Does Communities that Care work?

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An evaluation of a community-based risk prevention programme in three neighbourhoods

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1 Introduction

Introducing the report

In the mid-1990s the Joseph Rowntree Foundation (JRF) funded the Communities that Care (CTC) prevention initiative.[1] This early intervention programme targets children living in communities and families that are deemed to put them at risk of developing social problems. The CTC approach focuses on specific geographical areas and involves bringing together local community representatives, professionals working in the area and senior managers responsible for service management. Participants are given training and provided with evidence of the levels of risk and protection in their community. From this they design an action plan that seeks to enhance existing services or introduce new ones likely to reduce risk.

Although it has become international, CTC has its origins in the USA.[2] In commissioning the CTC programme in the UK, JRF had to develop an infrastructure to facilitate the implementation of the Communities that Care approach. This involved four main elements:

- the transference and anglicising of techniques developed in the USA to a UK setting
- setting up an independent charitable organisation responsible for running the CTC programme in the UK
- funding three demonstration projects in the UK
- funding an evaluation of these projects.

This is the second evaluation report on the first three CTC demonstration projects. The first report was based on interim findings and focused on the early development and set-up of the programme. This is the final report of the five-year evaluation. In making the assessment of CTC we incorporate findings from the first interim report while looking in more detail at how the demonstration projects have developed and what impact they had between January 2000 and July 2002. Everything the reader needs to know about the findings of the evaluation is available in this report. In the remainder of this chapter we explain what the Communities that Care programme is about, and say how we set about evaluating the three demonstration projects. Chapters 2, 3 and 4 describe what happened in each of the three areas, what was delivered as a result of CTC activity and what changes, if any, took place as a result of CTC demonstration projects. In the final chapter we discuss the main findings of the evaluation, recommendations for CTC and lessons for future policy implementation in the area of early intervention and prevention for children and their families.

Introducing Communities that Care

The empirical and theoretical base of the CTC prevention approach

Two main strands underpin the Communities that Care approach to prevention. First, empirical evidence shows that certain risk factors within communities are associated with particular types of future problem behaviour (Hawkins *et al.*, 1992; Farrington, 1997). Risk factors are types of behaviour and attitudes that children, their siblings, friends or parents may have (Farrington, 2000). They include such things as lack of discipline in families, poor supervision by parents, underachievement in primary school, lack of neighbourhood attachment, and having friends involved in problem behaviours.[3] Risk factors are seen to increase the chance that a child will grow into a young person with problem behaviours (Farrington, 2000). Hawkins *et al.* (1992) reviewed the longitudinal research evidence in the USA to show how risk factors cluster around four domains: the family, the community, the individual and the school. Farrington (2000) argues that those most at risk of developing problem behaviour are those who have multiple risk factors across the four domains. Twenty-four risk factors have been identified as important in CTC USA, and 17 in CTC UK (see Appendix 2).[4]

The Communities that Care approach proposes that early intervention and prevention with children and their families has to be guided by evidence throughout (Hawkins *et al.*, 2002). This is achieved through three processes. First, CTC has developed a number of research tools that are used to identify and measure the levels of risk and protection within geographical areas. The CTC approach to prevention aims to identify and measure the levels of risk factors in defined geographical areas, highlighting those that are most likely to lead to greater social problems amongst young people, and then target them with interventions. These tools are school self-report surveys and the collation of information from local and national records that constitute a risk audit. Second, CTC provides evidence of 'what looks promising' in terms of tackling risk. In 1999 JRF produced a publication called *Promising Approaches*. It provided information on programmes that had been assessed to be either effective in reducing risk factors or showing promise of doing so.[5] Finally, CTC projects are encouraged to evaluate the initiatives they put in place, and to undertake a regular review of risk and protection by rerunning the risk audit and reassessing the Action Plan after a period of time.

The theoretical basis for CTC is what Catalano and Hawkins (1996) call the social development model. For them, child development is influenced by the quality of the interaction between children and adults. They argue that for children to grow up problem free and healthy they need to be given clear standards of behaviour and

have positive social bonding with adults. To aid this process children and young people need to be given opportunities to be involved and valued in their families, schools and communities, to gain social and learning skills, and to be given recognition and praise, ensuring that their positive behaviour is recognised. The social development model therefore sees the development of pro-social factors as a means of protecting children from the consequences of risk factors. Protective factors are seen as more cross-cutting and contribute to reducing risk in all areas. The CTC approach therefore advocates the reduction of risk factors and the promotion of pro-social factors that will help children to manage their circumstances better (Pollard *et al.*, 1999).

CTC as a process not a programme

It is important to recognise that, although often referred to as a programme, CTC is more of a process leading to the identification of a programme of work, and a method of facilitating the delivery of well co-ordinated services that reduce risk and increase protection. CTC does not deliver services by itself but facilitates and activates change in a local area. The changes it aims to influence are:

- to transform professional practice (both operational and strategic), creating multi-agency and partnerships working around the provision of children's services

- to actively involve the local community as partners in the process of identification of risk and protection and designing of programmes to address risk and increase protection

- to use evidence to make changes to services. CTC identifies problem risk and protective factors and levels of protection by the use of locally collected data

- to bring new resources into the area that might enhance existing services, or create new programmes of work.

Table 1 outlines how the CTC process is structured. One of its attractions is having a set-out process that participants can follow. Each CTC project is expected to follow this model.

Table 1 The Communities that Care process

Phase One	Community readiness	1 Identify and assess the readiness of areas to receive a CTC project
Phase Two	Measuring risk and protection and auditing existing local resources Involving a wide range of partners in the process	1 Involve broad membership of community and local professionals, forming Community Boards and Key Leader Groups 2 Run training for local community on CTC process 3 Undertake a risk and protective audit that measures level of risk and protection 4 Undertake a resource audit to assess local resources that are already in place and identify gaps
Phase Three	Constructing an Action Plan	1 Bring evidence together from risk and resource audits to identify priorities 2 Identify relevant programmes of work to be implemented and write implementation plan. Use *Promising Approaches* (Utting, 1999)
Phase Four	Implementation	1 Identify service delivery agents 2 Identify resources for programmes of work 3 Implement programmes
Phase Five	Review	1 Reassess levels of risk 2 Evaluate impact 3 Set new targets 4 Return to Phase Two

How CTC is meant to work

The first phase of the CTC process is community readiness. Communities that are interested in using the CTC methodology are assessed on how prepared they are for setting up and implementing an early intervention and prevention programme (Hawkins *et al.*, 2002). There is limited knowledge in the UK about how this operates in practice although in the USA there has been a growing debate about how communities can be assessed as ready to receive community-based interventions (Hawkins *et al.*, 2002). It is suggested that readiness needs to 'define the community that will be involved, identifying key stakeholders who should be engaged, recruiting a community leader to champion the process, assessing conditions, activities and initiatives already operating in the community, and assessing conditions that could inhibit successful implementation of the CTC system' (Hawkins *et al.*, 2000, p. 959). In our previous report (France and Crow, 2001) we highlighted two factors that seemed most important. First, areas need to assess the quality and extent of partnership arrangements in the area. If there is a history or problem or limited experience of partnership working difficulties arise. Second, there needs to be an assessment prior to implementation of the infrastructure for community engagement. If this does not exist, community involvement can be problematic. Since our report

Feinberg *et al.*, in their 2002 study of 21 CTC projects in the USA, have also suggested that the attitude of professionals towards prevention also needs to be assessed as negative perspectives can act as a barrier to implementation.

Once an area decides to use the CTC methodology and contracts CTC to provide the materials, Phase Two of analysis and training begins. At the start, a CTC project forms two boards. One is a Community Board that aims to involve a broad range of local people and local practitioners working in the programme area. This could include local teachers, district nurses, community development workers and social workers. The Community Board is responsible for the day-to-day running of the project, the management of resources and the overseeing of the development and implementation of the local Action Plan.

The second group is a Key Leaders Group. This involves senior professionals such as Directors of Education and Social Services responsible for strategic development and services across the city. Key Leaders are seen as essential to the programme and are expected to meet regularly to help the programme progress. They help the Community Board in four ways. First, they support the involvement of local workers. They ensure that time is allocated in the workloads of professionals to give priority to the work of CTC. Sending a strong message about the importance of the CTC programme to local managers and professionals ensures that it gets local support. Second, Key Leaders identify resources and opportunities for drawing in financial support for the programme. This can include linking CTC into other national initiatives and funding programmes. Third, Key Leaders have the power to resolve problems that may be hindering the work. Finally, Key Leaders have a role in 'championing' the CTC programme, ensuring it is recognised locally as an important initiative that needs to be fully integrated into strategic planning. It is expected that both these groups will, over the life of the programme, have a change in personnel.

CTC also advocates the use of a local co-ordinator. These should be brought in early to help the local project go through the assessment process that they have designed. They also have responsibility for involving and supporting the local community, liaising with the strategic partners and other agencies, and fundraising. Co-ordinators are not expected to deliver programmes, but they are expected to help bring in funding and resources from other services or initiatives so that the Action Plan can be implemented.

Once formed, Community Boards with the aid of co-ordinators are provided with evidence of the levels of risk and protection within their local areas. They all receive opportunities for training on how to analyse and understand risk and protection in

their areas. This risk audit, as it is called, is compiled from questionnaires completed by young people in the area, and from records available locally and nationally (what American researchers refer to as archival data). From this evidence the Community Board identifies between three and five risk factors that need to be targeted and reduced and undertakes an analysis of resources (a resource audit) to identify gaps in services where changes need to be made. Once risk and resource audits have been undertaken the Community Boards design an Action Plan to be implemented in local areas. This Action Plan matches the risks to be tackled with the services that need to be put in place to reduce those risks. The selection of programmes is guided by existing evidence of what works or looks promising,[6] ensuring that initiatives chosen are evidence-based. Local projects are encouraged to select programmes suitable for tackling elevated risk factors and low levels of protection identified for targeting. Once the Action Plan is in place, projects are expected to set up task groups with a mixture of professionals and local people. Their role is to oversee the implementation of the programme of work and to resolve any difficulties that might occur. Since CTC itself has no resources to deliver services, delivery is the responsibility of others.

Introducing the research

Reading about how research was done is often regarded as the least interesting part of any report, but it is important to explain how we studied the first three CTC projects in the UK.[7] The evaluation of community-based prevention programmes in general, and of CTC in particular, has itself been the subject of much debate. This is not the place to describe that debate in detail, although a review of the debate and our response to it can be found elsewhere (Crow, 2000 and Crow, 2001, pp. 52–6), and it is also referred to in the methodological paper available at http://www.shef.ac.uk/ccr/.

Our evaluation sought to address three main questions:

1 Has CTC been successfully implemented? This involved looking at how the CTC process has been used and what new services were delivered to children and families as a result of the three CTC demonstration projects' involvement with the CTC process.

2 Did any change occur in the three demonstration areas?

3 What caused any change and what role (if any) did the three demonstration projects have in influencing any identifiable change?

Looking at process and outcomes

In order to address these three questions we looked at both the process by which the projects were implemented and their outcomes. While CTC is a programme that has a theoretical base and guidance on how it should be implemented, it was still necessary to look carefully at how it *was* implemented. Process research enables researchers to look at the extent to which the programme has been implemented in the way intended, what problems have been encountered in implementing the programme, and what lessons can be learned that can be passed on to others (Weiss, 1998; Shaw, 1999). It also enables the researchers to interpret the results of the programme, so that it is possible to say not only whether it worked, but why it may have worked or not, and whether some aspects worked better than others in particular contexts (Pawson and Tilley, 1998). The process evaluation mainly involved qualitative research, including observations and attendance at meetings, analysing documentary sources, and interviews with the key personnel concerned, but more structured questionnaires were also used. For example, the research team attended over 150 meetings and interviewed over 200 professionals and local people over the life of the evaluation.

The outcome of the CTC demonstration projects can be evaluated by reference to both its long-term goals and its medium-term aim. In the long term, the goal is to reduce the levels of four problem behaviours among young people: drug abuse, youth crime, school-age pregnancy and school failure. The CTC proposition is that these behaviours can be influenced by addressing certain factors which either increase the risks of young people becoming involved in them or protect them against involvement (Hawkins *et al.*, 1992). Thus, in the medium term it is critical to look at the extent to which there are changes in the risk and protective factors as a measure of outcome. Measuring changes in problem behaviour can only come further down the road of implementation. Our evaluation could only, at this stage of implementation of the local projects, hope to establish a baseline measurement and detect short-term effects indicated by changes in the percentage of children with high levels of risk or low levels of protection using an instrument similar to that recommended by CTC USA. It is far too early to identify longer-term outcomes.

Research design

The research in this evaluation incorporated a before-and-after design to evaluate the impact of CTC by measuring the amount of change in the risk and protective factors before and after intervention in the three areas where CTC was taking place.[8] Our original plan was to have a before measure for 1998 and then an after measure three years later. The first CTC project started in March 1998, with researchers from

the University of Oxford conducting a survey of schools in the summer of that year and producing a report on archival data the following year. The information from that survey was used as the basis for the three demonstration risk audits. Our intention was to use this material as the basis for our evaluation baseline (before measure).

In addition to collecting information from the three areas where CTC was taking place, it was also decided to collect similar information from comparison areas that were as similar as possible to the CTC implementation areas. Amongst researchers this is known as a classic 'experimental' and 'control' design, although our experience of large-scale social research told us that in the kind of study that we had in prospect, this kind of terminology, which is more appropriate to the laboratory, should not be used too literally. Instead we saw the non-CTC comparison areas as being more of a point of reference outside the area where the projects were being implemented so that we could see what was happening elsewhere, it would also help us judge the impact of CTC compared to other trends and developments in youth behaviour and attitudes.

Thus the original research design can be represented as shown in Table 2.

The original intention of our evaluation was to measure change in risk and protection using the same data collected for the risk audits undertaken by CTC UK for the three CTC demonstration projects. This included school survey data, and local and national records. However, the original data collected and collated by CTC UK[9] was problematic and not of the quality we required for our analysis. In our review of the risk audits we discovered that the data collected did not conform to CTC USA standards of measurement (see Hawkins *et al.*, 1997). The school-based self-report survey did not use the USA-validated questions and many questions that would contribute to constructing a reliable measure of risk and protection were missing. We also identified significant problems with response rates and the process used to collect the survey data. It was also the case that the local and national records proved to be inadequate for the purpose of evaluation. First, much of the data used did not have temporal or spatial relevance. Second, the quality of the data was questionable. We had concerns that much of it was unreliable or limited in its ability to measure change over time. As documented elsewhere,[10] getting good-quality data on local areas is very difficult. The various items of information used for CTC risk

Table 2 CTC research design

	CTC	Non-CTC
Northside	A	X
Westside	B	Y
Southside	C	Z

audits were assessed by us on five criteria: their robustness, spatial and temporal viability, availability and comparability. Only schools data met all five criteria.[11] Thus, the archival records material has been used here mainly to place the areas studied in their social and economic contexts, and only in a few instances to explore changes.[12] To undertake this we have relied upon the Deprivation Index (DTLR, 2000), Neighbourhood Statistics (ONS, 2001) and schools data (DfES, 2002).

As a result, the main instrument for our evaluation for measuring change was a school-based self-report survey that we designed. In the CTC model the school survey stands as a proxy measure of community-level risk and protection (Hawkins *et al.*, 2002). We took the USA survey as the basis for the construction of our evaluation survey and although it still needed some 'anglicising' it reflected the standards set by the USA as a measure of risk and protection (Arthur *et al.*, 1999; Pollard *et al.*, 1999). Modified versions of our survey have since been used by CTC UK for risk audits in new projects, in addition to those studied here. It has also been used for a national survey (Beinert *et al.*, 2002[13]) and for the national evaluation of On Track phase one (Armstrong *et al.*, 2004[14]).

One final point that the reader needs to be aware of was the delay in implementation of the three demonstration projects.[15] It was assumed by all involved in developing CTC in the UK that implementation would take place over a three-year period. Our evaluation strategy was designed around this time frame. After 18 months it became clear that this time frame was inappropriate and that if we were to be in any position to comment on outcomes of the programme a longer time period was needed to capture implementation of the Action Plans. As a result JRF agreed an extension to the evaluation, taking it from three years to five. Our questionnaire was therefore administered on two occasions, immediately prior to the implementation of the CTC Action Plans (1999/2000) and just over two and a half years later (Autumn 2002). The findings in this report relate to this timescale although where appropriate we have brought information up to date (January 2004).

The school surveys

It is necessary to say a little more about the school surveys and the response rates (see Appendix 3 for details of response rates). Nearly 11,000 children answered the two school surveys (5,516 the first and 5,334 the second). The surveys included questions about pupils' personal and social circumstances, their families, neighbourhoods and school experiences, the availability and use of alcohol, tobacco and other drugs, delinquent and anti-social behaviour, and spare-time activities. Altogether there were 195 separate items of information. Much of the questionnaire was devoted to asking for young people's views about these topics, and their

responses to the various questions were put together to compose 16 risk factors and seven protective factors.[16] Identical questionnaires were used for both surveys. Inevitably such a large-scale study produced a wealth of information that cannot be presented in detail here. What follows highlights the main results relevant to the evaluation of CTC.

All the children in schools covering the CTC and comparison areas completed survey questionnaires. All schools undertook a second run of the survey with those students who had been missing first time around. This increased the response rates across the whole programme. However, only some of these children actually lived in the CTC or comparison area concerned. Therefore it was possible to distinguish between four groups of pupils on the basis of whether they went to schools covering the CTC or comparison area, and on whether or not they actually lived in the CTC or comparison areas, or lived outside them, as Table 3 illustrates.

Initially the intention was to make before-and-after comparisons between children who lived in the CTC areas with those who lived in the comparison areas. However, preliminary analysis showed that, apart from Northside, the children from the CTC and comparison areas were not comparable in various respects. Furthermore, that approach would not eliminate any effects the schools themselves might have: that is, additional interventions run as part of the school programme not included in the measurement, or simply differences in the quality of the schools.

Table 3 Research cohorts[17]

CTC		Non-CTC	
(a) Live in area 2,233 (31%)	(b) Live outside area 4,943 (69%)	(c) Live in area 2,860 (57%)	(d) Live outside area 2,179 (43%)

Consequently the main focus of the analysis presented here compares only those children who went to schools serving a CTC project area who actually lived in the CTC area (cell (a) above), with those pupils who went to the same schools, but did *not* live in the CTC area (cell (b) above).[18]

In looking at whether there was any evidence of change we concentrated on whether the proportion of children in the CTC area scoring positive for risk factors had changed. We also looked at children scoring very high on these risk factors and for reductions in high risk. We therefore considered data that showed the percentage change in the proportion of the population having ‘any risk’ and ‘high risk’. ‘Any risk’ simply means the percentage of children who were at risk at all in relation to the various CTC risk factors, and ‘high risk’ refers to those children who said ‘yes’ in response to more than half of the questionnaire items that made up a risk factor.[19] It

is important to point out that the 'any risk' measure includes 'high risk'. 'High protection' refers to children scoring positive for more than half of the items in the factors and 'any protection' refers to children with any items positive. High protection is good and low protection is a matter of concern. These factors were considered in relation to the various 'domains' that CTC uses: community, family, school and friends. To be able to understand what the results refer to it is necessary to know what the risk and protective factors refer to, and a table summarising them is presented in Appendix 2.

The construction of alternative risk audits

As a part of our analysis we decided that it would be valuable to conduct our own risk audits to help us assess how effective CTC had been in targeting the most appropriate risk and protection factors in the three areas. CTC UK provided all three demonstration projects with a risk audit in 1999 based upon data collected in spring 1998. As outlined above, the survey used by them was not the instrument recommended by CTC USA and it did not assess risk and protection appropriately. Furthermore the archival data did not conform to CTC standards (Hawkins *et al.*, 1997). Once it became clear that the data used in the risk audits was inappropriate for our evaluation needs we collected data in 1999/2000 for our before measure (as discussed above). Our average was taken from the mean scores of all the population surveyed in the CTC schools living in and out of the CTC area and in the comparison areas. It is important to recognise this is not a national average, but functions adequately as a comparison for deprived neighbourhoods for this study. Although this data is 12 to 18 months newer than the original risk audit data collected by CTC UK we would not expect the levels of risk and protection to have changed substantially. As a result we have used our before data to undertake and construct a risk and protection audit of the three demonstration projects and the comparison areas. Initially, we used the CTC USA method of aggregating items to risk factors to construct an average figure for risk comparing the results from each area. We did not use standardised scoring because there were no national comparisons. This was the method used in the first risk demonstration audit so our results should reflect these findings. In constructing this analysis we have drawn upon measurement methods used by CTC USA. They have a long history of measuring risk and have developed a detailed methodology that identifies, scientifically, levels of risk and protection through the school survey. Our final audit did not replicate the method for two reasons. First, some of the survey questions used to construct the risk and protective measures vary between the USA and UK and therefore we were not in a position to include all of them in our analysis. Some had to be removed because of reliability problems and others had to be weighted. Second, we used a more incremental 'risk only' code that ensured a rational scale. We believe at this early stage, and for

reasons of integrity of methods, that this is a reliable and accurate measure for identifying categorically high levels of risk and low levels of protection equivalent to the system used by CTC USA. This being said, the differences between the two methods of analysis are minimal for this study and therefore we would not expect major differences to emerge in the identification of values of risk or protection that are outside the range expected for a normal population.

Qualifications and concluding remarks

There are four important factors that need to be kept in mind when reading this report. First, evaluating a new project in its early stages is always inclined to be problematic (Fulbright-Anderson *et al.*, 1999). The three demonstration projects are still in their formative stages, and what one studies may not be the projects in their final form. It is also the case that social interventions seldom achieve a static form, being more likely to evolve as personnel, and the circumstances in which they have to operate, change. Evaluation is a documentation of this process as much as anything else and sometimes it is difficult to know what is being measured. Second, Communities that Care is a long-term programme, the true results of which have to be viewed over many years, whereas we were only able to look at the first two and a half years. It could be argued that the projects will have had insufficient opportunity to make a noticeable impact in this time. Several of the initiatives in pilot areas, based on *Promising Approaches*,[20] involve work with very young children and their families. While the school surveys are used as an indicator of community change in CTC, because they were carried out in secondary schools they were not able to measure change for those under the age of eleven (or for parents and the wider community). Third, measuring changes that arise as a result of community-based programmes like CTC is incredibly challenging and complex (Weiss, 1998; Fulbright-Anderson *et al.*, 1999). Being able to capture the impact of individual programmes on individual behaviour is hard enough (Utting *et al.*, 2001) but CTC is a community-focused initiative and we were asked to measure CTC not at the level of individuals but at the community level. Evidence from elsewhere shows that such an approach is not without its potential difficulties and problems (Pawson and Tilley, 1998; Fulbright-Anderson *et al.*, 1999; Hollister and Hill, 1999). For example, making connections between project work programmes and evidence of social change is incredibly difficult. In the discussion that follows it is important to remember this issue because it may have implications for our final results. We shall also return to it in our concluding discussions. Finally, it is also important to recognise the likelihood that being evaluated had some impact on the demonstration projects concerned. In the early stages of the research the project participants were very aware of being studied, and their co-operation in obtaining information and in obtaining access to schools was critical (France, 2001). We also provided each school with its own report

of its data. How they used this in their planning remains an unknown. The researchers did maintain a clear role as researchers, rather than as agents in the change process. Nonetheless the possibility that the research did have some unintended influence in making the projects more self-conscious about what they were doing needs to be borne in mind in reading this report.

What follows is a report about how these three demonstration projects have developed over the first five years of their project life. It is not necessarily an indication of how they will always be, or of their long-term outcomes. Neither is it a definitive evaluation of the CTC approach although it can, we believe, make an important contribution to this debate. Subsequent CTC projects that have not been evaluated as yet may well have developed differently. They are also likely to have developed differently for a number of other reasons, not least because they and CTC UK will have had the lessons and experiences of these first three projects available to draw on as well as the products of the evaluation: for example, the new school survey. So care needs to be taken in assuming that the results of this study can be generalised to other CTC projects in the UK.

2 Southside

Southside profile

The Southside CTC area was located in a Welsh city with a population of just under 250,000. Historically, its economy was built upon shipbuilding and coal mining. These industries declined substantially in the 1980s leaving the city with a high level of unemployment, although by 2001 unemployment had dropped to near the national average.[1] The city was predominately white, with only 1 per cent of its population being from ethnic minorities.[2] Levels of crime in the city varied. Sexual offences, robbery and burglary were all below the national average, while the highest levels were in motor vehicle offences, with the rate of theft of a motor vehicle being more than double the national average. Figures for theft from a motor vehicle were also high.

The economic and social profile of Southside

The CTC area consisted of one full ward and a small section of an adjoining ward.[3] The main ward (Southside 1) had a population of 6,342. It was predominately white, and the proportion of young people (under 18) was above the national average. In terms of deprivation, the main ward is within the top 15 per cent of the most deprived wards in Wales (see Table A2 in Appendix 1).[4] As shown in Table 4, unemployment in the area was higher than both the city and national average and the number of people not owning a car was also below the national average. Sixty per cent of households owned their own property, although there were also a large number of people who rented from the local authority. Most of the property in the area was of a high or good standard. Health was also a problem with those registered as permanently sick or disabled being three times the national average. Similarly for those asked to self-report their health the figures for poor health were nearly double the national average. It was this ward that the work in Southside CTC focused upon.

Table 4 Economic and social characteristics of Southside

	Southside 1 (%)	Southside 2 (%)	City (%)	National (%)
Level of unemployment	4.6	3.0	3.6	3.0
Extent of car ownership (one car)	63.8	79.5	71.5	70.6
Extent of property ownership	60.0	76.0	69.6	68.9
Percentage renting local authority housing	26.6	12.0	14.3	13.2
Permanently sick or disabled	14.0	9.6	9.8	5.5
Self-report of health over last 12 months as ‘not good’	17.2	11.5	13.4	9.2
Lone-parent households with dependent children	10.6	9.0	7.5	6.5
Percentage of under-16s who are dependants of income support claimants (Source: ONS, 2001)	41	25	N/A	24

All data from ONS, Census 2001 unless noted otherwise.

The part ward (Southside 2) was included because, although official figures did not show it as an area of need, and it appeared to be reasonably affluent and without major social problems, senior local professionals believed that the area had significant problems relating to housing and youth nuisance which had never been properly recognised in the allocation of resources until then. Levels of deprivation were also low compared to the other CTC areas. For example, it was ranked 466th in terms of deprivation (see Table A2 in Appendix 1).[5] None of the officially recognised deprivation domains were in the top 15 per cent of most problematic areas. As shown in Table 4, in terms of housing tenure, two-thirds of the population owned their own property with 12 per cent renting from the local authority and 7 per cent renting privately. Unemployment was also below the national average and the number of people with a car was well above the national average. Despite this it was felt that these figures masked pockets of deprivation and other social problems that only local professionals and local people were aware of. For example, while deprivation seemed low, health problems were well above the national average. Those registered permanently sick or disabled are nearly double the national average.

From our school survey data collected in 2000, Southside was, in the majority of cases, similar to the average community in the UK.[6] It was a reasonably stable environment with only 15 per cent of young people saying they had changed homes more than three times. Young people living in the CTC area also had positive perspectives of their communities. Eight out of ten children said they liked living there. About a fifth of young people indicated they would like to leave their neighbourhood, while a quarter (24 per cent) felt unsafe at night. Where figures differed from the national average was in perceptions of crime and drug dealing. In national figures 23 per cent of all young people stated that they thought crime and drug dealing was a problem in their communities; in Southside this figure was 38 per cent.

The Southside schools

The CTC area in Southside had a large secondary school located in the centre of the main ward. A large proportion of local children and young people attended this school. Historically, it was a school with substantial difficulties regarding achievement. For example, in 1996/97 only 19 per cent of students managed to achieve five GCSEs at grades A–C. By 2000 the school had managed to improve its results to 28 per cent (see Table 5). The school saw itself as a ‘community school’, encouraging closer working relationships with parents and local people. As a result it was successful in helping to establish a Family Centre on the school site and in bringing in extra resources for youth workers linked to the school. During the life of the CTC programme it was also very active in improving attendance.

Table 5 Southside school indicators, 2000[7]

	School A (%)	School B (%)	LEA (%)	National (%)
Free school meal entitlement (Source: annual school census, 2000)	39	24	21	18
5 or more GCSEs, grades A–C	28	45	46	48
Unauthorised absence	13.6	1.4	1.9	1.5
Authorised absence	4.2	3.5	8	N/A

For example, in 2000 it appointed an Attendance Manager who was responsible for monitoring and improving attendance. The school also reconstructed its discipline policy and improved its internal referral system for children identified as having problems. A second secondary school was located on the edge of the main ward, close to the boundary with the part ward. Approximately 20 per cent of this school population lived in the CTC area.[8] Historically this school had been more successful. For example, as shown in Table 5, 45 per cent of its pupils in 2000 who took GCSEs gained five passes at A–C. In general young people from the CTC areas who attended these two schools said that they liked their school experience. For example, from our self-report data 75 per cent said that they often or very often enjoyed school subjects. These figures matched the national average,[9] as did figures on truanting or being bullied. Variations existed between age groups, with older pupils (above Year 7) likely to have less positive attitudes about school, to have truanted more and to have experienced bullying.[10] This is comparable to national figures.

One of the unique developments in Southside was the introduction of a Learning House. Only four of these exist in the country, involving two schools working collaboratively to try and improve local levels of achievement. Its key objective was to target resources at children who were disaffected and lacking the skills to gain access to the mainstream curriculum. After being assessed, identified children attend for two days a week. It was claimed that the results were very good, with attendance improving by 90 per cent.

Phases One and Two

Set-up and early implementation in Southside

The Southside ward had a well-established community development programme in place from the mid-1990s. In the early stages of the CTC project, concerns were raised about the ability of CTC and the community development programme to work together. As work progressed, although tensions remained, the two programmes managed to work well together, and both projects found collaboration possible and

valuable. As a result of an existing social infrastructure there were many local people already active within the local area. This was a benefit for the development of the CTC programme. In addition, the community development programme was already developing partnership working within the local area. Many professionals met on a regular basis and knew each other's work prior to CTC arriving. The main city of Southside also had a long history of partnership working, which was already well established at the strategic level, and senior professionals were already working collectively to develop more co-ordinated services. As a result of both of these developments CTC was able to integrate with, and build upon, an existing local infrastructure. This aided its setting up and early development (France and Crow, 2001). As a result Southside was one of the most active demonstration projects. It had the broadest membership of local professionals and had the highest numbers of local people involved. While it was the last to start it completed Phase Two (set-up) almost at the same time as the other two projects.

The selection of risk and protective factors

The selection of risk and protective factors in Southside was lengthy and challenging. The audits provided by CTC UK were too complex, not well focused on measuring risk factors, had no evidence about protective factors and were poorly presented. There was also a major problem with the audits because there was no national average against which to compare Southside levels of risk. As a result, people working in the project found it difficult to make a judgement about which risk and protective factors to select. Although they tried to maintain an objective and scientific approach to analysis it remained a struggle. The selection process became a negotiation between local perspectives and understandings and the 'scientific' evidence provided by the risk audit. CTC UK claim that this is an important part of the process in that it allows for an analysis to be made that considers and reflects local circumstances.

Southside selected five risk factors: disadvantaged neighbourhoods, low achievement in schools, poor parental supervision, availability of drugs, and alienation and lack of social commitment. As outlined above we undertook an alternative risk audit constructed around the method used in the USA (see Figures 1–4).[11] In Figures 1–4 the risk and protective factors are outlined in domains. If the risk factors are above the '0' line then the risk is above the average (negative). If protection is below the '0' line then protection is below the average (negative). When it comes to looking at our survey data the risks selected by the CTC project do not match our profile. First, availability of drugs (Figure 4) is not a high risk factor. In fact the only community risk factor that comes out above the average is 'disorganisation and neglect'. Second, 'parent supervision' (Figure 1) comes out below average. In

fact there are no risk factors within the family domain that are a point above the average. This being said, protection is lower especially in the area of family rewards and family attachment. Finally, like the other three risk factors targeted by the CTC audit, alienation and lack of social commitment (Figure 2) comes below the average score. In fact 'friends involved in problem behaviour' would have been a more relevant risk factor to target.

Figure 1 Risk and protection profile relative to average scores: family factors, Southside

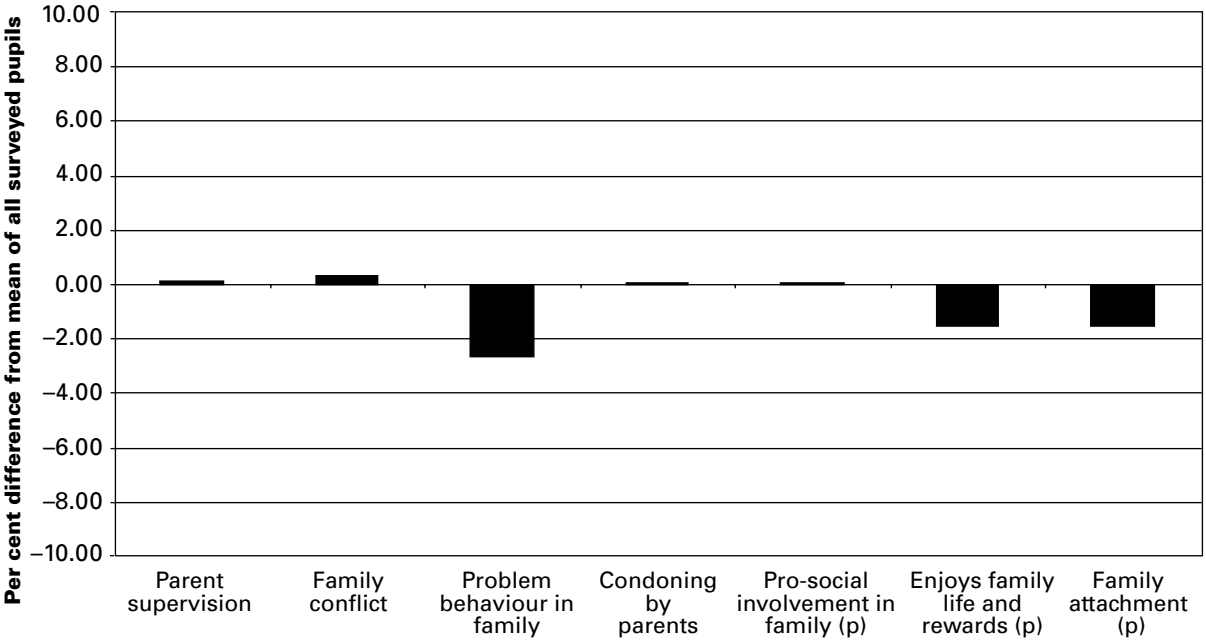


Figure 2 Risk and protection profile relative to average scores: peer/individual factors, Southside

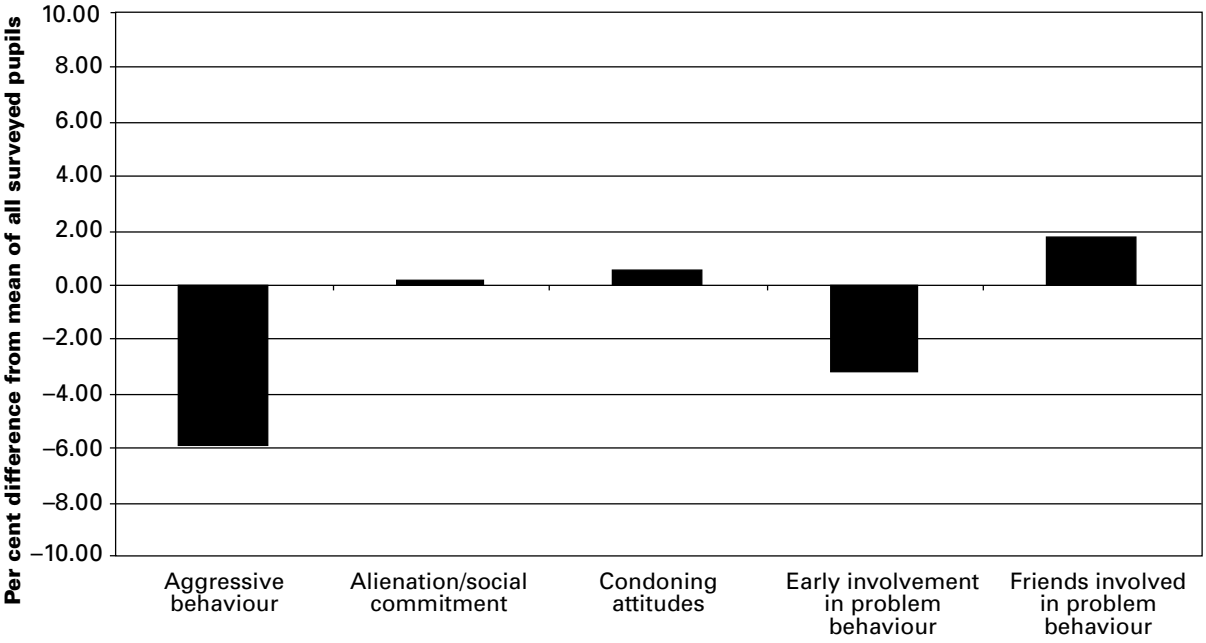


Figure 3 Risk and protection profile relative to average scores: school factors, Southside

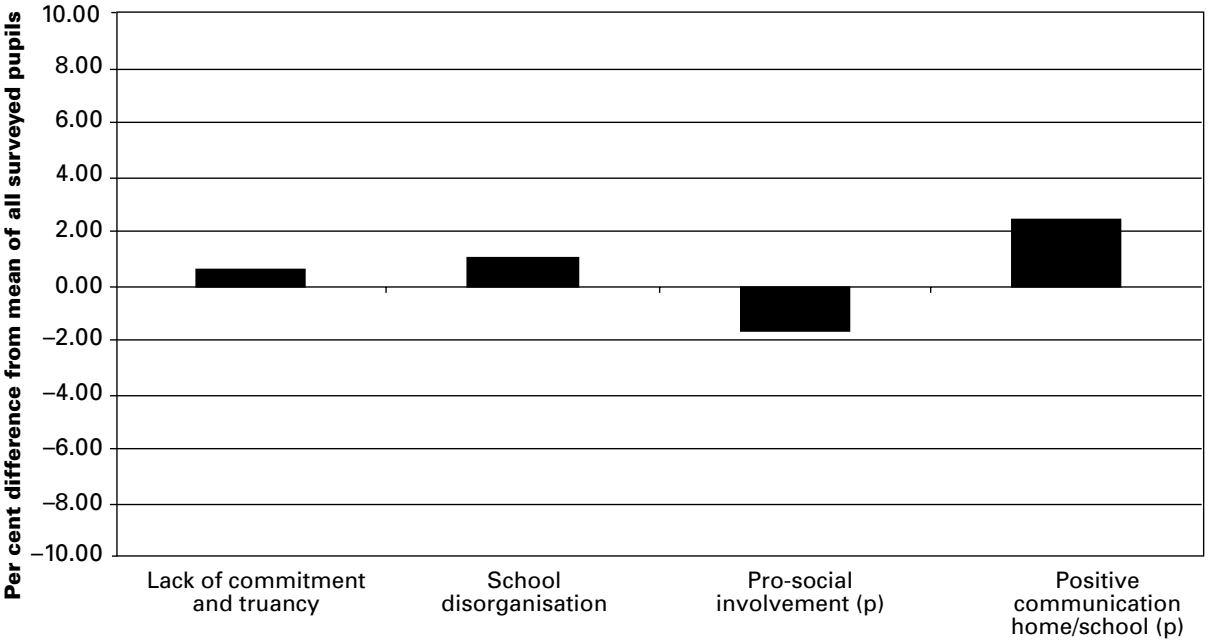
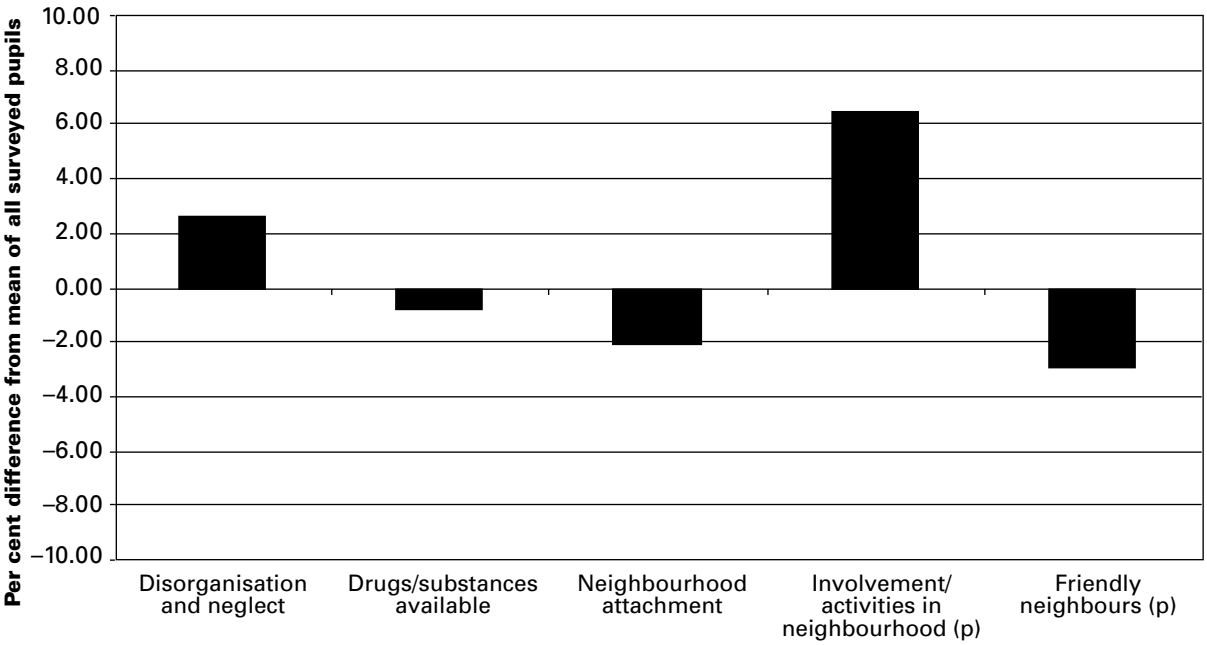


Figure 4 Risk and protection profile relative to average scores: community factors, Southside



'p' = protective factor

Southside also selected two risk factors that were not measured by the survey and therefore could not be measured using our survey data. These are ‘disadvantaged neighbourhoods’ and ‘low achievement in schools’. The evidence from national data sets for selecting these two risk factors is not strong. In terms of deprivation the main CTC area in Southside comes out in the top 15 per cent of deprived communities in Wales and although the levels in Wales and England cannot be compared Southside would not come into the top 10 per cent of deprived communities in England. It is also the case that the second ward included in Southside as a part of the CTC area is even less deprived than the first. This weakens the case for targeting the CTC area as a disadvantaged neighbourhood. Similarly, in terms of low achievement the schools that serve the CTC in Southside have historically been improving. While the main secondary school is still below the national average it is a school that is improving every year. The second school is even better in that it has just about reached national-average status.

Clearly, the problems associated with the construction and development of the Southside risk audit had a major effect on the ability of the project to select the highest and most problematic risk factors. Not having the quality risk audit report that matched the standards set down in the USA and not having a normative measure created real problems for Southside to be able to select the highest risk factors. We believe that if the local Community Boards had been given a risk audit that conformed to the CTC USA standards it is likely that their choice of risk and protective factors would have been different. This is an important issue and something we will return to in our concluding discussion in Chapter 5.

Phases Three and Four

Project development and action planning

In the first phase of the CTC programme Southside engaged more professionals and local people than any of the other demonstration projects, and was also more focused and organised. As a result, when it came to implementation the project was in a stronger position to achieve success. Southside’s Action Plan was developed in consultation with local and city-wide organisations and had an extensive range of targets (19). This allowed for failure of individual targets without resultant programme failure. The targets were broad, and included changing and enhancing existing services, as well as creating new services. They also included some ‘quick win’ targets, which helped sustain community engagement, as well as keeping professionals interested in the programme, since it could be seen to deliver outcomes quickly. The organisational approach to implementing the Action Plan was similar to Northside and Westside. Task groups were organised around each risk

factor, and their brief was to ensure that all the relevant targets were worked on and implemented. The task groups themselves had regular reviews and there was an annual Action Plan review. This allowed the Action Plan to remain relevant, and kept the work focused on the entire range of targets.

Implementation of the Action Plan

The Poor Parental Supervision and Discipline task group (see Table 6) oversaw the implementation of four of the six programmes outlined in the Action Plan. Enhanced detection and treatment of post-natal depression and the Home Start programme were implemented before the CTC Action Plan was established. Both were city-wide initiatives that trained professionals. The task group's most evident success during the demonstration project was the running of three different parenting courses, two of which were in *Promising Approaches* (Parent Network and Children's Behaviour). Six courses were run in total across the three parenting programmes. Twenty-six parents took part with 19 completing the full programme of training. Courses ran for eight weeks and each session was for one to two hours. The task group was also responsible for introducing the High Scope curriculum in a local nursery with a Mother and Baby group. No information was available about how many people took part. No progress was made on the plans to improve screening and speech therapy provision for young children during the demonstration period.[12]

The Disadvantaged Neighbourhood task group organised two joint action projects. The housing management initiative was developed with the help of CTC. It appointed a senior dedicated officer for a local estate that had suffered from high levels of vandalism and voids. The task group also achieved a number of other successes, including the implementation of a multi-agency clean-up campaign, the employment of part-time community wardens on the estate and the development of a local newsletter.

The second joint action programme was the Community Policing Initiatives. Part of the work involved training housing department and police staff in mediation skills. Twelve members of staff were identified, but difficulties arose over getting training in place, as a consequence of which little happened. This task group also established a Domestic Violence forum involving over 40 people. It set up its own steering group that met regularly during the demonstration period. It developed localised systems of communication with the aim of speeding up response times to identified problems.

Table 6 Programme overview and change

Risk factor identified	Action planned	Action implemented	Change identified over timescale	Was change attributable to CTC?
Disadvantaged neighbourhood	Housing management project Domestic Violence forum No More Repeats programme Training of mediators	Housing management project Domestic Violence forum	Not able to measure	___
Availability of drugs	Drugs availability campaign Peer education programme	Drugs availability campaign	Promising evidence	Possible
Poor parental supervision	High Scope programme Health visitor Home Start Parent training Training social workers Speech therapy	High Scope programme Health visitor Home Start Parent training	Decrease in risk levels in family domain[13]	Possible
Low achievement in schools	Parent classes in school Cognitive skills programme Home/school project Mentoring project		Increase in GCSE results 5 with A–C. Increase in Key Stage 2 results in 5 out of 6 primary schools	No
Alienation and lack of commitment	Youth work initiative Access to further education	Youth work initiative	Decrease in risk levels in peer domain[14]	Possible

The Availability of Drugs task group developed a number of local projects that aimed to reduce young people's involvement in the abuse of tobacco, alcohol and other drugs such as cannabis. This involved a crackdown by police, Trading Standards and customs on unlicensed traders of tobacco and alcohol. As a direct result of the task group's recommendations, local agencies targeted tobacco and alcohol bootlegging in 2000. This included a raid on a local estate by Customs and Excise in summer 2000, the secondment of a local officer temporarily to the Drugs Squad, and a telephone number to report bootleggers.

The task group for the risk factor related to alienation and lack of commitment helped increase the level of youth work provision within the area. The local community development project developed Youth Work Alliance, which sought to co-ordinate and expand youth provision. Objective One[15] money that CTC had secured was used to run programmes of work. Ten initiatives were developed under this programme of work of which CTC was a partner. This included the appointment of

new staff, the running of targeted programmes for young people at risk, and the development of new facilities in the area. The project did not collect information on the number of young people involved, but it was claimed to be ‘substantial’.

The only task group that was unable to fully implement any initiatives was the School task group. The task group suffered from having no direct representation from primary schools. Some of this tension was felt to stem from the negative connotations of the title of the risk factor, ‘low achievement beginning in primary school’. Another problem was a history of poor interaction between the schools. CTC was directly responsible for the introduction of Project Charlie in one local primary school but the hoped-for introduction of Talk Health made little progress. There was also limited progress in establishing after-school facilities, with some primary and secondary schools running different forms of provision, using Neighbourhood Opportunities Fund (NOF) funding.

What factors affected implementation?

Southside managed to implement the most initiatives amongst the three demonstration projects. This happened for three main reasons.

Good project infrastructure and management

Part of the strength of the Southside project was the establishment, early in the life of the programme, of good principles of project management. Two factors made substantial contributions. First, although the project did not undertake any formal evaluation each task group had to undertake regular reviews of its work. This involved all partners reflecting on practice and identifying whether targets were being met. From this it was possible for the Action Plan to be continually assessed, and to identify problems and difficulties. As a result resources and energy could be deflected from areas of work where little progress was being made. For example, it was recognised early in the process of implementation that schools needed senior management involvement because the problems were of a deep-seated nature. Second, possible future problems were identified in advance so that they could be avoided. This was especially relevant regarding a change in co-ordination. Southside had a change of co-ordinator, but unlike Northside and Westside a strategy was developed that help to avoid problems and delay in the changeover. This approach to project management helped to maintain continuity and momentum.

Diverse partnerships

Good practice in partnership working across all aspects of the project was also critical to Southside successfully implementing a programme of work. At the strategic level, the local Director of Education was a ‘champion’ of CTC from the start of the project. He ensured that CTC became well known at agency level, and ensured that,

towards the end of the period, CTC became part of the city's developmental plan so that it could be continued and extend its area of cover. Additionally, Southside had the bonus of committed and relevant Key Leaders. For example the Key Leaders Executive included the Head of Social Services, the Head of Probation, a senior police officer, the Director of Housing and the local secondary head teacher. This ensured that there was CTC representation at almost all levels.[16] At the operational level, Southside workers were well supported by senior management in their CTC role, and therefore it was easier for them to remain involved. There also was a commitment to replace them by senior management if local professionals moved post. However, despite the local Director of Education's role as chair of the Key Leaders, and the local head teacher being a Key Leader, Southside did have real difficulties implementing programmes in schools, as detailed above.

From the beginning of the demonstration project there were attempts to ensure that there was as little divide as possible between Key Leaders and the Community Board members. This was addressed by the use of mixed meetings and events and giving access to all meetings of representatives from either or both groups. The advantage of this was the enhancement of partnership working and sometimes more tangible benefits were evident. The Southside project also involved a broad section of the community. There were several factors that helped to achieve this. The CTC area itself covered one entire ward and a small part of another. Although there was little shared sense of community, efforts were made from the beginning of the project to ensure that no parts of the CTC area were excluded. Therefore meetings were rotated around the area and events were held in all the different parts. There was already a history of community engagement in the area, without the tensions that had existed in Westside. Tenants' groups were running, which made it easier to attract people to become involved in CTC, and some shared facilities already existed. It was also the case that a community development programme was already running when CTC was set up. Initially there were concerns that this could cause some tension, since the two projects had similar remits. However the two worked well together, which benefited CTC by giving it more access to the community, and allowed it to build on existing partnership working and community engagement. Of further benefit to the CTC project was the fact that a Family Centre was set up at the same time as CTC. This created opportunities for community involvement that were well utilised, and gave a geographical focus to the community. CTC was well known in the community due to concerted efforts to publicise it at a number of different locations and events throughout the area, and through working alongside the community development programme and the Family Centre. The range of programmes that were being run, or overseen, by CTC helped with community engagement. A broad range of people were involved in the Community Board at the beginning of the project and their support continued during the planning stages, but there was less of a role for them once the task groups were set up. Southside did

find it difficult to recruit new community representatives, and there was little representation from young people. As in the other two demonstration areas, people were concerned that the representation was not broad or extensive.

Funding

One of the critical factors that helped the process of implementation in Southside in the early stages of the programme was access to funding. The CTC co-ordinator was insightful in identifying an early opportunity to build CTC into a number of critical long-term developments that were taking place within the local area. First, the local secondary school had been active in developing a local Family Centre. CTC built a number of programmes into its Action Plan that would be part of this development. As a result, resources for some of the work were already in place when CTC moved towards implementation. Second, a similar situation arose with the bidding for the first wave of Sure Start[17] monies. The CTC planning team was in the process of constructing their Action Plan when a call for Sure Start bids was made. The CTC co-ordinator took central responsibility for writing the bid document and built CTC objectives into the plan. As a result, when the bid was successful money was made available for the development of the family-based work in the CTC Action Plan. Having this funding available at the time of implementation made the process much simpler.

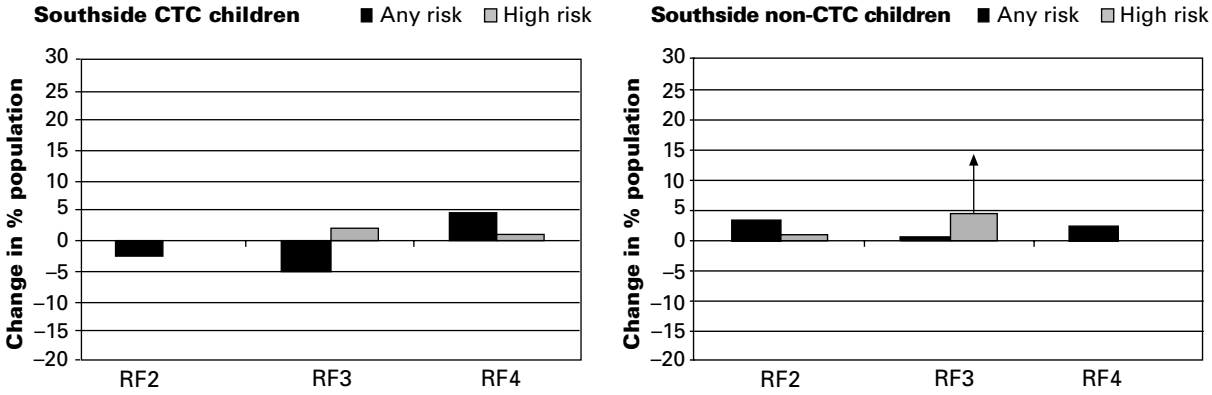
But the question of funding was also a reason why some parts of the Action Plan did not get implemented. For example, from the schools' point of view lack of resources attached to the proposed actions was a problem. The primary schools were happy to consider options being proposed by the Southside CTC project but not if it was going to either cost the school money or require staff to give up time to help develop funding bids. As a result they did not get engaged in the process.[18] Finding funding was a constant challenge for the CTC co-ordinator. She found herself very much involved in developing funding bids and trying to raise money consistently. One of her regular complaints was that a co-ordinated funding base or infrastructure where a small pot of money was made available to the CTC project would have helped them increase their levels of implementation.

Evidence of change and local impact

Because Southside implemented CTC more successfully than the other areas, we looked at changes that occurred within each cohort separately in order to provide a more detailed explanation (see Figures 5–11). The analysis compared the proportions of children with risk in each area after the interventions with before intervention. This allowed us to look at significant change as if each group were an experiment in itself. Where changes for each group are significant this is indicated by an arrow showing the direction of change.

The black columns in Figures 5–11 show change in overall risk (all children responding positively for any risk question, including those at high risk) and the grey columns show change *only* in those children classified as high risk (more than half the items comprising the risk factor answered positively[19]). This is because there are often different patterns evident for the majority of children who may score quite low and the children who are scoring very high, who are a source of most concern. Children responding negatively to all the questionnaire items that comprise a risk factor are considered not at risk and are not shown.

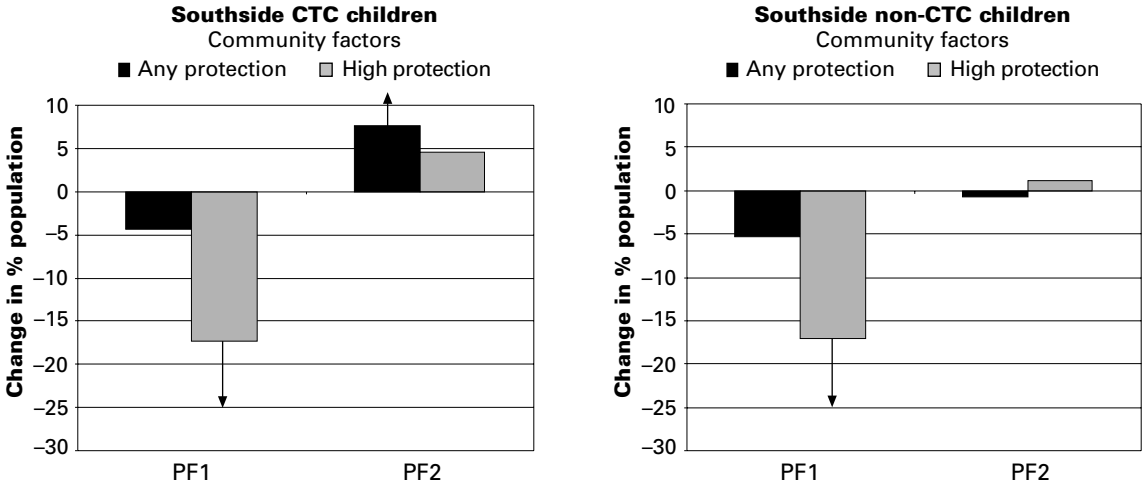
Figure 5 Community risk



For community-related factors, the CTC children reported less increase in risk generally than the non-CTC children although RF4 (lack of neighbourhood attachment) increased more in the CTC group than in the non-CTC group, but not significantly, and overall, risk went down (remembering that 'any risk' includes 'high risk'). The grey columns showing high risk for availability of drugs (RF3) increased, but not significantly, while for non-CTC children, high risk for availability of drugs increased significantly.

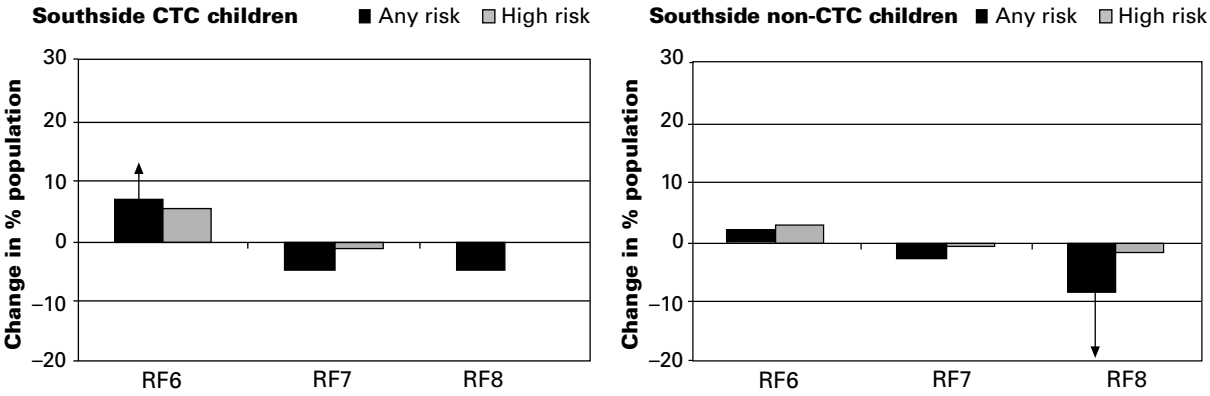
RF1 (disadvantaged neighbourhood) cannot be measured by the use of the school-based self-report data. As discussed previously they require national data gathered from other databases and settings.

Figure 6 Community protection



Clearly increases in risk are not desirable, whereas increases in protection are, and conversely a decrease in protection may indicate increased risk. There were changes in both of the protective factors relating to the community. Opportunities for pro-social involvement in activities and sports in the area (PF1) declined generally amongst the CTC children (–4.3%, n.s.) and in the non-CTC children (–5.3%, $p<0.001$). Seventeen per cent fewer children attended two or more activities (giving high protection in our terms, $p<0.001$) in both areas, and this result seemed to indicate a general decline in outside activities for Southside. For protection factor 2, rewards for pro-social involvement, indicating friendly neighbours, protection increased in the CTC group (by 8%, $p<0.02$) and correspondingly higher protection also increased (4.5%, but not significant). The non-CTC children remained the same.

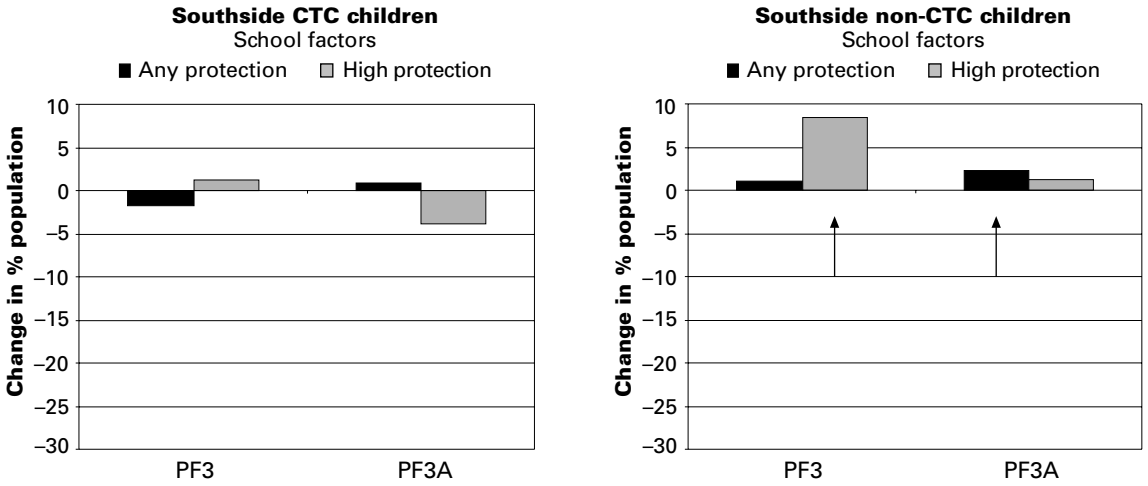
So for community factors overall, the CTC children generally fared better than the non-CTC children, particularly in relation to improved protection in the community.



Changes were evident in two school risk factors. For risk factor 6, aggressive behaviour in school, CTC children experienced increased risk generally, particularly for 'any risk' amongst boys (+7.2%, $p<0.05$), whereas non-CTC children did not. For risk factor 8 (school disorganisation relating to school rules and consistent standards of behaviour), risk decreased for CTC children but not significantly, whereas for non-CTC children the decrease was significant (–8%, $p<.001$).

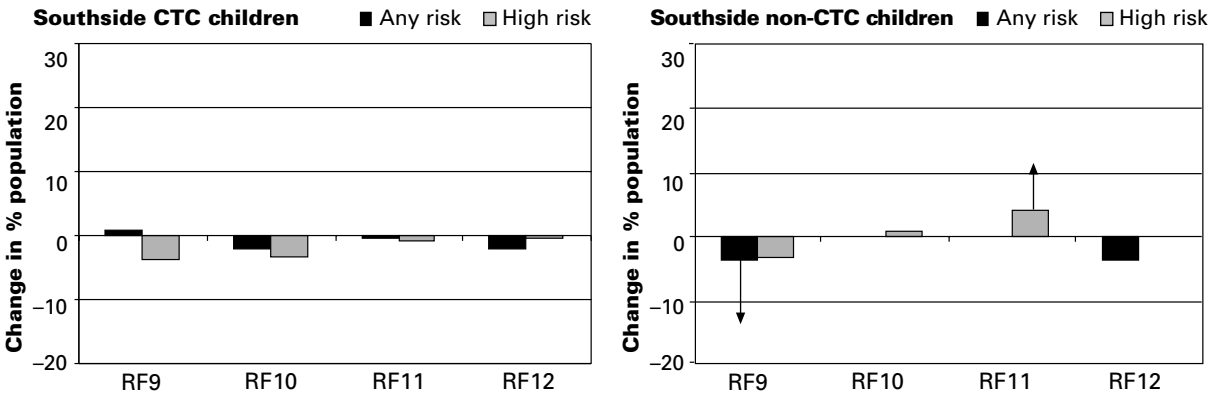
In terms of RF5 (low achievement in schools), no self-report data is available although achievement data is collected nationally. From this data both of the secondary schools in the area improved their scores on numbers of young people getting five or more GCSEs A–C. For example school A went from 28 per cent to 32 per cent. A more dramatic change took place in the primary schools. In total five out of the six local primary schools improved their scores in Key Stage results.[20] In two cases the increase took them over the national average for Wales. One of the schools saw their results move over 20 points between 2000 and 2002.[21] Such success cannot be attributed to CTC especially as this is one area in the project Action Plan that they failed to implement. Such a development is very positive and may well have positive outcomes for children in the Southside area in years to come.

Figure 8 Schooling protection



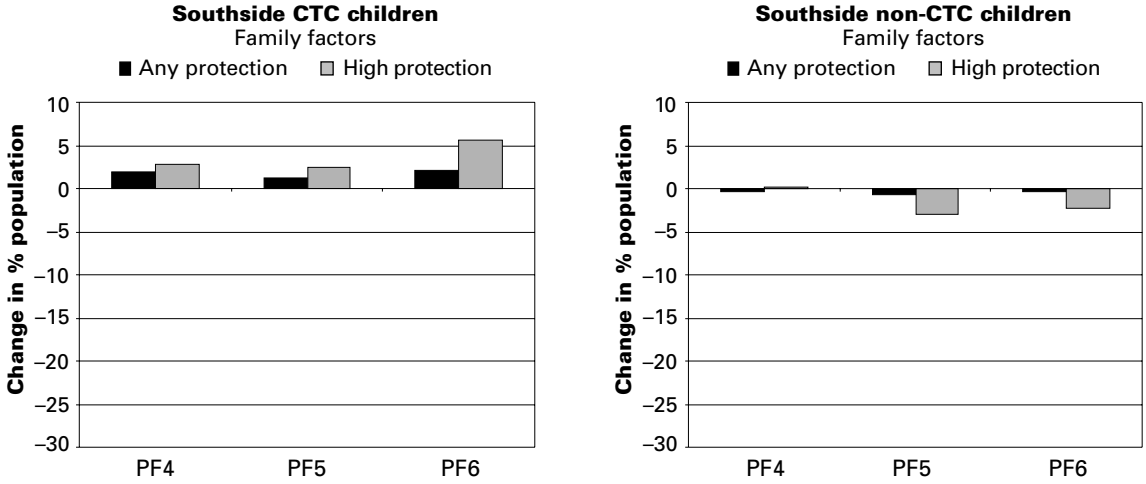
CTC children: There were no changes in opportunities for pro-social involvement in school (PF3) and for rewards for pro-social involvement (PF3A, which reflects teachers' involvement and praise). High protection declined for this factor (4%, but not significantly), mainly due to a sharp decline for Year 8 children (14%, $p<0.02$). Non-CTC children: Where the CTC children showed no change, for opportunities for pro-social involvement in school (PF3), high protection for the non-CTC children increased significantly (8.5%, $p<0.001$), particularly for Year 9s. In the non-CTC group there was a small but significant overall improvement in any protection for rewards for pro-social involvement (+2%, $p<0.02$). So for risk and protection factors relating to schooling, the changes were mixed, with the non-CTC children faring better generally than the CTC children.

Figure 9 Family risk



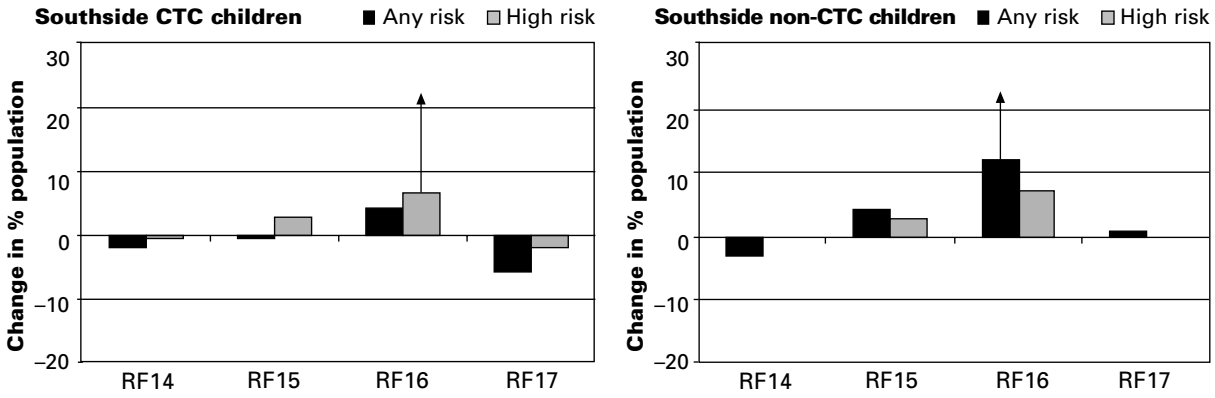
CTC children: There were no significant changes in any of the four factors relating to the family. Non-CTC children: There were significant changes for non-CTC children in two risk factors concerned with parenting, although the degree of change was quite small. The proportion of children at high risk of poor parental supervision (RF9) decreased significantly.[22] On the other hand, the proportion of children at high risk for a family history of problem behaviour (RF11) increased significantly in the non-CTC group (4%, $p<0.002$), especially amongst Year 8 children (7%, $p<0.01$), and particularly for boys,[23] while there was only a very small decrease for the CTC children.

Figure 10 Family protection



CTC children: Generally for CTC children, the proportion of children with any protection and with high protection for family factors increased, but not significantly. Non-CTC children: The proportion for the same factors decreased, but not significantly. Changes were too small for significance in either group. The decreases for non-CTC children on opportunities for pro-social involvement in the family (PF5) and rewards for pro-social involvement in the family (PF6) were more marked for younger children (Years 7 to 9). Overall, then, for family factors, there was a positive trend of decreasing risk and increasing protection for the CTC children, and a decline for the non-CTC children.

Figure 11 Individuals and their friends – risk[24]



There was a mixed picture for risk factors relating to individuals and friends. Alienation and lack of social commitment (RF14) remained stable overall, but there were fluctuations for

different year groups in both the CTC and non-CTC groups. Attitudes condoning problem behaviour (RF15) increased significantly in both groups, but for Year 7 only (8%, $p<0.05$ for CTC area and 7%, $p<0.02$ for non-CTC children). The proportion of children at high risk for early involvement in problem behaviour (RF16) increased significantly in both groups (6.6%, $p<0.01$ in the CTC area and 7%, $p<0.001$ in the non-CTC area). For both areas older children (Years 10 and 11) and boys showed the most increases, but these effects were only significant for the non-CTC children. However, significantly more children reported increases in risk at any level in the non-CTC area (black columns) but increases in the CTC area were smaller and non-significant.

Did CTC have an impact in Southside?

Table 7 shows that for each group separately, when risk increased significantly in the CTC group, it also increased in the non-CTC group (RF16 and PF1), suggeting that both areas followed a general trend.

Table 7 Increases in risk for CTC area and for non-CTC area children attending the same schools

Risk factor	CTC area before/after	Non-CTC before/after	Comparison of means	
			CTC	Non-CTC
Community				
RF2	-	-	–*	–
RF3	-	–	–*	–
RF4	-	-	–*	–
PF1	–	–	–*	–
PF2	–	-	–*	–
School				
RF6	–	-	–*	–
RF7	-	-	–*	–
RF8	-	–	–	–*
PF3	-	–	–	–*
PF3A	-	–	–	–*
Family				
RF9	-	–	–	–*
RF10	-	-	–*	–
RF11	-	–	–*	–
RF12	-	-	–	–*
PF4	-	-	–*	–
PF5	-	-	–*	–
PF6	-	-	-	-
Peers/Friends				
RF14	-	-	–	–*
RF15	-	-	–*	–
RF16	–	–	–*	–
RF17	-	-	–*	–

– Significant increase in risk [25]
- Significant decrease in risk
** Effect significant for CTC or non-CTC (difference in means)* [26]

Also shown are summary results from an analysis of variance, comparing change in the means of the CTC group with change in the non-CTC group, controlling for age and sex (see Appendix 2 for methods and detailed tables). There were significant differences between the CTC and the non-CTC group in all of the risk factors except for PF6, rewards for pro-social involvement in the family, where protection increased for both groups but not significantly.

- Fourteen out of 20 tests showed a positive effect for the CTC area. The effects were strongest on community and family factors, where the CTC children showed most decreases in risk and there was the most CTC-related activity.

- School factors particularly favoured the non-CTC children, especially for protection, and these results are consistent with what might be expected since Southside did not implement any school-based interventions.

- Individual and peer factors showed a general trend for increase in risk in both the CTC and non-CTC areas, but the CTC children showed less of an increase than the non-CTC children. If, as the analysis suggests, trends of increasing risk in the larger context continue, then CTC might have an inhibiting effect, particularly on attitudes and early involvement in problem behaviour, but probably not on feelings of social exclusion or rebellious attitudes (RF14).

The results of the analysis of variance, contrasting the areas, should be treated with caution because on almost every measure of risk there remained differences between the groups, suggesting that further more detailed and complex methods of individual matching that were out of the scope of this study would be appropriate for further development of this research. More complex and detailed analysis would take into account the underlying methodological problems in comparison of differences between risk scales. This analysis, therefore, should be seen as exploratory within the scope of the evaluation.

Conclusion and postscript

The Southside CTC project was the most active one, and the one most clearly identifiable as having been implemented in accordance with the CTC model. Good infrastructure and clear management were accompanied by a strong partnership working ethos and community involvement. Specific initiatives sought to tackle issues of identified risk such as the availability of drugs and ‘early years’ work to improve parental and childhood behaviour. The results of the school survey did not show an unequivocal CTC impact effect although there was evidence that life in the CTC area was improving. For example, evidence showed that in the CTC area, for

children and young people, risk was on the decline especially in community and family-based risk factors. This would suggest that something positive may have been happening in the CTC area that was not happening elsewhere (or that something negative was occurring for children from other areas that was not affecting CTC children), but it is not possible to be sure that this could be attributed to the presence of CTC itself. Furthermore, there seemed to be some positive developments in terms of educational achievement in that primary schools' Key Stage 2 tests showed remarkable changes over the CTC period of intervention. Although this cannot be attributed to CTC it is a positive development for the future.

Since the end of the evaluation the CTC project in Southside has continued to thrive and grow. It continues its work and a project infrastructure is still in place. An example of this success is that the local authority now funds the co-ordinator's post and has started a larger roll-out of the programme across the city. More recently, data has been collected from across the city and the Southside project is going through Phase Four (review). It is revisiting the original plans to assess its success. CTC is still seen both locally and strategically as important to the preventative strategy in the city. It clearly still has a future.

3 Westside

Westside profile

Westside is located in a West Midlands city with a population of approximately 300,000. Historically, its main industry was engineering, but in the mid- to late 1980s this declined significantly. Unemployment remains well above the national average, and employment opportunities were limited. The city of Westside has a significant ethnic population (12 per cent), mainly of Asian descent. Crime in the city was higher than the national average in all areas.[1] For example, in 2001 violence against the person was 19 per cent compared to 11 per cent nationally, while burglary was 13 per cent compared with 8 per cent nationally.

The geographical area used for the CTC demonstration project is divided between two electoral wards. In the original bidding process the local authority decided to construct a geographical area that brought together three separate communities. The main rationale for this was that all three areas suffered high levels of deprivation and crime, and had also been excluded from many of the city's developmental initiatives in the past. All three areas saw themselves as having separate and distinctive communities. The construction of the CTC area therefore put together three areas that were not 'naturally' associated although as we will see they were all areas with high levels of deprivation.

Economic and social profile of Westside

Together, both wards had approximately 35,000 residents, but the three CTC areas only included approximately 4,700 people (14 per cent of the total population from both wards). In what we refer to as Westside 1 the focus was on a small problem council estate of 170 properties. This community had a long history of social problems and high levels of crime and vandalism. It was also claimed to have had a high percentage of void properties and a transient population.[2] The quality of housing in this ward was very poor, with over 20 per cent of all properties not having central heating. Over the life of the CTC project this housing estate was taken over by a newly formed company within the private sector. During the later stages of the intervention period its population was moved out and a whole new rebuilding programme took place.

Westside 1 had a high proportion of people from ethnic minorities (57 per cent), and a high proportion of under 18s (36 per cent) compared to the national average. It was also in the top five most deprived wards in England and Wales, and ranked highest in the city itself.[3] In the second ward (Westside 2) there were two areas designated for the CTC project. Area 1 had approximately 980 households, of which 38 per cent were living in council properties. Altogether it had a population of just over 2,500. The second area was smaller, with 640 households and a population of

1,110. Seventy per cent of the population were Asian and 53 per cent were under 18. Although this ward was not as deprived as the first, it was still within the top 15 per cent of the most deprived wards in England and Wales.

Table 8 shows that across all social and economic indicators the two CTC areas have major problems. Even though Westside 1 was clearly more deprived, both areas can be seen to have levels of poverty and social problems above the city and national average.[4] Unemployment was the highest in the city in Westside 1 at 7.6 per cent and car and property ownership was well below the national average for both areas. The number of families and children dependent upon benefits is substantially higher across both areas than both the city and national averages. A similar case exists in terms of health in that the numbers of people registered as sick and disabled and self-reporting poor health is higher in both areas than the city and national averages.

From our school-based survey, young people had perceptions of their community that were somewhat less positive than the national average.[5] For example, nationally eight out of ten young people liked their neighbourhood. In Westside it was seven out of ten. Thirty per cent said they would like to leave it, compared with 23 per cent nationally. Similarly, 36 per cent of young people thought their neighbourhood had lots of crime and drug dealing, while 33 per cent thought it was not safe at night.[6] Both of these figures were substantially higher than the national average, suggesting that not only was the CTC area highly deprived, but also that it had large numbers of young people who felt negative about their community and its environment.

Table 8 Economic and social characteristics of Westside

	Westside 1 (%)	Westside 2 (%)	City (%)	National (%)
Level of unemployment	7.6	5.5	4.0	3.0
Extent of car ownership (one car)	49.8	57.1	66.8	70.6
Extent of property ownership	49.1	59.7	69.2	68.9
Percentage renting local authority housing	6.7	12.4	8.3	13.2
Permanently sick or disabled	9.1	7.9	6.1	5.5
Self-report of health over last 12 months as 'not good'	12.1	11.8	10.0	9.2
Lone-parent households with dependent children	14.2	10.0	8.3	6.5
Percentage of under-16s who are dependants of income support claimants (Source: ONS, 2001)	32	27	22	24

All data from ONS, Census 2001 unless noted otherwise.

Westside schools

There was no secondary school in any of the Westside areas, although there was a large secondary school nearby. Approximately 42 per cent of children from the CTC areas attended this school, with the other 58 per cent being spread across the city. In 2000 the head teacher of this school was replaced and the school underwent a restructuring. The school had a small intake of transient children. They also had a high number of refugees (Ofsted Report, 2001). The school had a special needs unit, which ensured that they had a high proportion of pupils who needed extra help (30 per cent of the school population in 2000). Levels of achievement were well below the national average with just 23 per cent of young people receiving five GCSE A–C grades (see Table 9). In 2000 the school had an authorised absence rate of 12 per cent that was well above the national average.

The CTC area was also served by three primary schools. All of their local head teachers were active in the CTC programme, although one was subsequently removed from her post by the local authority because of problems in the school. One of the primary schools had a low achievement rate for Key Stage 2 on all of the three critical scores. A second primary school was more successful in that it had above the national average score in science in 2000. In the third school levels of achievement were higher than the other two schools in 2000.

From our school-based survey, young people in Westside had similar experiences of school to others around the country. For example, on average 43 per cent of all CTC young people claimed to enjoy school on a regular basis, and 31 per cent said they disliked school often or very often. These figures were very similar to national figures outlined in Beinart *et al.* (2002). Bullying and truanting, as reported by young people themselves, were also similar to other groups across the country. For example, 40 per cent said they had been bullied in the last 12 months and 30 per cent said they had truanted at least once in the previous 12 months.

Table 9 Westside school indicators, 2000

	School A (%)	LEA (%)	National (%)
Free school meal entitlement: secondary (Source: annual school census, 2000)	32	20	17
5 or more GCSEs, grades A–C	23	40.8	49.2
Average GCSE point score	23.2	34.2	38.9
SEN, with statement	3.6	N/A	2.5
SEN, without statement	30.1	N/A	N/A
Unauthorised absence	4.3	1.3	1.0
Authorised absence	12.4	8.8	7.6

Phases One and Two

Set-up and early implementation in Westside

One of the main reasons why the city of Westside was chosen for a demonstration project was because of its well-established and innovative partnership work. Before the CTC project arrived, the city within which Westside was located had undertaken a restructuring of its professional working practices and resource allocation. The city had been subdivided into four areas. All services were to be managed around these divisions, and all agencies had to allocate workers and resources to areas. As a result, partnership working was a central requirement. Each area had an area co-ordinator and a partnership group responsible for service delivery and resource allocation. While this model had its problems[7] it provided a good infrastructure within which to locate a project like CTC. These local co-ordination groups also had responsibility for community development and social inclusion. In all three areas included in the CTC boundaries, local residents expressed disillusionment with how the local authority had been tackling social problems. While professional partnership was well established, partnership work with local tenants and residents was not. One of the key reasons Westside bid for the CTC programme was to use it as a mechanism for addressing this issue. Across the CTC areas there was little infrastructure to support community development and engagement and it was hoped that CTC would help contribute to the development of new forms of community engagement.

In Phase Two the project followed the CTC model of implementation but it had major problems involving local people in the programme. A more detailed explanation for this is outlined in our previous report (France and Crow, 2001) but in general the historical tensions between professionals and local people and the lack of an infrastructure for engagement remained problematic throughout the implementation period. Much attention was given to the CTC co-ordinator getting actively involved in community-based work. This remained a constant problem for the co-ordinator. The expectation was that they would not only implement the main components of the CTC process but also contribute to the development of new structures for community engagement. While much effort was targeted on this work Phase One was dominated by a small group of committed and interested professionals from across the three geographical boundaries.[8] Very few local people became active in this first phase.

The selection of risk factors

The Community Board did manage to select their risk factors and from their analysis of the risk audits they chose four. These were: disadvantaged neighbourhoods, poor parental supervision, low achievement in schools and lack of commitment to school including truancy. The professional workers were the key players in analysing the risk and resource audits and also the construction of the Action Plan. This being said, problems existed in keeping a wide range of professionals fully engaged and the local co-ordinator had to take core responsibility, alongside a small number of committed professionals, for making sure the Action Plan process was achieved. Westside also had the same problems as Southside around the quality of the risk audit they received. It was too detailed and confusing, not well focused on risk factors and had no information about protection. It also lacked normative data so no comparisons could be made. People involved in the selection process therefore struggled to make sense of the data and make their choices.

Our risk audit evidence shows that alternative risk factors should have been considered. The CTC board selected the 'lack of commitment including truancy' risk factor but in our analysis it comes out below the average (Figure 14), suggesting that it was not as problematic as others. A similar issue emerges over the selection of the family risk factor 'parent supervision' (Figure 12). Evidence shows that it was below the average in terms of risk. Other factors should have been targeted. For example, 'high turnover and lack of neighbourhood attachment' (Figure 15) was highest amongst all the risk factors. In the peer domain risk was low amongst all measures (Figure 13). This being said, evidence from the analysis of protection factors indicates that it was low in the family domain with three out of the six being below the average. Work with parents clearly was important although selection was based on the experience and impressions of professionals involved, rather than based on evidence from the risk audit. Two of the risk factors selected could not be measured by the self-report survey, those of 'disadvantaged neighbourhoods' and 'low achievement in schools'. Data for assessing these is gathered from national data. Given that the two areas included in the CTC area have high levels of deprivation (top 10 per cent and 15 per cent) and the local school has consistently low achievement levels (less than 18 per cent), it would seem appropriate that these two risk factors were selected.

Figure 12 Risk and protection profile relative to average scores: family factors, Westside

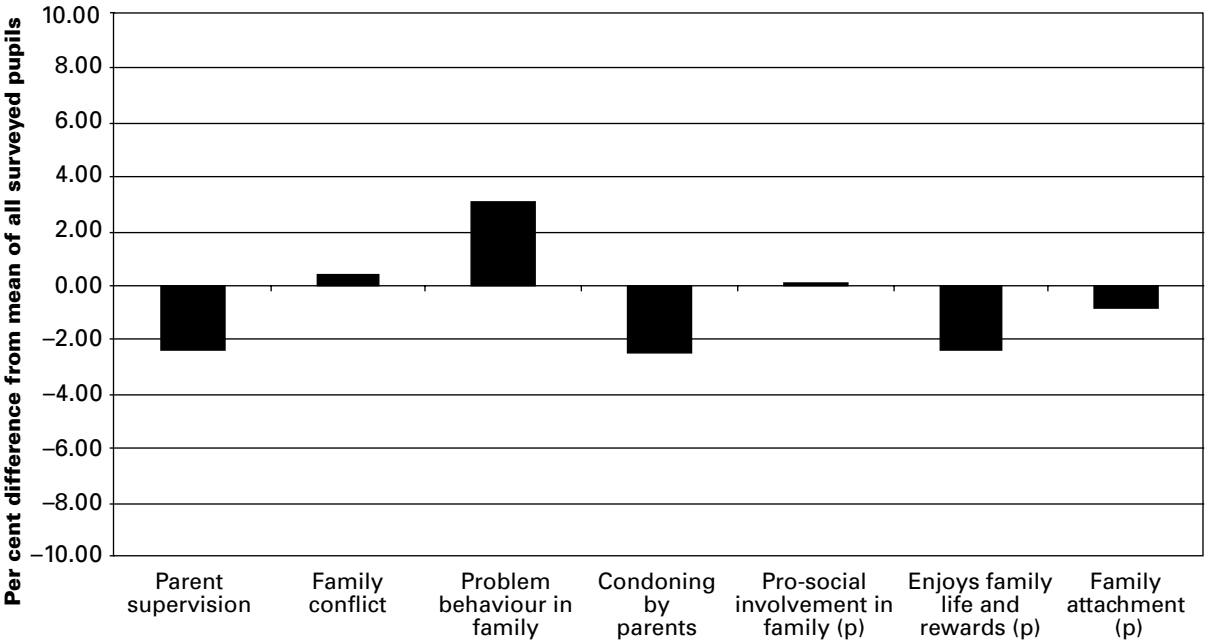


Figure 13 Risk and protection profile relative to average scores: peer/individual factors, Westside

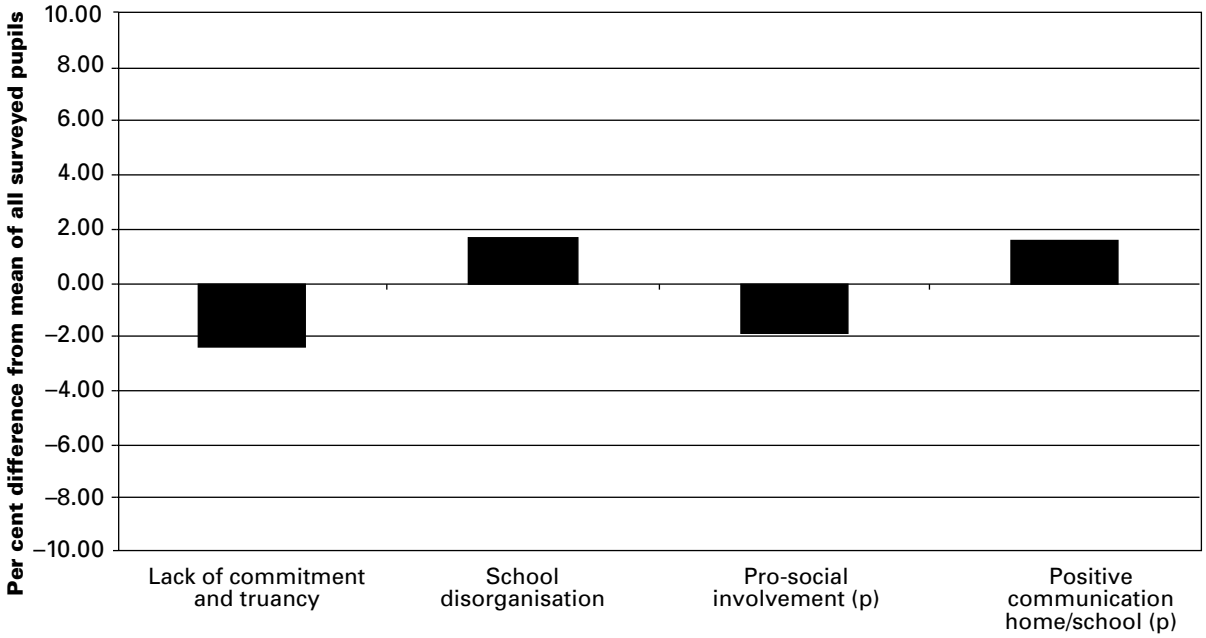


Figure 14 Risk and protection profile relative to average scores: school factors, Westside

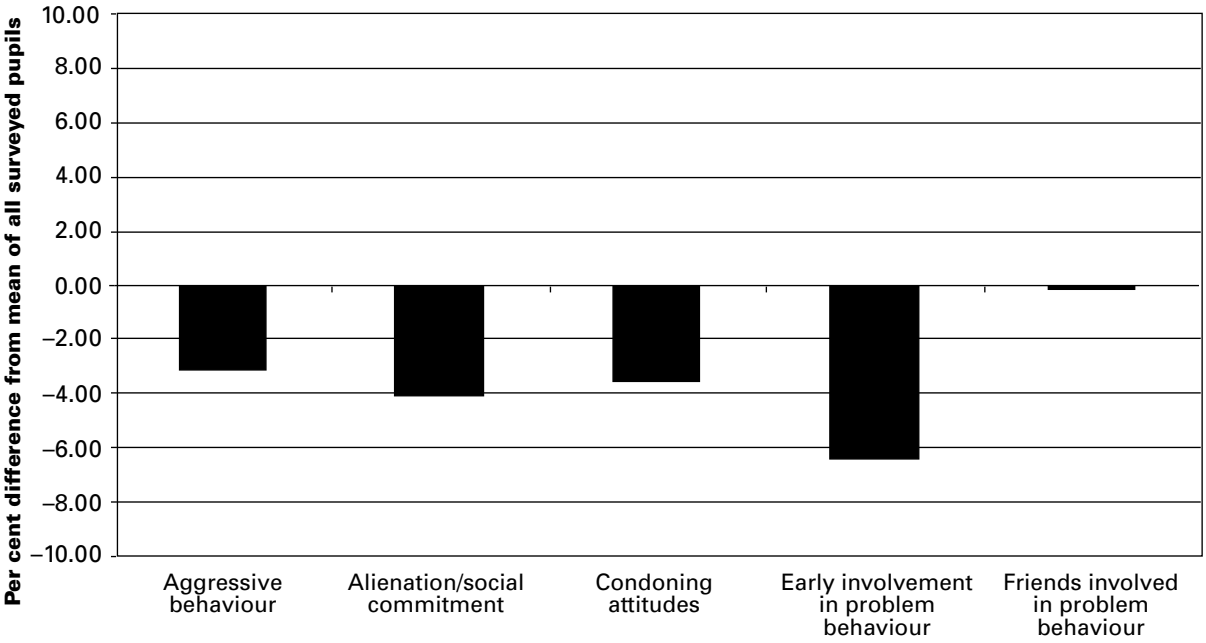
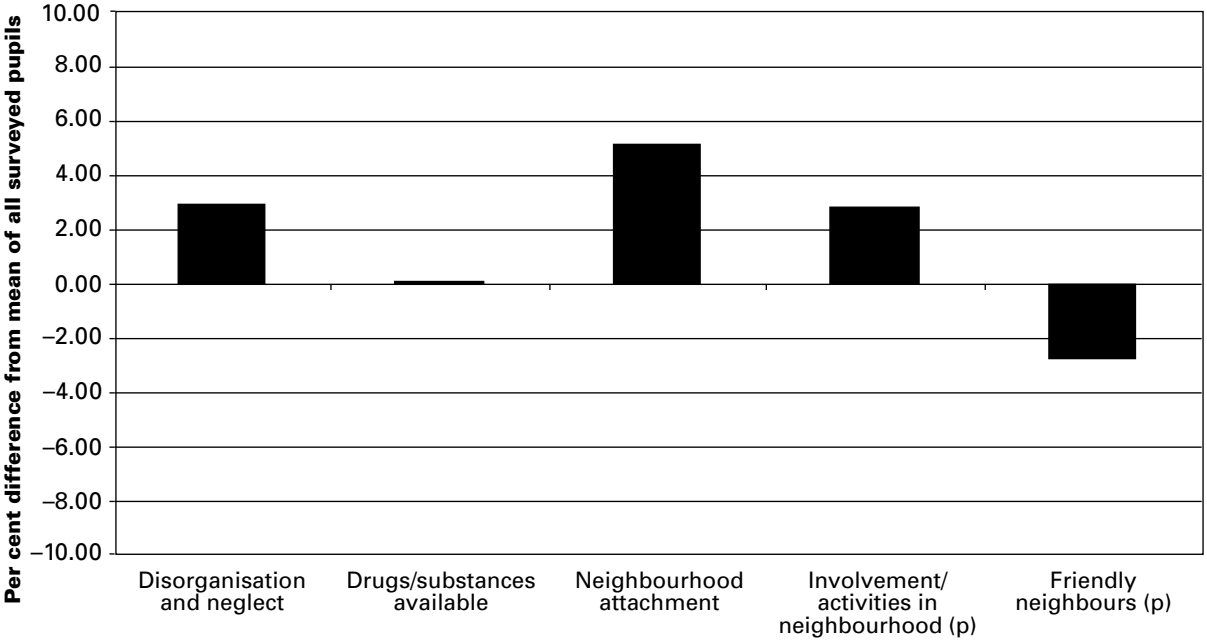


Figure 15 Risk and protection profile relative to average scores: community factors, Westside



'p' = protective factor.

There are two issues worth considering. First, even though Westside was clearly the most deprived community out of the three demonstration programmes, the number of risk factors that seemed problematic remained low. Only one risk factor (high turnover and lack of neighbourhood attachment) was five points above the average and only four risk factors were over one point above. Second, protection was low across the Westside area especially in the family domain and targeting on protection within the Action Plan would have been valuable. But Westside had no data on protection, therefore they were not able to plan their delivery around increasing the levels of protection.

Similar to Southside, Westside had to make their selection on a risk audit that was problematic. As a result the selection of risk and protection had to rely heavily upon the interpretation of the data by the participating professionals. Although there was a strong attempt to maintain objectivity local professionals struggled because of the poor quality of the data and difficulties associated with understanding it.

Phases Three and Four

Project development and action planning

At this point in the process the co-ordinator left and was replaced three months on. This in effect delayed the final construction of the Action Plan. The final set of plans outlined in the Action Plan was focused on the implementation of new programmes. There were no recommendations for changing or enhancing existing services. The focus was on producing new evidence-based programmes. A strong influence was the local social work team and the three local primary head teachers. As a result two of the programmes proposed were located in these agencies. There was much debate within the area over the use of *Promising Approaches* (Utting, 1999). It was felt by many of the professionals to be inadequate as it only included ‘evaluated programmes’ that had been tested. Local professionals felt that this marginalised local programmes which had, in the eyes of professionals, been seen to be effective. As a result there was substantial resistance to using *Promising Approaches* to select programmes. This being said the CTC planning team did select four of its interventions from *Promising Approaches*. The other four programmes were based on local initiatives.

As outlined above, local professionals heavily dominated the CTC project in Westside. This had implications for what was delivered and how. In the second phase major changes took place in how the project was organised. These changes reflected the history of partnership work in Westside and attempts to address some

of the problems identified above. In 1996 the city introduced six Area Co-ordination Teams as a method of establishing services that were targeted on local needs. These Co-ordination Teams were multidisciplinary in nature, and involved representatives of all the major service deliverers and members of the local community. The CTC project was located within this structure and the Area Co-ordinator responsible for the CTC area was the line manager of the CTC co-ordinator. In the early stages of the project there was tension about how this worked in practice.[9] After the second co-ordinator left the project it was decided that the CTC project would be integrated into the Area Co-ordination structure. This eventually saw the abolition of the Key Leaders Group and Community Board. Once the Action Plan was identified four task groups were formed and each had responsibility for overseeing the delivery of the Action Plan. All reflected the risk factors selected and involved a range of professionals interested in these particular areas. For example, in the Family Links programme the three head teachers of the local primary schools were actively involved, alongside the PSE (Personal and Social Education) co-ordinator for the city, in developing a programme with the trainers of Family Links. Similarly the local social work team was active in helping develop the local parenting programmes that were to be set up under the Poor Parenting task group. In both these groups a lot of hard work concentrated on identifying how such programmes would work in the area and what kind of training, staffing and resources would be needed.

Implementation of the Action Plan

The Action Plan had two stages of delivery (see Table 10). Stage one aimed to implement three new programmes: the Webster Stratton Parent and Video programme, which was a parenting course, the Family Links programme, which was a whole school approach to tackling the emotional health of the children, and a PALs programme. This was a local initiative that aimed to enhance future opportunities for young people to be engaged in local youth services. Stage one also aimed to support the establishment of World Book Day. The PALs initiative was never implemented although a substantial amount of time was spent on its development. It was recognised early on that the resource audit undertaken in Phase Two in terms of disadvantaged neighbourhoods had not been detailed enough, therefore it was decided to revisit the process and develop a programme of work based upon a new audit. By the end of the evaluation this programme had been developed but not implemented. Funding was sought from the SRB[10] fund for CTC but the SRB board rejected it, as the money had been reallocated to other priorities. One other programme was added after the completion of the Action Plan had taken place. The Area Co-ordinator felt that evidence from another local programme (Community Parents) suggested that the quality of parenting could be affected by using trained

parents as mentors to help local mothers who needed support. Evidence was taken from a localised evaluation run by the health service. Stage two initiatives were seen as longer-term developments, although no work was done on getting them ready for implementation. All of the work done between 2000 and 2002 focused on the four initiatives mentioned above.

In the early stages of delivery the focus was on getting resources for the programme. The Community Board had decided that the implementation would be staggered so that 'early wins' could be achieved. This would help them in future searching for resources. The main approach was to focus on the implementation of the Webster Stratton Parent and Video programme and in particular to get resources to run a number of courses. The Key Leaders alongside the Area Co-ordinator had identified £250,000 within the Single Regeneration Budget. A bid was submitted for the funding of the Webster Stratton programme but was rejected at first because of its focus on children and not young people. The main remit for SRB was young people aged 14 and over and the prevention aspect of the CTC bid was seen as inappropriate. After much discussion and debate between the project co-ordinator, Key Leaders and the SRB a second bid was submitted with a stronger focus on young teenage parents. Although this tension remained a budget was released for the running of two Webster Stratton programmes. This was eventually expanded to four over the two-year implementation time period. Although SRB had ring-fenced £250,000 for the CTC project no other bid was submitted for resources until late in the programme.

Four 15-week Parent and Video courses were run during the demonstration project, all four being independently evaluated. The task group was very active in the early stages, with representatives from eight agencies regularly attending meetings, enabling the organisation to be put in place for the courses to run. In total 59 parents were involved in the four 15-week courses. Fifty-four of these were mothers, and seven were from minority ethnic groups. Twenty-nine of them completed the course, attending a minimum of nine sessions each. The Parent and Video programme used a validated set of before-and-after surveys to measure change in parents. Evidence from these evaluations showed:

- a statistically significant increase in parents' self-esteem
- a reduction in parents' depression and anxiety
- a statistically significant reduction in parents' stress
- observational changes in children's behaviour.

Table 10 Programme overview

Risk factor identified	Action planned	Action implemented
Disadvantaged neighbourhood	World Book Day PALs programme	World Book Day
Poor parental supervision	Webster Stratton Parent and Video programme Community Parents	Webster Stratton Parent and Video programme Community Parents
Low achievement in schools	Family Literacy programme Child Development Advisory Service (Stage 2) PATHs (Stage 2)	
Lack of commitment to school including truancy	Family Links programme	Family Links programme (6-month implementation only)

At the end of the demonstration period the task group came under a new task group called Parents who Care which is now being funded by the Children's Fund Initiative.[11]

A Family Links programme was also set up directly because of the CTC demonstration project. Following training for all members of staff and two parent group leaders, the programme was introduced into all three primary schools in the CTC area in January 2002. This was partly enabled by the three primary schools agreeing to work together to identify training days and to sign up for the programme. Over 100 members of staff in the three schools were involved in full-day training in January 2002, prior to implementation. It was not fully implemented at the time of writing, as local parents had not been involved.[12] Evaluation of the programme started in January 2002 and early indications are that it is making positive improvements.[13]

The remit of the Community task group was to devise its own action plan to tackle the risk factor 'disadvantaged neighbourhood'. As well as organising several capacity-building exercises to try to increase community engagement, it worked hard to run an annual local promotion for World Book Day, targeted at all primary-age children in the three CTC schools. This ran from 2000 to 2003. No such promotion had previously taken place and its success was strongly influenced by the partnership working fostered by CTC. It was hoped that the project could be evaluated for inclusion in future issues of *Promising Approaches*, although this had not so far happened. The Community Parents programme commenced in stage one, although the health authority, without CTC involvement, delivered this. Questions remain over how much this initiative could be seen as a part of the CTC programme. The third, and major, strand of work that this task group was involved in was the

development of the Participate and Learn Plus (PALs) programme, a modification of the PALs programme included in *Promising Approaches*. This is a cognitive learning programme for young children. The Westside programme was a reworking of this approach aimed at older children (14 plus) so that it would reach the criteria set down by SRB. As outlined above this was not delivered in stage one.

What factors influenced implementation?

Geography

Difficulties remained over the geographical construction of the CTC area. Problems arose because the CTC project area overlapped into a second Area Co-ordination area and had three very separate communities included in its structure. There remained little rationale for this model other than that they were clearly deprived areas that had serious problems. This caused a number of problems. First, getting the local community involved was very difficult. Different groups could not see the advantage of being part of a project that only covered three different areas. None of the three neighbourhoods identified with the structure imposed on them by the programme. Second, there were duplication problems for professionals and difficulties in communication between agencies with an interest in this work. There were disagreements over who should be involved and who was representing what agency. Third, having the CTC area spread across two distinct Area Co-ordination Teams raised problems over how one Area Co-ordination Team could make plans or influence resources in an area serviced by another Area Team. Throughout the programme this question of geography remained a barrier to overcome.

Funding

Westside also had difficulties over funding. Their problems were not so much related to not having money available to fund the Action Plan as they had £250,000 made available through SRB, but over the criteria and time frame for spending it. As discussed previously, the local CTC co-ordinator had to work very hard to get any money released to the project because the money made available had to be spent on over 14s. As a result only a small proportion of this resource was ever spent on the project.

Co-ordination

Co-ordination in Westside was challenging. The CTC co-ordinator had to manage not only the complexity of the geographical infrastructure of the project but also high expectations about community development. From the beginning of the programme there was an expectation at both managerial and operational level that the CTC project would address issues of community involvement. One of the core reasons local professionals had wanted to secure a CTC demonstration project was to aid the

process of community engagement and development. While CTC is keen to be party to this type of work it does not claim itself to be a community development programme. Similar to Southside (and Northside), the Westside project also had changes in co-ordination through its life. The first co-ordinator left 12 months into the programme and the replacement co-ordinator was someone who had been a member of the local CTC Community Board. At varying times throughout the following period considerable tensions arose over who was controlling the project in that Area Co-ordination was seen as using CTC as a mechanism for getting its own targets and agenda addressed. This created a lot of tension within the local Community Board and eventually this led to the second co-ordinator leaving the project. At this stage Area Co-ordination took over responsibility for the management and running of the project. The consequences of this are discussed below.

Restructuring of the local project

Westside was a very different project to Southside (and also, as we shall see, Northside). It had a different historical context, a different local authority infrastructure and different membership. All these factors, as discussed above, were influential in shaping how the project developed and how it managed to implement its Action Plan. Similar to Southside, these managerial and structural problems were a consistent challenge to the CTC project in Westside. After the second co-ordinator left, the local Area Co-ordination Manager decided that a total restructuring of the project was required. As a result the Area Co-ordinator decided not to appoint a new CTC co-ordinator, but to amalgamate the CTC co-ordinator functions into his own responsibilities. He therefore took over the running and management of the whole programme. While there was some resistance to this by partners, it was agreed that Area Co-ordination would take over responsibility for overseeing implementation of the limited CTC Action Plan. At the same time the city was developing its Local Strategic Partnership Plan as required under the Local Government Act 2000 and its neighbourhood renewal strategy. In this process the Area Co-ordinator responsible for the CTC project in Westside saw an opportunity to try and locate the CTC approach into the strategic objectives and practices of the city. He produced a new management plan that was accepted at the local level to relocate the Key Leader functions into a city-wide steering group. This was to operate under the Local Strategic Partnership and was therefore to oversee the implementation of the CTC programme in Westside and the city. At the same time the CTC project area was to be reconfigured into two projects and a new set of working arrangements was planned for reconstituting local Community Boards.

It is too early to have a full understanding of the impact of these changes because they are still being developed into concrete plans, although there are some interesting early observations. First, the restructuring re-enforced a totally

professional infrastructure for the CTC programme, driven by a committed individual. At one level this was not a problem; in fact it could be argued that this structure helped ensure implementation, especially in primary schools, and in the creation of new parenting programmes. The evidence suggests that implementation was achieved because of the commitment of certain individual professionals, such as local head teachers and social services representatives. Local people were not included at this stage. Neither were they involved in the delivery of programmes.[14] As a result it has to be said that the Westside approach in Phase Two to implementing CTC was not in accordance with the CTC model, community engagement being a core requirement of that model. Nonetheless, the involvement of the community was a core objective for the new projects created in Westside under the restructuring that has since occurred. Increased community participation may yet emerge in future. Second, the relocation of CTC into a new city-wide forum enabled CTC to widen its support base and to gain recognition in city-wide plans. This had the effect that resources were targeted at supporting the programme in the long term, and consequently opportunities exist for a sustained programme of work to emerge. Third, unlike the other two projects, Westside had a strong focus on the use of evaluation. It was the only project to evaluate any of its work. This was mainly because of the professional focus of the programme. Issues of evidence-based policy and practice were a central concern in the city and in professional practice. CTC not only provided the opportunity for this to be put into practice, but also provided information about how it could be done within programmes.[15]

Evidence of change and local impact

In our analysis there was no significant change in the levels of risk and protection across the CTC area. But we have the view that it is highly unlikely that the Westside CTC project would have made a significant impact at this stage of its life. The local CTC project targeted two specific areas of work. First, the Community Parents and Parent and Video programmes targeted local parents targeted by social services. These tended to be parents with young children who were having personal difficulties. The numbers involved were small, and the level of involvement was limited to 12 weeks maximum. It was also the case that the parents targeted had young children under the age of five; therefore any impact this work had would not have been picked up at this stage of the evaluation.

Second, the Westside project implemented two school-based programmes. It remains unclear how much effect the World Book Day would have had, although it can be assumed that it would be only one of a number of local school-based programmes aimed at improving reading. The Family Links programme involved all three local primary schools, but it was not implemented until six months before the

end of the implementation period. The numbers involved were high but the level of contact with the programme at the six-month point was low. It is unlikely, therefore, that any impact would have shown up in our analysis at this stage of the programme.

Conclusion and postscript

In Westside there was implementation and much promising activity, although it was predominantly a professionals' project and local community involvement was limited. However, the picture was a complicated one, first because there was not one clearly defined neighbourhood for the initiative but three separate communities which were not contiguous, had separate identities, and one of which became redeveloped during the intervention period. Second, CTC took place as part of more general Area Co-ordination work and other initiatives, so that it became intertwined with these rather than being a single clearly identifiable intervention. The Key Leader functions were relocated within a city-wide steering group. Thus in many respects the Westside approach was at variance with the received CTC model. It is also worth noting that Westside was the one area with a significant minority ethnic population. This is good from the point of view of testing how CTC fares in multicultural communities, but the important question is the extent to which it is taken on board equally by all ethnic communities. Again there were changes, but no clear overall pattern. Two specific initiatives were developed, the Webster Stratton Parent and Video programme and the Family Links programme, which were largely successful and which may well in due course have a significant impact on the futures of the children and families involved. However, the number of people involved was limited and it may therefore be hard to discern a neighbourhood effect, and also because they involved young children it is too early to expect that any impact could be detected by this evaluation. In fact there were relatively few changes apparent from the school surveys that could be attributed to living in the CTC area.

Since the completion of the CTC evaluation the activity of the project has been focused on restructuring its organisation. Building on plans put in place prior to the end of our evaluation the local Area Co-ordinator has constituted a CTC evaluation and implementation group. It involves a broad range of people including senior policy makers and implementers, local practitioners and local people. In fact one of its successes has been involving local parents who had been involved through the Webster Stratton Parent and Video series. A critical question that emerged from the programme was that parents enjoyed the experience and found support from each other. As a result they are looking to find other ways of acting collectively and being involved in the programme. The evaluation of the Family Links programme (phase 1) has also been completed. This has shown positive results in terms of implementation and teachers' perspectives of change. Children also showed positive changes that

may have arisen as a result of the Family Links programme. It remains unclear where the project is moving in this next phase. Local professionals have had a number of discussions with CTC UK about broadening out the programme and starting new CTC projects in deprived areas of the city. As yet nothing has been decided although discussions continue. This being said, CTC as a model and idea is still active and trying to make an impact in Westside.

4 Northside

Northside profile

Northside is located in a city in the north of England that is semi-rural, although it has a large council-owned housing stock. The population is approximately 225,000 and covers 22 electoral wards. Its main industrial base was coal mining, but since the late 1980s this had virtually disappeared. It has high unemployment across the city and is seen as an area with high levels of poverty and social needs.[1] For example in 1998 42 per cent of the city's children were classified as living in poverty.[2] It is a city with a very small minority ethnic population, 99 per cent of its population being classified as white.[3] Crime levels[4] in the city varied. Violence against the person is well below the national average whereas for burglary the figure is above the national average.

Economic and social profile of Northside

The Northside demonstration project covered a single ward with a population of 9,516. As with the city as a whole there were few minority ethnic groups living in the area (99.4 per cent were white). The project area had within its boundary a number of smaller neighbourhoods, but had a clear local identity as a community. In terms of deprivation Northside was within the top 10 per cent of the most deprived communities in England (see Table A1 in Appendix 1).

Northside has substantial problems with poverty, unemployment and health. As can be seen in Table 11 unemployment is above the national average. The percentage of lone-parent households with dependent children is also well above the national average as is the number of households with children under the age of 16 receiving income support, indicating that a large proportion of families with children living in Northside are living in poverty. Other indicators support this conclusion. For example, Northside is well below the national average in car ownership. It also has very low levels of home ownership. Even though over half of the Northside population own their own property this is well below the national average. Northside also had a high proportion of residents who rented from the local authority with over a third of its total population being tenants of the local authority. This is nearly three times higher than the national average. People living in Northside also have substantial health problems. Figures from the Census show that 11.7 per cent of its population is registered as permanently sick or disabled. This is over double the national average. In terms of general feelings of good health, those self-reporting their health as 'not good' is a third higher than the national average.

Table 11 Economic and social characteristics of Northside

	Northside (%)	City (%)	National (%)
Level of unemployment	4.1	3.9	3.0
Extent of car ownership (one car)	63.8	67.8	70.6
Extent of property ownership	56.5	64.2	68.9
Percentage renting local authority housing	33.4	23.6	13.2
Self-report of health over last 12 months as 'not good'	15.7	14.1	9.2
Percentage of permanently sick or disabled residents	11.7	10.4	5.5
Lone-parent households with dependent children	8.4	7.3	6.5
Percentage of under-16s who are dependants of income support claimants (Source: ONS, 2001)	32	23	24

All data from ONS, Census 2001 unless noted otherwise.

Even though Northside has substantial problems with poverty and health, children and young people who completed our self-report survey had quite a positive view of their community. For example eight out ten young people said they liked living in the CTC area and only a fifth (21 per cent) said they would like to leave it given the opportunity. Young people also thought that, on the whole, their communities were safe with only a quarter (24 per cent) saying they felt unsafe at night. These figures compare well with the national average.[5] Where the experience of the community differed was in young people's perceptions about fighting, drug dealing and crime. Nationally 23 per cent of young people said there was crime and drug selling in their community. In Northside more than a third (34 per cent) highlighted these as major activities in their community. Similarly, nationally 16 per cent of young people reported that there were lots of fights in their community, whereas in Northside the figure was substantially higher at 28 per cent.

Northside schools

Northside had one main secondary school located in the middle of the ward that serves the children and young people of the area (school A). This school was closed in 1996 and reopened under a new name and headmaster in 1998. In 2000 this headmaster left and was replaced. The school has small numbers (555[6]) and a high proportion of students who are entitled to free school meals (53 per cent[7]). As outlined in Table 12, only 18 per cent of pupils gained five or more GCSEs at A–C grades in 2000. This is well below the national average and indicates a school with major problems with achievement levels. This reflects a historical trend of poor and low achievement.[8] It is also the case that this school has a high number of children with special needs, both statemented and non-statemented.[9] For example, in 2000 6 per cent of the children in the school were statemented with 18 per cent being registered as having special needs. Absences were also a major problem with 9.8 per cent recorded as authorised and 6.4 per cent as unauthorised.

Table 12 Northside school indicators, 2000

	School A (%)	School B (%)	LEA (%)	National (%)
Free school meal entitlement (Source: annual school census, 2000)	54	24	26	15
5 or more GCSEs, grades A–C	18	39	34.9	51.6
Average GCSE point score	21.3	35	32.2	34.7
SEN, with statement	6.5	4.7	N/A	2.5
SEN, without statement	18.4	7.6	N/A	N/A
Unauthorised absence	6.4	1.8	1.0	1.3
Authorised absence	9.8	8.4	7.6	7.5

Approximately 200 children aged 11 to 16 from the CTC area attend an alternative school outside the area (school B). This school was more successful and had a history of improvement. For example, in 2000 39 per cent of its students received five GCSE A–C grades, which is over double the level of school A. The number of children with learning and/or behaviour problems was generally less than in school A, although the number receiving a formal statement was similar. Authorised and unauthorised absence levels in school B were a lot better than in school A although they remained just above the national average.

Initially five primary schools served the whole CTC area, but in 2000 two schools amalgamated into one. Historically, all the local primary schools had performances in Key Stage 2 below the national average. One of the schools where pupils had performed above the national average in mathematics was an exception to this. Apart from this achievement levels remained below the national and local education authority (LEA) average.

From our self-report school survey only 46 per cent of all CTC children claimed to enjoy school on a regular basis, while 32 per cent said they disliked school most of the time. These figures are very similar to national figures outlined in Beinart *et al.* (2002). Experiences of bullying and truanting reported by the pupils were similar to those of other groups across the country. For example, 43 per cent said they had been bullied in the last 12 months and 27 per cent that they had truanted at least once in the previous 12 months.

Phases One and Two

Set-up and early implementation in Northside

Northside had a group of local people who were active in their community, and a community action group existed prior to the setting up of the CTC programme. It was involved in trying to draw in more resources from the local authority and government

programmes. Much of the everyday community activity and volunteering revolved around several local churches. Thus, one church ran a mother and toddler group, while another ran local voluntary youth provision. Relationships between local people and professionals prior to the start of the CTC project were tense. Community representatives expressed strong feelings of 'being let down' by the local council and its workers at the start of the project, and that as an area it had been starved of resources over the years. As the project developed these tensions remained. Furthermore, partnership working was not well established within the local authority at the start of the CTC programme. Apart from a crime prevention partnership and certain statutory partnerships, the area had little history of such work. Over the life of the project this changed, mainly as a result of government initiatives.

A detailed review of membership is discussed elsewhere (France and Crow, 2001), although it is worth highlighting that certain agencies had been hard to engage in the early stage of the programme. In Northside major difficulties existed over engaging the schools. In the early stages of the programme one of the primary schools had representatives on the CTC Management Board, but this involvement waned quite early on in the process. By the end of the intervention period none of the local primary schools were involved in the project. In discussions with the local primary schools it became clear that other pressures such as meeting achievement targets and finding staff time to be involved worked against the schools getting involved. It was also the case that after a change of co-ordinator, contact between the programme and the local primary schools declined. The story was slightly different in the secondary schools. First, only one of the schools was engaged (school A). There was tension over involving school B. The head teacher did not want to get involved in CTC as he thought it was not appropriate for his school, feeling it might stigmatise it as a problem school. This seemed to reinforce local perceptions of the school as not being 'community orientated'. School A did get involved initially yet, similar to the primary schools, by the end of this phase their involvement had ended. Similar reasons explain this disengagement although it may not have happened if the original head teacher had remained. He had a clear and strong commitment to CTC and gave his staff time and resources to get involved. Once he had left no staff from school A ever attended meetings.

The selection of risk factors

Northside had been the first demonstration project to start, and at the beginning there was a lot of enthusiasm and interest amongst local people and professionals. In the early stages, Northside had a small group of local people involved that helped drive the project forward. These had been actively involved in selecting the risk factors from the audit and deciding the programmes needed to tackle them. As discussed in the previous two chapters there were a number of problems with the

risk audit process. The audits provided by CTC UK were too complex, were not well focused on measuring risk factors, had no evidence about protective factors and were poorly presented. There was also a major problem with the audits because there was no national average against which the area could be compared. As a result, people working in the project found it difficult to make a judgement about which risk and protective factors to select. In Northside (similar to Southside and Westside) a substantial amount of work went into the process of trying to be objective in their approach and to base their final decision making upon the evidence provided in the audits. Hours of meetings were held and much discussion took place between a whole range of partners over what the reports had to say about risk. As a result of this process they selected five risk factors: disadvantaged neighbourhoods, poor parental supervision, low achievement in schools, friends involved in problem behaviours and parental attitudes condoning problem behaviour.

Once the decision about the risk factors had been made, local people and professionals presented their findings to Key Leaders. At this meeting there was substantial disagreement in that the Deputy Chief Executive was disappointed with the lack of a risk factor that recognised what he saw as the substantial local drug problem. Similarly, the Chief Education Officer disagreed with the finding that the problem of underachievement was a primary school problem. She argued that the problem in Northfield of underachievement lay with secondary schools. As a result of this there was a polarisation of positions and lengthy arguments about the key findings that never really got resolved.

In our risk audit the highest risk factors were community disorganisation and neglect (Figure 19) and aggressive behaviour in schools (Figure 17). After these two it was poor parental supervision (Figure 16), family conflict (Figure 16), problem behaviour in the family (Figure 16) and availability of drugs (Figure 19) that came highest. Given the previous discussion concerning the profile of the community and local schools the local Northside CTC project was right to select disadvantaged neighbourhoods and low achievement in schools. Evidence from national data clearly shows that local children and young people live in a highly deprived area and are getting achievement scores well below the national average. Poor parental supervision was not really the right risk factor to select in the family domain as it was not a high risk. The local audit was also problematic because it selected ‘friends involved in problem behaviour’ (Figure 17) and parental attitudes condoning problem behaviour (Figure 16). Neither of these came up as a significant risk. Alternatively the local area could have selected community disorganisation, availability of drugs and family conflict. It is also important to recognise that the risk audit provided to CTC Northside did not address issues of protection. No evidence was provided on protection levels, therefore the project was unable to identify work that might need to

improve levels. For example, from our analysis, protective factor rewards for pro-social involvement in the family are low compared to other protective factors. If the local Community Board had this information it may have helped them target their work. By not having the evidence on protection the CTC project was not in a position to construct a programme of work that not only tackled levels of risk but also aimed to increase protection.

Figure 16 Risk and protection profile relative to average scores: family factors, Northside

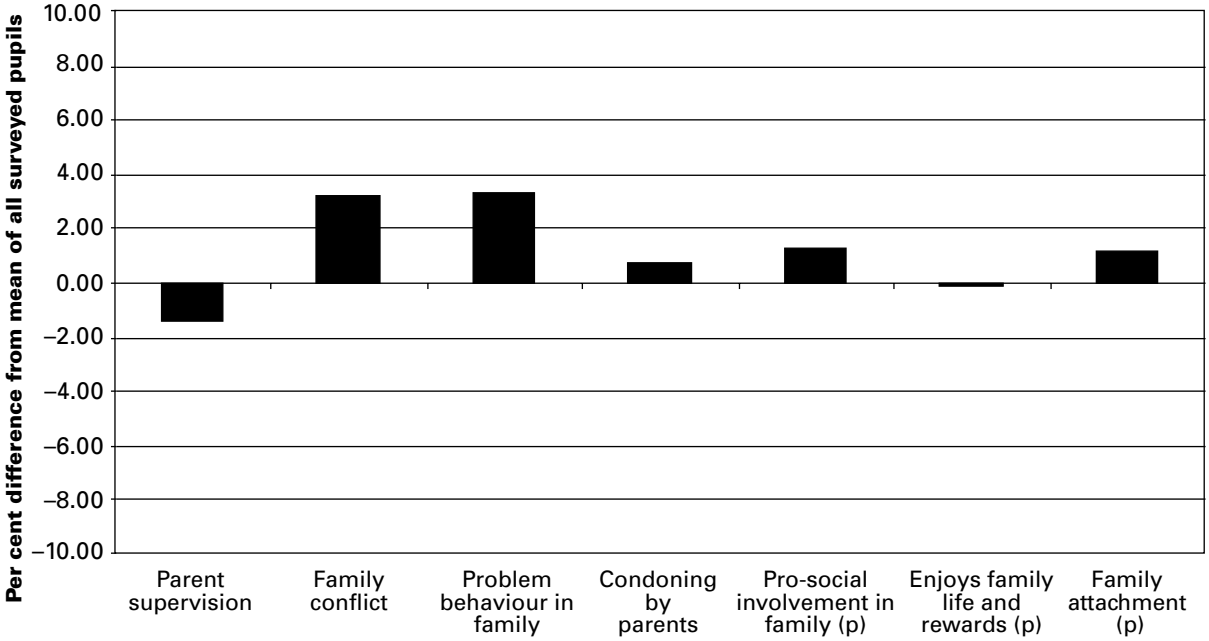


Figure 17 Risk and protection profile relative to average scores: peer/individual factors, Northside

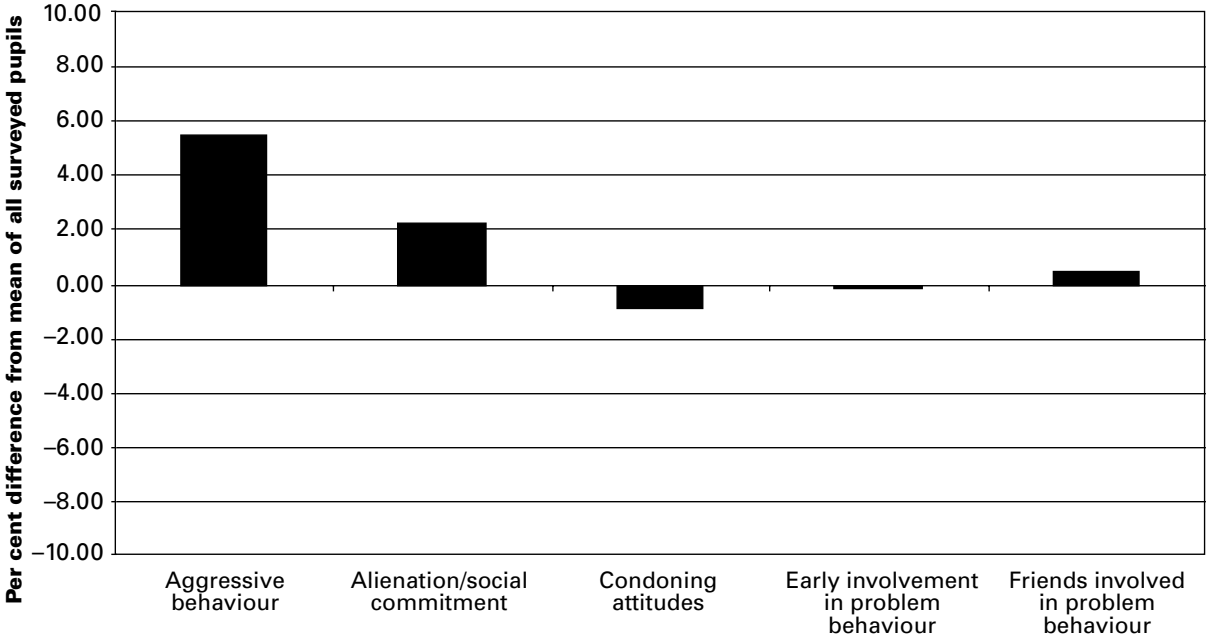


Figure 18 Risk and protection profile relative to average scores: school factors, Northside

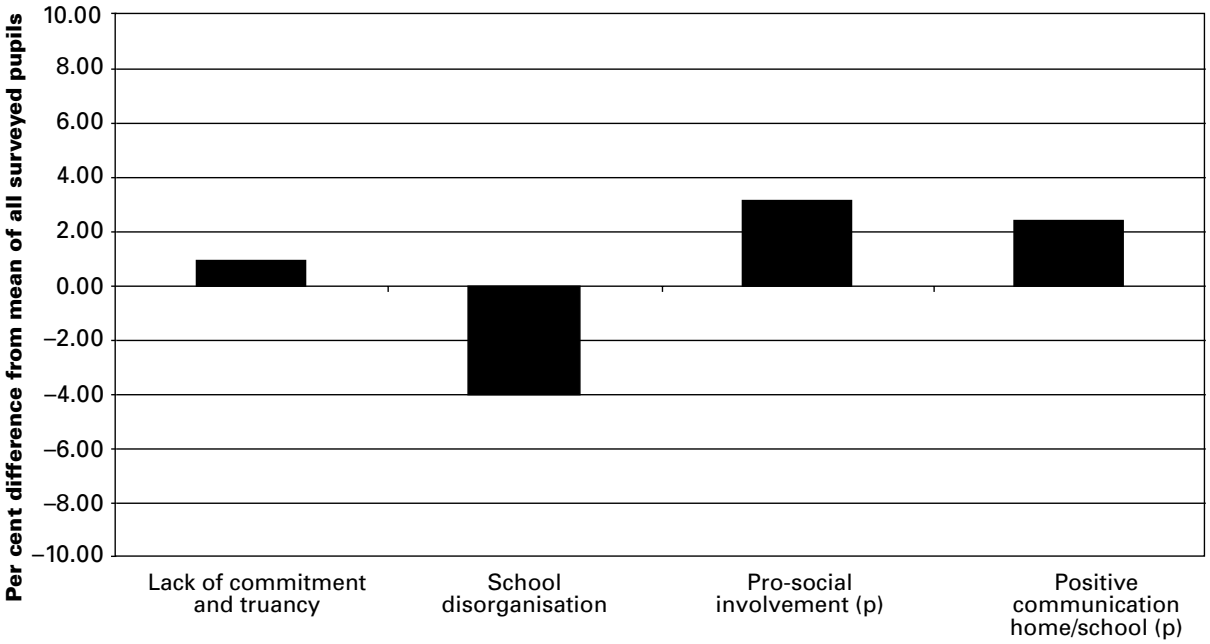
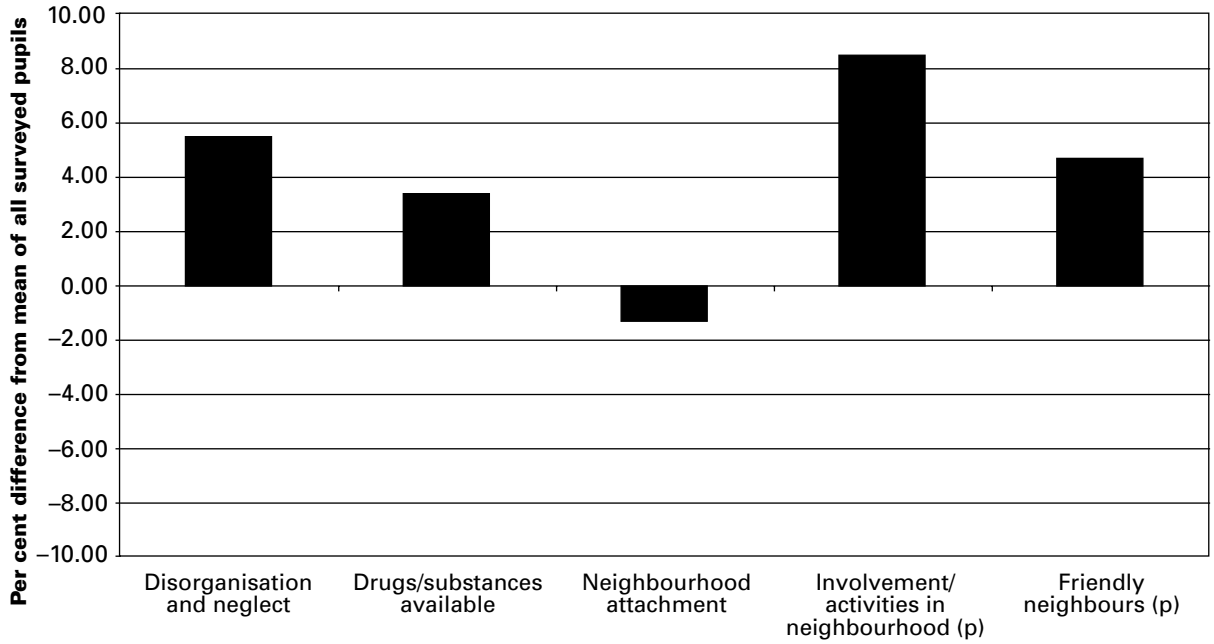


Figure 19 Risk and protection profile relative to average scores: community factors, Northside



'p' = protective factor.

The result of our analysis does suggest that, as in Southside and Westside, problems existed in getting a reliable measure of risk and protection for Northside. The limitations of the audit and the problems of not being able to make comparisons clearly meant that local people struggled to make an objective decision about risk and protection.

Phases Three and Four

Project development and action planning

Once Northside had selected their risks and undertaken a resource audit[10] the group of professionals and local people went about selecting programmes that would tackle the risks. This involved them drawing upon the *Promising Approaches* booklet and assessing if any locally run programmes could be adapted to tackle risk. The full list selected can be seen in Table 13. The CTC project selected eight programmes of work spread across four of the risk factors. In the process two major decisions were made. First, it was decided, by the Community Board, that four parent-training programmes would be developed. These were designed to contribute to the reduction of the family risk factors of parental attitudes condoning problem behaviour and poor parental supervision. Second, the Community Board also decided that reducing 'disadvantaged neighbourhoods' was beyond their ability, as it would require major structural changes. As a result they dropped this risk factor from their list and decided to concentrate on what they thought was achievable.

Table 13 Programme overview

Risk factor identified	Action planned	Action implemented
Disadvantaged neighbourhood	None	None
Poor parental supervision	Parent Craft Webster Stratton Parent and Video series	Parent Craft
Parental attitudes condoning problem behaviour	Community Parents programme Healthy Living Centre	
Friends involved in problem behaviours	Enhancing youth work provision	Enhancing youth work provision
Low achievement in schools	PATHs project Home School Link Worker Out of School Club	 Out of School Club

Northside devised five task groups to help with the implementation that had been agreed in the Action Plan. Each task group had a range of local people and professionals involved. It was planned that the Community Board would remain in place and that it would act as a place where each task group would report on its developments and plan strategically for the next steps. But as the programme progressed both the task groups and the Community Board stopped operating. People started to leave the programme and very few new people joined. This arose because of the lack of success the project had in implementing its programme of work and feelings of disenchantment with the lack of support they were receiving from the local authority or particular agencies. This being said, a small number of local people did remain because they felt a strong desire to see CTC through to its conclusion.

Implementation of the Action Plan

As outlined in Table 13, Northside only managed to implement three interventions over the period of two and a half years. The first intervention was called 'Parent Craft'. This was developed by a group of midwives who were keen to develop support services for mothers-to-be. With the support of CTC they designed and implemented a questionnaire regarding antenatal provision to 50 local pregnant women. As a result of its findings, a drop-in antenatal session in the Northside area was established. However, attendance remained disappointing and the service was withdrawn within a few weeks of set-up. A second intervention was the Joint Action Project with Voluntary Youth Workers. In spring 2001 an event took place to bring the voluntary youth workers in the area together, to discuss what was happening and find out about funding opportunities. The event was well attended, thanks in part to the organisation by the CTC co-ordinator. The next meeting failed to happen, as invitations were not issued until a week before it was due to take place. There were no further events. Finally, CTC was involved in helping one of the local primary schools establish its Out of School Club initiative. Attendance was good with around 50 children per session turning up. The CTC co-ordinator was very helpful in setting up the project, providing advice about procedures and funding opportunities. Staff and some parent volunteers ran the clubs. However, the school would have presumably set up clubs without CTC assistance, as it was an issue raised in their Ofsted report. CTC enabled the process to take less time, and was helpful in providing information and ideas, but was not the driving force behind the setting up of the club.

The three interventions that were implemented had only limited success. All three required little support at the strategic level since they were cheap to run and were only enhancing existing services. They all required the commitment of individuals and co-ordination. Meanwhile the five initiatives that did not get implemented required committed support at the strategic level as well as more substantial funding. The Parent and Children Videotape Series (PCVS), the Community Parents programme and the Healthy Living Centre all failed to make progress due to not having funds for implementation. The Community Parents programme also suffered from a dispute with Home Start that was already operating in the area. There were also difficulties with the two education-based initiatives, introducing PATHs (Promoting Alternative Thinking Strategies) into schools, and the appointment of a Home School Link Worker. Local schools had previously been trained to use Circle Time, a programme not included within *Promising Approaches*, and although there was no ongoing support with this programme, there was reluctance by the LEA to introduce PATHs. It had been planned that a Home School Link Worker would improve links between local schools and parents, as well as be responsible for delivering open access parenting skills courses. Although strategic planners accepted the viability of the post in principle and a draft job specification was drawn up, with the promise of funding from the Children's Board, no further progress was made, again due to strategic reluctance.

What factors impacted on implementation?

As outlined above, Northside struggled as a project to implement its programme of work. It is important to outline what factors affected this process. Northside was the first to be set up, but by the end of the intervention period it had almost stopped working. It had four main, interrelated problems: the strategic retreat of Key Leaders, problems with local agencies, problems of co-ordination and lack of funding.

Strategic retreat of Key Leaders

The Northside CTC project was seriously affected by the lack of support at the strategic level. Initially the Deputy Chief Executive of the city championed CTC. However, early into the project he was promoted and therefore effectively withdrew from the CTC Key Leaders Group. The project never again had the same level of strategic push behind it. The Northside Key Leaders Group initially included senior representatives from most key agencies. However, support from these representatives wavered over the course of the programme, and attendance at meetings began to fall, particularly at the time the Action Plan was being developed. There was particularly poor attendance from representatives of the local council, police and education department. New Key Leaders were brought into the

programme to try and remedy the problem, but they were less enthused by the project because they had not been involved at the start, and had limited understanding of how it worked.

Towards the end of the implementation period the local authority set up a Children and Young People's Board. This multi-agency group was to manage children and young people's services more coherently. The board was expected to eventually represent, plan and commission all services for children in the town. Despite some disagreement by the CTC Community Board, the Key Leaders Group was disbanded on the understanding that a subgroup linked to the Children and Young People's Board would replace them. There was concern by local people that CTC would just be one of a 'myriad of projects' and it would move down another layer of management responsibility. Two years on the Children and Young People's Board had still not taken up the Key Leader functions. Strategic support for CTC was therefore limited to one or two individuals. This created problems in gaining access to funding in particular. Key Leaders were inactive and not supporting the programme, therefore CTC was unable to identify possible sources of internal or external funding.

Problems with local agencies

In Phase Two partnership working on the ground also declined. The Community Board met irregularly, and throughout the project there was little communication within agencies about CTC. Most Community Board members saw their CTC involvement as being different to their normal work, and therefore rarely shared information about this project to other colleagues. This made it difficult for CTC to become mainstreamed, since only a few individuals really knew or understood the project. In the early days of the task groups professionals and local people did work together, but as problems emerged over implementation this type of working declined. Those professionals who stayed active in the project found it difficult to work without any strategic support, and as a result there was substantial drift and inactivity amongst professionals. Serious problems also arose in the implementation phase because some of the key agencies were not fully engaged in the process.[11] This limited the success rate of the CTC programme. Local people also became disillusioned. Lack of interest by the Key Leaders and the decline of professional involvement coupled with the lack of success led to members of the Community Board feeling despondent. As a result tensions increased between the two groups and local people felt that once again they had been let down by many of the professionals.

Problems of co-ordination

Co-ordination was also problematic. During the demonstration period Northside had three co-ordinators. This had a significant impact on momentum. The first co-ordinator left after just one year in post. Until this time Northside had been the fastest developing of the three demonstration projects. However, when this co-ordinator left it took the authority over six months to reappoint, so much of the momentum disappeared. While the post was being advertised a representative from another agency was seconded to the post. This created disagreements within the project about how the work should be managed. When the project finally appointed a new co-ordinator, she had to deal with these tensions in the early stages of her job. Co-ordination continued to be a point of conflict, partly due to the fact that this co-ordinator's strength was in strategic development rather than community engagement, which upset local people and led to them perceiving her as less effective than their first co-ordinator. Some impetus did return to the project, but by this stage much time had been lost. A year before the end of the demonstration period the co-ordinator went part-time, and five months later left the project altogether. Due to disagreements within the local authority over the salary and the source of funding, the co-ordinator was never replaced. As a result the project went through the last twelve months of implementation period without any co-ordinator. Once again local people became disillusioned, and local professionals became less involved.

Lack of funding

Northside had serious difficulties getting resources in for the implementation of the Action Plan. Not one piece of funding was provided by external sources and all three of the interventions cost nothing to CTC. For example, the Out of School Club was run by volunteers and resourced by the school (i.e. use of building and equipment was free). Similarly, the youth work initiative had little cost attached to it. The local CTC co-ordinator organised a meeting of volunteers and provided a room and snacks. The final intervention was Parent Craft and this was funded by the health service and staffed by the local midwives. As a result no costs were incurred or needed covering. A number of the other initiatives lacked funding (the Healthy Living Centre, Home School Link Worker etc.), which was the main reason they never got implemented.

Evidence of change and local impact

Given the evidence on implementation it was clear that CTC stood little chance of having an impact on the levels of risk and protection in the Northside area. Over the two and a half years of implementation it only managed to put into place three

interventions. Two of these folded in the first six months and the other one would have more than likely happened without CTC because it was a recommendation of Ofsted. As a result Northside has had implementation failure.

Conclusion and postscript

In Northside, after an early and promising start, the project struggled to sustain momentum, especially after the loss of consecutive co-ordinators. Much of the Action Plan was not implemented. The three initiatives that were implemented had only limited success and were unlikely to have any impact on the levels of risk and protection. Key factors that impacted on why they did not manage to deliver related to the lack of committed support at the strategic level and the lack of funding. There were also problems with local partnership working and tensions between agencies, which in turn led to disillusionment amongst local residents.

Since the completion of the process evaluation (July 2002), little has changed in the Northside CTC area. A small group of very committed local people have been working with professionals from the area to try and resolve the problems of employing a local co-ordinator. In 2001 the city of Northside collected data from all its secondary schools using the CTC survey. It has been planned to roll out a city-wide programme even before the results of the evaluation were known. Most of the discussion around getting the programme restarted has revolved around getting a co-ordinator in place. The local authority is willing to support this but also wants the local Northside co-ordinator to have responsibility for city-wide implementation. This has caused a number of problems in getting a new co-ordinator in place. For example, much focus has been on identifying a relevant grade and job description, which has delayed appointment. A number of adverts have been placed but then retracted because of disagreements. In a recent discussion with a senior person in the authority it was stated that this problem was now resolved and they should be appointing ‘very soon’. Local people are less optimistic, claiming that this just example of a ‘long list of promises that have not been followed through’ (Local community representative, 2003). Recent information suggests that they have now employed a new co-ordinator who started in February 2004.

5 Discussion and recommendations for the future

Introduction

In the opening chapter of this report we said that we set out to address three main questions:

- Was CTC successfully implemented?
- What changes occurred, if any?
- If there were any changes, could these be linked to what the CTC projects delivered?

As we also explained in the first chapter, answering these questions is by no means straightforward. To some extent the answers will have become apparent in the three previous chapters. However, the time has come to draw the material together in an attempt to make some overall assessment and recommendations. The following discussion also draws on our earlier report and considers the findings over the five years of our evaluation. Before considering our conclusions we need to reflect upon the strategy used to evaluate CTC.

Evaluation limitations

Our report does not add up to a resounding endorsement of the CTC programme. Little impact has been identifiable. There is no evidence of impact in Northside and Westside and only 'promising evidence' in Southside, which remains inconclusive. But there are some important points to be borne in mind in reading the results of our evaluation. Community-based evaluations such as ours have to contend with three possible problems. First, all community programmes such as CTC have to face the possibility of what Fulbright-Anderson *et al.* (1999) call 'theory failure'. That is, the theory underpinning the community project being evaluated (what it plans to do and why it sees this as a means of tackling the problem it is aiming to address) is basically flawed. All community projects are underpinned by a 'theory of action'. In this evaluation the 'theory of action' of CTC is that if risk is reduced and protection is increased, so future social problems will be reduced. The time frame for assessing this in this evaluation was too short to identify whether theory failure is a problem or not. A second potential limitation arises through 'implementation failure' (Weiss, 1998). In this instance the evaluators have nothing to measure because local projects have not delivered anything. As we have outlined earlier, this was clearly a problem in Northside and to some degree in both Westside and Southside with regard to sections of their Action Plans. This has limited what we can say about the

outcomes of the demonstration projects after five years. Finally, evaluators of community-based projects have to contend with the possible risks of 'measurement failure' (Weiss, 1998; Fulbright-Anderson *et al.*, 1999; Hollister and Hill, 1999). While our evaluation has managed to construct measures that capture major evidence of risk and protection as 'before-and-after measures', we are aware that our measures still have their limitations. For example, we were unable to identify whether some of the work with younger children and parents has had an impact. These results would not show up in our youth survey results at this time. Similarly, because of the lack of data collected around some of the project work in Southside we are unable to say with confidence if CTC had an impact in certain areas. For example, we do not know how many young people were involved in the youth work initiative. As a result we cannot say with confidence if what they did was likely to show up in our survey results.

While we recognise the limitations of the evaluation, we believe it has managed to capture important knowledge and learning about the processes involved. A longer-term evaluation is more likely to measure change in key risk and protective factors. However, one of the most important features of the present study is that it can be no more than an early indication of how these first three UK projects are progressing. All three projects are still running in one form or another, and much can still happen. As we noted in Chapter 1, CTC is a long-term programme, with aims that may only be realised over the period that it takes for a generation of young children to grow up. It should be no surprise, therefore, if a study of a period of two and half years, reliant on the results of a survey of secondary school children, does not show significant impact.

Implementation of the Communities that Care approach

When we started on the process of evaluating the three demonstration projects there was a debate in the academic journals over how CTC should be evaluated (Farrington, 1997, 1998; Pawson and Tilley, 1998). This is not the place to revisit this debate in detail but there is an important finding from this evaluation that does make a contribution to this debate. At the centre of this discussion was a disagreement between Farrington and Pawson and Tilley about what CTC was and how much it reflected one or many processes. For example, Farrington argued that:

> It's [CTC] procedures (mobilizing key leaders, establishing a Community Board, measuring risk factors, choosing interventions etc.) are carefully specified in detailed manuals, backed up by technical assistance and training sessions to try to ensure that the same programme is implemented everywhere. (Farrington, 1998, p. 205)

Pawson and Tilley took exception to this definition, arguing that CTC would not be one programme but many. They suggested that such a position failed to recognise the complexity of the programme and the social context in which it would be delivered. Each CTC project would differ in whom it engaged in the process and how they interpreted the CTC manuals and advice. They argued that it was unlikely that there would be only one model of CTC. Our evaluation supports such a position. In our process of evaluation of the three pilot projects it has been clear that CTC has been adapted to local circumstances and that we have been examining not one but three very different projects. These have evolved as a result of complex negotiations between their historical circumstances and their present-day context. All the projects would claim to be using the CTC methodology but all have involved different sets of people, used different methods of evaluating risk audits and undertaken resource audits in different ways. Even though all three projects selected three risk factors that were the same, the programme of work that arose out of the local decision-making process led to three very different Action Plans being developed and implemented.

We set out on this evaluation in the belief that we were evaluating one model, and discovered that as the programme developed we were in fact evaluating three separate models. All three areas used the CTC process as a guide but all deviated and varied their approach as a result of local circumstances and issues. As Pawson and Tilley stated, ‘undoubtedly we are dealing here with a programme whose myriad features give it incomparable “vertical and horizontal complexity”’ (Pawson and Tilley, 1998, p. 79). We have seen across the three demonstration projects that using the CTC model has not been without its challenges. This being said, we can say that all three projects have drawn upon the CTC material for assistance in developing their Action Plans, that all three have tried to maintain a focus on identifying risk and protective factors and all three have set about developing interventions that aim to improve the quality of local services for children and families. It is important to recognise the issue of complexity and different interpretations of the process, not only for future users of the CTC model but also for future evaluations.

Key findings and recommendations

While we have not been in a position to say much about the outcomes of the CTC demonstration projects, we have gathered substantial information about the process, especially in terms of what works in the development and delivery of early intervention programmes such as Communities that Care. Our findings have provided us with details on a number of issues concerned with setting up and delivering early intervention and prevention programmes that focus on risk and protection. In the discussion that follows we will draw attention to what we believe to be the most significant findings. From these we will highlight what implications they

have for a programme such as CTC for both improving existing practice and for future development. To conclude we will turn our attention to the Green Paper *Every Child Matters* and identify key messages from this research that need to be considered in the implementation of its proposals in England.

Community readiness

We think, five years on, that it is appropriate for us to reflect on the question of community readiness. As we highlighted in our introduction there is little known in the UK about what 'readiness' is and how we might assess it for programmes such as CTC. We discovered in this research that the historical background and starting point of each project was very different, especially in terms of partnership working, geography and community involvement. These factors had significant implications for how a project managed to progress over the five years. For example, in Northside the lack of partnership working created a number of significant difficulties for the project as it tried to move forward. The relationships between local people and professional workers prior to the start of the CTC project were tense and, with the exception of crime prevention partnership working, were not well founded. Not having significant experience of how to work together at all levels created problems as the project developed. Alternatively, in Westside the geography and previous experience of partnership work shaped the different stages of implementation. For example, having a history of community partnership meant that professionals drove the process forward. This resulted in a small programme of interventions being constructed that featured new services being delivered by existing professional groups such as social services and schools. It also resulted in evaluation being a central feature of service delivery. The Southside project also benefited from an inherited history of partnership. It had a well-established community development programme in place prior to the start of the project, and a Learning House to improve levels of achievement. As a result local people were already actively involved in the area. Having strong support from senior managers and Key Leaders from the beginning brought other positive gains in implementation. As a result Southside managed to move faster and achieve more than either of the other two projects.

This raises interesting questions about 'community readiness'. Evidence presented in earlier chapters show the varied starting points for each of the projects. It would seem that Southside's success in being able to follow the CTC model and implement a wide range of programmes was not just related to good management and co-ordination (although these were critical as the discussion that follows will show). The fact that the Southside project was located in a community that was already starting to address many of its difficulties and had created a positive infrastructure in which to work suggests that other CTC projects located in similar environments should be

able to achieve greater levels of success. For example, Southside had an active community development programme that helped to broaden the membership of the CTC group. It had local schools that were already addressing low achievement, and a local authority that was creating opportunities for change. In one sense it was a community that was already improving. Alternatively Westside and Northside had a lower starting point and more problems to overcome. Disadvantage was entrenched as was academic underachievement. Lack of infrastructure or tensions between professionals and local people made it very difficult for both projects to have an effect. All of this had an impact at various stages of the programme and was influential in affecting implementation of the Action Plan.

CTC UK needs to recognise the diverse starting positions and develop different implementation models for different types of communities. Clearly, as the evidence from this evaluation has shown, 'no one model fits all' and a range of different models that can be used in different situations will create opportunities to build on communities' strengths while recognising their weaknesses.

Recommendation : We would not suggest that CTC, or any similar projects aiming to construct preventative programmes, only works with 'improving communities' or those that seem better organised. We would, however, propose that a more detailed community assessment at the beginning of any new project is undertaken, outlining where a community is in terms of 'readiness'. This we believe is essential in that it should identify how 'ready' they may be for supporting the development and implementation of the prevention programme proposed, but also it would highlight areas of risk that are likely to exist if the project is set up. This can help project workers prepare for problems in advance, through having risk management strategies in place. This research (and that of others such as Feinberg *et al*., 2002) suggest that the evaluation of readiness should include an assessment of:

- existing partnership working – identifying existing problems and difficulties that might need to be addressed prior to starting the programme

- how far senior partners, i.e. at the strategic level, are committed to the programme and how they see their responsibilities in the process

- the community participation/engagement infrastructure and an understanding of how willing the community is to be involved

- the history of stability and consistency in management and leadership

- what beliefs and commitments local managers and operational staff have to using a prevention approach to service delivery.

If problems exist in any of these areas prior to start-up, time should be given to try and resolve them before making progress towards implementation. Evidence from this evaluation shows that weaknesses in any of these areas can undermine the implementation of a programme in the later stages of the project. Development time spent early in the life of the project will have longer-term benefits.

Recommendation : CTC UK should explore the development of different models of implementation for different types of communities depending on the different starting positions they are likely to encounter.

Partnership working

Given that CTC sees partnership working as a critical component of its practice it is not surprising that there are important findings from this evaluation that can make a contribution to how partnerships need to operate in community-based programmes. It is clear from the evaluation that having a wide range of partners involved in the programme is critical. One of the unique qualities of CTC is that it recognises that making changes to service delivery or bringing in new practices and services within a geographical area needs to include people from all levels. This has four dimensions.

First, Key Leaders (strategic partners such as Head of Education/Social Services, chief executives etc.) are critical to this process. For example, in Northside the ‘strategic retreat’ of a number of the Key Leader representatives two years into the programme greatly affected implementation of the Action Plan. Alternatively in Southside the active involvement of Key Leaders greatly improved implementation. This is of major importance for community-based programmes such as CTC as it clearly improves performance. Having ‘champions’ at the strategic and planning level is also very important not only to ensure implementation but also for identifying future opportunities and resources and for helping to unblock the system if difficulties arise. There are a number of examples from this evaluation that show how influential Key Leaders can be in the process.

A second dimension relates to operational and managerial staff responsible for delivery of services on the ground. Having a wide range of key personnel involved at the operational and managerial level throughout the programme is important. It is especially valuable to have groups involved who are responsible for the delivery of services that might be chosen. For example, trying to deliver programmes based in primary schools hit major problems in Southside because some of the key personnel

had not been involved in the planning and development stages. None of the local head teachers or any of the LEA advisers who had responsibility for curriculum development had been involved in the process. As a result they resisted, and rejected the recommendations made by the Community Board. Even the intervention of the Director of Education could not help resolve this. The fact that they were not involved in the analysis of the risk audits, the selection of risks and the planning of the programmes of work meant that when approached they did not feel a responsibility to take up the proposals. Alternatively, in Westside, where primary head teachers were involved throughout, a new form of working (Family Links programme) was implemented in all three local schools. It is no coincidence that this happened. It arose because of the active engagement of head teachers from the onset of the programme. One of the weaknesses of the CTC programme was its lack of attention to monitoring and evaluating its own membership. None of the CTC demonstration programmes engaged in sustained analysis of their own membership. The evaluation had difficulty identifying who was active within the projects because this data was never regularly recorded and maintained. Given that CTC relies on partnership working as a core aspect of delivery, monitoring participation at all levels is critical if CTC is to build a sustainable community of active partners in the process.

A third dimension relates to partnership that brings together the strategic, the managerial and the operational alongside active involvement with the community. It is clear from this evaluation that being 'joined up' and crossing not only agency boundaries but also hierarchal institutional boundaries is critical if successful implementation of early intervention and prevention is to be achieved. One of the strengths of the CTC model is that it defines 'community' using a broad definition that includes not only local residents and tenants, but also deliverers of services and senior management responsible for city-wide resources. Although problems existed over putting this into practice in two of the areas, the example of Southside is valuable and important. Conflicts between agencies were avoided by the setting up of a detailed consultation process at the development stage of the Action Plan and twelve months into its implementation. Each agency was given an opportunity to comment on what was being proposed. This ensured debates were undertaken within the different agencies at the managerial level. At the same time the project built an internal communication strategy between Key Leaders and the Community Board that helped avoid confusion and uncertainty. Local people were allowed to be party to discussions and meetings of Key Leaders, while joint events were held to ensure that support for the work was practical. Alternatively in Northside these structures did not exist, so that tensions between agencies such as schools and the project were never addressed. These problems then undermined implementation. Having a clear strategy for collaboration across hierarchical boundaries was critical if the work was to progress.

Finally, CTC puts much store on inducting participants into the programme early. Early intervention and prevention approaches to tackling social problems are still in their infancy. It is only in recent years that prevention has become an issue for policy and practice. As a result the knowledge base and practice of professionals are limited and therefore having mechanisms for building up knowledge and understanding is critical if prevention is to become more established in service delivery. Evidence from our first report showed that people needed training and information about the programme. This could have both advantages (create knowledgeable communities) and disadvantages (create experts that exclude others). Building and expanding this knowledge base is critical to the success of prevention programmes. As projects expand and change, getting new partners or replacements for those that leave, further training and induction are needed. Evidence from this report shows the importance of this issue in terms of keeping the project 'on track'. For example, in Northside when Key Leaders started leaving, new appointments came in as replacements. They had little knowledge of the programme and its methods, aims and objectives. As a result Key Leaders were not as committed to the process and focus was lost. Similarly evidence from the first report highlights how few new people joined the programme and that those who did had problems 'getting up to speed'. A similar process continued into Phases Three and Four. New participants were few and far between and those who did join had problems understanding the process. CTC does not have a policy or practice for inducting new members to the programme and this has, in Phases Three and Four, created problems for maintaining and expanding involvement.

Recommendation : Prevention programmes such as CTC need to undertake regular reviews of their membership to ensure critical players are fully engaged in the process throughout. Good management systems need to be developed to monitor participation. If people are missing or if key members leave they need to be replaced as soon as possible. This should apply at both professional (strategic, management and operational levels) and local community level. One group in particular that should be involved from the start of the programme is local primary school head teachers. They are critical for future programme implementation.

Recommendation : Structures and systems need to be built into the programme that ensure that communication and collaboration between the different levels of partnership are addressed early on. This will help to maintain consensus and agreement on what is to be done.

Recommendation : Prevention projects need to develop on-going induction processes for new volunteers and staff. These need to include details of the process, the aims and objectives of the work, and the history of the project. They need to be

clear and engaging, as new entrants will not have been through the early planning and induction experience of the set-up phase.

Project management and co-ordination

How projects are managed also affects implementation. Because CTC is a multi-agency programme that involves people from all levels of professional practice, arrangements for communication amongst those involved are especially important. If problems exist with communication, then, as this evaluation has shown, problems can emerge with the practice.

The role and management of co-ordinators is critical here. As we have shown, co-ordinators are essential for helping the programme progress, and we recommend that all community-based prevention projects like CTC have someone employed with co-ordination responsibilities. This was most apparent when co-ordinators left a project. How each project managed the loss of co-ordinators greatly affected how fast the project could develop and, in the case of Northside, what they were able to deliver. Having a transitional procedure in place to avoid disruption to the project, similar to that devised in Southside, is essential. Co-ordinators play a critical role in the project. They are responsible for bringing partners together, overseeing delivery, fundraising, managing resources and strategic development. Without some form of co-ordination projects can grind to a halt and frustration arises amongst members of the project. This was a major problem in Northside. Without co-ordination for nearly 18 months professionals began losing interest and local people lost faith. As a result programme implementation was greatly affected. In Westside the problem was avoided by integrating co-ordination into an existing structure. While this had its problems it managed to ensure that progress was maintained.

Recommendation : Communication is essential over all the stages of implementation. Evidence from this evaluation shows that good communication and transparency over decision-making, especially between local communities and senior politicians and policy makers, are critical. Prevention projects such as CTC need to ensure that in all their practice they build in consultation processes as a critical aspect of their work to ensure that all parties are fully informed, aware of decisions and able to avoid conflict. This is fundamental for relationships between communities and decision makers.

Recommendation : Projects that are community based and aimed at developing co-ordinated services in the field of prevention need to have a designated person responsible for co-ordination. The project also needs to ensure that risk management strategies are in place with regard to co-ordinators. They are central

players and success can be determined by their influence. Having transitional arrangements clearly helps to maintain momentum and allows local projects to keep focused on the task in hand.

From Action Plan to delivery

The experience of moving from Action Plan to delivery of the three demonstration projects highlights a number of important issues. First, this stage is one of the most difficult, and full of potential problems that could undermine success. Moving from planning to action requires substantial effort and a lot of hard work on the part of all parties involved. Second, the Action Plan has to be constructed as a consensus of all parties. One of the problems for Northside was that it made recommendations to agencies not involved or consulted in the process. As a result they received substantial resistance to their plans across the authority. Alternatively, in Southside one of the reasons they implemented a large number of interventions was because they constructed a plan that had been agreed with local partners. Agencies were consulted before the final plan was put together. This allowed dialogue and discussion to take place, ensuring that implementation would be realistic. Third, building an Action Plan that has a wide range of interventions allows for failure. Even when it seems that no problems exist, problems can emerge that undermine implementation. Building an Action Plan that recognises this likelihood helps ensure that the programme is not threatened. In Southside, for example, they had their failures (i.e. education) but this did not undermine the whole programme. Having a wide range of interventions – some that were 'quick and easy wins' – allowed the project to show some early success and build its credibility locally. One of the problems for all projects was the limited guidance they received on how to do this.

The issue of money is also critical in this process. All three projects had a small set-up grant from JRF. This was helpful in paying for a co-ordinator and buying in the services of CTC UK.[1] It helped all areas move through Phases Two and Three without any real financial worries. The problems came when the money ran out when trying to implement the Action Plan. In Westside the need for money to help towards the implementation was identified early in the project, but it had a criterion attached to it (for over 14s only) that limited its usefulness. It also had a time frame that made it difficult for the money to be useful over the period needed by the local project. In the end the project only managed to spend a small percentage of what was available. Southside had more success in that the local authority released extra resources to pay for the extension of the co-ordinator's role[2] and quick thinking by the CTC co-ordinator at an early stage of the action planning to link the proposed interventions into the Sure Start bid ensured resources were available for a range of family-based interventions. This being said, major problems existed over getting

funding for other aspects of the Action Plan, which delayed or limited implementation. Northside had the biggest problems since no money was found to help implementation. After two years of wrangling the local authority did provide resources for the continuation of the co-ordinator post but by then the project had almost collapsed. No resources were found to help with the implementation of the Action Plan, and as a result the local Community Board and co-ordinator struggled to implement key aspects of the project Action Plan. The lack of resources for prevention work is not surprising, given the lack of prioritising of prevention in service delivery in the UK, but it is clearly an important issue for future programmes. The CTC process was lengthy, hard work for all involved and it brought in a whole range of local professionals and people. This was a large commitment of people's time and energy. In the early stages of the programme it was backed by the local authorities that took on the demonstration projects. It would seem, therefore, that the local authorities had a responsibility at the critical stage of implementation to provide real resources as a way of supporting the Action Plans that were developed. If we are to move beyond a short-term approach to tackling embedded social problems and test out longer-term invention projects such as CTC, then there is a requirement that the local or national state invest in the outcomes of this process. There are two implications of not doing this. First, the area is likely to maintain a fragmentation of prevention services that are tied to short-term funding opportunities. Co-ordination and sustainable services will not happen. Second, if the project lets people down in deprived communities after they have put so much time and effort into developing co-ordinated plans then they are likely to feel cynicism and negativity about the willingness (or not) of public services to support local initiatives.

Recommendations :

- Projects such as CTC need to develop guidance material on good practice in designing and implementing an Action Plan. All three projects had little knowledge about how they might produce detailed plans that could be implemented.

- For projects engaged in the process of action planning resources need to be made available for implementation. It is not enough just to support the process of planning. Forward planning on how the outcomes are to be funded needs to be in place early.

Risk and protection

There is a growing belief within the field of criminology (Farrington, 2000), youth justice (CTC, 2001), and social work (Hawkins *et al.*, 2002) that targeting risk and

protective factors is the best (and perhaps only) way forward for policy and practitioners as a means of preventing future social problems. Over the past five years Communities that Care has been at the vanguard of moving this idea from theory into practice (CTC, 2001). CTC is concerned with the establishment of 'scientific prevention' within the UK context. It provides a method of identifying risk and protection (the risk audits) and then provides guidance on how the risks might be tackled (Utting, 1999). The CTC approach and its exponents (e.g. Farrington, 2000; Hawkins *et al.*, 2002) have had a major impact on policy, not only in the UK but globally. The risk factor paradigm dominates a range of policy developments[3] and is seen by many agencies and organisations as the solution to the 'youth problem'. This is not the place to engage in debates about 'theoretical paradigms', but it is relevant to comment that at present little critical reflection on this approach has been undertaken.[4] Part of the success of CTC and the risk factor paradigm is its appeal to what some would regard intuitively as 'common sense'. For example, Farrington suggests, 'Importantly, the paradigm is easy to understand and to communicate, and it is readily accepted by policy makers, practitioners and the general public. The paradigm avoids difficult theoretical questions about which risk factors have casual effects' (2000, p. 7). This, we believe, should not be justification alone for its full adoption into policy and practice. As others have indicated theory *is* important (Wikström and Sampson, 2003; Wikström, 2004), especially regarding causality. Greater debate needs to take place about the limitations and problems of the risk and protection paradigm (Pitts, 2000; Bessant *et al.*, 2003; Wikström, 2004). We believe the time is ripe for such a debate to take place.

Of more general and practical concern is the question of the identification and targeting of risk and protective factors. CTC sets itself the task of identifying the levels of risk and protective factors in troubled communities. Communities are then encouraged to select programmes that have evidence of what works. From this evaluation we have shown that the process of identifying and selecting risk and protection in the demonstration projects was problematic. Risk audit reports were complex and confusing and local areas had problems making sense of them. There was no information on protection or on any form of normative standard. As our analysis has shown, all three areas then targeted a range of risks that were not necessarily a priority. The selections of certain risk factors were self-evident (disadvantaged neighbourhood and low achievement in schools in particular), but others chosen were more haphazard and influenced by interpretations of very complex data. In the end the results did not reflect the evidence. This being said, we are aware that CTC UK has made substantial progress in this area and their new risk audits, using the modified version of the survey adapted by the University of Sheffield evaluation, has addressed many of these issues. For example, length has been reduced, a normative standard now exists and protection is included in the

analysis. They are aware that getting a reliable measure is critical, otherwise other influences will undermine the evidence and the model.

Although the science of CTC in the UK has been greatly improved we believe there is still much to be done. Issues around the usefulness of archival data remain. From our experience there is limited national and local data that can realistically be useful for measuring risk and protection at the level of the community. In many cases this is out of the hands of CTC and partly the responsibility of national government, although CTC may well be in a unique position, from its experience, to build up a more comprehensive understanding of what data is useful and how other data needs to be improved. We would recommend that CTC UK become involved in work, like their American partners (Hawkins *et al*., 1997), in developing validated measures of archival data for measuring risk and protection. Presently, archival data is used in the risk audits more as contextual data, not as measures of risk and protection. In terms of two measures, disadvantaged neighbourhoods and low achievements in schools, this development is imperative. No school survey measures exist, therefore archival data is critical for measuring change over time in risk and protection. The issue in terms of disadvantaged neighbourhoods is very much about getting repeat data and is a long-term issue not only for CTC but also for national government. At one level CTC is unlikely to make a major change in the levels of deprivation on its own. This task will be the responsibility of many different agencies. This being said, being able to monitor it over the life of the programme and measure change remains important. 'Low achievement in schools' is slightly different. As our evaluation showed, this data is available and of a good standard although we would suggest that more work in this area needs undertaking. For example, schools have to collect a range of data annually for the DfES and this is a comprehensive data set that is available at the local and national level. Undertaking a more detailed analysis of what is available and how it can measure risk and protection in schools would be a significant improvement on what exists at present.

The effect of not having good archival data leaves CTC dependent on the school self-report survey as a single measure. While such an approach is clearly useful (Pollard and Lofquist, 1997; Farrington, 2000) it also has its limitations. The school surveys act as a 'proxy' for risk and protective factors in the community and data is gathered from children aged 11 to 16 years old. CTC is a community-based programme and avoiding individual measures is reasonable and acceptable, but given the focus on early prevention and work with younger children we think a survey for younger children (eight, nine and ten year olds) could be a valuable tool for measuring risk and protection evident amongst younger children. It would capture a more detailed community perspective of children (as primary school children are less mobile) and provide data that would capture local impact earlier. Doing work with this

age group is challenging but as evidence from other studies has shown, it is possible (Armstrong *et al*., 2004; France and Hacking, 2004). But CTC is in a position to start innovative work in the UK that could enhance our knowledge of risk and protection.

There is also an important issue about the measurement of longer-term outcomes. CTC aims to reduce youth crime, drug abuse, teenage pregnancy and school failure. In the demonstration area risk audits little quality evidence was provided on measures of these core objectives. This creates a long-term problem for CTC projects and for future evaluators. Not having a benchmark against which to assess either impact over the long-term period or to assess the CTC theory (for example, does reducing risk lead to decreased future social problems?) is a central problem. Recent changes to the construction of the risk audits have included measures for some 'problem behaviour' (youth crime and drug abuse) but no measures exist for teenage pregnancy or school failure. While finding reliable data in these areas is difficult, CTC has to start developing evidence that will show long-term changes in these areas.

One of the other major questions about the identification of risk and protection that has emerged out of this evaluation relates to the interplay between the 'science' (provided by the risk audits) and local knowledge of professionals and lay people. From our evidence the selection of risk factors was a process of negotiation where science was meant to dominate. But because of the poor quality of the risk audits this negotiation gave local partners a major defining role in the selection process. Maintaining an 'objective' reading of the data was problematic. CTC does not see this as a problem. As it stands local people and professionals are encouraged to engage in a process of selection that allows them to use their own skills, knowledge and information about the area to make the final choices over which risk factors to select. As far as we are aware this aspect is still a central part of the risk factor selection process, although it is not clearly recognised or acknowledged in the CTC literature. This does raise a number of important and critical questions for how science is used in the process of assessing risk and protection. For example, what local knowledge or perspectives should be included in this process and what should be excluded? How does local knowledge relate to the 'science' and the evidence provided by the risk audit? How should it change the facts provided by the risk audit? What are the criteria for local knowledge overriding the science of the audit? How this process works needs to be developed further and recognition needs be given within the guidance about the important role other perspectives make to the process. Such a position should not necessarily be seen as problematic[5] but CTC needs to be clear about how this should operate and who should contribute to providing what is meant by local knowledge.

Recommendations :

- More developmental work needs to take place on examining the risk and protection paradigm and its implications for policy and practice.
- CTC UK needs to undertake a validation exercise identifying the reliability of archival data and its role in measuring risk and protection.
- CTC UK needs to undertake a detailed review of data available at school level to identify improved measures of achievement at the local level.
- CTC UK needs to develop a school-based survey to measure risk and protection for children aged eight, nine and ten.
- CTC UK needs to develop robust and validated measures on problem behaviours.
- CTC UK needs to develop guidance and advice on how lay and professional perspectives contribute to its understanding of levels of risk and protection identified in the risk audits.

Lessons for the future: *Every Child Matters* and the new policy agenda

In 2003 the government set out new proposals aimed at restructuring children's services in England. The Green Paper *Every Child Matters* sets out plans that will bring children's services under one organisation at national and local government level:

> … we are proposing here a range of measures to reform and improve children's care – crucially, for the first time ever requiring local authorities to bring together in one place under one person services for children, and at the same suggesting real changes in the way those we ask to do this work carry out tasks on our and our children's behalf. (DfES, 2003, p. 1)

While the proposals have a strong focus on changing child protection procedures and practice, they also aim to influence how services work together in providing universal and targeted services for children and families. This involves setting up a centralised strategic management board in local authorities, with representatives from all main service providers to oversee and monitor services. It also requires major changes in how local services operate in providing a wide range of children's

services. At the core of this proposal is the development of multi-agency working that brings together key providers to ensure co-ordinated services.

The Green Paper sets out the challenge by identifying the extent of the problem. It argues that if educational failure, ill health, teenage pregnancy, youth offending and abuse and neglect are to be addressed then local and national government need to intervene early in the lives of children and families who are identified as being at risk. At the core of its analysis is a risk and protection factor framework that recognises the importance of targeting families and communities that have multiple risk factors. It also prioritises the development of protective factors as a mechanism for addressing the critical long-term problems.

While the longer-term outcomes of CTC remain unknown, other evidence from this evaluation offers insights into how local areas could achieve such objectives as laid out in the Green Paper. We are not advocating that all local areas commission CTC, but there are key lessons that would be worth adopting in the implementation phase of the Green Paper. Two issues in particular are of importance. First, at the heart of the Green Paper is a desire to construct local universal and targeted preventative services that help tackle levels of risk and protection. But, as the paper itself highlights, professionals working in children's services have limited knowledge and skills about how to do this. The CTC approach to using evidence clearly offers an opportunity to build a strong local evidence base that will help move this objective towards realisation. While technical problems still need to be resolved by CTC UK, the risk assessment model, and in particular the school based self-report survey they have devised, does offer a way of providing evidence of risk and protection in the locality. Collecting self-report data from children and young people about their behaviour and attitudes is, as we have shown, a potentially powerful tool identifying local levels of risk and protection. It also offers the opportunity of long-term measurement. But the process of auditing risk is also very powerful. Local professionals and communities find the process of analysing the data and making priority decisions based on evidence very useful in helping them construct services that are evidence based. Being involved in the process is also educational for participants, in that as people become more involved in the programme of assessment, they also become more knowledgeable about risk and protection. CTC offers a route into developing local capacity and knowledge about local levels of risk.

A second major contribution that learning from this evaluation can make to the implementation of the Green Paper objectives is the desire to bring together core agencies to provide co-ordinated and responsive services for children and families. It recognises the tensions in such a strategy, for example, between organisational objectives and responsibilities and collective objectives, but it is clear that future

practice in this area will need to be multi-agency focused. Again CTC has much to contribute to this process. While it seems to be stating the obvious, CTC has shown that such a process is complex and time consuming, and requires strong leadership from above. But the CTC approach also shows how some of the problems highlighted in multi-agency practice can be overcome. Evidence from this evaluation has shown how the process of assessment, action planning and implementation can aid multi-agency practice in that it gives a forum for joint working around objectives that are relevant to all partners. Professional workers and local people also highlighted the importance of having training and support in this work, recognising that professionals need access to other forms of information to ensure that best practice is achieved. The CTC experience shows how evidence can be a unifying process that keeps different agencies focused on the question to be addressed. For example, the risk audits produced by CTC brought together a whole range of local professionals. As a result of their collaboration around identifying risks they designed an agreed Action Plan that was to structure their future practice. Even though one demonstration project never managed to implement it, the process of evidence assessment was a powerful tool for joint working. Such a process is also able to engage even those agencies that find it difficult to undertake collaborative working outside their agency framework. For example, local schools can be brought into this process if they see the value and long-term benefits to their children. While getting schools involved remains a challenge, CTC showed that if they are engaged from the beginning of the process and are involved in decisions about the types of services most appropriate for their school they will be willing partners. Clearly such findings should give those responsible for the future implementation of the prevention aspects of the Green Paper important messages about how to overcome some of the difficulties they are likely to encounter in this process.

Concluding remarks

It is worth noting that CTC in the UK has moved on. Not only has it expanded its development and influence in the policy arena in the UK, but also it has increased the number of projects it is supporting that use the CTC model. The research reported here was based on the first three demonstration projects, which started in 1998/99. In 2003 there were 35 projects around the UK. Much will have been learned in the period since the first projects were set up and, given that these three demonstration projects turned out to be very different from each other, it is quite likely that the projects running today are different from those that started four years ago. Which brings us to the question of what exactly has been evaluated so far. As mentioned above, it can be argued that this report should not be regarded as a full and final evaluation of the three demonstration projects. Nor can it be regarded as an evaluation of the CTC model per se. There are those, such as Farrington (1998,

2000), Patterson *et al.* (1992), and Hawkins (2003), who suggest that the CTC approach can only be tested on the basis of many more projects, and there is some truth in this. In April 2003, together with the Dutch Ministry of Justice and Ministry of Health, Welfare and Sport we organised an international seminar of researchers engaged in studies of CTC programmes. It was clear from the discussions there that much research is in progress and contemplated which will cast further light on CTC. One thing that became clear from that seminar was that it takes quite some time for CTC to be satisfactorily established in any one country. In the UK in recent years there has been a tendency, inspired as much as anything by government short-termism, to expect projects to be set up and bearing fruit within months, or at most a year or two. This shows a distinct lack of understanding of the ways that communities operate. The Dutch and Australian participants at the seminar were talking in terms of it taking several years to get a CTC programme to the point where it was viable and testable. Even the Americans who pioneered CTC were only just beginning to contemplate a full-scale evaluation comprising 24 projects (Hawkins, 2003), having been running CTC since the early 1990s. We therefore see this report as a contribution to a broader and ongoing process of CTC evaluation.

Notes

Chapter 1

1 See France and Crow (2001) for a review of why this decision was made.

2 CTC has also been set up in the Netherlands and Australia.

3 For a general overview of risk factors see Appendix 2.

4 For a detailed review of the evidence used to identify these risk factors see Communities that Care (2001).

5 Evidence was gathered from work done in the USA (i.e. CTC USA, 1996; Sherman, 1997) and the UK. No such British equivalent existed, therefore experts were commissioned to provide examples of effective practice or promising approaches (Utting, 1999).

6 This information is published in *Promising Approaches* (Utting, 1999).

7 A methodological appendix explaining the research methods and presenting the data in more detail is available at http://www.shef.ac.uk/ccr/.

8 This was not an individual measure of risk and protection. We assessed reduction in risk through any change in the percentage of children with high or low factors and degree of change as to any change overall in the mean risk and protection.

9 The risk audits were developed for CTC UK by representatives from Oxford University.

10 Social Exclusion Unit (2001).

11 Even here there remained problems with secondary school data because this only provided data on school populations (which could be spread across large geographical areas), not specific neighbourhoods.

12 The limitations of the records data are discussed in more detail in the methodological paper at http://www.shef.ac.uk/ccr/.

13 CTC UK has since undertaken validation work on the survey.

14 Again this is a slight modification of the CTC UK survey.

15 See France and Crow (2001) for detailed discussion.

16 A summary of these can be found at the end of this report in Appendix 2. Risk factor 1 is deprivation, measured not through the survey, but through comparison of national data.

17 A detailed breakdown of response rates for each area can be found in Appendix 3.

18 As we will see in the discussion that follows, no CTC demonstration project implemented programmes of work in secondary schools. This made this comparison possible.

19 There is a risk that this method could lead to selection regression which could influence the results.

20 Utting (1999).

Chapter 2

1 A rate of 3.6 per cent compared to a national rate of 3 per cent.

2 This reflects the national figure for Wales, which is 97.9 per cent.

3 Approximately 20 per cent of the ward is included. The section targeted was at the top end of the main CTC area.

4 The figures on multiple deprivations for England and Wales cannot be compared. Although the domains are the same, the calculations undertaken to get the ranking are different (DTLR, 2000).

5 Out of 865 wards in Wales.

6 Compared with data from *Youth at Risk?* (Beinart *et al.*, 2002).

7 Much school data is unavailable in Wales.

8 Figures taken from school self-report survey collected in 2000.

9 As set down in Beinart *et al*. (2002).

10 This is in line with findings by Beinart *et al*. (2002).

11 Details of this method are outlined in the section on 'The construction of alternative risk audits' in Chapter 1 of this report.

12 As a result of the national shortage of speech therapists.

13 Using comparison of means.

14 Using comparison of means.

15 This area of Wales has received Objective One status from the European Union. This is recognition that the large geographical area selected is rated as highly deprived. As a result it receives extra grant aid from the European Budget.

16 With the exception of Health.

17 Sure Start is a national programme set up in 1998 that aimed to tackle poverty and disadvantage for parents and children.

18 It was not the only reason. The primary schools did not like the risk factor 'low achievement beginning in primary schools' as they saw it as blaming them for the problem.

19 See the methodology report at http://www.shef.ac.uk/ccr/ for detailed explanations of cut-off for risk points.

20 Using the point score measure of core subjects.

21 Source: Southside LEA, National Assembly for Wales, 2000 and 2002.

22 The proportion declined equally in CTC children, but the change, due to smaller group numbers, was not statistically significant.

23 This figure has to be taken with caution because significant differences existed between the two cohorts.

24 There were no protective factors for this domain.

25 Protective factors are shown reversed: for example, increase in a protective factor is shown here as *decrease* in risk.

26 Where there are differences in the direction of change, for example if the CTC mean risk decreased, and the non-CTC mean risk increased, effect (*) is for decrease in risk. Where the direction of change is the same, the effect (*) is for decrease. For example, if the CTC mean risk decreased and the non-CTC mean risk also decreased, the effect is for the largest decrease in risk, and where both areas increased, the effect is for the *lesser* increase in risk.

Chapter 3

1 ONS 2001 Census data.

2 Westside bid for CTC programme 1997.

3 See Table A1 in Appendix 1.

4 See Table A1 in Appendix 1.

5 Compared to figures in Beinart *et al.* (2002).

6 See Beinart *et al.* (2002) for national comparisons.

7 For example, tensions existed between centralised planning and local need – especially in areas such as education.

8 Details of who these were are outlined in France and Crow (2001).

9 One critical tension was the uncertainty about who 'owned' it. Was it a CTC project independent of any particular agency or was it an Area Co-ordination project?

10 SRB (Single Regeneration Budget). Areas in England receive extra resources through this organisation. Areas of deprivation and need are identified and resources are targeted at regenerating through project funding.

11 The Children's Fund is providing money from a central government fund to support the development of preventive services for children and parents.

12 This was being planned as a second stage.

13 France and Hacking (2004), unpublished report.

14 From a recent visit evidence shows this has been changing as part of the new approach to rebuilding the programme (September 2003).

15 For example in its *Promising Approaches* publication (2000).

Chapter 4

1 Northside is located in a county that has European Objective One status.

2 The national average being 31 per cent.

3 ONS 2001 Census data.

4 All crime data is taken from ONS Census data.

5 See Beinart *et al*. (2002).

6 In 2002.

7 Ofsted Report, 2002.

8 Ofsted Report, 2002.

9 A formal external process exists for children with special educational needs. This is recorded as statemented children. Resources are given to the school on the numbers they have. Non-statemented children are those that have been identified within the school as needing special help but no extra resources are provided.

10 For a more detailed overview of this process see France and Crow (2001).

11 See discussion on the implementation of PATHs and the Home School Link Worker.

Chapter 5

1 This included payment for the risk audit, training and general support materials.

2 It would seem that Northside has now also put resources into the appointment of the next co-ordinator.

3 For example it is a major force in youth justice policy, the Children's Fund, Sure Start and the new Green Paper, *Every Child Matters*.

4 There are exceptions to this: see, for example, Pitts (2000) and Bessant *et al.* (2003).

5 There is an interesting literature in medicine about the importance of lay perspectives to understanding social problems. See Williams and Calan (1996).

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Appendix 1: Indices of deprivation

Table A1 Westside and Northside: indices of deprivation, 2000 (rank out of 8,414 national wards, with 1 being the most deprived)

	Westside 1	Westside 2	Northside
Rank of index of multiple deprivation	845	182	480
Rank of income domain	789	173	745
Rank of employment domain	1,013	279	268
Rank of health domain	980	571	153
Rank of education domain	102	42	1,125
Rank of housing domain	667	98	3,262
Rank of child poverty index	1,191	448	917

Source: DTLR (2000).

Within worst 5% Within worst 10% Within worst 15%

Table A2 Southside: indices of deprivation, 2000 (rank out of 865 Welsh electoral divisions, with 1 being the most deprived)

	Southside 1	Southside 2
Rank of index of multiple deprivation	101	466
Rank of income domain	83	312
Rank of employment domain	144	383
Rank of health domain	129	294
Rank of education domain	55	377
Rank of housing domain	677	848
Rank of child poverty index	72	240

Source: DTLR (2000)

Within worst 5% Within worst 10% Within worst 15%

Appendix 2: Summary of risk and protective factors

Methodological note: risk and protection factors

The following is a summary of changes to the calculation of risk and protection factors used during the evaluation of the three CTC demonstration projects. Our risk factor calculations differ from the standard CTC process used in the USA in the following way:

- We used only the positive checked items.
- We used a cut-off point for risk (see methodological appendix at http://www.shef.ac.uk/ccr/).
- The most important items in the scale* have a greater value (i.e. we applied weighting), except RF4 (high turnover and neighbourhood attachment) and RF6 (aggressive behaviour) where all items are equally weighted (see methodological appendix at http://www.shef.ac.uk/ccr/).
- We used an incremental scale (additive) rather than an average score.**
- We excluded items where the pattern of responses was inconsistent with the rest of the scale.*
- There are fewer factors (items for some factors did not go together*).
- All factors include more than one item.
- We used values of 1–100 for all the factors.

* Determined by the reliability analysis (see methodological appendix at http://www.shef.ac.uk/ccr/). RF4 is calculated differently (see note).

** Children who did not answer all the items in the risk factor were excluded for that risk factor.

Table A3 Protection factors

	Items: see reliability section in methodology appendix for item weights (items with greater weight are listed first).	Similar to CTC factor	Reliability of factor
PF1 Opportunities for pro-social involvement, community	Incremental scale of 3 items: Child attends non-school-based activities in neighbourhood: groups/clubs; leisure/sports centres; scouts/guides	No	0.65
PF2 Opportunities for pro-social involvement, community	Incremental scale of 3 items: Friendly neighbourhoods – people in neighbourhood are: proud of me; encourage me; notice I'm doing well	Yes	0.82
PF3 Opportunities for pro-social involvement, school	Incremental scale of 4 items: Proactive at school. Child at school has lots of chances to: be part of class discussions/activities; talk to a teacher 1 to 1; help decide things; take part in out-of-school activities	Yes	0.71
PF3a Rewards for pro-social involvement, school	Incremental scale of 4 items: Good teacher relations. Teachers praise hard work; teachers let me know when doing well; school lets parents know; feels safe at school	Yes	0.73
PF4 Family attachment	Incremental scale of 4 items: Shares thoughts/ feelings father; shares thoughts/feelings mother; close to father; close to mother	Yes	0.75
PF5 Opportunities for pro-social involvement, family	Incremental scale of 3 items: Parental relation: chances to do fun things with parents; parents ask opinion; can ask Mum/Dad for help	Yes	0.66
PF6 Rewards for pro-social involvement, family	Incremental scale of 4 items: Parental rewards: parents show they're proud of me; parents notice when doing well; enjoys time with mother; enjoys time with father	Yes	0.73

Table A4 Risk factors

	Items: see reliability section in methodology appendix for item weights (items with greater weight are listed first).	Similar to CTC factor	Reliability of factor
RF2 Community disorganisation and neglect	Incremental scale of 1–5 items: Bad neighbourhood: graffiti, fights; crime and drug selling; empty buildings; feels unsafe after dark	Yes	0.79
RF3 Availability of drugs	Incremental scale of 1–5 items: 3 items, 'easy' to get hold of at any age in the area: cannabis, heroin or cocaine 2 items, 'easy' for child y7–8, 'very easy' y9+ to get hold of: alcohol; cigarettes	Yes	0.90
RF4 High turnover and lack of neighbourhood attachment	Incremental scale of 6 items: doesn't like the neighbourhood; wouldn't miss it on moving; wants to get out; changed homes 2+ times; changed schools 2+ times; people move about a lot	No	0.63
RF6 Aggressive behaviour including bullying	Count of any of 4 items: Child has: been bullied sometimes within last year; bullied others sometimes within the last year; seen pupils picked on; seen a pupil attack a teacher	Yes	0.42
RF7 Lack of commitment to school and truancy	Incremental scale of 9 items: Rarely/never enjoys school; truanted several days at least (in last year, any age); finds subjects very dull; rarely tries best; often hates school; any truancy in last month (y7–8) or 3+ days in last month (y9+); thinks school unimportant to life; 5 days off in last month ill/other	No	0.77
RF8 School disorganisation	Incremental scale of 4 items. School has no clear rules on: lateness, absenteeism; bullying. No punishments by teachers	Yes	0.70
RF9 Poor parental supervision	Incremental scale of 8 items: Parents have no clear family rules; would not catch child if drank alcohol; don't know who the child is with; would not catch child if played truant; don't ask about homework; don't know if not home on time; don't need a call if child is late; have no clear rules on drugs/alcohol	Yes	0.78
RF10 Family conflict	Incremental scale of 3 items: Between family of child – insults/shouting; serious arguments; always arguing about the same things	Yes	0.77
RF11 Family history of problem behaviour	Incremental scale of 6 items: Child's brothers/ sisters have: smoked cannabis; smoked cigarettes; drunk alcohol regularly; been excluded from school; taken illegal drugs; and family member had serious alcohol/drug problem	No	0.75
RF12 Parental condoning of problem behaviour	Incremental scale of 5 items: Child believes parents think it would be 'a bit wrong' for child to: draw graffiti; drink alcohol; smoke; steal more than £5 worth; and 'not wrong' to pick a fight	Yes	0.76
RF14 Alienation and lack of social commitment	Incremental scale of 7 items dealing with oppositional behaviour: Child thinks rules get in the way; likes to see how much they can get away with; thinks it's alright to beat someone up with provocation; does things that make people mad; thinks it's OK to cheat at school; thinks it's OK to steal if not found out; does not think it's important to be honest with parents	Yes	0.80

Table A4 Risk factors ***(continued)***

	Items: see reliability section in methodology appendix for item weights (items with greater weight are listed first).	**Similar to CTC factor**	**Reliability of factor**
RF15 Attitudes condoning problem behaviour	Incremental scale of 10 items: attitudes of child. A bit wrong to: take a weapon to school; drink alcohol regularly y7–8; play truant; smoke cigarettes y7–8; smoke cannabis; steal more than £5; use other drugs; get pregnant. Not wrong to: pick a fight; smoke cigarettes y9+; drink alcohol regularly y9+. Not very wrong to attack intending serious hurt	Yes	0.91
RF16 Early involvement in problem behaviour	Incremental scale of 7 involvement items: Age of child: drinking alcohol regularly <15; first drunk <15; first smoked <13; first smoked cannabis <15; first arrested <15; first sniffed glue/solvent (any); excluded from school (any)	Yes	0.76
RF17 Friends involved in problem behaviour	Incremental scale of 10 involvement items: Child has friends who: smoke cannabis; play truant regularly; have been arrested; smoke cigarettes; stole car; been excluded; sold drugs; tried alcohol; used drugs; carried a weapon to school	Yes	0.85

Appendix 3: Numbers and completion rates for individual schools

Table A5 Numbers and completion rates for individual schools

		CTC				Non-CTC		
Area/Survey	**School**	**Pupils**	**Completed**	***Rate (%)***	**School**	**Pupils**	**Completed**	***Rate (%)***
Northside								
1st survey	NE1	601	501	*92*	NC1	1,034	978	*95*
2nd survey		552	462	*84*		1,151	1,103	*96*
1st survey	NE2	1,340	1,234	*92*				
2nd survey		1,407	1,200	*85*				
1st survey	**Area**	**1,941**	**1,785**	***92***		**1,034**	**978**	***95***
2nd survey	**totals**	**1,959**	**1,662**	***85***		**1,151**	**1,103**	***96***
Westside								
1st survey	CE1	492	451	*92*				
2nd survey		552	442	*80*				
1st survey	CE2	35	21	*60*				
2nd survey		-	-	-				
1st survey	CE3	12	10	*83*	CC1	903	738	*82*
2nd survey		-	-	-		1,021	861	*84*
1st survey	CE4	35	25	*71*				
2nd survey		34	18	*53*				
1st survey	CE5	63	50	*79*				
2nd survey		62	43	*69*				
1st survey	**Area**	**637**	**557**	***87***		**903**	**738**	***82***
2nd survey	**totals**	**648**	**503**	***78***		**1,021**	**861**	***84***
Southside								
1st survey	SE1	715	609	*85*	SC1	1,035	815	*79*
2nd survey		717	659	*92*		961	653	*68*
1st survey	SE2	861	772	*90*				
2nd survey		831	754	*91*				
1st survey	**Area**	**1,576**	**1,381**	***88***		**1,035**	**815**	***79***
2nd survey	**totals**	**1,548**	**1,413**	***91***		**961**	**653**	***68***