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Implementing the Communities That Care Prevention System: Challenges, solutions, and opportunities in an urban setting

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Abstract

Introduction: *Communities that Care (CTC)*, refined and tested for over 25 years, offers a step-by-step coalition-based approach to promote well-being and prevent risk behaviors among youth. CTC guides coalitions to identify and prioritize underlying risk and protective factors; set specific, measurable community goals; adopt tested, effective prevention programs to target selected factors; and implement chosen programs with fidelity. CTC has been implemented in a variety of communities, but has only recently begun to be systematically evaluated in diverse, urban communities.

Methods.—This manuscript presents a process evaluation of CTC implementation within a Midwestern ethnically diverse, urban community. In-depth surveys of 25 black male youth aged 8-14 years and their caregivers were conducted to determine the degree to which coalition-selected priorities aligned with the experience of black families. Implementation and survey data were collected and analyzed between 2014-2017 and 2017-2018, respectively.

Results: Roughly 30% of youth reported ever being bullied or bullying someone else on school property; this aligned with the coalition's decision to focus on positive social skills and bullying prevention. Additional data aligned with the coalition's intent to expand its community action plan to encompass other priorities, including family transitions and mobility. For example, roughly 1/3

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of caregivers went on welfare and 1/3 of families moved to a new home or apartment in the past year.

Conclusions: In communities whose residents have experienced historical and current inequities, an effective community prevention plan may need to address structural as well as social determinants of well-being among youth and their families.

Introduction

Communities that Care (CTC), refined and tested for over 25 years, is a placed-based community planning framework to identify, prioritize, and address risk and protective factors that underlie youth risk behaviors.[1-3] CTC offers a step-by-step coalition-based approach to promote well-being and future success among youth and prevent risk behaviors. CTC provides a structure for engaging community stakeholders, a process for establishing a shared community vision, tools for assessing community levels of risk and protection, and processes for prioritizing risk and protective factors and setting specific, measurable community goals. CTC guides the coalition to create a strategic community prevention plan that addresses the community's profile of risk and protection with tested, effective programs, and to implement chosen programs with fidelity. CTC instructs the coalition to monitor program implementation; periodically reevaluate community levels of risk, protection, and outcomes; and make adjustments in prevention programming if indicated by data.

CTC has demonstrated success in smaller, predominantly Caucasian communities.[4,5] Twenty-four communities in 7 states participated in a group randomized controlled trial (RCT) of the CTC prevention system. Middle school students in CTC communities were less likely to initiate delinquent behavior and substance use across a 5-year period, including the final year during which study-provided resources had ended.[6,7] Effects were stronger for those youth who did not engage in delinquent behaviors at baseline, highlighting the importance of early prevention and intervention.[8] More recent analyses have shown that students in CTC communities remained less likely to initiate delinquent behavior and substance use through age 21.[9-11] Additionally, findings from a quasi-experimental study in Pennsylvania suggest that significant public health benefits can be gained from wide-scale CTC implementation, including an 11% reduction in delinquency.[5,12]

CTC has only recently begun to be systematically evaluated in ethnically diverse, urban communities – particularly those that may be reluctant to adopt prevention programming initially developed and implemented within predominantly white communities. Cullen and Jonson have called for studies to determine whether CTC can be successfully implemented within urban communities marked by concentrated disadvantage and challenges in building collective efficacy.[13] This call to action acknowledges the need for place-based approaches to prevention in communities where risk and protective factors may be structural in nature. The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work, and age; these circumstances are shaped by structural factors – namely, the distribution of money, power, and resources in a society.[14,15]

This manuscript presents a process evaluation of CTC implementation within an ethnically diverse, urban community in the Midwestern United States. To prepare for the present

implementation, Parker and colleagues (under review) summarized information gleaned from community readiness interviews and concluded that both structural barriers (e.g., economic hardship) and interpersonal barriers (e.g., poor relationships between parents and teachers) should be addressed to promote well-being of youth and families in the community.[16]

Methods

This coalition is one of the first to utilize the CTC PLUS system, which consists of web workshops with instructional videos and other digital materials. Sources of data for the present process evaluation included (1) CTC coaching notes, (2) coalition and workgroup meeting attendance and minutes, and (3) monthly summaries of activity maintained by the CTC coordinator. The CTC fidelity tracking tool, Milestones and Benchmarks [17] was reviewed periodically by the coalition and CTC coordinator throughout 2014-2017 to ensure activities were consistent with CTC. The CTC coordinator, who acted as a facilitator during coalition meetings, met at least twice monthly with a coach from the Center for Communities that Care to discuss standard CTC procedures and refine procedures, as necessary, without compromising fidelity.

For the present study, it was agreed that the coalition's selected prevention program would be implemented by a partnering pre-K-8 public school, the largest within the community, and the local Boys and Girls Club. Each organization serves similar, partially overlapping segments of the community. In the partnering school, black and Latino students are overrepresented and white students are underrepresented (6% white, 42% black, 31% Asian, 17% Latino) relative to the surrounding community. Over 90% receive free or reduced price lunch. While coalition efforts were intended to benefit all youth in the community, this project was part of a larger research collaboration to promote healthy life trajectories of black men. For this reason, the coalition's research partner recruited a small sample of black families from the partnering school (25 male youth/caregiver dyads) to answer questions corresponding to coalition priorities and the experience of racism, a structural barrier to well-being and future success that is of particular interest to coalition members. Collecting data of this nature is unique with respect to previous implementations and evaluations of CTC.[17-20]

CTC implementation data and supplemental survey data were collected and analyzed between 2014-2017 and 2017-2018, respectively. The University of Minnesota IRB determined that coalition members were not research participants; the IRB and school district approved consent, assent, and research procedures for collection of supplemental data from black families.

Surveys of Black Families.

Letters of invitation were sent from the school principal to families with a black male student between the ages of 8-14 years. School-based research staff phoned caregivers to provide further information, answer questions, and screen interested families for eligibility. Staff explained that interviews were being conducted to better understand issues related to the well-being and future success of black young men, and to inform the way that school

and health professionals think about children's behavior and plan programs to promote children's well-being and future success. Inclusion criteria were caregiver-reported black or African American ethnicity and male gender of child, and age of child within 8-14 years, inclusive. African immigrants and refugees were excluded. Structured interviews were held at school. After obtaining consent from caregivers and assent from children, trained members of the research team interviewed family members in separate rooms. Each family member was compensated with a $20 gift card for participation. Of 87 eligible families, 25 participated (29% response rate).

Positive Social Skills among Children.—The experience of being bullied on school property was assessed using a single item from the CDC Youth Risk Behavior Surveillance Study [21] (see Table 3), revised to assess "ever" being bullied and bullying others on school property. Children completed the *Prosocial Behavior* subscale (e.g., I try to be nice to other people - I care about their feelings; 5 items; α=.54) of the Strengths and Difficulties Questionnaire (SDQ).[22]

Transitions and Mobility among Children and Caregivers.—Four items from the Family, Friend, and Child Life Events measure [23] and six items from the Peri Life Events Scale [24] were administered to assess family transitions and mobility among children and caregivers, respectively (see Table 3). Two additional items were administered to caregivers to reflect stressors that can precipitate transitions and mobility (harassed by bill collectors; trouble with the law).

Relationships with Teachers and Academic Engagement among Children and Caregivers.—Children completed two items from a teacher support scale [25] and two items from the National Center for School Engagement [26] (see Table 3). Caregivers completed three items from the Parent and Teacher Involvement Questionnaire [27] and one educational aspiration item adapted from the National Longitudinal Study of Adolescent Health [28] (see Table 3).

Emotional Well-Being and Mental Health among Children and Caregivers.—Children completed the following subscales of the SDQ: *Emotional Symptoms* (e.g., I have many fears - I am easily scared; 5 items; α=.40); *Conduct Problems* (e.g., I fight a lot - I can make other people do what I want; 5 items; α=.71); *Hyperactivity/Inattention* (e.g., I am restless - I cannot stay still for long; 5 items; α=.68); *Peer Relationship Problems* (e.g., I would rather be alone than with people of my age; 5 items; α=.29).[22] A total SDQ score was also calculated (20 items; α=.77). Caregivers completed the Depression, Anxiety, Stress Scales (DASS), Short Form: *Depression* (e.g., I couldn't seem to experience any positive feeling at all; 7 items; α=.89); *Anxiety* (e.g., I felt that I was close to panic; 7 items; α=.79); *Stress* (e.g., I tended to overreact to situations; 7 items; α=.87).[29]

Perceptions and Experiences of Racism among Children and Caregivers.—Children and caregivers completed a modified version of the *Awareness of Racism* scale, which assessed the extent to which children and their caregivers perceived that others would see children through a lens of low, negative expectations (see Table 3; 4 items; α=.47 among children; α=.78 among caregivers).[30] Remaining items were developed by

coalition members to assess children's personal experiences and expectations of racism in the community, from the perspective of both children and caregivers (see Table 3).

Reactions to Hazel Park Community Coalition Priorities.—Items were developed by coalition members to assess and youths' and caregivers' reactions to selected evidence-based prevention programming, as well as caregivers' reactions to coalition priorities and receipt of referrals to related services (see Table 3). In addition, caregivers were asked one open-ended question, "Is there anything else that you think the coalition should be focusing on?"

Results

Implementation of CTC.

As detailed by Fagan and Hawkins,[3] CTC implementation progresses through five phases. Table 1 contrasts typical implementation of the CTC Prevention System with particularly notable aspects for the Hazel Park Community Coalition. Challenges and flexible solutions that preserved fidelity are highlighted. Consistent with CTC guidelines, community board members divided into workgroups to transform the community's vision into action. Table 2 shows the dates and attendance rates of community leader, community board, and workgroup meetings between February, 2015 and May, 2017. Board members expressed appreciation for CTC's workgroup structure because it efficiently divided members' work. A higher proportion of members attended workgroup meetings than larger coalition meetings, potentially because workgroups were smaller, more focused, and time-limited with respect to tasks.

Implementation of the Olweus Bullying Prevention Program (OBPP).[31]

OBPP has been implemented at the partnering school since January 2017 and the partnering Boys & Girls Club since spring, 2017. OBPP content is delivered during weekly meetings at the school and through different forums at the Boys & Girls Club, including small groups concentrating on "team skill building" prior to participation in the club's sports programs, and "summer assembly" meetings. To date, over 700 students have been reached through implementation activities.

The intention of OBPP is to accomplish climate change within organizations and the surrounding community (e.g., acting to prevent or intervene in bullying situations; changing norms). Youth receive program materials through group meetings. The broader community (e.g., caregivers, local businesses) is made aware of the program and asked to support climate change. To engage and involve caregivers and the broader community in the coalition's first prevention initiative, the coalition devoted one of its newsletters to OBPP. In addition, a school staff member worked with youth to write and stage a play, titled *The Twilight Zone*. During the play, groups of youth depicted instances of bullying, froze in place, and then reenacted the scene such that the former bully engaged in respectful, supportive behaviors. At both sites, those responsible for implementing OBPP and monitoring fidelity have observed that videos and activities are particularly effective in

eliciting engagement and discussion among youth. One administrator noted that students are better able to identify and appropriately respond to bullying.

Alignment of Coalition Priorities with the Experience of Black Families.

Table 3 contains key indicators of Hazel Park Community Coalition priorities among black male youth and their caregivers. Roughly 30% of youth reported ever being bullied or bullying someone else on school property. When compared to normed values of the SDQ, mean levels for Prosocial Behavior were slightly lower (M=7.8 vs. M=8.4).[31]

Over a 1-year period, roughly 1/3 of caregivers went on welfare and 1/3 of families moved to a new home or apartment. Over 40% of youth reported additional family tensions and stressors, including arguments between parents and someone in the family being arrested. On average, youth and caregivers reported positive relationships with teachers and high levels of academic engagement. When compared to normed values of the SDQ, mean levels for black males in the present sample were higher for Emotional Symptoms (M=3.6 vs. M=1.5), Conduct Problems (M=3.1 vs. M=1.5), Hyperactivity-Inattention (M=4.4 vs. M=3.1), Peer Problems (M=2.4 vs. M=1.5), and Total Difficulties (M=13.5 vs. M=7.6).[32] When compared to normed values of the short-form version of the DASS-21, mean levels for caregivers within the present sample were lower for depression (M = 1.9 vs. M = 2.8) and similar for anxiety (M = 2.0 vs. M = 1.9) and stress (M = 4.7 vs. M = 4.7).[33]

Table 3 also contains perceptions and experiences of racism. Black male youths' general awareness of racism varied; the mean level was at the scale mid-point (M=2.0). On average, youth perceived that their teachers understood racial and cultural differences and did not behave in a racist or discriminatory way. They tended to perceive opportunities to get ahead in their community and in life, and reported low levels of being treated badly in the past year because they were black. Caregivers' responses to similar questions demonstrated a similar pattern of response, but were more tempered. Roughly a quarter of caregivers stated that their black sons had ever had contact with the police in a way that might be considered stressful. Of these caregivers, roughly 1/3 attributed the stressful contact to behaviors that were racist or discriminatory on the part of police.

Table 4 shows that black caregivers (M=4.2) and youth (M=4.0) were "satisfied" and "happy," respectively, with the coalition's decision to focus its initial prevention efforts on the prevention of bullying and promotion of positive social skills. Caregivers' reaction to the coalition's four priorities was also favorable; the mean evaluation (M=4.5) fell between "satisfied" and "very satisfied." When asked if there was anything else upon which the coalition should be focusing, caregivers expanded upon the coalition's identified priorities and highlighted related factors that may be considered both interpersonal and structural in nature (see Table 4).

Table 4 also shows that small, but sizable percentages of caregivers have received school referrals to assist in issues related to family transitions and mobility (17%), academic engagement (20%), and emotional well-being and mental health (13%).

Discussion

A key emphasis of the present implementation of CTC PLUS is identifying ways in which community-driven prevention may be enhanced for communities whose residents are experiencing historical and current inequities relative to the broader society. Two early insights emerged. First, coalitions should review and potentially refine standardized research procedures, survey items, and related communications to ensure that practices and language are likely to be well-received by the community. Practices and language that have been well received by other communities may elicit negative responses (e.g., feeling labeled and stereotyped). The CTC system is designed to be "locally owned"; therefore, responsiveness to local context is critical. The CTC process is flexible enough to allow modifications to standardized procedures and survey items in terms of "style" rather than "substance" in order to preserve fidelity.

Second, coalitions may wish to ensure that prevention efforts include structural issues facing caregivers and other adults in the community (e.g., those experiencing economic hardship and challenges to social cohesion) as well as youth. The present implementation of CTC has begun with the introduction of the Olweus Bullying Prevention Program (OBPP) into a local partnering school and Boys & Girls Club. Through this evidence-based program, the coalition is promoting the development of positive social skills among youth. The program may also assist in promoting emotional well-being and mental health. Both the partnering school and Boys & Girls Club provide programs to promote academic engagement. What the coalition is not yet addressing in a systematic fashion are family *transitions and mobility*, one of its four prevention targets and something that coalition members believe is key to the overall well-being and future success of youth, as well as the ability for caregivers to provide a supportive context for youth. Moving forward, coalition members will consider how this priority can be addressed. One prevention approach receiving increased attention in policy circles is the "two-generation approach," which involves the intentional coordination and alignment of programs and services for children and adults to equip the whole family with tools and skills for success.[34-36]

Additional frameworks may assist this CTC coalition and others to consider how they can target structural determinants of well-being and future success. The World Health Organization (WHO) established a Commission on Social Determinants of Health to summarize evidence for how the structure of societies – through governance, policies, culture, and values – determines the health of populations.[37] Application of the WHO framework to CTC might involve advocacy on the part of coalition members at the city and county levels for policies and programs that will benefit adult residents, including caregivers of youth (e.g., access to affordable and high-quality education and job-training, affordable housing, criminal justice reform, reintegration into society if a family member has experienced incarceration). Additional resources to guide advocacy efforts may help coalition members to consider how they can prepare for "policy windows" [38] and partner with interest groups and advocacy organizations to encourage policymakers' adoption of evidence-based policies and programs.[39,40]

Limitations of this evaluation include its focus on a single community, lack of information from individual coalition members, and – due to the early stage of CTC implementation – lack of information about whether coalition activities are changing risk and protective factors in the community. Insights from this evaluation may inform CTC implementation in other ethnically diverse, urban communities, particularly where residents have experienced historical and current inequities rooted in race, ethnicity, or socioeconomic status. Data collected as part of the supplemental survey of black families augment traditional CTC tools.

Conclusions.

Community-driven prevention requires an ongoing commitment of resources by community leaders to promote sustainability; cultivation of relationships and efficient use of skills among diverse coalition members to promote investment of time and creative, responsive prevention strategies; and ongoing evaluation and adjustment of prevention strategies to promote optimal well-being among youth and their families. In communities whose residents have experienced historical and current inequities, an effective community prevention plan may need to address structural determinants of well-being among youth and their families.

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Conflict of Interest Statement:

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Table 1.

Phases of the CTC Prevention System: Typical implementation and notable aspects of implementation by the Hazel Park Community Coalition.

	Typical Implementation	Hazel Park Community Coalition Notable Aspects of Implementation
Phase I: Get Started	*Overarching Goal:* Assess community readiness and position the community to undertake collaborative prevention activities. **1** Identify key leaders within community, preferably through a champion willing to encourage CTC as a prevention strategy. **2** Hold meetings with potential leaders to assess community readiness to adopt CTC and local implementation barriers. **3** Hire a coordinator to facilitate coalition activities; the convening organization typically hires the coordinator. **4** Obtain school district support for administering the CTC student survey, which provides epidemiologic data to compare to national norms to identify elevated risk factors and depressed protective factors in the community. [a]	• Principal of partnering school acted as coalition's CTC champion and provided names and contact information of potential key leaders; these individuals in turn recommended others. • Coalition coordinator was hired by University research partner; this person held meetings with potential leaders and conducted readiness interviews. • Coalition was unable to obtain school district support for a passive consent procedure for administering anonymous CTC student surveys to students. • School administrators and other coalition members expressed concern that a disproportionate number of survey items assessing risk factors and behaviors could lead youth and other community members to feel labeled. • Selected survey items assessing substance use were removed because they were not essential to the creation of composite variables that would be compared to national norms. [b] • In place of removed items, coalition members inserted items to reflect local concerns (e.g., experiences of discrimination). • Coalition planned a supplemental survey of black male youth and their caregivers.
Phase II: Organize, Introduce, and Involve	*Overarching Goal:* Form a diverse and representative coalition to coordinate prevention efforts. [c] **1** Community leaders garner support for prevention and identify candidates for the CTC community board. **2** Community board develops a vision statement and establishes workgroups to transform this vision into action. **3** Together, the community leaders and board comprise the coalition.	• Reflecting pre-existing relationships, leaders included heads of youth-serving organizations within the focal urban neighborhood, as well as professionals focused on the well-being of diverse youth and families within the county. • Coalition members included stakeholders from government (1), law enforcement/justice (1), education (6), health (4), social services (1), the faith community (1), culture/diversity (1), neighborhood groups (1), parent groups (2), and youth serving organizations (3). • With consultation from the Center for Communities that Care, length, content, and language of CTC PLUS materials were adjusted to better fit the time constraints of coalition members and community culture. • Opinions of caregivers were sought during monthly parent-teacher organization meetings. • As an engagement tool, the coalition distributed newsletters every 3-4 months to caregivers via mail and children's backpacks.
Phase III: Develop a Community Profile	*Overarching Goal:* Identify risk and protective factors that are a priority for prevention efforts. **1** Use local epidemiologic data (e.g., CTC youth survey, rates of student suspensions and mobility) to identify risk and protective factors in the community. **2** Assess existing prevention resources to determine the degree to which resources are evidence-based,	• Inability to obtain school district support for a passive consent procedure resulted in a low participation rate among 6th and 8th grade students who were administered the CTC student survey (57%); this meant that data was less likely to be representative of the school as a whole. • CTC student survey data was augmented by archival data within community (e.g., school-level student attendance; standardized test scores; suspensions; proportion of students receiving free and reduced lunch; retention of students over time, an indicator of family mobility; school district graduation rates). • Assistance from coalition coordinator, hired full time to facilitate work of the coalition, proved essential to following the CTC process – particularly, conducting research into existing

	Typical Implementation	Hazel Park Community Coalition Notable Aspects of Implementation
	accessible, and being utilized by members of the community.	community resources and different prevention program options, and documenting coalition efforts and key decisions. • Community board selected four CTC factors for preventive action: academic failure, depressive symptoms, early and persistent antisocial behavior, and transitions and mobility. • Three selected factors were reframed in positive terms to inspire coalition and community members (i.e., academic engagement, emotional well-being and mental health, positive social skills).
Phase IV: Create a Community Action Plan	*Overarching Goal:* Choose one or more evidence-based prevention policies and programs that target the coalition's identified factors. *d* **1** Resource Assessment workgroup identifies programs that may fill service gaps and reports results to the community board. **2** Community board develops a community action plan.	• A review of the Blueprints for Healthy Youth Development website yielded seven initial candidate programs: Good Behavior Game,[41] Positive Family Support,[42] Raising Healthy Children,[43] Positive Action,[44] Promoting Alternative Thinking Strategies (PATHS),[45] Reading Recovery,[46] and the Olweus Bullying Prevention Program (OBPP).[31] • Board members encouraged selection of OBPP to address positive social skills. • Coalition members reached out to two communities who were implementing OBPP to confirm that the program would be a good fit.
Phase V: Implement and Evaluate the Community Action Plan	*Overarching Goal:*Implement and evaluate the community action plan, which positions the coalition to adjust programming as indicated. **1** Implement selected prevention programs with fidelity. **2** Evaluate impact of prevention programs on youth behaviors.	• The principal of the partnering school and the branch director of the local Boys & Girls Club agreed to implement OBPP within their organizations. • All school and Boys & Girls Club staff received training in OBPP implementation and monitoring of fidelity by a certified trainer with 5 years of experience; this individual provided consultation to each site for one year. • Evaluation of OBPP is currently underway. • Coalition intends to expand community action plan to encompass remaining coalition priorities (family transitions and mobility, academic engagement, and emotional well-being and mental health).

a"On average, 89% of students completing the CTC Youth Survey as part of the 24-community RCT were white (range, 64% to 98%), 3% were black (range, 0% to 21%), 10% were of Hispanic origin (range = 1% to 65%), and 37% were eligible for free or reduced-price lunch (range, 21% to 66%)."

*b*Lifetime and "past 30 day" use of the following items were removed from the CTC Youth Survey: LSD or other psychedelics; cocaine or crack; MDMA ("ecstasy"); sniffing glue, breathing the contents of an aerosol spray can, or inhaling other gases or sprays in order to get high; Tyrexatine ("T-Rex", "Reck"); methamphetamines ("meth"); prescription opiate pain relievers, such as Vicodin®, OxyContin®, or Tylox®, without a doctor's orders; prescription tranquilizers, such as Xanax®, Valium®, or Ambien®, without a doctor's orders; prescription stimulants, such as Ritalin® or Adderall®, without a doctor's orders. Questions assessing alcohol, tobacco, and marijuana use were retained.

*c*For the CTC RCT within smaller-sized cities and towns,[6,7] leaders included policymakers at the city level (e.g., mayor, police chief, school district superintendent).

*d*CTC recommends using the University of Colorado's Blueprints for Healthy Youth Development website (www.blueprintsprograms.com) for a menu of the most rigorously evaluated evidence-based programs.

Table 2.

Coalition member attendance of meetings.

Type of Meeting and Date	No. Invited	No. Attended	Attendance Rate
Community Leaders			
2/5/2015 [a]	24	11	46%
7/10/2015	29	10	34%
7/22/2015	36	17	47%
Community Board			
11/4/2015	15	13	87%
12/16/2015	16	6	38%
1/20/2016	17	13	76%
2/17/2016	18	13	72%
3/16/2016	19	5	26%
5/25/2016	17	10	59%
6/22/2016	18	6	33%
9/21/2016	16	6	38%
10/24/2016	17	7	41%
11/16/2016	17	5	29%
3/6/2017	20	11	55%
5/1/2017	24	11	46%
Risk and Protective Factor Workgroup			
12/21/2015	3	3	100%
1/21/2016	3	3	100%
Resource Assessment Workgroup			
2/29/2016	3	2	66%
3/29/2016	3	3	100%
5/18/2016	3	3	100%
Funding Workgroup			
3/3/2016	2	2	100%
Community Board Maintenance Workgroup			
2/11/2016	3	3	100%
2/16/2016	3	3	100%
3/10/2016	3	3	100%
Community Outreach Workgroup			
2/29/2016	2	2	100%

[a]Four additional individuals who were not invited attended the meeting with a colleague who was invited.

Table 3.

Key indicators of Hazel Park Community Coalition priorities and experiences of racism among black male youth and their caregivers (n=25 dyads).

Black Male Youth	% Yes or Mean (SD)	Caregivers	% Yes or Mean (SD)
Positive Social Skills		***Transitions and Mobility, Past Year***	
Ever been bullied on school property? [a]	32%	I took on a greatly increased work load.	40%
Ever bullied someone else on school property? [a]	28%	I was laid off from work.	24%
SDQ, Prosocial Behavior [b]	7.8 (1.7)	I took a cut in wage or salary.	16%
		I went on welfare.	32%
Transitions and Mobility, Past Year		I was harassed by bill collectors.	16%
My parents had problems with money.	38%	I moved to a worse residence or neighborhood.	16%
I moved to a new home or apartment.	36%	My relationship with my spouse/significant other changed for the worse.	24%
My parents argued a lot.	42%	A close family member, significant other, or friend got in trouble with the law.	32%
Someone in my family was arrested.	44%	*Total number of events (of 8)*	2.0 (1.9)
Total number of events (of 4)	1.6 (1.4)		
Relationships with Teachers & Academic Engagement (1-3 scale) [c]		***Relationships with Teachers & Academic Engagement (1-5 scale)*** [d]	
My teachers really care about me.	2.8 (0.4)	Have you felt your child's teacher cares about your child?	4.0 (0.8)
My teachers really listen to what I have to say.	2.5 (0.6)	Have you asked your child's teacher questions or made suggestions about your child?	3.7 (1.2)
I am interested in the work I get to do in my classes.	2.5 (0.5)	Have you stopped by to talk to your child's teacher?	2.8 (1.1)
I want to go to college.	2.8 (0.5)	How disappointed would you be if (child) did not graduate from some type of post-high school degree program, like college or a vocational school?	4.2 (1.0)
Emotional Well-Being and Mental Health [e]			
SDQ, Emotional Symptoms	3.6 (2.0)	DASS, Depression	1.9 (3.1)
SDQ, Conduct Problems	3.1 (2.2)	DASS, Anxiety	2.0 (3.2)
SDQ, Hyperactivity/Inattention	4.4 (2.3)	DASS, Stress	4.7 (4.8)
SDQ, Peer Relationship Problems	2.4 (1.8)		
SDQ, Total Difficulties	13.5 (5.9)		
Perceptions & Experiences of Racism (1-3 scale)		**Perceptions & Experiences of Racism (1-5 scale)**	
Awareness of Racism, Total Score [c]	2.0 (0.4)	***Awareness of Racism towards Child, Total Score*** [f]	3.7 (0.9)
Some people will treat me differently because I am African American.	1.6 (0.8)	Some people will treat my child differently because he is African American.	4.1 (0.9)
The way I look and speak influences what others expect of me.	2.3 (0.7)	The way my child looks and speaks influences what others expect of him.	4.0 (1.2)

Black Male Youth	% Yes or Mean (SD)	Caregivers	% Yes or Mean (SD)
People might have negative ideas about my abilities because I am an African American.	2.0 (0.7)	People might have negative ideas about my child's abilities because he is an African American.	3.7 (1.1)
Things in the African American community are not as good as they could be because of lack of opportunity.	2.2 (0.6)	Things for my child are not as good as they could be because of lack of opportunity in the African American community.	3.0 (1.2)
Personal Experiences and Expectations of Racism in the Community [c]		***Perceptions of Child's Experience of Racism in the Community***	
My teachers understand racial and cultural differences.	2.9 (0.3)	The teachers at your child's school understand racial and cultural differences. [d]	3.9 (0.8)
The teachers at my school behave in a way that is racist or discriminatory. [g]	1.2 (0.4)	The teachers at your child's school behave in a way that is racist or discriminatory. [d,g]	1.6 (0.9)
To what extent do you feel that there are opportunities for African American people to get ahead in the Hazel Park community?	2.8 (0.5)	Has your child ever had any contact with the police in a way that might be considered stressful?	24%
Do you think it will be harder for you to get ahead in life because you are African American?	1.4 (0.6)	*(If yes)* In your opinion, did stressful contact ever occur because the police were being racist or discriminatory in their behavior? [g]	33%
In the past year, how often have you been treated badly by other people because you are an African American?	1.4 (0.6)		

[a] Prior to the bullying questions, the following explanation was provided, "Bullying is when one or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when two students of about the same strength or power argue or fight or tease each other in a friendly way. Does that make sense, or would you like to talk about what bullying is again?"

[b] Scores for subscales can range between 0-10; scores for the total difficulties scale can range between 0-40.

[c] 1 = not at all, 2 = a little, 3 = very much

[d] 1 = not at all, 2 = a little, 3 = some, 4 = a lot, 5 = a great deal

[e] Scores for subscales can range between 0-21.

[f] 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree

[g] After the question, the following explanation was provided to youth/caregivers, "For example, treating me/your child differently because of the color of my/his skin."

Table 4.

Reactions to Hazel Park Community Coalition priorities and related referrals among black caregivers and youth (n=25 dyads). [a]

	Caregivers Mean (SD)		Youth Mean (SD)	
Reactions to Coalition Priorities and Initial Community Action Plan				
Overall Reaction: The Hazel Park Community Coalition has decided to address four factors they believe may promote the well-being and future success of children: (a) Positive Social Skills, (b) Transitions and Mobility, (c) Academic Engagement, and (d) Emotional Well-being and Mental Health. How satisfied are you with the decision to focus on these four factors? [b]	4.5	(0.7)	na	na
Positive Social Skills: The school has chosen the Olweus Bullying Prevention Program to encourage positive social skills among the boys and girls who come here. How satisfied (caregivers)/happy (children) are you with the approach the school is taking to promote positive social skills? [b]	4.2	(0.9)	4.0	(1.0)
Referral to Resources Addressing Coalition Priorities Prior to Coalition Organized Efforts		**% Yes**		
Transitions and Mobility: Has the school referred you to any school or community resources that can help with family transitions and mobility, such as housing assistance programs, local charities, and shelters?		17%	na	na
Academic Engagement: Has the school referred you to any school or community resources that can help with academic engagement, such as academic tutoring for your child?		20%	na	na
Emotional Well-Being and Mental Health: Has the school referred you to any school or community resources that can help with mental health, behavioral health, and other aspects of a family member's well-being?		13%	na	na
"Is there anything else that you think the coalition should be focusing on?" (Sample responses)				
(1) Teasing, bullying… differences.				
(2) Safety in classrooms, safe transferring from school to bus stop.				
(3) Not suspending kids for every single thing.				
(4) Attendance and grades… more people to help tutor the kids.				
(5) Homeless kids that don't have a place to stay and meal to eat.				
(6) More activities for youth, especially in summer, like camps that kids can't afford.				
(7) Getting kids off the street, providing after school activities… more learning centers beyond just a hangout spot. Having men, adults to lead, inspire them.				
(8) African American men who are role models for African American boys… Most African American boys don't have a father figure.				
(9) Recreation for youth, Big Brother programs… parent and child relationships.				
(10) Reinforce the meaning and value of a community.				

[a] na = not applicable

[b] Caregivers: 1 = highly dissatisfied, 2 = dissatisfied, 3 = no opinion, 4 = satisfied, 5 = highly satisfied

Youth: 1 = very unhappy, 2 = unhappy, 3 = no opinion, 4 = happy, 5 = very happy