. *Prevention in Mental Health: Research, Policy, and Practice*. Beverly Hills, Calif.: Sage:253–261, 1980.

Crowley, J. *Alliance for Change: A Plan for Community Action on Adolescent Drug Abuse*. Minneapolis: Community Intervention, 1984.

DeFrank, R., and Levenson, P. Ethical and philosophical issues in developing a health promotion consortium. *Health Education Quarterly* 14(1):71–77, Spring 1987.

DiCicco, L.; Biron, R.; Carifio, J.; Deutsch, C.; Mills, D.J.; Orenstein, A.; Re, A.; Unterberger, H.; and White, R.E. Evaluation of the CASPAR alcohol education curriculum. *Journal of Studies on Alcohol* 45(2):160–169, 1984.

Elder, J.P., Hovell, M.F.; Lasater, T.M.; Wells, B.L.; Carlton, R.A. Applications of behavior modification to community health education: The case of heart disease prevention. *Health Education Quarterly* 12(2):151-158, Summer 1985.

Felner, R.D.; Jason, L.A.; Moritsugu, J.N.; and Farber, S.S. *Preventive Psychology: Theory, Research, and Practice*. New York: Pergamon Press, 1983.

Festinger, L.A. *A Theory of Cognitive Dissonance*. Palo Alto, Calif.: Stanford University Press, 1957.

Flay, B. Mass media linkages with school-based programs for drug abuse prevention. *Journal of School Health* 56(9):402–406, Nov. 1986.

Fox, K., and Kotler, P. The Marketing of Social Causes: The first 10 years. *Journal of Marketing* 44:24–33, 1980.

Fuerst, M. Field would welcome private help. *U.S. Journal of Drug and Alcohol Abuse 12(2),* 1(Feb.):18–19, 1988.

Garbarino, J. Preventing child maltreatment. In: Price, R. *Prevention in Mental Health: Research, Policy, and Practice*. Beverly Hills, Calif.: Sage:63–108, 1980.

Gesten, E., and Jason, L. Social and community interventions. *Annual Review of Psychology* 38:427–460, 1987.

Goodstadt, M. School-based drug education in North America: What is wrong? What can be done? *Journal of School Health* 56(7):278–281, 1986.

Griffin, T. Community-based chemical use problem prevention. *Journal of School Health* 56(9):414–417, 1986.

Hansen, W. Effective school-based approaches to drug abuse prevention. *Education Leadership*, Mar.:9–14, 1988.

Hansen, W.B.; Malotte, C.K.; and Fielding, J.E. Evaluation of a tobacco and alcohol abuse prevention curriculum for adolescents. *Health Education Quarterly* 15(1):93–114, 1988.

Hopkins, R.H.; Mauss, A.L; Kearney, K.A.; and Weisheit, R.A. Comprehensive evaluation of a model alcohol education curriculum. *Journal of Studies on Alcohol* 49(1):38–50, 1988.

Jason, L.A.; Felner, R.D.; Moritsugu, J.N.; and Farber, S.S. Future directions for preventive psychology. In: Felner, R.D.; Jason, L.A.; Moritsugu, J.N.; and Farber, S.S. *Preventive Psychology: Theory, Research, and Practice*. New York Pergamon Press:297–309, 1983.

Jessor, R. Adolescent problem drinking: Psychosocial aspects and developmental outcomes. Paper presented at the Carnegie Conference on Unhealthful Risk-Taking Behavior Among Adolescents. Stanford, Calif., Nov. 1984.

Killip, D.C.; Lovick, S.R.; Goldman, L.; and Allensworth, D.D. Integrated school and community programs. *Journal of School Health* 57(10):437–444, 1987.

Larsen, J. Community mental health services in transition. *Community Mental Health* 23(4):16–25, 1987.

Leventhal, H.; Prohaska, T.R.; and Hirschmans, R.S. Preventive health behavior across the lifespan. In: Rosen, J.C., and Solomon, L.J, eds. *Prevention in Health Psychology*, Vol. 8. Hanover, N.H.: University Press of New England, 1985.

Mauss, A.L.; Hopkins, R.H.; Weishert, R.A.; and Kearney, K.A. The problematic prospects for prevention in the classroom: Should alcohol education programs be expected to reduce drinking by youth? *Journal of Studies on Alcohol* 49(1):51–61, 1988.

McGuire, W.J. Personality and Susceptibility to Social Influence. In: Borgatta, E.J., and Lambert, W.W., eds. *Handbook of Personality Theory and Research.* Chicago: Rand McNally, 1968, pp. 1130–1187.

Miller, A., and Lloyd O., *Delinquency and Community: Creating Opportunities and Controls*. Beverly Hills, Calif.: Sage, 1985.

Murray, D. Dissemination of community health promotion programs. The Fargo-Moorhead Heart Health Program. *Journal of School Health* 56(9):375–381, 1986.

National Institute on Drug Abuse. Comprehensive community programs for drug abuse prevention: Implications of the community heart disease prevention programs for future research, by Johnson, C.; Anderson, R.; and Solis, J. In: *Preventing Adolescent Drug Abuse: Intervention Strategies.* Research Monograph 47. Rockville, Md.: the Institute, 1983, pp. 76–114.

National Institute on Drug Abuse. Doing the cube: Preventing drug abuse through adolescent health promotion, by Perry, C., and Jessor, R. In: Glynn, T.; Leukefeld, C.; and Ludford, J. *Preventing Adolescent Drug Abuse: Intervention Strategies.* Research Monograph 47. Rockville, Md.: the Institute, 1983, pp. 51–75.

National Institute on Drug Abuse. The etiology and prevention of substance use: What can we learn from recent historical changes?, by Johnston, L. In: *Preventing Adolescent Drug Abuse: Intervention Strategies*. Research Monograph 47. Rockville, Md.: the Institute, 1983, pp. 155–171.

Olson, L. Foundations saying we all have a stake in schools. *Education Week* Feb. 24, 1988a, pp. 22–23.

Olson, L. Donors seek deeper, more lasting results from gifts. *Education Week* Mar. 2, 1988b, pp. 27–29.

Ounce of Prevention Fund Magazine, Chicago, Fall 1987.

Pentz, M. A. Community organization and school liaisons: How to get programs started. *Journal of School Health* 56(9):382–388, 1986.

Pentz, M. A.; Cormack, C.; Flay, B.; Hansen, W.B.; and Johnson, C.A. Balancing program and research integrity in community drug abuse prevention: Project Star approach. *Journal of School Health* 56(9):389–393, 1986.

Perry, C. Community-wide health promotion and drug abuse prevention. *Journal of School Health* 56(9):359–363, 1986.

Perry, C., and Jessor, R. The concept of health promotion and the prevention of adolescent drug abuse. *Health Education Quarterly* 12(2):169–184, 1985.

Planning for Prevention in the District: Final Report of the Mental Illness Prevention Working Group. Washington, D.C.: Aug. 1985.

Public Health Service, U.S. Dept. of Health and Human Services. Toward a healthy community: Organizing events for community health promotion. Washington, D.C., Supt. of Docs., U.S. Govt. Print. Off., 1985, pp. 80–113.

Rogers, E. *Diffusion of Innovations* (3rd ed). New York: Free Press, 1983.

Rothman, J. Three models of community organization practice, their mixing and phasing. In: Cox, F.M. *Strategies of Community Organization,* 3rd edition. Ithasca, Ill.: F.E. Peacock Publishers, 1979, pp. 25–45.

Rutter, M. Resilient children. *Psychology Today,* Mar. 1984, pp. 57–65.

Sofaer, S. Community health planning in the United States: Postmortem. *Family and Community Health* 10(4):1–12, 1988.

Steckler, A. Review of: *Implementing Change in Communities: A Collaborative Process,* by Sarah Archer. In: *Health Education Quarterly* 12(2):215–218, 1985.

Susskind, E., and Klein, D. *Community Research: Methods, Paradiagrams, and Applications*. New York: Praeger, 1985.

Watzlawick, F., Weakland, J.H.; Fisch, R. *Change: Principles of Problem Formation and Problem Resolution*. New York: W.W. Norton, 1974.

Werner, E., and Smith, R. *Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth.* New York: McGraw-Hill, 1982.