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If At First You Don't Succeed...Keep Trying: Strategies to Enhance Coalition/School Partnerships to Implement School-Based Prevention Programming

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Abstract

Community-based coalitions have been advocated as a promising mechanism to reduce youth involvement in violence, delinquency, and substance use, but coalitions have not always been successful in ensuring widespread adoption of evidence-based prevention strategies. This paper describes the strategies used by 12 community coalitions to collaborate with schools to select and implement school-based prevention programs, including the barriers to establishing coalition/school partnerships and methods for overcoming these challenges.

In this five-year research project, all communities adopted school-based prevention programs. Coalitions helped achieve this outcome by building relationships with school personnel, fostering champions within the school, creating win/win situations in which schools' needs were addressed, and initiating school-based prevention programs as pilot efforts that were later expanded. While success was achieved in all cases, persistent messaging about the importance of youth problem behaviours was needed to overcome schools' concerns about using academic time to teach prevention messages and replacing current practices with unfamiliar programs.

Findings from this study can be used by coalitions and prevention scientists that want to partner with schools to reach a large population of students with effective prevention programming. The results are also of value to researchers and practitioners interested in fostering widespread dissemination of other types of evidence-based programs.

Keywords

adoption; school/community partnerships; coalitions; violence prevention

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Youth violence is a major social problem. Given the financial costs to society of youth violence (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004), and evidence that the early onset of violent offending is associated with longer, more frequent, and more violent criminal careers (Farrington, 2003; US DHHS, 2001), the prevention of youth violence is both a fiscal and social priority (Homel, Cashmore, Gilmore, Goodnow, Hayes, Lawrence, Leech, O'Connor, Vinson, Najman, & Western, 1999).

While prevention programs that have been proven effective in reducing youth involvement in violence and delinquent behaviours have been identified (Catalano, Arthur, Hawkins,

Berglund, & Olson, 1998; Farrell, Meyer, Kung, & Sullivan, 2001; Homel et al., 1999; US DHHS, 2001), they have not been widely disseminated. In the United States, Kumpfer and Alvarado (2003) estimated that only about 10% of practitioners implement family-focused programs that have evidence of effectiveness, and a national study of schools (Ringwalt, Ennett, Vincus, Thorne, Rohrbach, & Simons-Rudolph, 2002) found that 82% reported using drug prevention curricula, but only 27% were implementing programs that had evidence of success in reducing substance use.

Although schools are just one community agency through which prevention programming can occur, school-based programs are appealing because they can target a large proportion of the community's population, thereby increasing the potential to create community-level changes in desired outcomes (Spoth & Greenberg, 2005). Given their broad reach and utilisation of teachers to implement programs, school-based programs can also be cost effective (Aos et al., 2004). Unfortunately, little is known regarding strategies to enhance the dissemination of evidence-based programs in general and school-based efforts in particular. The development and testing of such methods is a priority for prevention research (Glasgow, Lichtenstein, & Marcus, 2003; Pentz, Jasuja, Rohrbach, Sussman, & Bardo, 2006; Saul, Duffy, Noonan, Lubell, Wandersman, Flaspohler, Stillman, Blachman, & Dunville, 2008; Spoth & Greenberg, 2005; Wandersman, 2003). More information is needed regarding attempts to "bridge science and practice" (Arthur & Blitz, 2000; Saul et al., 2008); that is, to investigate processes through which practitioners gain access to information about tested and effective interventions and decide to put them into everyday use (Cherney & Sutton, 2007). These issues are important because widespread community change is unlikely to occur without greater uptake of effective programs that reach a larger proportion of the community (Spoth & Greenberg, 2005).

Community-based coalition efforts offer promise in helping to install evidence-based programming designed to prevent children's involvement in problem behaviours (Cherney & Sutton, 2007; Feinberg, Greenberg, Osgood, Sartorius, & Bontempo, 2007; Homel, 2005; Spoth, Redmond, Shin, Greenberg, Clair, & Feinberg, 2007; Wandersman & Florin, 2003). Coalitions can bring together diverse community stakeholders (e.g. from human service agencies, law enforcement, schools, churches, youth-serving organizations, business, and other agencies and individuals interested in preventing youth violence), coordinate prevention services across multiple organizations, and target risk factors in multiple domains of children's lives. Prior research has indicated that it is very difficult for coalitions to engage schools in prevention efforts (Flewelling, Austin, Hale, LaPlante, Liebig, Piasecki, & Uerz, 2005; Hallfors, Cho, Livert, & Kadushin, 2002; St Pierre & Kaltreider, 2004). The current study describes the strategies used by coalitions participating in a U.S. research project to successfully partner with schools to implement evidence-based programs to prevent children's involvement in problem behaviours.

The Process of Adoption

The ways in which schools move through the process of adopting new prevention programs, and the steps that locally-based coalitions can take to foster this process, are not well understood. As described by Rogers, organizations of all types progress through five stages when considering new innovations, which include: 1) gaining knowledge about the new innovation, 2) being persuaded to use it, 3) deciding to use it, 4) implementing the new innovation, and 5) confirming the decision (Rogers, 1995; Rohrbach, Grana, Sussman, & Valente, 2006). This paper focuses on the first three stages of adoption in order to describe the barriers to adoption identified by schools, the strategies used by coalitions to work with school personnel to overcome challenges, and the factors that helped convince schools to adopt new programs to prevent adolescent violence, delinquency, and substance use.

Some barriers associated with the first three phases of the adoption process have been previously identified. Significant challenges include difficulty accessing scientific evidence regarding program effectiveness, a shortage of resources, organizational barriers, and lack of supportive staff or administrators (Glasgow et al., 2003; Mihalic, Fagan, Irwin, Ballard, & Elliott, 2004; Saul et al., 2008). Schools, like other agencies, need assistance to obtain and comprehend information regarding tested and effective programs in order to complete the first stage in the adoption process. Such information is often published in scientific journals inaccessible to school personnel, and these articles frequently describe methodological issues and procedures not easily understood by practitioners (Mihalic et al., 2004). While more user-friendly materials and lists describing “best practice” or “model” programs are more readily available now than in the past (see, for example, <http://www.campbellcollaboration.org/>; <http://www.colorado.edu/cspv/blueprints/>; and <https://preventionplatform.samhsa.gov/>), such lists often rely on differing criteria to establish effectiveness and making sense of these data can still be difficult for school staff (Hallfors, Pankratz, & Hartman, 2007).

A particularly difficult barrier for schools to overcome prior to adopting a new classroom-based prevention curriculum is finding room in the school schedule for the program (Elias, Butler-Bruene, Blum, & Schuyler, 2000; Fagan & Mihalic, 2003). Many administrators will be reluctant to spend classroom time on prevention if they do not believe such programs will improve students' academic learning or address behavioural problems that may impede learning (St Pierre, 2001; Webster-Stratton & Taylor, 1998). Even if classroom time is made available, adoption of new programs is contingent on support among key personnel. While formal acceptance of the program may come from administrators, staff support is needed in order to find implementers willing to teach the program fully, with enthusiasm, and in a manner that elicits a positive response from students. The decision to adopt a new program is facilitated when there are champions within the school who will advocate for the program and increase others' support for it (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Mihalic & Irwin, 2003; Miller & Shinn, 2005; Rohrbach et al., 2006). Fostering champions might entail approaching administrators or teachers who are known for being open to new innovations, then working with them to gain the support of other parties (Group, 2002; Kellam, Werthamer-Larsson, Dolan, Brown, Mayer, Rebok, Anthony, Laudolff, & Edelsohn, 1991). Follow-up conversations may be needed to establish relationships of trust and respect and to reach consensus on implementation procedures (Fagan & Mihalic, 2003; Kalafat & Ryerson, 1999; Piper, King, & Moberg, 1993).

While challenges to adoption have been identified by prevention scientists, their experiences typically arise when negotiating with schools to adopt new programs in order to evaluate their effectiveness. This paper studies the adoption process from the perspective of local coalitions who wished to partner with schools to achieve a common vision of fostering the healthy development of adolescents in their communities. Because they are initiated from within the community, coalition-driven prevention efforts should engender a greater degree of local ownership, which, in turn, should facilitate the adoption, implementation, and sustainability of programming (Spoth, Greenberg, Bierman, & Redmond, 2004; Wandersman & Florin, 2003).

ⁱWhile the processes affecting program implementation are also important, this paper focuses on the stages leading up to the decision to adopt new programs. Other papers have described the challenges that arose during implementation (Fagan et al., 2008a; Fagan et al., 2008b).

Method

The Community Youth Development Study

This study relies on data from coalitions participating in the Community Youth Development Study (CYDS), a 5-year community randomized trial involving 24 small- to medium-sized towns in seven states in the United States. The 24 communities ranged in size from 1,500 to 50,000 residents and were randomly assigned in fall 2002 to implement the Communities That Care (CTC) prevention system (n=12) or to provide prevention services as usual (n=12). The 12 intervention communities received training and technical assistance in the CTC system, funding for a full-time coalition staff member (the CTC coordinator), and up to \$275,000 over Years 2-5 to implement prevention programs targeting schools, families, and students in Grades 5-9, the age focus of the study. The Community Youth Development Study was designed to test the efficacy of the CTC system in increasing communities' selection and implementation of tested and effective prevention programs, as well as reducing adolescent risk factors, increasing protective factors, and decreasing levels of adolescent violence, delinquency, drug use, and other adolescent problem behaviours (Hawkins, Catalano, Arthur, Egan, Brown, Abbott, & Murray, 2008).

CTC is a community-based prevention framework that involves five phases: 1) assessing community readiness to undertake collaborative prevention efforts; 2) forming a diverse and representative prevention coalition; 3) using epidemiologic data to assess prevention needs; 4) choosing evidence-based prevention policies and programs based on these data; and 5) implementing the new policies and programs with fidelity (i.e., in a manner congruent with the programs' theory, content, and methods of delivery) and monitoring implementation and impact. CTC is based on the premise that communities have different levels of problem behaviours and different risk and protective factors that should be addressed via community-specific prevention plans (Hawkins, Catalano, & Arthur, 2002; Hawkins, Van Horn, & Arthur, 2004). Recognition of community differences helps ensure local ownership of prevention programming, as does the series of CTC training workshops that provide coalition members with the skills needed to implement CTC and achieve their common vision of healthy youth development. Sampson and colleagues (1997) have suggested that communities with high levels of collective efficacy (i.e., neighbourhoods in which residents trust one another, are oriented towards achieving the same goals, and are willing to take action to prevent crime) have a better likelihood of preventing crime, and the CTC emphasis on joint decision-making and action is predicated upon a similar hypothesis. Communities using the CTC model are expected to experience more consensus among decision makers and service providers regarding the problems faced in their communities and the solutions needed to overcome these issues, and better collaboration in implementing programs that have proven effectiveness in reducing youth delinquency and violence.

Data Collection and Analysis

Given the fact that little is known about program adoption in general and coalition/school partnerships in particular, this paper relied on qualitative data to describe the process of adoption of school-based prevention strategies. Given the small number of intervention communities (12) involved in the project, detailed analyses of community differences that relied on quantitative data were not possible. Moreover, because communities were enacting a community-specific prevention model (i.e., the CTC system), they each utilised a somewhat different approach in deciding when and how to adopt school-based prevention strategies. To this end, descriptive data analysis was considered the most useful and appropriate means of identifying commonalities across communities while still recognising unique circumstances surrounding the adoption of school-based prevention strategies by the 12 intervention communities participating in this project.

Descriptive data regarding coalitions' efforts to engage schools in offering prevention programming was obtained through technical assistance (TA) contacts with the 12 intervention communities. TA primarily involved weekly phone calls between staff at the Social Development Research Group at the University of Washington and the local staff person to the CTC coalition, the CTC coordinator. The TA provider recorded detailed notes of each call to describe the coordinators' activities, such as individual or group meetings with community stakeholders. In addition, coordinators used an on-line reporting system to record their interactions with community members, coalition membership, and other activities.

The lead author reviewed all implementation documentation, created a timeline of meetings that occurred between coalition members and school personnel prior to adoption of new programs, and conducted 1-hour phone interviews with CTC coordinatorsⁱⁱ in the last year of the study to discuss this information. The prevention literature was reviewed prior to the interviews to identify strategies used by other coalitions or prevention scientists to foster adoption of school-based programs. Based on this review, all coordinators were asked in the phone interviews to describe: 1) the primary steps taken to foster adoption of school-based curricula, including the content, tone, and perceived effectiveness of meetings with school representatives; 2) who in the school was first approached about school-based programs; 3) the greatest barrier to adoption in their community; and 4) the most influential factor leading to adoption. Questions were open-ended and did not lead the coordinators to identify issues similar to those described in the literature. The results reported below are based both on the interviews and the implementation documentation and are descriptive in nature, highlighting common themes that led to the formation of coalition/school partnerships and the adoption of school-based prevention programs.

Formation of the CTC Prevention Coalitions and Initial Selection of Programs

All intervention communities formed a prevention coalition in the first year of the study. At the end of this year, in May, 2004, 516 volunteers were participating in CTC coalitions in the 12 intervention communities. While a range of community stakeholders were represented (law enforcement, health and human service agencies, youth-service groups, local or state government, business, religious groups, youth, and parents), school personnel comprised the greatest proportion of all members, at 26% of all membership. School representatives included superintendents, curriculum specialists, principals, vice principals, prevention staff/counsellors, teachers, and other staff.

After coalition formation, subgroups of the coalitions reviewed data reported by their own population of 6th-, 8th-, 10th, and 12th-grade students on the Communities That Care Youth Survey, which was conducted every 2 years. The CTC Youth Survey provides valid and reliable self-reported measures of 30 risk and protective factors, substance use, and items related to non-violent and violent delinquent behaviours (Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002). Coalition members were trained to focus on trends in their local data and identify student-reported risk and protective factors that were consistently elevated or depressed over time. Coalitions then prioritized two to seven factors to target with prevention activities. To avoid duplication of programs, coalition members also

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ⁱⁱIn 8 of the 12 communities, the coordinator who made the initial contacts with the school(s) was still employed and completed the interview. In the ninth community, the current coordinator was hired after the decision to adopt the school program but was previously part of the CTC coalition and knew details concerning meetings with school members. In two other communities, the coordinator who had primarily worked with schools was no longer employed, so the former coordinator and/or members of the coalition were contacted. Finally, in the 12th community, both the existing and a former coordinator had facilitated the adoption of school programs and both were interviewed.

conducted a resource assessment of current programs and policies already in place in their communities that addressed their priorities.

Next, coalition members attended the 2-day CTC Community Planning Training to select prevention programs that would be implemented beginning in the 2004-2005 school year. In order to receive research funds for implementation, coalitions had to choose programs which: a) had been tested in controlled trials and had demonstrated effectiveness in reducing risk factors, enhancing protective factors, and reducing youth behaviour problems of children in Grades 5 through 9; and b) addressed their community's prioritized risk and protective factors. Coalition members selected programs from the *CTC Prevention Strategies Guide* (<https://preventionplatform.samhsa.gov/>) which included descriptions of 39 tested and effective programs for the study age group, including parent training programs, school-wide interventions, school-based prevention curricula, mentoring programs, after-school activities, and community-based interventions. During the Community Planning Training, the coalition reviewed the community's student survey information and inventory of current prevention programs and considered potential programs' implementation requirements, financial costs, human resources needed, and local social/political factors that might influence implementation. They then selected programs which they thought could be implemented with fidelity, were affordable, and would be supported by program providers, participants, and the broader community.

In Years 2-5 of the study, the new programs were implemented, and coalition members monitored the quality of programs using implementers' self-reports and observations by coalition members (Fagan, Hanson, Hawkins, & Arthur, 2008). Each spring, the coalition reviewed program implementation data and results from subsequent administrations of the CTC Youth Survey and revised their prevention plans as necessary to best ensure success in reaching desired reductions in risk factors and problem behaviours. Over time, most communities maintained the program(s) initially selected and some added new programs to address needs not already being met. It should be emphasized that the CTC model does not require communities to use school-based prevention strategies, and communities were not mandated to do so in this study; however, all intervention communities adopted school-based programs at some point during the five-year study.

Results

Adoption of School-Based Programs

At the initial Community Planning Training, communities chose one to four tested and effective prevention programs to implement during Year 2 (2004-2005). All 12 adopted at least one non-school-based program, most commonly tutoring, mentoring, and parent training programs (see Table 1). Five communities ("early adopters") adopted school-based programs, while seven communities ("late adopters") did not. In the latter group, four communities adopted school-based programs in Year 3, one community did so in Year 4, and two communities adopted school programs in Year 5. Over the 5 years, 9 different school-based prevention programs were implemented across the 12 intervention communities. Seven of these programs involved delivery of a classroom-based curricula that focused on prevention of substance use, delinquency, and violence; one (Program Development Evaluation) was a school-wide initiative; and one (the Olweus Bullying Prevention Program) included both school-wide components and a classroom curriculum. Five sites selected and implemented multiple school-based programs, sometimes using non-study funding from school districts or other sources. In total, 18 school-based program replications occurred during the study and they included nearly 20,000 participants over the four years of implementation.

Differences were observed between early and late adopters of school-based programs. The early adopters had somewhat more success recruiting school personnel into the newly established CTC coalitions. In May, 2004, school personnel comprised 28% of all coalition members across the five early-adopting sites, compared to 22% of late-adopting community coalitions (see Table 1). Early-adopting sites also had more school representatives (36 total members, representing 16% of their membership) at the Community Planning Training, compared to the late-adopting sites (26 total members; 9% of their membership), and a greater proportion of the attendees were school administrators in early-adopting (11%) versus late-adopting (6%) sites. Having school personnel, particularly those with decision-making power, present at the training event when program selection was discussed appears to be associated with an increased likelihood of adoption.

Early-adopting sites had strong support from school personnel. In all five early-adopting sites, the school representatives expressed belief in the utility of using the Communities That Care approach to prevention; specifically, using tested and effective programs to address elevated risk and depressed protective factors reported by students in their own community. While implementation details had to be finalized after the Community Planning Training, administrators' support was strong enough to ensure that implementation would proceed. The Coordinator in Community A summarised the importance of gaining early support from the middle school principal in her community by stating "The program may not have happened without him...if it had been [the CTC coalition] alone pushing for the program, it may have happened eventually, but it could have taken a lot longer..."

In contrast to the early adopting sites, the late adopters typically lacked champions from the school during the initial year of the study. Key school stakeholders with low support usually did not attend the Community Planning Training in these communities and so missed the opportunity to review students' prevention needs and to share in their community's prevention programming decision-making. When school personnel were present in these sites, they tended to resist in-school programming, citing the competing priority to improve students' academic achievement and their belief that prevention programs would not address this need. For example, in Community X, the Coordinator described that the school was under state pressure to improve students' academic performance, which had resulted in teaching "double doses of reading and math, the elimination of electives" and no time for prevention programming. As a result, this community and the other six late-adopting communities initially selected programs that did not require classroom time. Importantly, in these communities, coalition members continued to build relationships with school personnel. Ultimately, all were successful in implementing new school-based programs that had evidence of effectiveness and some adopted multiple programs.

According to interviews with coordinators in all 12 sites, three primary strategies were used to foster adoption of school-based programming: 1) building relationships with and fostering champions among school personnel, 2) creating a win/win situation by identifying the schools' greatest perceived needs and offering a solution to them, and 3) piloting programs to 'get a foot in the door.'

Building relationships

Every coordinator interviewed emphasized the importance of building relationships with school personnel to garner their time and attention to discuss prevention issues. In some cases, coordinators had pre-existing relationships that allowed immediate entrée to

ⁱⁱⁱSome of the programs targeted the same students in multiple years, either by providing booster sessions or because the programs were implemented school-wide. Thus, while 20,000 participants were exposed to programming across the four years, this figure double- or triple-counts some students who received multiple years of the intervention.

administrators or staff. In other cases, relationships had to be built, usually through multiple conversations conducted during formal meetings and informal visits. Coordinators were strategic in deciding whom to approach and often relied on their and their coalition members' connections with school personnel. They used their collective knowledge of the school to determine who would be most receptive to prevention messages and best able to influence the decision to adopt a new program.

Coordinators used a top-down approach to leverage support for new programs in 12 of the 18 programs that were adopted (see Table 1) and began by engaging district or building administrators. In these cases, coalition members already had a relationship with an administrator or worked to form such a relationship, knowing that in their school district(s), decisions had to be first endorsed by school executives. For example, the CTC coordinator in Community T, formerly a high school teacher, had close ties to school district officials and used these connections to recruit the school district superintendent, district curriculum coordinator, and junior high school principal to the CTC effort in the first year of the project. He also understood that their endorsement was critical for program adoption because, as the Superintendent indicated, "We don't need to get the teachers' permission to do this program." In most top-down approaches, principals were the primary contact, but in three communities, the superintendent was approached first, and in Community H, the coalition began with a school committee devoted to drug prevention.

In contrast, three communities used a bottom-up approach (see Table 1). They started by engaging teachers, recognising that the school administration was not likely to be receptive to new programming, particularly if it was introduced by someone who was not employed by the school district. In each case, the coordinators also had pre-established relationships with teachers who they perceived to be receptive to innovation and prevention approaches. For example, the coordinator in Community I, a former teacher, asked a teacher she had worked with to review the Life Skills Training program for possible adoption "as a personal favour." In this case, and in other bottom-up examples, once teachers were on board, they, not the coalition, approached the administration to solicit approval for the program. Three communities simultaneously approached administrators and teachers with information on potential programs, hoping that engendering support from key personnel in multiple positions would better ensure adoption.

Creating a win/win situation

When building relationships with school personnel, coalition members strove to not only achieve their own goal---the adoption of tested, effective prevention programs---but also to provide solutions to needs identified as important by the school, thereby creating a win/win situation. Many communities used a three-pronged strategy to do so, by 1) educating schools about the prevention needs of their students; 2) promoting the advantages of using a tested and effective intervention to target risk factors and problem behaviours; and 3) demonstrating how the new program would address other school concerns.

Although schools had been conducting the CTC Youth Survey since 1998, some administrators and teachers had never seen the results. The CTC coalition shared this information using easy-to-interpret charts and common sense language and argued that students in their own districts were experiencing risk factors and engaging in problem behaviours in rates that were too great to ignore. Rather than rely on 'scare tactics' that conveyed only the extent of the problem, coalition members emphasized that solutions did exist to address problems, specifically, strategies that were proven effective in reducing risk and enhancing protection. To address proactively the argument that such programs cost too much money, coalition members provided evidence that many tested and effective strategies save taxpayers money in the long-run via the programs' effectiveness in preventing crime,

reducing utilisation of substance abuse and mental health services, and improving student graduation rates (Aos et al., 2004). They challenged school personnel to invest their time and money in strategies that did work rather than those that did not. In most cases, coalitions were also able to offer funding from the study to get programs started.

In late-adopting sites, these arguments had to be repeated many times, during formal presentations and informal interactions, in order to counter individual resistance to innovation and systematic barriers to adoption. When these challenges still could not be overcome, coalitions had to find more persuasive messages. Given schools' primary mission to enhance academic achievement, coalitions showed how the proposed prevention programs would help students succeed academically. To do so, four coordinators demonstrated that the new program would help fulfil mandated learning requirements, not add to them. Coordinators and coalition members also presented research that demonstrated more academic success (i.e., higher standardized test scores and grades) in schools that had lower rates of risk factors and higher rates of protective factors (Arthur, Brown, & Briney, 2006; Fleming, Haggerty, Catalano, Harachi, Mazza, & Gruman, 2005), to show that implementing prevention programs could enhance academic achievement.

When general messages lacked the impact necessary to convert sceptics to adopters, coordinators identified specific school needs and proposed solutions to them. The coordinator in Community N asked her superintendent to identify his district's needs, then stated, "We [the CTC coalition] want to help you. How can we do this?" In this community, teachers needed individual time with students to improve academic performance. The coordinator showed that the Stay SMART program met several of the district's academic standards and offered a staff person to teach it, which would allow classroom teachers time to meet with students. The superintendent agreed to the proposal. Similarly, in Community C, the middle school supported adoption of Skills for Adolescence, but only if the CTC coalition provided staffing so that teachers could focus on the district mandate to raise literacy standards.

The final strategy used by all coalitions was to provide detailed information on the proposed program and how it promoted healthy youth development and reduced problem behaviours. In formal and informal presentations, they shared evidence of general program effectiveness and demonstrated how the program would address the local prevention priorities identified from the CTC Youth Survey. In about half the cases, coordinators also obtained copies of the new curricula and encouraged staff and administrators to review it. In Community T, the coordinator and school principal visited a nearby town to observe the Skills for Adolescence program, after which the principal voiced his support, stating: "I want this." In another two cases, the coordinator and school administrator talked to the program developer/trainer to learn more about the program.

Other researchers have suggested that competing programming can impede the adoption of new programs (Elias et al., 2000; Piper et al., 1993). In this study, several communities faced this challenge, as schools already had (non-effective) programs in place to address prevention issues. In these cases, coalition members worked with schools to determine if current prevention efforts should be retained or dropped, typically by contrasting the proposed program with the status quo. In Community G, the high school health teacher reviewed the Towards No Drug Abuse curriculum with the community coordinator and agreed to adopt it because it "was similar to what she was [already] teaching...it could improve upon it because it was tested and effective...it was all packaged and ready to go... [and] it could make her teaching easier." In Community T, the Chief of Police had his officers teaching a program (Drug Abuse and Resistance Education, DARE) in the schools and did not want it to be dropped. The CTC coalition and school district negotiated with the

chief to move DARE to a different grade than the new program (Skills for Adolescence), but after two years and repeated discussions, the chief was persuaded that his department would make a greater impact on youth by partnering with teachers to deliver Skills For Adolescence and discontinuing DARE. The district superintendent summed up the negotiations in a press release stating: “We have been able to provide for the students of [city] drug education and the association... with law enforcement officers without duplicating services. This has been a win-win situation!”

In two other communities, school personnel could not be convinced to change programs. In Community J, the high school principal and health teachers were satisfied with their current health programming and stated that they did not have room in their schedule for a new program which they felt covered similar topics. In Community N, the district Superintendent supported the introduction of Life Skills Training, but told the coordinator that she would have to persuade individual schools and teachers to adopt it. In one of the middle schools in this district, the health teacher acknowledged the benefits of the new program, but told the coalition coordinator that she had developed the health curriculum currently in use and “that’s job security”; she was worried that her job would be threatened if an outside program were to be adopted.

Getting a foot in the door

During interactions with school personnel, coalitions did not critique past prevention choices made by the school, but rather stated that they wanted to help the schools meet their mutual goals of helping students to succeed. For late-adopting sites, it was particularly important that CTC coalitions demonstrate their ability to partner in this effort. To do so, coordinators and coalition members used a ‘foot in the door’ approach, taking small steps to build credibility and trust with schools in the hopes that they would eventually adopt a school-based program.

Coalitions that began with a non-school program (i.e., late adopters) showed schools how these extracurricular prevention activities helped students meet academic goals (e.g., through after-school tutoring programs) or improved student/parent communication and bonding (e.g., through parent training programs). In all seven late-adopting sites, coalitions asked schools to help them recruit students and parents into these programs and sometimes negotiated school space in which to conduct programming but did not demand teacher time or financial resources. They kept schools updated on program successes both to reinforce the message that prevention works and to communicate that they were doing their part in the community to meet student needs.

Some coalitions found that piloting the in-school programs could engage support when full enthusiasm was lacking or systemic challenges could not be overcome. In Communities N and C, schools would not provide their own staff to teach new programming, so the coalitions provided staff initially to teach the programs and hoped that schools would eventually supply their own teachers. The coordinator in Community I knew from prior interactions that the district was reluctant to adopt new innovations, so she negotiated a two-year pilot of the Life Skills Training program. By Year 3, the primary teacher had become a program champion and persuaded the school board to not only adopt the program, but also to pay for its materials and training. In Community T, the Skills for Adolescence program could not be taught in all seven elementary schools in 2005-2006 due to lack of funding. The coalition initiated the program in the school with the most supportive principal, then invited teachers from all other schools to attend the initial training and asked the school curriculum director to observe a lesson. In this manner, they engendered further understanding of and support for the program and were able to implement it district-wide in 2006-2007 with partial funding from the community.

Persistence pays off

As these examples illustrate, the most vital strategy, employed by all coalitions, was persistence. Building relationships, making presentations, and establishing trust required time and much effort. Without these repeated efforts, it is likely that the late adopters would have continued to prioritize traditional academic courses or non-effective prevention efforts over proven-effective prevention programs. Coalitions needed to have a long-term perspective when negotiating with schools, as successes sometimes occurred only after multiple conversations and repeated messaging that students needed tested and effective prevention programming and that adopting these programs could also address academic needs. Some coalitions used all the methods described above and still required several years before adoption took place. For example, in Community X, the middle school principal and curriculum director both agreed in November, 2005, that implementing Stay SMART during school hours made sense to them and should be, in their words, a “slam dunk” with other administrators and teachers. Yet, the coordinator found that more than 55 additional meetings and 2 years were required before a teacher agreed to implement the curriculum. In the end, adoption was achieved in this community, and all other intervention sites.

Discussion

The Communities That Care system was designed to enable community-based coalitions to identify community-specific prevention needs and install tested and effective programs to prevent the development of youth problem behaviours, including violence, delinquency, and substance use. While CTC does not mandate the use of school-based prevention programs, communities in the Community Youth Development Study endorsed such programming because there are numerous school-based curricula shown to be effective at reducing risk factors, improving protective factors, and reducing problem behaviours (Catalano et al., 1998; Farrell et al., 2001; Gottfredson, 1997; US DHHS, 2001). Moreover, such programs have been shown to be cost-effective (Aos et al., 2004) and can reach many youth. Given this evidence, and wishing to achieve community-wide reductions in problem behaviours, all 12 coalitions participating in this study sought and obtained the adoption of school-based programming at some point during the 2004-2008 school years. They did so by fostering relationships with schools, creating win/win situations, or beginning programs as small pilot efforts, then expanding. In this manner, they were able to build trust and credibility with schools and engender their support in achieving a common vision of healthy youth development.

While all communities were successful in partnering with schools, two communities did not adopt school-based programs until the fifth year of the study. In these sites, partnerships were particularly difficult to achieve and multiple conversations and strategies were needed to help schools progress through the phases of adoption. Across all sites, the most common barriers to adoption of curricula included schools' lack of internal champions for prevention, failure to perceive the benefits of new programs, focus on improving academic performance, and already-full schedules.

A lack of program champions was identified in all cases in which coalitions could not convince schools to adopt a new program^{iv}. The 18 programs that were adopted were all facilitated by champions within the school, though in many cases these supporters had to be developed over time. Coalitions used multiple strategies to highlight the benefits of new programs, beginning by showing how the innovation addressed student needs identified on

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^{iv}Even though all communities implemented school-based programs, five communities attempted to persuade schools to adopt additional middle or high school programs but were unsuccessful.

the locally-administrated CTC Youth Survey. They demonstrated that the new program(s) fulfilled mandated learning or prevention requirements, reduced problem behaviours more effectively than current programming, and helped to promote positive youth development, including academic performance. Then, coalitions demonstrated to schools that they could work together to meet these goals. Although finding room in the school schedule to teach curricula was a common barrier, coalitions found that when administrators and/or teachers became active supporters, they would make room for the new program. Some prevention curricula were taught in academic classes, including science, social studies, and English. CTC coalitions that were not immediately successful in fostering adoption of school programs found it effective to enact other prevention strategies and then communicate their successes to schools. Doing so not only enhanced their credibility, but also demonstrated that they were working in partnership with schools to foster healthy youth development.

Many of the strategies used in this study to overcome barriers to adoption have been utilized by prevention scientists in previous research, such as cultivating champions (Edwards et al., 2000; Mihalic & Irwin, 2003; Miller & Shinn, 2005; Rohrbach et al., 2006) and showing how new programs meet school needs (St Pierre, 2001; Webster-Stratton & Taylor, 1998). While many researchers have been successful in persuading schools to adopt new programs, some have faced challenges that could not be overcome or could not generate levels of support necessary to sustain programming (Fagan & Mihalic, 2003; Piper et al., 1993; St Pierre & Kaltreider, 2004). The findings from this study illustrate the advantages of using community-based efforts to install new tested and effective programs, and researchers who wish to establish partnerships with schools may increase their likelihood of success by seeking assistance from local coalitions that operate in the communities they are targeting.

Other studies of coalitions have not shown them to be successful in engaging schools in prevention efforts (Flewelling et al., 2005; Hallfors et al., 2002; St Pierre & Kaltreider, 2004). In this study, coalitions achieved partnerships by utilising the Communities That Care prevention system to identify their communities' greatest prevention needs, communicate these needs to school officials, and convince them that students would best be served by a combination of community-based and school-based programs. The Communities That Care model provides a structured framework for helping to translate scientific evidence into community practice by simultaneously emphasizing the installation of tested and effective programs and joint decision-making by a broad-based coalition invested in preventing adolescent violence, drug use, delinquency, and other problem behaviors. Thus, CTC can help community coalitions and local agencies move through Roger's (1995) stages of adoption, from gaining knowledge about the new innovation to deciding to use it and actually implementing programs.

In this study, coalitions helped schools proceed to adoption by providing detailed information about new programs to school officials, addressing the barriers to implementation identified by school personnel, and demonstrating to schools that they were not alone in trying to foster healthy youth development. Unlike outside researchers, coalition members typically had pre-existing relationships with school officials, which allowed greater credibility and easier entrée to school personnel. Even when success was not achieved immediately, the locally-based coalitions could take small steps, repeated over time, to bolster their credibility, demonstrate their interest in partnering with schools, and foster champions. By seeking adoption from within the community, coalitions engaged in joint decision-making and worked with partners to achieve a common vision. This collective action was expected to increase local ownership of programs, lead to higher quality implementation, and make program sustainability more likely (Edwards et al., 2000).

Although this paper has focused on techniques to foster coalition/school partnerships and promote the adoption of school-based programs, coalitions can use the CTC framework and *CTC Prevention Strategies Guide* to gain access about a variety of effective prevention programs that can be implemented to address community-specific prevention needs. Each community in this study adopted multiple programs, including school-based curricula and school-wide change interventions, afterschool tutoring and mentoring programs, and home- and group-based parent training curricula. These programs addressed a greater number of risk and protective factors and reached more individuals with prevention services than any single program would have. As a result, communities were able to increase their likelihood of achieving community-wide reductions in problem behaviours.

The CTC model of change (Hawkins et al., 2008) posits that community collaboration and high quality implementation of programs will lead to reductions in risk factors, increases in protective factors, and healthier development of youth. Early evaluations of the study have indicated that school-based and other programs have been well implemented (Fagan, Hanson, Hawkins, & Arthur, 2008) and that children in the intervention communities report a significantly slower increase in risk factors and less initiation of delinquency compared to children in control communities (Hawkins, Brown, Oesterle, Arthur, Abbott, & Catalano, 2008). While the small number of communities prohibits an evaluation of whether the number of programs adopted or levels of implementation fidelity are related to student outcomes, the main findings suggest that CTC is a promising framework for promoting the dissemination of effective prevention programs and helping communities to prevent the development of problem behaviors among their youth.

While all 12 communities in this project were successful in working with schools to adopt new programs to prevent violence, substance abuse, and other behaviours, participation in the Community Youth Development Study likely contributed to success. All intervention sites received six CTC training workshops that were open to school personnel and up to \$275,000 over 4 years to implement prevention programs. In addition, technical assistance providers provided coaching and support to local CTC coordinators, which sometimes involved sharing new developments in prevention science with the coordinators, discussing strategies to use with school personnel, and rehearsing presentations in advance of meetings. These benefits limit the generalizability of these findings. It should also be noted that the strategies described in this paper are based on the CTC coordinators' perspective. School personnel were not interviewed for their perspectives on these issues. Future research investigating coalition-based models of prevention and strategies for dissemination may wish to address these limitations, including analyses that examine relationships between program adoption, implementation fidelity, program sustainability, and reductions in community levels of problem behaviours.

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Table 1
Characteristics of Coalitions, School-based Prevention Programs Implemented, and Primary Strategy Used to Adopt New Programs in the Community Youth Development Study (CYDS)

Community	Percentage of School Representatives on the Coalition (Year One)	Number of School Coalition Members Who Attended the Year One Community Planning Training	Program(s) Selected (Study Years Implemented)	Primary Strategy Employed by Coalition to Foster Adoption	Total Enrollment in Programs Across All Years ²
EARLY ADOPTERS					
A	19% (6/32)	3	All Stars (Years 2-5) Program Development Evaluation (Years 2-3) Class Action ¹ (Year 5)	Top-down Top-down Top-down and bottom-up	513
T	36% (18/50)	11	Life Skills Training (Years 2-5) Lion's-Quest Skills for Adolescence (Years 3-5)	Top-down Top-down	6297
O	26% (10/39)	3	Lion's-Quest Skills for Adolescence (Years 2-5)	Top-down	959
C	22% (17/77)	13	Lion's-Quest Skills for Adolescence (Years 2-5)	Top-down and bottom-up	1237
J	38% (19/50)	6	Life Skills Training (Years 2-5)	Top-down	1576
Total	28% (70/248)	36			10,582
LATE ADOPTERS					
I	20% (8/40)	7	Life Skills Training ¹ (Years 3-5) Olweus Bullying Prevention ¹ (Year 3-5)	Bottom-up Top-down	1093
N	28% (22/80)	4	Stay SMART (Year 3) Life Skills Training ¹ (Years 4-5)	Top-down Top-down	1003
H	17% (9/53)	0	Life Skills Training ¹ (Years 3-5)	Top-down	1881
W	16% (4/25)	2	Project Alert (Years 3-5) Project Towards No Drug Abuse (Year 5)	Top-down Bottom-up	1638
Q	25% (8/32)	5	Olweus Bullying Prevention (Year 3-5)	Top-down	3150

Community	Percentage of School Representatives on the Coalition (Year One)	Number of School Coalition Members Who Attended the Year One Community Planning Training	Program(s) Selected (Study Years Implemented)	Primary Strategy Employed by Coalition to Foster Adoption	Total Enrollment in Programs Across All Years ²
G	25% (6/24)	5	Project Towards No Drug Abuse (Year 5)	Bottom-up	288
X	25% (8/32)	3	Stay SMART (Year 5)	Top-down and bottom-up	145
Total	22% (65/291)	26			9198

¹ Community funded the program with local rather than study funding

² Enrollment figures were derived by estimating the number of individuals exposed to programming each year it was offered, then totaling these figures; if the same students received multiple years of programming, they were counted separately for each year of programming they received.