Community Mental Health Promotion Principles and Strategies

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Introduction

Community settings are complex and dynamic, composed of many sub-settings such as schools, workplaces and neighbourhoods, in which population groups from childhood through to old age live, grow, learn, work and play. As such, the community setting offers important opportunities for promoting mental health with diverse population groups across a range of different settings and sectors. Working at the community level speaks to the policy imperative of adopting a whole-of-community perspective to population mental health, as endorsed by the World Health Organization (WHO) Global Mental Health Action Plan 2013–2020 (WHO 2013a). A whole-of-community approach to mental health promotion means engaging the wider community composed of multiple actors, sectors and systems, to address the social determinants of mental health and reduce mental health inequities. A community approach to mental health promotion views mental health as a positive resource for individuals and communities embedded within the social, cultural, environmental and economic contexts of everyday life. This approach is based on a socio-ecological perspective, as outlined in chapter 'Concepts and Principles of Mental Health Promotion', and conceptualizes mental health as resulting from the interaction over time of the person with the environment, placing a particular emphasis on social settings and systems and the influence of broader social, economic and political forces. Community practice, therefore, calls for comprehensive multilevel interventions addressing systems of socialization, social support and control operating at multiple levels.

There are many different definitions and meanings of the term 'community', from those that describe a geographically based community such as a local neigh-

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bourhood, city or rural locality, to groups of people who share a common identity or interests, for example, communities based on ethnic, sexual, religious or cultural identities, who may not be geographically based. The majority of definitions do, however, refer to such key features as a group of people sharing values and institutions, a sense of belonging or shared social meaning, and social structures that serve to connect interdependent social groups (Rifkin et al. 1988). Community approaches for promoting health and wellbeing are well documented in the health promotion literature and there are many excellent examples of their application which the reader may wish to consult (Bracht 1999; Laverack 2006; Minkler 2012). The area of community mental health promotion is probably less well documented. However, many of the fundamental principles of community health promotion programme planning and delivery apply equally well to the practice of community mental health promotion.

Community working is essentially characterized by collaborative practice, based on the facilitation of active community participation and the enhancement of community empowerment. These are the fundamental guiding principles of a community model of practice. In this chapter we explore the application of these principles and examine the main factors which influence their successful implementation in practice. The rationale for implementing community mental health promotion is outlined and the underlying principles are discussed. Many of these principles, for example, those relating to good practice in developing collaborative partnerships, equally apply when working in other settings such as schools, workplaces and health services, as discussed in the other chapters in this book. Following an overview of the main conceptual approaches to community practice, structured frameworks for community-based intervention planning, implementation and evaluation are outlined and the steps involved in translating concepts of community practice into reality are considered. The Communities That Care initiative is highlighted as a practice example of a community-wide system for engaging community stakeholders in a structured process of planning and implementation of evidence-based community interventions.

Rationale for Community Mental Health Promotion

Community mental health promotion provides a unique opportunity to put into practice the principles of community participation and empowerment, which were outlined in the World Health Organization's Declaration of Alma-Ata (WHO 1978), the Ottawa Charter for Health Promotion (WHO 1986) and subsequent health promotion declarations. The concepts of participation and empowerment occupy a special importance in community mental health promotion practice. Community engagement strategies that embrace participation and empowerment have a positive impact on the development and delivery of more appropriate and acceptable interventions and have positive effects on social cohesion, social support and the individual self-efficacy of those who are actively engaged (O'Mara-Eves et al. 2013). It is well recognized that enduring change is more likely to occur if the key

stakeholders, including citizens, community groups, health professionals, statutory and voluntary agencies, are involved in a process of bringing about change at a wider socio-environmental level. A whole-of-society approach recognizes the value of engaging a broader set of community actors in addressing the social determinants of mental health and bringing about positive and enduring change (WHO 2013b). A community perspective shifts the 'center of gravity' from a focus on individuals to the community as the locus of practice (Robertson and Minkler 1994), building on the community assets of skills and knowledge, social networks and organizations, to enhance good health and wellbeing (South 2015).

Conceptual Approaches to Community Practice

There are two main conceptual approaches to community working that can be identified; interventions which adopt a community-based or community organization approach and interventions that embrace a community development approach. Interventions adopting a community-based approach are those where the main purpose of the community setting is to consult with, and reach, as wide a range as possible of community members. Community-based approaches can include engagement with communities at different levels; ranging from consultation or collaboration on intervention development and design, through to involving community members more directly in the delivery of interventions such as peer-based or lay delivered approaches. Community organization approaches have been defined as those involving and mobilizing major agencies, institutions and groups in a community to work together to coordinate services and create programmes for the united purpose of improving the health of a community (Robinson and Elliott 2000). Examples of these approaches are the large-scale community interventions, such as the Communities that Care initiative (Hawkins et al. 2002), as described in this chapter. Community development approaches, on the other hand, are often described as 'bottom-up' or grassroots initiatives where community members actively participate in identifying their own needs and organize themselves in planning and devising strategies for meeting shared needs, gaining increased self-reliance and decision-making power as a result (Labonté 1993). The principles of active participation and empowerment are central to this collective process. The community development approach, in which local communities identify and address local concerns, appears to hold much promise for community mental health promotion, especially when working in low-resource settings.

There are clearly ideological differences between the community organization and community development approaches with consequent implications for planning and implementation processes such as consultation mechanisms, community participation, empowerment, ownership and control. While models may vary in the degree and extent of community participation, control and ownership, a key feature of community approaches is that community members are actively engaged in community change. Adopting a community approach calls for a change in the style of

practice and the role of the professional in implementing such programmes within the community setting. Professional skills and competencies are required in facilitating effective community participation and the development of structures and collaborative mechanisms for the implementation of community interventions. Minkler (2012) provides a useful resource for orienting practitioners towards community approaches and methods of collaborative working.

A community health development continuum is a useful way of conceptualizing the process of translating community participation and empowerment principles into practice on the ground. Community development may be portrayed as involving a series of stages each with varying degrees of potential for maximizing community empowerment (Jackson et al. 1989; Labonté 1989). The stages include: personal development, mutual support, issue identification in community organizations, participation in organizations and coalitions, and collective political and social action. These stages represent a continuum from personal to collective levels of empowerment. Both the psychological and community empowerment process is embraced with the potential for empowerment being maximized as one moves from the individual to the collective action end of the continuum. Individual level empowerment may entail personal development and capacity building such as skills training or improved self-efficacy. This level of empowerment may be necessary for a person to function within and participate in a group process or indeed in society. Likewise, social involvement may lead to increased personal development. Active participation in community groups or partnerships is recognized as offering important opportunities for both personal and community empowerment (Florin and Wandersman 1990). Participation in the group collective process is a way of increasing awareness of the influence of wider social structures on health issues and also of acquiring skills and capacities required to strengthen local community capacities. Ideally, community participation should lead to increased empowerment among community members and increased capacity and control as a result of the process. Interventions operating at these different levels of the continuum are discussed in this chapter to highlight the application of empowerment principles in mental health promotion practice.

Principles of Community Practice

At a theoretical level, community mental health promotion practice draws on a socio-ecological model of health, which underscores the importance of the larger socio-environmental context within which individuals, group systems and social settings are embedded. Individuals, families, communities and the wider socio-economic, cultural and structural determinants of mental health interact with each other at each of these different levels forming complex and synergistic systems (Vaandrager and Kennedy 2017). Interventions that are informed by this perspective are directed at multiple levels such as community norms, social structures, policies and services. Stokols et al. (1996) describe ecologically informed programmes as

addressing '… interdependencies between socio-economic, cultural, political, environmental, organisational, psychological, and biological determinants of health and illness' (p. 247). The community may be seen as the interface between multiple interacting systems, that is, individual, group, organizational, environmental and policy systems. As such, community interventions have the capacity to address these multiple interacting levels thereby increasing the synergistic or interactive effects of the intervention. This perspective, which has been outlined in chapter 'Concepts and Principles of Mental Health Promotion', emphasizes the importance of mediating structures such as schools, workplaces and community settings as providing key contexts for social interventions operating from the micro to the macro levels.

Community Engagement and Participation

Community engagement has been defined as constituting a continuum of approaches for engaging communities in activities to improve their health and reduce health inequalities (Popay 2006). These approaches range from more restricted forms of engagement, such as information sharing and community consultation, to more active engagement strategies involving community participation and empowerment strategies. Shediac-Razallah and Bone (1998) argue that at the core of these related concepts is the idea of; 'the process of enabling individuals and communities, in partnership with health professionals, to participate in defining their health problems and shaping solutions to those problems' (p. 95). Community participation has been identified as one of the key mechanisms of enabling people to gain control over their health and that of their community. The Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (WHO 2016) identified cities and local communities as having a major role in promoting equity and social inclusion through meaningful local engagement. The process of community participation is recognized as a prerequisite of empowerment, promoting a sense of control and ownership, which in turn leads to increased capacity or competence and promotes more sustainable change (Bracht and Kingsbury 1990; Flynn 1995; Robertson and Minkler 1994). As Bracht et al. (1999) point out 'participation facilitates psychological empowerment by developing personal efficacy, developing a sense of group action, developing a critical understanding of social power relationships and developing a willingness to participate in collective action' (p. 87).

Community participation is also seen as mutually benefiting both the community and the success of the intervention, as change is more likely to occur when the people it affects are involved in the change process (Kreuter et al. 2000). Obtaining meaningful community participation, however, can be challenging. Practitioners need to be mindful that participation may occur in different ways and at different levels ranging from token involvement (e.g. information sharing and consultation) to real control of the process (partnership, delegated power and control). Participation can be manipulative and passive, rather than empowering and may risk obscuring the need for analysis of larger institutional structures such as socio-economic

systems and policies, which can override local determinants of wellbeing (Labonté 2009; Wallerstein et al. 2011). The classic depiction of the degrees of participation in Arnstein's (1971) 'ladder of participation' and Brager and Specht's (1973) 'spectrum of participation' are useful reminders of the need to ensure maximal levels of participation in the development of the community organization process.

Community engagement is recognized as a critical strategy in addressing the social determinants of mental health and health inequities. A review by O'Mara-Eves et al. (2013) found good evidence that community engagement interventions have a positive impact on health behaviours, leading to improvements in health and self-efficacy and social support in disadvantaged groups. However, it is unclear whether one particular model of community engagement is more effective than another. Readers are referred to the National Institute for Health and Care Excellence (NICE) Guidelines on 'Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities' (NICE 2016), which outline a useful set of overarching principles of good practice, and guidelines on implementation and evaluation.

Community Empowerment

Empowerment has been defined as a social action process through which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life (Rappaport 1985; Wallerstein 1992). Empowerment is, therefore, viewed as an action-oriented concept with a focus on transforming power relations and removing psychological and structural barriers to change. Empowerment processes have been informed by the writing of Paulo Freire, who described consciousness-raising processes based on a continuous process of dialogue, critical reflection, participation and action (Freire 1970). Community empowerment may be differentiated from empowerment at the individual level, since as a multilevel concept it operates at the different system levels of the group, organizational and wider community levels (Zimmerman 2000). Labonté (1990) links these levels of empowerment through the idea of a continuum. This continuum ranges from personal and small group empowerment to community organization, coalition building and political action. Israel et al. (1994) argue that empowerment at the individual level is linked with the organizational and community levels through the development of personal control and competence to act, the availability of social support, and the acquisition of interpersonal, social and political skills. An empowered community is where individuals and organizations apply their skills and resources in collective efforts to meet their respective needs. Through participation, individuals and organizations within an empowered community provide enhanced support for each other, address conflicts within the community and gain increased influence and control over the quality of life in their community. An empowered community has the ability to influence decisions and make changes in the larger social system. A community empowerment approach recognizes the cultural, historical, social, economic and political context

within which the individual exists. Therefore, empowerment at the community level is connected with empowerment at the individual and organizational levels. A model of empowerment that links all three levels (individual, organizational and community) is regarded as providing the most effective means to collectively provide the support and control necessary to develop needed skills, resources and change.

Social Inclusion and Cohesion

Belonging to a social network of communication and supportive relationships is protective of good health and positive wellbeing (Wilkinson and Marmot 2003). There is a large body of evidence which shows that more socially isolated people have poorer health and increased mortality (Berkman and Glass 2000; Holt-Lunstad et al. 2010; House et al. 1988) and that more socially cohesive societies are healthier and have lower mortality rates (Kawachi 2010). A socially inclusive society may be defined as one where 'all people feel valued, their differences are respected, and their basic needs are met so that they can live in dignity' (VicHealth 2005). Durkheim (1951) was one of the first to propose that a lack of cohesion in society or 'anomie' contributes to negative mental health and is a leading factor influencing rates of suicide. Variations in suicidal behaviour and anti-social behaviour have been linked to the presence or absence of social cohesion (OECD 2001). Among the factors identified as being protective of good health and positive social outcomes are: a culture of co-operation and tolerance between individuals, institutions and diverse groups in society; a sense of belonging to family, one's school, workplace and community and a good network of social relationships (Moodie and Jenkins 2005). Strong social networks are associated with improved health and wellbeing and can act as buffers against everyday stressors (Marmot Review Team 2010). Social contact and support can play a critical role in fostering greater self-confidence, reducing isolation and enhancing community resilience (Friedli 2009).

It is widely recognized that social exclusion damages mental and physical health and contributes significantly to inequities (Wilkinson and Marmot 2003; Commission on Social Determinants of Health 2008; WHO and Calouste Gulbenkian Foundation 2014). A very comprehensive definition of social exclusion has been provided by the WHO (2006), which includes: living in conditions of deprivation and vulnerability, such as poverty; inadequate access to education, health and other services; lack of political influence, civil liberties and human rights; geographic isolation; environmental exposure, racism or historical trauma; disruption of social capital and social isolation; exposure to wars and conflicts, and alienation or powerlessness. Social exclusion can lead to individuals and communities feeling marginalized, fearful and disempowered in their ability to influence decisions and to participate fully in the social, economic, political and cultural systems that affect their lives.

The concept of social capital describes the features of social relationships within a social group or community. Putnam (2001) defines social capital as 'the connections among individuals - social networks and the norms of reciprocity and trustworthiness that arise from them' (p. 19). Social capital is not conceived as an

individual resource but is seen as an ecological characteristic, which emerges from the interactions and shared norms that are inherent in the structure of social relationships and that are external to the individual (Henderson and Whiteford 2003). A distinction is made between different forms of social capital, with bonding social capital referring to trusting and cooperative relationships between members of a community or group who share a common social identity (e.g. based on race, ethnicity or social class), whereas bridging social capital refers to connections between people who do not share a common social identity. Bonding social capital can be associated with the formation of groups based on exclusivity, which can be damaging for those who are not included, while bridging social capital has been found to be more strongly related to improved wellbeing (Kawachi 2010), thereby highlighting the importance of social inclusion.

Research on social capital and inequality indicates the importance of community cohesion such as levels of trust, reciprocity and participation in civic organizations, as important influences on health status. Putnam (2001) indicates that economic inequality and civic inequality are less in areas with higher values of social capital. Similarly, Putnam (2001) reports that in areas with low levels of social capital and high levels of perceived inequality, self-reported wellbeing and levels of happiness are lower. Empirical studies also show that higher levels of income inequality are associated with a higher prevalence of mental disorders (Pickett and Wilkinson 2010; Pickett et al. 2006). Wilkinson (1996) emphasizes the importance of psychosocial pathways in examining the relationship between income inequality, social capital and health and Wilkinson and Pickett (2009) examine how inequalities erode trust in societies and lead to increases in anxiety and illness. In their book *The Sprit Level*, Wilkinson and Pickett (2009) showed that in all countries where information was available, societies with larger income differences have poorer health including: lower life expectancy, higher rates of infant mortality, higher levels of mental ill-health, lower levels of child wellbeing, illicit drug use and obesity. Greater inequality was also found to damage social relationships and be associated with less community cohesion and trust, and more social problems such as violence and homicide rates. In their 2018 book *The Inner Level*, Wilkinson and Pickett elaborate on the psychological impacts of inequality and present data showing how low social status is associated with higher levels of stress, anxiety and depression. They also discuss how the presence of material inequalities and social hierarchies affect mental health through influencing social values, sense of self-worth and how people relate to each other. Friedli (2009) also argues that the experience of inequality is corrosive of good social relations and impacts negatively on people's mental health and their sense of social and emotional wellbeing. In reviewing the relationship between social capital, mental health and inequalities, Whiteford et al. (2005) and Friedli (2009) identify the potential of mental health promotion interventions to enhance social capital and community resilience. For example, community actions designed to build social trust and cohesion and strengthen community networks and increased participation by excluded groups can make an important contribution to promoting community mental health and wellbeing (Friedli 2009; Whiteford et al. 2005; Wilkinson and Pickett 2009).

Supportive Physical Environments

Access to safe, clean and welcoming environments that provide opportunities for interaction with people and nature can foster a sense of belonging and community connectedness, which in turn contribute to promoting positive mental and physical health and wellbeing (Kent and Thompson 2014). Environmental interventions that improve the quality of the built environment, including improving housing and urban regeneration projects which address the psychosocial aspects of deprivation, can also lead to positive mental health impacts (Ellaway et al. 2001; Thomson et al. 2003, 2006; Weich et al. 2002; Whitley et al. 2005). There is a growing body of literature on the relationship between health and place that indicates that access to natural or green spaces and the quality of the built environment have a beneficial impact on mental health (Dalgard and Tambs 1997; Depledge et al. 2011; Ellaway et al. 2001; Weich et al. 2002; Whitley et al. 2005). While a number of studies have identified the features of the environment that are associated with mental health problems such as depression and anxiety, including air pollution, traffic levels, high density living, crime and violence (Echeverria et al. 2008; Gary et al. 2007; Gee and Takeuchi 2004; Latkin and Curry 2003), fewer studies have focused on how improvements to the environment can lead to improvements in mental health and wellbeing. There is a paucity of studies assessing how environmental improvements can lead to positive mental health impacts, especially in low and middle-income countries (LMICs). A systematic review by Turley et al. (2013) reported that slum upgrading programmes involving physical environment and infrastructure interventions (e.g. improvements to water, sanitation, waste management, energy upgrades and transport infrastructure) in LMICs can positively influence the mental and physical health of residents by reducing stress, injury and disease transmission.

Despite a limited evidence base, a number of reviews from high-income countries (HICs) support the association between mental health and aspects of the physical environment, including: high-rise living, graffiti, damp housing, noise, overcrowding, fear of crime and the importance of having a place to meet others and socialize (Clark et al. 2007; Evans et al. 2003). Chu et al. (2004) identified five key environmental domains that can promote a sense of wellbeing: control over the internal environment, quality of housing design and maintenance, presence of valued ‘escape facilities’ such as access to green spaces and community facilities, absence of crime and fear of crime, and social participation. However, Guite et al. (2006) point out that many studies fail to take account of the influence of socio-economic deprivation and factors such as type of housing, ethnicity and other socio-demographics on the association between the environment and mental health. In a cross-sectional survey of residents in council properties in Greenwich, London, Guite et al. (2006) reported that both the design and social features of residential areas are important for residents’ mental wellbeing and interventions need to address both aspects. The most important factors identified in their study were: neighbour noise, sense of overcrowding in the home, access to green space and

community facilities, and fear of crime. A number of studies indicate that green space can offer a salutogenic and stress-reducing environment, especially in deprived urban communities (Beyer et al. 2014; Roe et al. 2017; Ward Thompson et al. 2016). Mental health impact assessments, such as the Mental Well-being Impact Assessment Toolkit (MIWA) developed in the United Kingdom, can play a useful role in determining the potential of environmental changes in improving population mental health (Cook et al. 2011), including determining the impact of climate change and natural disasters on the mental health of local communities (Ampuero et al. 2015).

As it is estimated that over half of the world's population live in urban environments, urban planning has an important role to play in promoting community mental health and wellbeing. The importance of the health impact of urban planning has been central to the WHO Healthy Cities and Communities initiative, which aims to develop healthy sustainable cities and integrate health considerations into urban planning processes at the local level (Barton et al. 2003). The UN Sustainable Development Goals (UN 2015) bring a clear focus on the importance of creating greener and healthier living environments globally, through, for example, SDG 11 – *Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable*. In addition, the Shanghai Declaration (WHO 2016) identified key roles for cities and local authorities in advancing policies that create co-benefits between health and wellbeing and other city policies.

With regard to healthy community design, environmental health planners recommend 'mixed-use design' (Lee and Maheswaran 2011) where land is used for varying purposes from residential use to retail and employment, with connectivity and short distances between places of interest. In a review of the evidence, Brown and Grant (2007) recommend paying attention to the following aspects: green design of roads and transport routes in order to reduce stress for those travelling on them; providing a range of open spaces for people to use including parks, gardens, verges, river banks, trees for shade and shelter and visual interest; balancing soft surfaces and vegetative cover for local air hygiene and temperature control and using nature as an integrated element of planning. Access to green space, community gardens, natural green playgrounds for children have all been found to have a positive influence on mental health and wellbeing (Vaandrager and Kennedy 2017). As outlined in chapter 'Implementing Mental Health Promotion in Primary Care. Inge Petersen', the Green Gyms initiative in the United Kingdom provides an opportunity for local communities to improve their health and local environment through participation in practical gardening and conservation activities, with positive physical, social and mental health benefits for participants. Community gardens have also been found to promote active lifestyles and contribute to healthy diets (van den Berg and Custers 2011). An important aspect of these initiatives is not only the green environment but also the social opportunities afforded for different community groups to connect and network and the empowerment gained through the collaborative group activity and social engagement. Local environ-

ments that facilitate outdoor activities, physical activity, meaningful engagement, socialization with neighbours as well as aesthetic enhancements contribute to better health and wellbeing (Vaandrager and Kennedy 2017).

Virtual Communities

Online platforms and social media that stimulate social connections are increasingly being used to connect communities and share information among 'virtual communities' and are potentially an effective way of reaching hard-to-reach populations. In addition to increasing access to health services through innovative mhealth and ehealth interventions, digital platforms are also being employed to advance the empowerment of disenfranchised communities, including the social participation and economic empowerment of women in low-income countries, as endorsed in the Sustainable Development Goals (UN 2015). The innovative use of apps and social network sites has the potential to transform the delivery of online campaigns, training and education with regard to civic engagement, advancing human rights, gender equity and political participation. With regard to the impact on mental health and wellbeing, the literature on online social networks suggests that empowering and social support processes can take place within online social networks with potential beneficial effects for psychological wellbeing (Batenburg and Das 2015). However, research on Social Networking Sites also shows that using online social platforms can have a negative impact on the wellbeing of young adults leading to negative social comparisons, negative self-perceptions and psychological distress (Haferkamp and Kramer 2011) and a decline in life satisfaction (Kross et al. 2013). On the positive side, the innovative use of online platforms and mobile apps has been applied to strengthen mental resilience and community engagement. For example, the Fit in je Hoofd app was launched in Belgium by the Flemish Institute for Healthy Living (www.fitinjehoodfd.be) and the Place Standard app in Scotland (www.placestandard.scot), developed by the Scottish Government, NHS Scotland and Architecture and Design Scotland was designed to enable increased community engagement between planners and communities to design healthy spaces and places. While online social networks have the potential to reach and connect isolated people and marginalized communities, there is also concern that, due to the digital divide, inequities could be increased rather than decreased. As technical and literacy skills vary greatly between socio-economic and socio-demographic groups, the use of online technologies, including use of dedicated mobile and ehealth technologies, could impact negatively and increase social and health inequities. It is estimated that about half the world's population do not have online access and that issues such as accessibility, affordability, inadequate digital education and lack of digital literacy constitute real barriers to realizing the potential of online technologies for many communities around the world.

Planning the Implementation of Community Mental Health Promotion Interventions

Building on the rationale and principles of community mental health promotion practice, community interventions cannot succeed unless they are adequately planned and implemented. The importance of good planning in implementing mental health promotion interventions has already been outlined in chapters 'Implementation Processes and Strategies for Mental Health Promotion' and 'A Generic Template for Implementing Mental Health Promotion'. These implementation steps are also followed in working in the community setting. Adopting a community planning model or overarching framework for guiding the planning process is strongly recommended. The Five-Stage Community Organization Model by Bracht et al. (1999) provides a useful structured framework for community-based planning and delivery. This model, outlined in Box 1 below, is based on the principles of partnership and empowerment. Employing a theoretical model such as this ensures that the development of the intervention is guided by a systematic framework and allows each stage of the process to be viewed within the context of an overarching structure. This model, which draws on earlier models of community organization practice, proposes five stages, each of which has a number of key elements. Bracht et al. (1999) point out that the stages are in fact overlapping and that community involvement is recommended at all stages. These stages correspond quite closely with those outlined in the generic template for action in chapter 'A Generic Template for Implementing Mental Health Promotion'. The Rural Mental Health Project in Ireland (Barry 2003) applied Bracht's five-stage model in engaging the participation of local communities in planning and implementing a range of interventions designed to improve mental health at the community level. The adoption of a structured planning model is identified as being critical to the successful implementation of complex, multifaceted community-based mental health promotion interventions (Barry 2005).

A community perspective to promoting mental health calls for implementation strategies that will ensure that the desired processes of community engagement and participation take place and that programme outcomes can be achieved. Working at the community level requires skills in collaboration, partnership working and political savvy concerning local power structures. Interventions need to be tailored to the local community setting and have the flexibility to evolve organically in response to local needs, interests, capacities, emerging opportunities and challenges. The WHO Healthy Cities and Communities movement provides many examples of how intersectoral partnerships and community participation are used in mobilizing resources for building healthier and resilient communities (de Leeuw 2009; Heritage and Dooris 2009; Norris 2001). For all these reasons, the implementation of community-based interventions requires an implementation process that will guide effective planning and delivery based on the principles of collaborative working and partner-

Box 1 Model of Community Organization (Bracht et al. 1999)

1. Community Analysis and Assessment

   Define the community.
   Collect data.
   Assess community capacity, barriers and readiness for change.
   Synthesize data and set priorities.

2. Design and Initiation

   Establish a core planning group and select a local organizer or co-ordinator.
   Choose an organizational structure.
   Identify and recruit organization members.
   Define organization's missions and goals.
   Clarify roles and responsibilities of citizen members, staff and volunteers.
   Provide training and recognition.

3. Implementation

   Determine priority intervention activities.
   Develop a sequential work plan.
   Generate broad citizen participation.
   Plan media interventions.
   Obtain resource support.
   Provide a system for intervention monitoring and feedback.

4. Program Maintenance and Consolidation

   Integrate intervention activities into community networks.
   Establish a positive organizational climate.
   Establish an ongoing recruitment plan.
   Acknowledge the work of volunteers.

5. Dissemination and Reassessment

   Update the community analysis.
   Assess the effectiveness of intervention programs.
   Summarize results and chart future directions.

ships, facilitating meaningful community participation and empowerment. Readers are referred to chapter 'Implementation Processes and Strategies for Mental Health Promotion', which outlines core processes in implementing effective intersectoral partnership working.

Plan for Intervention Monitoring and Evaluation for Continuous Improvement

The complexity of multifaceted community interventions presents a particular challenge in terms of evaluation, both in terms of the methodologies applied and the role of the evaluator. Brown (1995) outlines the following challenges for evaluators of comprehensive community initiatives:

- Broad multiple goals dependent on an ongoing process of synergistic change.
- Programmes are purposively flexible and responsive to local needs and conditions.
- The principles of community empowerment, participation and ownership are central to their mission.
- Recognize the nature of longer-term community change requiring longer time frames than more narrowly defined approaches.
- Produce impacts at different levels in different spheres.

Selecting appropriate research designs for comprehensive community initiatives is, therefore, critically important. The following key elements are identified: define interim and long-term outcomes, develop reliable and appropriate indicators of change, select measures/tools for assessing change, and build the capacity of the local community to contribute to the evaluation process. Complex multicomponent community interventions call for equally complex evaluation designs that will focus as much on implementation as on outcomes (Komro et al. 2016). Evaluation approaches also need to assess how interventions strategies are adapted as the community initiative evolves over time to address new and emerging issues in a dynamic and changing environment (Patton 2008). Based on adopting a theory-based evaluation approach, Lafferty and Mahoney (2003) outline some useful recommendations for developing an evaluation plan for a community asset-building initiative. Further details on the methodological issues involved in evaluating community partnerships and comprehensive community initiatives may also be found in the writings of Connell et al. (1995), Henricks Brown et al. (2017) and Komro et al. (2016). The reader is also directed to the resources listed in Box 2 on community intervention evaluation methods.

Process evaluation takes on a particularly important role in the context of multifaceted multilevel community interventions. Comprehensive process evaluation systems are necessary to track the quality of implementation and to ensure adequate documentation of effective processes and activities leading to desired outcomes (Cunningham et al. 2000). As highlighted earlier in this chapter, the formulation of logic models provides a useful opportunity for evaluators and practitioners to share their perspectives and expertise in formulating intervention design and sequential planning. Logic models also provide a useful blueprint for sharing perspectives in monitoring the process of implementation and collaboration, and identifying desired outcomes. The practitioner and/or programme implementer has a key role to play in this process, as data on intervention implementation are collected as

Box 2 Online Community Intervention Evaluation Resources

- The *Action Catalogue* is an online decision support tool that is intended to enable researchers, policymakers and others wanting to conduct inclusive research, to find the method best suited for their specific project needs.
- *CDC Evaluation Resources* provide an extensive list of resources for evaluation, as well as links to key professional associations and key journals.
- *Evaluating Community-Based Initiatives* is a special edition of The Evaluation Exchange, a periodical from the Harvard Graduate School of Education. The issue provides ample information about community initiatives.
- *The Role of Community-Based Participatory Research* is a comprehensive website developed by the US Department of Health and Human Services that is dedicated to providing information on CBPR.

Print Resources

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events occur. Using multiple methods, data may be recorded in the form of activity logs, records of meetings, process reports together with critical observations and reflections. This detailing of the intervention in action permits an accurate record of the intervention as it unfolds and plays a crucial role in informing the detection of intermediate level changes that lead to ultimate outcomes. As outlined in chapter ‘Implementation Processes and Strategies for Mental Health Promotion’, use of a theory of change approach and evaluation logic models provides a systematic

framework for intervention monitoring and feedback on intervention activities and impacts, and can be incorporated as an integral part of intervention planning and delivery. Realistic evaluation (Pawson and Tilley 1997) has been identified as a useful framework for evaluating community initiatives as this approach seeks to link the specific context of an initiative with the mechanisms of change, that is, how interventions achieve change over time in specific contexts. At a more general level, Gabriel (2000) points out that in the spirit of a community approach, evaluators must become partners with practitioners and the community in '… adapting their designs, assessment techniques and reporting strategies to fit the local context and needs' (p. 340). This calls for a movement away from traditional evaluation approaches to one characterized by partnership with key players. Participatory evaluation approaches may be used for this purpose, including empowerment evaluation (Cox et al. 2009; Fetterman and Wandersman 2005), community-based participatory research (Minkler 2010), collaborative and utilization-focused evaluation (Patton 2008). Empowerment evaluation emphasizes building the evaluation capacity of individuals and organizations so that evaluation is integrated into the intervention management process. A useful seven-step guide to empowerment evaluation is provided by Cox et al. (2009). Participatory action research approaches may also be employed in order to identify outcome and process goals and objectives that are consistent with the community empowerment concept (Israel et al. 1994). Participatory action research entails involving community members in all aspects of the intervention action and research in a collaborative and reflective process.

Community Implementation Strategies

Implementing Multilevel Community Interventions

The implementation of comprehensive community interventions calls for the use of appropriate implementation models and strategies that will guide the sequencing of intervention delivery and ensure that desired outcomes are achieved. Complex community interventions are typically composed of multiple components that may be planned to be delivered across different levels of the social ecology: at individual, organizational, community and macro-policy level. Interventions at each level may in turn be composed of multiple elements, which may also be linked across levels, with each programme element logically connected to supportive activities at the next level, that is, individual skills building linked to supportive community organization activities. These types of multi-component interventions require an implementation approach that will plot the sequence of events that are needed for effective outcomes to be achieved at each level. The use of a theory of change approach, as previously outlined in chapter 'Implementation Processes and Strategies for Mental Health Promotion', is recommended for such complex interventions. In developing a theory of change, Connell and Kubisch (1998) recommend starting with the

identification of the long-term outcomes and working backward towards needs and resources assessment. Intermediate and short-term outcomes can then be identified, together with input from stakeholders regarding their assumptions about the intervention activities that lead to these outcomes. Logic models can also be helpful in articulating a theory of change as they provide a graphical depiction of the anticipated process and outcomes.

Based on social ecology principles, Goodman (2000) recommends four key strategies for implementation of complex community interventions. These are:

- Developing logic models as a strategy for mapping out complex community-based interventions and providing a framework for collecting data as events occur permitting the accurate monitoring and recording of the intervention as it unfolds. This type of qualitative data forms the basis of a detailed process analysis of intervention implementation.
- Using the logic model as a strategic blueprint for assuring the quality of implementation as planned.
- Staging the implementation of the multiple intervention strategies or elements (as represented in the logic model) sequentially across the different social ecological levels, that is, individual, organization, community and policy levels. Each intervention may require its own staging so that it fully matures.
- Employing strategies that foster the development of community capacities to implement multifaceted interventions and to manage complex exchanges.

An example of such an ecologically oriented multi-component programme is the Midwestern Prevention Project (MMP), a comprehensive intervention designed to prevent adolescents' use of tobacco, alcohol and marijuana (Pentz et al. 1990, 1997). This community-based intervention consists of five elements or components: school-based programme, parent programme, community organization, health policy change, mass media coverage and programming. The intervention project, which runs over a 3–5 year period, integrates demand and supply reduction strategies through the school-based programmes for teaching youth drug resistance skills and community policy change aimed at institutionalizing intervention programming and limiting youth and community access to drugs. Mass media is also used to communicate messages regarding non-drug use, and seeks to bring about changes in health policies and community practices to reduce youth access to targeted substances. Each ecological domain – the school, home, community and policy – is targeted in a specific timeline beginning with the school intervention in the first year and ending with the health policy changes. The policy changes are implemented by parents together with school and community leaders as part of the parent and community organization programmes. A highly structured co-ordinating mechanism was employed to facilitate programme planning and implementation across the different intervention modalities. A detailed process model was used to guide the practical steps taken in planning, implementing and evaluating the different programme elements and Pentz et al. (1997) reported that the process involved continual programme planning even after community acceptance and support of each programme component. The MMP has been shown to be equally effective with both high-risk

and low-risk groups of young people with evaluations showing net reductions of up to 40% in adolescent daily smoking and marijuana use, and similar though smaller reductions in alcohol use, which have been maintained through high school graduation (Pentz et al. 1997). The programme has also demonstrated significant reductions in parent alcohol and marijuana use, and increased positive parent–child communication about drug use. Another example of a highly structured, multilevel community-based programme is Project Northland (Perry et al. 1996, 2002), which addresses youth alcohol use and also illustrates the importance of a systematic planning and implementation process in successfully implementing multifaceted community programmes.

The Communities That Care (CTC) initiative is a comprehensive community-wide system, which aims to provide communities with a framework or operating system to assist them in the focussed planning and implementation of interventions for positive youth development (Hawkins et al. 2002). The CTC system is described by Hawkins (1999) as a research-based system that helps to guide and empower communities in engaging in planning through objectively assessing their own profiles of risk and protection, and choosing and implementing effective strategies to address their unique strengths and needs. This programme has been introduced in over 500 communities in the United States and has also been replicated in Europe and Australia. We will now examine the CTC in more detail.

Practice Example: Communities That Care (Hawkins and Catalano 2002; Hawkins et al. 2002)

The Intervention

Communities that Care (CTC) is a community-based prevention system for mobilizing communities to address adolescent health and behaviour problems, such as substance misuse, youth crime and antisocial behaviour, through a focus on empirically identified risk and protective factors and the implementation of evidence-based interventions (Hawkins and Catalano 2002; Hawkins et al. 2002). CTC provides the community with a structured process for engaging community stakeholders in forming a coalition or community prevention board and a process for developing a shared community vision and action plan based on the selection of tried and tested intervention approaches. The CTC system is manualized and includes training events, guides and structured protocols for community leaders and coalition members. Training and tools are provided for the assessment of community risk and protective factors for youth health, the prioritization of specific risk and protective factors to be addressed (at individual, peer, family, school and community level), and the setting of specific measurable community goals. Based on the community assessments, CTC guides the community coalition in developing a strategic community action plan for the implementation of evidence-based intervention approaches and supports the ongoing monitoring and evaluation of the

implementation of the plan. The interventions are, therefore, tailored to the needs of each community and include services and programmes (e.g. mentoring, family-based or school-based programmes), designed to address multiple risk and protective factors in as many participants as possible. While communities may implement interventions targeting higher-risk youth, CTC emphasizes the delivery of a more universal approach to promoting positive youth development and reducing community-wide problem behaviours for the general population of young people (van Horn et al. 2014).

Collaboration between multiple community actors and sectors is a core element of the theory of change, as CTC seeks to generate greater community participation and ownership in developing evidence-based community approaches to address youth health and behaviour problems. The CTC system brings together a wide range of stakeholders including young people and their families, schools, community leaders, elected officials, law enforcement agents, community agencies and organizations, health professionals, youth services, business community and local residents. The process of building collaborative capacity in communities is based on the Social Development Model (Catalano and Hawkins 1996). This model is an integration of social control theory and social learning theory, and asserts that the most important units of socialization – family, school, peers and community – influence behaviour and youth development sequentially. Therefore, providing youth with opportunities, skills and recognition can strengthen bonding with family, school and community, which in turn motivates young people to adopt healthy and prosocial behaviours. The CTC theory of change suggests that it takes 2–5 years of implementing tested, effective interventions for community-level impact on risk and protective factors to be observed and 4–10 years for community-level impact on problem behaviours such as adolescent substance use, delinquency and violence.

CTC Implementation Stages

The installation of the CTC operating system in communities is supported through a programme of six training events delivered over the course of 6–12 months by certified CTC trainers. The implementation of the CTC system consists of five stages with a series of milestones and benchmarks to guide progress:

- *Phase 1 – Community Readiness Assessment*: Involves defining the community, identifying and gaining the support of community members, leaders and organizations and assessing current capacities and barriers.
- *Phase 2 – Involving the Community:* Local community coordinators and coalition members are trained in the CTC approach including: educating them in community activation processes and engaging in the CTC planning process, choosing an organizational structure to oversee planning and implementation activities, and citizen recruitment to form a community prevention board or coalition. The community coalition is organized to carry out the subsequent stages of the CTC, key roles and responsibilities are defined and members attend a 2-day orientation training.
- *Training in Compiling a Baseline Community Profile:* The community prevention coalition receives training in developing a data-based profile of the

community's strengths and challenges, for example, through a community or school-based survey, including levels of youth problem behaviours and risk and protective factors as well as an inventory of existing community resources. Coalition members participate in a 2-day training event on how to interpret the collected data and prioritize two to five risk factors for prevention action. A 1-day resource assessment training is held to assist coalition members in identifying if existing policies, programmes and services can address the priority areas.

- *Training to Develop a Community Youth Development Plan*: A 2-day training in community planning is held where the results of the community profile and assessments are examined and evidence-based policies and programmes are reviewed. The coalition members define clear measurable outcomes with respect to the prioritized risk and protective factors. Policies, actions and programmes are then selected from a list of tested, effective intervention approaches. An action plan is developed for implementing the selected new interventions and an evaluation plan is put in place to measure progress.
- *Implementation and Evaluation of the Plan*: CTC coalition members receive the Community Plan Implementation Training to develop the skills necessary to implement and monitor the community action plan. The training includes skills in identification of resources to support the plan, clarifying roles, developing good communication and monitoring of progress towards desired outcomes. From years 2–5, technical assistance and training is provided on implementing the selected interventions and the monitoring of progress towards the process and outcome goals. Intervention-specific implementation checklists are completed by the programme providers and 10–15% of programme sessions are observed to ensure high quality implementation. Local media is also engaged at this stage to educate the local community about the new interventions and mobilize their support.

Technical assistance is provided to local CTC coordinators and coalition members in implementing each of the five phases through twice-yearly site visits, weekly phone calls and email support.

Evaluation

The CTC strategies have been applied across diverse communities and have been shown to reduce the initiation of tobacco use, alcohol use, delinquency and violence among a longitudinal panel of students followed from Grades 5–10 in the United States (Hawkins et al. 2009, 2012). Implementation studies show that 18 months after the initial training began, the CTC system was implemented successfully with fidelity in the intervention communities (Quinby et al. 2008), and the selected evidence-based interventions were also well implemented (Fagan et al. 2008). The Community Development Study (CYDS) was the first community randomized trial of the CTC, which was conducted in 24 communities located across seven states in the United States. In this 5 year study, community sties were matched within states and were then randomly assigned to 12 intervention and 12 control communities (Hawkins et al. 2008). From 2003 to 2008 each of the 12 intervention communities

was provided with CTC training and funding for a local coordinator and the costs of implementing selected interventions in years 2–5. To test the effects of CTC in achieving change in delinquent behaviour and substance use, intervention communities were asked to focus on interventions for young people aged 10–14 years (Grades 5–9) and their families. The study shows that the priority risk factors and interventions differed between intervention communities, with 13 different interventions being implemented during 2003–2004 and 16 programmes implemented during the 2005–2006 school year. An average of three programmes covering school, family and community-based interventions were implemented in each community (e.g. Life Skills Training, All Stars, Lions Quest Skills for Adolescents, Big Brothers Big Sisters, and Strengthening Families). Data from a panel of 4407 Grade 5 students were collected annually from 2004 to 2009 until they reached Grade 12, assessing levels of adolescent drug use and delinquent and violent behaviour. One and half years after implementation of the CTC programmes, evaluation findings showed significant positive effects on delinquent behaviours with mean levels of targeted risks significantly lower in CTC communities compared with control communities (Hawkins et al. 2008) and significantly fewer were initiating delinquent behaviour between Grades 5 and 6 in CTC communities. No significant effects on substance use initiation were observed.

At 3 years follow-up, however, significant positive effects were also reported on the incidences of initiation of alcohol, cigarette and smokeless tobacco use and the start of delinquent behaviour (Hawkins et al. 2009). The prevalence of alcohol and smokeless tobacco use in the last 30 days, binge drinking in the last 2 weeks and delinquent behaviours in the last year were significantly lower among young people in the CTC communities. Significant effects were also found at 6 years follow-up (i.e. 1 year after study-provided resources for CTC installation were withdrawn), on the incidence of delinquent behaviour, alcohol use and cigarette use, and the prevalence of current cigarette use and past-year delinquent and violent behaviour in CTC communities (Hawkins et al. 2012). At 8 years follow-up, CTC participants at 12th Grade (aged 17–18 years) were also found to be more likely to have abstained from any drug use, drinking alcohol, smoking cigarettes and engaging in delinquency and violent behaviour compared to controls (Hawkins et al. 2014). There were, however, no significant differences between the groups in the prevalence of past-month or past-year substance use or past-year delinquency or violence. Oesterle et al. (2015) reported a significant gender effect at age 19 years with males in CTC communities significantly more likely than males in control communities to have abstained from any delinquent behaviour and from using cigarettes. Van Horn et al. (2014) examined the specific effects of CTC for young people with different profiles of problem behaviours. Using cross-sectional samples of 8–10th Grade students collected 6 years apart (in 2000 before the CTC interventions were implemented and in 2010, 2 years following external support to CTC communities was withdrawn) the study found a significant reduction in the likelihood of young people being an alcohol user in CTC communities but no intervention effects were found on the probability of being an experimenter with substance use for either grade. Significant positive effects were also reported for protective factors, including

opportunities and recognition for prosocial involvement and attachment, prosocial skills, healthy beliefs and clear standards, at community, school and peer/individual domains, but not on family domain (Kim et al. 2015).

While the positive effects of CTC were demonstrated using a longitudinal panel from the community randomized trial, as described above, similar effects on problem behaviours were not reported from an evaluation study by Rhew et al. (2016) using a repeated cross-sectional design in the same sample. A cluster randomized control trial (RCT) study was also conducted with 20 communities in Australia to examine the impact of CTC on alcohol use and alcohol-related crime in rural communities (Shakeshaft et al. 2014). This study reported significant reductions in the reporting of average weekly alcohol consumption and experience of alcohol-related verbal abuse in CTC communities at post-intervention, however, the evaluation found little evidence that CTC had reduced risky alcohol consumption and alcohol-related harm. The study authors concluded that legislative action may be required to reduce alcohol harm more effectively at a community wide level.

A cost–benefit analysis study (Kuklinski et al. 2015) reported that the net value of CTC 5 years from implementation was positive, ranging from USD 1.749 to USD 3.920 per young person. The cost–benefit ratio varied between USD 4.23 and USD 8.22 per dollar invested, indicating a significant economic return to society from CTC's impact on reducing delinquency, underage drinking and tobacco use initiation in young people at a community-wide level.

Recommendations for Replication

Hawkins (1999) reported that with adequate training, communities could effectively use the CTC in assessing their own profiles of risk and protection, and improve inter-agency collaboration, reduce duplication of services, co-ordinate allocation of resources, strategically target prevention activities to priority areas, increase use of research-based approaches and increase professional and community involvement. Analysis of the differences between the CTC and control communities showed that the CTC sites were more likely to adopt evidence-based interventions and to have greater levels of community collaboration 18 months after introducing CTC (Brown et al. 2007).

To date, the CTC has been implemented in a number of countries outside the United States including, Australia, Canada, Croatia, Germany, the Netherlands and the United Kingdom (Crow et al. 2004). A study by Burkhart (2013) examined the feasibility of implementing CTC in the European context. Based on reports from implementation of the CTC system in Europe, they commented on the need to take into account socio-cultural differences in how the concept of community is understood in different country contexts, and that it may, therefore, be necessary to consult with communities over a longer period than envisaged in the original CTC system. They also referred to the fact that evidence-based prevention programmes may not be as readily available outside of the US context. The European Monitoring Centre for Drugs and Drug Prevention (2017) identifies CTC as a promising approach but highlights the need for further evaluation of its effectiveness in the European context.

The CTC system is available for dissemination and has been placed in the public domain by Substance Abuse and Mental Health Services Administration in the United States. A menu of tested evidence-based interventions for 10–14 year olds included in the Communities That Care Prevention Strategies Guide is available at http://ncadi.samhsa.gov/features/ctc/resources.aspx and the Communities That Care PLUS website (www.communitiesthatcare.net) provides further details on getting started and access to digital tools and online workshops and support. A system for training new CTC trainers and technical assistance providers is offered to agencies and organizations that wish to build capacity to provide CTC to communities.

Further details of the training and other materials may also be accessed from the Blueprints for Healthy Youth Development website at: http://www.blueprintsprograms.com/factsheet/communities-that-care.

Conclusions

While it is acknowledged that there is no one best way of implementing community interventions, on the basis of the reviewed literature, a number of critical factors and conditions are identified that are needed to succeed. These key principles are now summarized.

Clarifying Boundaries of the Community
As there are many different definitions and meanings of the term 'community', ranging from community as a place or geographically based to communities of shared interest or social and cultural identity, clarity about community boundaries or sense of community is critical to effective intervention planning and development. Communities are complex and dynamic as they may be made up of unconnected people who have little sense of communality or shared identity or may be composed of numerous smaller communities. The initial task may be, therefore, to identify the appropriate unit of practice be that social group, neighbourhood or regional level.

Determining Community Readiness
Community readiness may have a particular significance when addressing mental health promotion as communities may not feel empowered or willing to take on interventions promoting positive mental health for groups in the community. It is, therefore, important not to rush into intervention planning and implementation in advance of determining the degree of readiness in the community to engage with mental health issues locally. As Wolff (2001) points out, the most successful community coalitions take time to establish relationships, personally visit the key local players and build strong personal links and support in order to engage effectively with, and mobilize the community.

Creating Clear Structures

The key feature of effective community-based interventions is successful collaborative working (Foster-Fishman et al. 2001; Wolff 2001). Structures for planning and delivery will vary between interventions but an agreed organizational structure is critical to effective community-based interventions. Clear lines of communication are important and can be enhanced, for example, by detailed minutes of planning, review sessions, clearly defined roles and expectations and a good flow of information. Successful community coalitions and partnerships are characterized by shared decision-making and a collaborative style of leadership, expanding leadership among members and delegating responsibility rather than relying on a single charismatic person.

Generating Community Participation

The active involvement of community members and representatives enables community interventions to be more responsive and understanding of local needs. Community participation also enhances acceptance for an initiative within a community and can lead to individual and community empowerment through building capacity locally, and enhancing control of the local environment. New members may need to be recruited as the intervention develops and there is an ongoing need to build trust and positive relationships between diverse groups of people around a shared goal. It is crucial to demonstrate that desired outcomes can be achieved, and clearly sequenced action plans and implementation teams, can all foster the translation of plans into action.

Translating Plans into Action

The importance of moving beyond the consultation and planning stages into concrete action is critical for success. Developing written action plans and realistic work plans, including measurable indicators of success, are important steps in translating key project aims and objectives into action. Feedback on the success and impact of intervention activities through process and interim evaluations can play an important role in motivating action or indeed changing the focus and direction of action. Action plans may need to be regularly reviewed in the light of evaluation findings and feedback from participants. Disseminating successes and media publicity of achievements play an important part in enhancing the motivation for change, increasing the visibility of the intervention and consolidating its role in the community.

Technical Assistance

The planning and implementation of community interventions is a highly complex task requiring a range of skills and expertise that may not be readily available within the community. In recognition of this, external technical assistance may need to be provided in assisting with planning, conducting needs assessment, designing strategies, facilitating partnership group processes, managing conflicts, dealing with start-up and sustainability and intervention evaluation.

Developing Core Competencies and Capacities

Ongoing training and support in developing a range of skills is critical to the functioning of working community partnerships. Skills in communication, leadership, management, facilitation and evaluation are all examples of core capacities from which community intervention projects can benefit. In this way sustainability will be ensured in terms of strengthening resources from within the community project team.

Sustaining Community Programmes

Planning for sustainability should begin early in the life of a community-based intervention and not in the last year of funding. Long-range plans for receiving ongoing support should be developed, including concrete funding goals and strategies for a diversified, broad and stable funding base. It may be useful to develop a timeline for seeking additional funds identifying possible sources and when they become available. The success of the sustainability plan should be regularly reviewed. Intervention integration with other service providers may also be considered along with support in-kind, volunteer engagement and so on. If an intervention does have to be ended then it is important that this also should be planned, signalled well in advance and carried out with sensitivity and due regard for the community members and organizations involved.

Comprehensive Evaluation

The complexity of multifaceted community interventions calls for equally complex and comprehensive evaluation study designs, incorporating the rigorous use of a range of methodological approaches to assess the relationship between intervention processes and outcomes. Gabriel (2000) argues that the traditionally detached and external role of the evaluator does not meet the needs of dynamic community interventions. This may be especially the case for interventions employing a community development or empowerment model. Partnership between the evaluator and the intervention community will enable the evaluator to have a better understanding of the actualities of the intervention activities and leads to a better-informed assessment of intervention processes and outcomes. The use of theory of change and logic models are recommended by a number of community researchers in order to articulate the critical connections between local community needs, the partnership/intervention activities and intended intermediate and long-term outcomes, thereby providing an effective blueprint for process and outcome evaluation. Participatory evaluation approaches, including empowerment evaluation and utilization-focused evaluation approaches, may also be employed in order to identify outcome and process goals and objectives that are consistent with the community empowerment concept. These community-based participatory research approaches enable the involvement of community members in the intervention research in a collaborative and reflective process and emphasize building the evaluation capacity of individuals and organizations as an integral part of the intervention process.

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