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CONTENTS

This article presents a community mobilization strategy that focuses on the dynamics of organizing church communities to implement and evaluate alcohol and other drug (AOD) abuse prevention programs. Although the literature abounds with extensive discussions and case studies of community practice models, it clearly lacks documentation of successful strategies for empowering communities to engage in program implementation and evaluation. A model community mobilization strategy is described that highlights the involvement of church congregations in family recruitment, retention and replication of AOD prevention programs. The evaluation of the strategy provides evidence of the success in rural, suburban, and urban settings. Key lessons are presented to

Mobilizing Church Communities to Prevent Alcohol and Other Drug Abuse: A Model Strategy and Its Evaluation

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ABSTRACT. This article presents a community mobilization strategy that focuses on the dynamics of organizing church communities to implement and evaluate alcohol and other drug (AOD) abuse prevention programs. Although the literature abounds with extensive discus-

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sions and case studies of community practice models, it clearly lacks documentation of successful strategies for empowering communities to engage in program implementation and evaluation. A model community mobilization strategy is described that highlights the involvement of church congregations in family recruitment, retention and replication of AOD prevention programs. The evaluation of the strategy provides evidence of the success in rural, suburban, and urban settings. Key lessons are presented to stimulate implementation of the model mobilization strategy in other church communities. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.haworthpressinc.com>]*

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The magnitude of AOD problems has caused continuing concern in rural, suburban, and inner-city communities nationwide. In response to these problems, many AOD abuse reduction strategies have been tried over the years. For example, controlling illegal drinking and illegal drug use among youth through laws and law enforcement is a constantly growing effort, but there is evidence that the illegal use of alcohol and other drugs cannot be eliminated as long as demand is strong (Hawkins, Catalano, & Associates, 1992; Johnston, O'Malley, & Bachman, 1995; Polich, Ellickson, Reuter, & Kahan, 1984). Treatment has been a conventional strategy to reduce demand among those with the most serious alcohol and other drug problems, but significant costs to society are already incurred by the time treatment is attempted; furthermore, high relapse rates among those treated present a continuing challenge to clinicians (Polich, Armor, & Braiker, 1981). A more promising strategy is prevention that focuses on reducing the demand for alcohol and other drugs before problems develop and before the high costs to individuals and communities are incurred.

There is evidence that AOD abuse prevention works (Blakely, Coulter, Gardner, & McColgan, 1996; Center for Substance Abuse Prevention, 1995a; Hawkins, Catalano, & Miller, 1992). The most widely used prevention methods have been school-based drug education and skill-building programs (Gardner, Green, & Marcus, 1994; Tobler, 1986); recently, however, community involvement in initiating change has become central to AOD prevention programming (Clapp,

1995; Center for Substance Abuse Prevention, 1995b; Manger, Hawkins, Haggerty, & Catalano, 1992; Johnson & Adams-Wolf, 1994).

Many types of community organizations engage their membership in AOD prevention activities. Businesses, churches, criminal justice agencies, human service agencies, health organizations, and schools are a few of these community organizations. The study presented here draws attention to a successful community practice involving church organizations and their congregations that implement AOD prevention programs. The involvement of church congregations community practice in the form of community organizing can be traced to Saul Alinsky and his Industrial Areas Foundation work, which began in 1940 (Robinson & Hanna, 1994).

Although religious systems are not commonly considered by the mental health community as a personal and social resource (Maton & Pargament, 1991; Pargament & Maton, 1996), it is argued that the church has tremendous potential to influence individual and community well-being through prevention activities (Maton & Wells, 1995). For one thing, more than one-third of volunteer activity in America is church-related (Samuelson, 1994). According to Goodstein (1993), congregations contribute more money to community causes ($6.6 billion) than do corporations ($6.1 billion). Further, Goodstein's survey found that 90 percent of the congregations in the U.S. have programs directed at community needs. Surveys also have shown that a majority of church-based community programs are directed toward at-risk families and children (George, Richardson, Lakes-Matyas, & Blake, 1989; McAdoo & Crawford, 1991; National Council of Churches, 1991).

According to some, social work has withdrawn from religious values and traditions in the context of community intervention (e.g., Robinson & Hanna, 1994). Further, the religious influence in prevention has received surprisingly little attention in the literature (Anderson, Maton, & Ensor, 1991; Maton & Pargament, 1987). In response to these voids, we present here a successful community mobilization strategy and its evaluation, one which centers on empowering church organizations and their members to create and maintain a social environment conducive to AOD abuse prevention program implementation.

The community mobilization model we present was implemented and evaluated as part of a five-year community-based project that focused on increasing community, family, and personal resiliency factors that reduce the likelihood that 12- to 14-year-old youths will

abuse alcohol and other drugs. The project, Creating Lasting Connections (CLC), was located in Louisville, Kentucky, and was funded from 1989 to 1994 by the Center for Substance Abuse Prevention (CSAP). The program's primary focus was on rural, suburban, and urban populations and involved both parents and high-risk youth in an intensive year-long prevention program. The success of the CLC program is well documented in COPES (1995) and Johnson, Strader, Berbaum, Bryant, Bucholtz, Collins, and Noe (1996). The CLC program and its evaluation were cited in the February 1995 report that Bernard C. McColgan, Director of the Division of Demonstrations for High Risk Populations, CSAP, gave to the CSAP Advisory Council, as one of only 21 out of 364 High Risk Youth Demonstration Grants with both rigorous evaluation (true experimental design) and significant findings. Later, in 1997, the CLC program was selected by CSAP as one of seven substance abuse prevention model programs.

In this paper, we first discuss the theoretical foundation of our community mobilization model. Second, we describe our model strategy and its evaluation. Third, we present evaluation results that assess how and to what extent the mobilization strategy stimulated community engagement. Finally, we highlight significant learnings from our program implementation and evaluation experience.

THEORETICAL FOUNDATION

Strategies to encourage communities to become involved in AOD use and abuse prevention among youth have drawn upon a number of different community practice theories (Clapp, 1995; Hawkins, Catalano, & Associates, 1992; Manger, Hawkins, Haggerty, & Catalano, 1992; Johnson & Adams-Wolf, 1994; Rothman & Reed, 1984). These theories include community and locality development (e.g., Biddle & Biddle, 1965; Chavis, Florin, & Felix, 1993; Lappin, 1985; Mayer, 1984), coalition-building (Dluhy, 1990; Mizrahi & Rosenthal, 1993), empowerment (Conger & Kanungo, 1988; Grosser & Mondros, 1985; Rappaport; 1981, 1987), functional community organizing (Hooyman & Bricker-Jenkins, 1985; Weil & Gamble, 1995), program development (Hasenfeld, 1995; Kurzman, 1985), resource mobilization (McCarthy & Zald, 1973; McCarthy, 1977; Pichardo, 1988), and social planning (Kettner, Daley, & Nichols, 1985; Lauffer, 1981, 1987; Rothman & Zald, 1985).

These and other community practice models are presented in the literature as ideal theoretical types. However, because of the considerable overlap among the models, Rothman (1995) advocates composite mixtures of practice models. Our model community mobilization strategy is conceptually linked primarily to two practice models: functional community organizing (Weil & Gamble, 1995), and program development (Hasenfeld, 1995).

The functional community-organizing model influenced our definition of a community. Functional communities are not bound by geographic configuration. While people in this type of community may or may not live in proximity, they share a concern about a common set of issues relating to the mission of their community. The central focus and desired outcome in mobilizing functional communities is action that emphasizes advocacy and provides services, and that changes policies, behaviors, and attitudes in relation to the chosen issue (Weil & Gamble, 1995).

Program development, which Hasenfeld (1995) claims has not received adequate attention in practice theory, provides the conceptual foundation for the process of mobilizing a community to prevent AOD use and abuse. This model is a rational and incremental practice method that underscores study, planning, problem identification, design, initiation, and evaluation (Kurzman, 1985). There are clearly delineated activities and tasks that are predetermined in some sequential order. An essential element of this model is gaining support from some community group that is connected to a larger support network. According to Hasenfeld (1995), the developer/organizer must often initiate and organize this action group. The action group then becomes the advocate for the program's objectives. Further, this group participates in program design, implementation, evaluation, and stabilization of the program in the community. Change agents, and their involvement in the program development and evaluation process, have been found to be especially important to stabilizing programs in communities (Glaser, Abelson, & Garrison, 1983; Havelock, 1973; Johnson, Frazier, & Riddick, 1983).

Our experience has been that church congregations are based more on relationships than on geographic location and churches that provide social service programs do so in a rational and systematic manner. Thus, the functional community organizing and program development models were selected as the theoretical foundation for our community

mobilization strategy. This strategy, which incorporates elements of both models, is outlined in the following text.

THE COMMUNITY MOBILIZATION STRATEGY

Defining Community

Following the functional community practice model, the CLC mobilization initiative targeted communities based on natural groupings and support systems that had shared activities and interests, and on social interaction, rather than on geography such as neighborhoods, precincts, or census tracts. The CLC decided to implement preventive interventions in church communities because church congregations are natural support systems that provide significant contact with families and social outreach programs, all of which create a sense of "community" (social interaction and functionality).

A first step identified church communities within the established boundaries of the targeted service delivery area (40- to 50-mile radius of Louisville, KY) and that were interested in learning more about the CLC demonstration project. Questionnaires were sent to all churches within this delivery area (McKelvy, Schneider, & Johnson, 1990).

The next step selected church communities interested in being and appropriate as demonstration sites. Site selection was based on five distinct criteria. The first criterion centered on the number of individuals with targeted characteristics who were accessible within the church community's sphere of influence. The second criterion related to social services or programs offered by the church community in the recent past and the relevance of such programs to the CLC program. The third criterion entailed an examination of program offerings by each community to determine whether services were delivered by members of the community itself, provided in cooperation with other communities, or contracted or referred to external sources (e.g., mental health agencies and self-help groups). The fourth selection criterion was a church community's willingness and, more important, its readiness for program implementation. With regard to readiness, the CLC asked five questions of each site which served as a "readiness scale" for the prevention effort. These questions measured community priorities, willingness, and resources. The final selection criterion was the project's ability to support a grant requirement to distribute services

across rural (counties surrounding Jefferson County within a 40- to 50-mile radius), suburban (within Jefferson County), and urban (within the City of Louisville corporate limits) settings.

Based upon the five selection criteria, eleven communities that met the minimum standards were placed in a pool for possible implementation. It was agreed that the provider organization would implement the program with as many of these communities as possible over the project period.

Mobilization Process

Drawing on the tenets of a program development model, we posited that a successful community mobilization strategy for a church congregation would involve a four-stage process that included (1) creating community advocate teams to become successful advocates for AOD prevention; (2) engaging community advocate teams in recruiting members of the community to receive program services; (3) engaging community advocate teams in retaining participants in the program and its evaluation; and (4) enhancing the community's capacity to empowering the community to create self-perpetuating program-related initiatives.

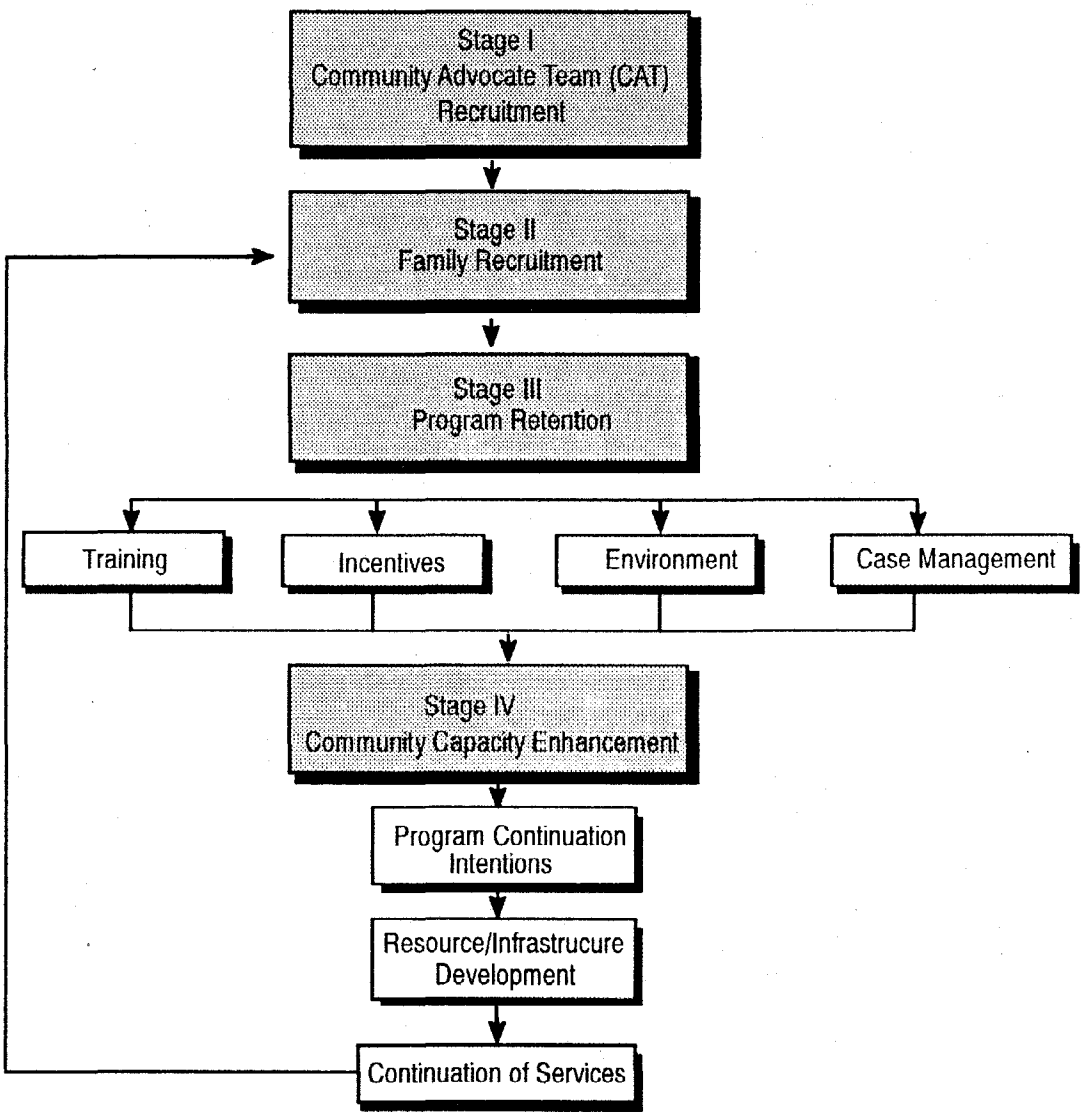
An earlier version of the CLC community mobilization strategy, described in Strader, Collins, Noe, and Johnson (1997), did not include capacity enhancement as essential to our mobilization strategy. The model was revised upon the realization that community involvement in creating a self-perpetuating program initiative may be the strongest evidence for a successful mobilization strategy (Havelock, 1995).

Figure 1 presents the revised community mobilization strategy model that was implemented in the CLC program. Each stage of the model is described and linked to elements of the program development and functional community organizing models, which were presented earlier as the theoretical foundation for our model strategy.

Stage I: Church Advocate Team Recruitment

Stage I focused on acquiring support from a community action group, organizing the group, and empowering the members to become advocates for the program's objectives, essential elements of the program development model (Kurzman, 1985; Hasenfeld, 1995). This mezzo-system level stage involved recruitment and training of key

FIGURE 1. Four-Stage Community Mobilization Strategy



church leaders to serve on a church advocate team (CAT). The CAT was one of the most critical features of our community mobilization strategy for two independent but conceptually related reasons. First, this group was primarily composed of highly regarded and well-known members within the targeted church communities. Because of their high visibility and knowledge of community members, the CAT's ability to discern who would benefit from a particular program's services provided the first step in the process of creating a strong recruitment base. Second, involving the CAT in the strategic recruitment plan provided a linkage between the prevention program provider and community members.

Members of the CAT of each targeted community were recruited using the following strategies. First, a project liaison was selected by the key church administrator, usually the pastor. The project liaison was responsible for inviting ten to twelve key community leaders (2 to 3 youth and 7 to 9 adults) to an initial CAT overview meeting. The purpose of the CAT overview meeting was to describe the project, to outline tasks, and to recruit at least eight to ten CAT members. Several overview meetings were often required in order to recruit the targeted number of CAT members who displayed the qualities essential for program success. Ideal candidates were responsible, well connected to the community, assertive, enthusiastic, open to new ideas, promoted moderate attitudes, and possessed good communication skills.

Stage II: Family Recruitment

During Stage II, the CAT became an advocate for the program's objectives, an essential element of the functional community and program development models (Weil & Gamble, 1995; Hasenfeld, 1995). CAT members were engaged in identifying and recruiting participants (high-risk families) for the CLC program and its evaluation. In this micro-system stage, the prevention service agency administering the CLC program and the CAT worked together to provide the prevention program for its targeted population of high-risk youth and their parents. This two-pronged recruitment effort assisted the service agency in maintaining continuous feedback from the community site concerning recruitment outcomes.

An elaborate set of events occurred to accomplish the recruitment of the target population. First, the CAT was involved in developing the family recruitment plan in collaboration with the project staff. Project staff developed a prototype family recruitment strategy, which served as a guide for developing a recruitment plan for each church site. However, it was important that the plan be personalized for each particular church community. Each site was somewhat different, and the success of the recruitment effort required the input of the CAT in order to make it effective for their particular community.

Following the program development model, project staff clearly delineated tasks and activities to implement sequentially (Hasenfeld, 1995). During family recruitment meetings, program staff identified recruitment tasks and CAT members volunteered to carry out the tasks according to a specific time line. Effective recruitment plans used the

following activities: recruitment during social events and celebrations, endorsements from leaders of the church, information meetings, advertising in church bulletins, newsletters, and local media, and telephone and face-to-face contact.

Without the assistance of the CAT members, the program staff would have had difficulty recruiting members of a designated target population partly because of the spatial and psycho-social differentiation between the agency and the church communities located in the large service area. The creation of a CAT facilitated community bonding, which encouraged families to join the program. The CAT functioned as a means to develop and nurture an array of other resiliency-enhancing activities for high-risk youth and families. In addition, the CAT was especially important in helping to initiate self-perpetuating programs in the communities, which is an important element of the program development model (Glaser et al., 1983; Havelock, 1973; Johnson et al., 1983).

Stage III: Family Retention

Although family recruitment was crucial for the viability and success of the community mobilization strategy, and in particular, for a program working with high-risk youths and their families, the retention stage of the model can be viewed as perhaps the most vital element of the strategy. It is at this stage that the CAT members are involved in implementing and evaluating the program in their respective communities, which is an essential element of the program development and functional community organizing models (Glaser et al., 1983; Havelock, 1973; Johnson et al., 1983; Hasenfeld, 1995).

Program staff initiated retention activities to ensure that participants remained in the program and in its evaluation. Without maintaining a sufficient number of participants, it would have been difficult to determine, even with the most rigorous evaluation, whether the program was successful.

Four specific features of the CLC program were designed, directly or indirectly, to enhance retention: (1) comprehensive training for parents and youth, (2) early intervention and case management services for families, (3) an incentive package, and (4) church community members' assistance in program implementation and evaluation. These features can be perceived as a matrix in which each works either independently or in conjunction with the others to create a lasting

connection between the program and its targeted population. Although, for discussion purposes and clarity, each feature is viewed as a separate entity, it is important to recognize that retention is most effective when emphasis is placed upon all program features simultaneously.

Because past research has shown that parental factors still emerge as important influences on adolescents (Coombs, Paulson, & Richardson, 1991; Brook & Brook, 1992), the CLC program consisted of twenty to twenty-five weeks of 2 1/2-hour sessions that focused exclusively on parents and their high-risk youth. Briefly, these training sessions involved family management and communication training for parents and youth through a modified version of *Say It Straight* (Englander-Golden, 1983) and *Not My Child* (Strader, 1988).

The use of early intervention and case management services was also viewed as a mainstay feature of successful retention (Bucholtz & Johnson, 1992). Within the CLC program, the case manager (1) played the role of participant-observer during program training sessions, (2) acted as the initial referral source for program participants, (3) initiated contact with all participants who were absent during a training session, and (4) initiated post-intervention follow-up services for a pre-set time period.

Case management services greatly enhanced the agency's ability to maintain continuous contact with its clientele, which in turn increased the community's desire to continue in the program. Further, by maintaining close relations, participants felt encouraged and supported to continue attending the program until its completion.

Incentives also played a key role in the retention stage. Through painful experience, many social service agencies have realized that despite the strength of a program's core training components, those in most need of services often terminate their involvement prior to program completion (Lorion & Ross, 1992). Our mobilization strategy required that agencies provide participants with some form(s) of incentive. Past research has shown that positive reinforcements in the form of incentives not only enhance retention (Bry, Conboy, & Bisgay, 1986), but also assist in meeting a program's desired outcomes (Stitzer, Bigelow, Liebson, & Hawthorne, 1982).

One obvious impediment to the introduction of incentives concerns resources. It was important, therefore, that the service agency administering the CLC program implement innovative incentives designed to give something, in addition to the program itself, back to the partici-

pating community, while at the same time remaining within the limits of their budget. Examples of incentives used by the CLC program included the provision of food for participants, daycare assistance, family portraits, transportation provisions, social activities, and nominal payments for the research interviews ($5.00 per interview). Participants also were encouraged to add incentives for each other. For example, participants were encouraged to bring their favorite recipe to distribute during break (intended as a form of communal bonding), and they were encouraged to provide mutual support to each other and their children.

The final feature of the program that aided retention was the involvement of church community members (via the CAT) in program implementation and retention activities. Following CAT training, CAT members were involved in: (1) co-planning the initial strategy for identifying the families with high-risk youth, (2) recruiting those families, (3) assisting in scheduling the trainings, (4) refining the strategy for presenting the training in their particular community, (5) scheduling evaluation interviews, (6) preparing linkages for successful self-referrals/interventions to service providers, (7) maintaining contact with families throughout the project; and (8) planning and managing the graduation celebration.

Stage IV: Community Capacity Enhancement

The effective transfer of responsibility for AOD prevention programming from an outside professional organization to a local community is an essential aspect of a community mobilization strategy. It is in the capacity enhancement stage that the active and ongoing involvement of the community in the program is demonstrated. This stage also optimizes the stabilization of an intervention, which is an essential element of the program development community practice model (Johnson et al., 1983; Johnson, Hexter, Garrison, & Sweet, 1996).

The capacity enhancement stage involves the successful transfer of responsibility for services to the community by stimulating local community intentions for program continuation and effective infrastructure and resource development. Success in the community capacity enhancement stage is measured by the actual continuation of services based on local community actions (Cohen & Kibel, 1993).

In order to stimulate local community intentions to continue program services, it is important for community leaders to perceive a need for the service, to believe the services being offered are effective, and to believe they have the ability to successfully continue the services. Since communities participating in the CLC project had expressed an interest in the program, it was clear they already felt a need for effective prevention services prior to the project. Additionally, the CLC project demonstrated positive results with participating families. Therefore, the community leaders were able to perceive the services as being effective. Through the involvement of local community members throughout the project implementation, the project staff were able to convince local community members of their own ability to continue the program services and accomplish effective results.

In addition to stimulating intentions to continue services, infrastructure and resource development are essential elements of transferring responsibility for providing prevention programming services from an outside professional organization to a local community. It was important to assist local populations in establishing linkages and networks with outside sources of funding that would enable them to acquire the needed resources for continuation efforts. Project staff assisted community representatives with grant writing and lobbying efforts to access needed resources. The program service model was designed to create the necessary local community infrastructure through the church advocate team members who were representatives of the targeted community. The CATs were involved with the project staff in a apprenticeship type relationship for a six-month period prior to the implementation of the family services. During this period, the CATs were trained to become the management team for the project, and they engaged in activities designed to enhance infrastructure. These included institutionalizing the program services within the church's existing service delivery structure and developing regular program kick-off and recruitment events.

Although these activities are crucial to the continuation of a service program, our prototype model placed much of the responsibility for continuation on the church community. Thus, the model was designed to empower program participants, CAT members, and other community leaders. In implementing this stage of the strategy, the prevention service agency remained relatively passive and played an observer-participant role, so as to shift responsibilities to the community and

away from the agency. The agency, however, needed to continue its relations with, and act upon the desires of, the community. For instance, if a community wished to continue to continue the program, in most instances it needed some level of support and assistance. It is important to note that the prior experience of the service agency was especially helpful when issues of technical assistance and resource development for continuation arose. At this point, the agency would begin to help the targeted community access funding through whatever sources were available. Thus, although the model promoted self-perpetuating and self-empowering community initiatives, the prevention services agency continued to play a key role in the process of service continuation.

EVALUATION METHODS

In order to assess the extent to which the community mobilization strategy successfully stimulated community participation in the prevention of AOD abuse, data from the larger evaluation of the CLC program were analyzed (Johnson, Berbaum, Bryant, & Bucholtz, 1995; Johnson et al., 1996; Johnson et al., 1998). The larger evaluation, which used experimental, reflective, and case study designs, focused on studying the processes and outcomes of five major program components: community mobilization, parent training, youth training, early intervention services, and case management services.

The study design for evaluating the success of the model community mobilization strategy was a multiple case study (church communities) using a priori shadow controls (staff judgments) and an adequacy of performance assessment (Rossi & Freeman, 1993; Suchman, 1967). This approach, although known to be less rigorous than experimental or quasi-experimental approaches, is appropriate when assessing a full service program, the sample size is small, no control group is available, and the gross effects can be presumed to be the same as the net effects. Studying multiple cases (church communities instead of a single one) increases confidence in the results (Yin, 1989).

To determine adequacy of performance, we employed various measures of success for each of the four mobilization stages. Within-site success is defined as getting within 10 percent of the a priori goal for each adequacy of performance measure.

In Stage I, CAT recruitment success was measured by comparing the actual number of church staff and volunteers who joined the CAT in each church community with a CAT recruitment goal of at least eight members, i.e., percent of CAT goal. In Stage II, family recruitment success was measured by comparing the number of families recruited in each of the church communities with a recruitment goal of 24 families (12 families for the experimental group and 12 for the comparison group) in each participating church community. This recruitment goal of 12 families per group was based on prior training experience, and taking into consideration group attendance, was the minimum needed to effectively implement the CLC training.

In Stage III, two measures of retention success were used to distinguish program and evaluation retention among those church community sites that implemented the CLC program. Program retention was defined as the percent difference between the number of both parents and youth who began the program compared to the number who completed the program, independent of participation in the evaluation. There was no retention rate norm to use for comparison purposes; however, a 90 percent retention rate was set as a program expectation. Evaluation retention was measured by first subtracting the number of parents and youths who completed the initial interview before the training (wave 1) from those participants who completed the interview after the training about seven months later (wave 2), and after ending the case management services 12 months after program initiation (wave 3), and then dividing each of the two numbers by the number of initial interviews at wave 1 (waves 2-1; waves 3-1). Each of these two retention rates are compared to a 70-percent rate, which tends to be the minimum rate for having evaluations published in peer-reviewed journals.

In Stage IV, we measured community capacity enhancement success by comparing the total number of initial program sites to the number of sites that achieved continuation of services. The definition of overall success in this stage is within-site success in at least four church sites in at least two of the three types of communities under study.

STUDY SITES

Questionnaires were mailed to 132 churches in the targeted service area to obtain demographic information, type of service offerings, and willingness to participate in the CLC program. Forty-two churches returned the questionnaire, of which 28 expressed an interest in participating in the program. Eleven church communities sent representatives to informational meetings and two requested site visits, for a total of 13 community sites. Based on the five selection criteria described earlier (target population size, number of social services, method of service delivery, level of participation readiness score, and church location), eleven church-based communities were selected as potential study sites. (See McKelvy et al., 1990, and Strader et al., 1997, for a detailed description of this selection process). Of these eleven sites, six study sites that were ranked as having the highest potential for program implementation success actually implemented the program. The participating church communities are described below in the sequence that program implementation was initiated.

Site 1 was an African-American, Baptist church community with a congregation of 800, which is located in West Louisville close to the downtown area. Although their evaluation readiness was low, CLC and its parent organization, Council on Prevention and Education: Substances, Inc., had a long history of providing services in this area and agreed to provide the program for the families residing in this neighborhood. The minister served as president of the West Louisville Ministerial Association, which was a collaborating entity in the grant proposal.

Church community Site 2 is in a suburb of Louisville, Kentucky, in the eastern part of Jefferson County, in a third-class, incorporated city. The church has its own school and that facility was used for all data collection. The church is in a predominantly white, middle-class area, and all participants in the program and evaluation fit that description. The third church community site was in Meade County, Kentucky, which has its seat in Brandenburg, about 45 miles southwest of Louisville. A collection of six churches, both Catholic and Protestant, banded together to participate in the CLC program. The high school building was used as the site for all data collection. All participants were white and lived in either rural or small town settings.

Church community Site 4 was in Bardstown, Kentucky, about 40 miles southeast of Louisville. One Catholic church participated in the

CLC project at this site. The Catholic church school was used to collect the data. All participants were white, middle-class people who lived in the Bardstown area.

Site 5 involved one Catholic church community in a suburban area located south of downtown Louisville. Participants were middle-class and white, with the exception of one African-American family. Data collection was conducted in the Catholic school complex.

Site 6 consisted of three churches near each other in a predominantly African-American urban community west of downtown Louisville. A proportion of the membership of these churches (one Catholic and two Protestant) did not live in the immediate church community; therefore, they commuted to church activities from other areas of Louisville and Jefferson County. All participants were African-Americans, of whom about one-half lived in the church community and the others lived elsewhere and commuted back to the church community to participate in church-related activities.

FINDINGS

Recruitment Success

Table 1 presents results about the CLC program's CAT and family recruitment success in the six participating church communities that required recruiting members for a CAT and each CAT recruiting a minimum of 24 families (12 assigned to the program and 12 assigned to the comparison group). The program successfully recruited eight members or more for all six advocate teams. In turn, the CATs in five of these six communities successfully recruited enough families to implement the program. In total, 70 CAT members and 165 families were recruited to participate in the CLC project. (COPES also initiated recruitment efforts [CAT and families] in a second project start-up in site 5, but, because the program retention and capacity enhancement data were incomplete, this project start-up is not included in this study.)

Only Site 1 (an African-American church community) failed to recruit the minimum number of 24 participating families. In this site, only three families were recruited for the program, and the CLC staff, the CAT, and the church pastor decided to terminate all implementa-

TABLE 1. Success Rate of Family Recruitment for the Creating Lasting Connections Project by Program Cycle and Church Advocate Team (CAT)

Cycle/Site	Church Community Profile	CAT Goal	No of CAT Members	Family Goal	Recruitment Actual	Percent of Goal %
Cycle One						
1	Urban/African-American/1 church	8	15	24	3	13 %
2	Suburban/White/1 church	8	10	24	39	163
3	Rural/White/6 churches	8	11	24	38	158
Cycle Two						
4	Rural/White/1 church	8	8	24	31	129
5a	Suburban/White/1 church[a]	8	8	24	28	117
Cycle Three						
6	Urban/Africa-American/3 churches	8	18	24	26	108
5b	Suburban/White/1 church[a]	8	8	24	24	100
Total			78		189	

[a] The program was implemented in this church community in program Cycle 2 and Cycle 3.

tion efforts. Failure to meet the recruitment goal in this church community may have been due to the CAT's decision to recruit families based on community need in a nearby public housing project rather than from among the congregation in general. Also, because of a low readiness score (as discussed earlier), it may have been more appropriate to work with the site leaders to increase their readiness to implement the program before attempting to recruit families.

Based on the above findings, the community mobilization strategy was judged to have been successfully implemented in the recruitment stage of the process for five of the six sites, representing sites in rural, suburban, and urban communities.

Retention Success

Table 2 presents the number and rate of program retention for parents and youth after the training and follow-up case management services phases in the participating church communities. Based on getting within 10 percent of the retention rate goal of 90 percent, the program successfully retained parents and youths in four of the five communities that fully implemented the program. The retention rate

TABLE 2. Number and Retention Rate of Parents and Youths Who Participated in the CLC Program by Church Community

	Parents				Youth			
	Entered Program	Completed Training	Completed Case Mgt.	Goal	Entered Program	Completed Training	Completed Case Mgt.	Goal
Site 2								
Number	20	20	19		24	21	20	
Rate		100	95	90		88	83	90
Site 3								
Number	19	19	19		24	24	24	
Rate		100	100	90		100	100	90
Site 4								
Number	17	17	17		24	22	22	
Rate		100	100	90		92	92	90
Site 5a								
Number	17	15	15		19	17	17	
Rate		88	88	90		89	89	90
Site 5b								
Number	15	13	13		19	17	17	
Rate		87	87	90		89	89	90
Site 6								
Number	19	13	13		25	17	17	
Rate		68	68	90		68	68	90
Total								
Number	107	97	96		135	118	117	
Rate		91	90	90		87	87	90

was lower than expected in Site 6, an African-American community, for both parents and youths. The less-than-desirable retention rate in the African-American church community may have been due to program length, which included more sessions than in other sites. Also, because of relocation and work schedules, three families dropped out of the program after the initial research interview but before the training began.

Table 3 shows the retention of evaluation participants in the five church communities that fully implemented the outcome evaluation. As these results show, the evaluation retention rate is lower than program retention for both parents and youths. It is interesting to note that the evaluation retention goal of 70 percent was achieved in the same four sites as was program retention, and that the program failed to achieve its evaluation retention goal only in Site 6, which was the African-American church community.

TABLE 3. Number and Retention Rate of Parent and Youth Evaluation Participants by Group, Church Community, and Wave

	Parent				Youth			
	Prog.[a]	Comp.	Total	Rate	Prog.[a]	Comp.	Total	Rate
Site 2								
Wave 1	20	15	35		24	18	42	
Wave 2	16	12	28		18	15	33	
Wave 3	17	12	29	83%	20	15	35	83%
Site 3								
Wave 1	19	15	34		24	20	44	
Wave 2	19	15	34		24	19	43	
Wave 3	18	14	32	94	22	19	41	93
Site 4								
Wave 1	17	14	31		24	19	43	
Wave 2	14	12	26		21	17	38	
Wave 3	13	12	25	81	18	15	33	77
Site 5a								
Wave 1	17	16	33		19	20	39	
Wave 2	16	12	28		18	15	33	
Wave 3	13	10	23	70	15	12	27	69
Site 6								
Wave 1	19	7	26		25	11	36	
Wave 2	10	5	15		15	7	22	
Wave 3	7	4	11	42	9	5	14	39
Total Retention[b]				75				74

Note: Prog. = Program Group. CAT = Church Advocate Team. Comp. = Comparison Group.

* Site 5b is not included because it was a replication and no outcome evaluation was conducted because of possible contamination.

a Includes 18 CAT parents and 21 CAT youth who participated in the program but were not included in the outcome evaluation which required participants to be randomly assigned to groups.

b Return rate = Total wave 3 aggregated across sites divided by total Wave 1 aggregated across sites.

When the overall program retention rate (completed training and case management) is used to measure success (91% [completed training] and 90% [completed case management] for parents and 87% [completed training] and 87% [completed case management] for youths), the prototype community mobilization strategy was judged to be successfully implemented in the retention stage. Further, the overall evaluation retention rates of 75 percent for parents and 74 percent for youths also suggest successful implementation.

Community Capacity Enhancement Success

In terms of community capacity enhancement success, Table 4 shows that the church communities were able to continue the AOD

TABLE 4. CLC Replication Projects Status Report

Community	Replication Status
Site 2	Completed
Site 3	Funding Not Acquired[a]
Site 4	Completed
Site 5a*	Completed
Site 6	Completed

[a] Site 2 (Rural) attempted to acquire funding for a replication project immediately after the program was completed but was unsuccessful. However, COPES is currently working on a proposal which, if funded, will provide training opportunities for this population.

* Site 5b is not included because it is the same community as site 5a.

program services after the demonstration project was completed. Four of the five sites that fully implemented the CLC program were able to obtain the funds necessary to initiate self-perpetuating AOD prevention programs, including the parent and youth training and the early intervention services. The follow-up services were not continued in any of the sites because of limited budgets. Despite their desire to continue the program services, Site 3 was unable to obtain funding. It is interesting to note that the community found to have had the smallest rates of evaluation and program retention (Site 6) was empowered to continue the program services and obtained enough funding to maintain the core CLC program.

CONCLUSION AND SIGNIFICANT LEARNINGS

We have presented here a model strategy for mobilizing church communities to implement AOD prevention programs. While individual features of the model strategy are not new to the field of AOD abuse prevention, we believe that this model, with its sequence of stages and activities, illustrates a mixture of functional community organizing and program development community practices. Based on the evidence presented, this church community mobilization strategy has proven to be highly successful in white American rural and suburban church communities. This success in white congregations occurred in multiple church communities that involved both a single church and a consortium of church organizations to participate in AOD prevention services.

Our model mobilization was only partially successful in urban African-American church communities. In one church community, we

were unable to recruit enough families to implement the AOD prevention program. In another African-American community, the program was implemented with the minimum number of participants, and program and evaluation retention was problematic; however, the church leadership was successful in raising funds to continue the AOD program service. The lack of participation in the urban African-American church congregations suggests that recruitment, retention, and continuation of services cannot be implemented using the same strategy in every community, but must be approached differentially, especially in neighborhoods of concentrated poverty. People of color, particularly those in oppressed and disadvantaged communities, have racial and cultural characteristics that need to be considered in community practice (Rivera & Erlich, 1995).

Though many in the prevention field consider the processes of recruitment, retention, and continuation of services as goals distinctly secondary to the program intervention itself, we feel that the relationship-building and maintenance that occur as a result of these efforts are absolutely inseparable from any programmed interventions designed for the community or targeted individuals. In an effort to advance the AOD abuse prevention field, we offer the following learnings from our community practice experience in the CLC project.

- Defining church congregations as communities of interest, with natural groupings and support systems which are separate from spatial/geographic boundaries, is important when implementing alcohol and other drug prevention services.
- Developing specific criteria to assess a community's readiness and implementation ability, and selecting sites based on those criteria, is a crucial component of a successful community mobilization strategy.
- Using community members in the project planning and in the implementation strategies enhances program success.
- Providing comprehensive and effective training, early intervention and case management services, incentive packages, and using community members in implementation are important elements of a community mobilization strategy.
- Systematically documenting implementation strategies and fabricating implementation and training outlines are keys to the success of service continuation efforts.

- Providing communities with technical assistance and support in resource development is essential in the service continuation process.
- Implementing a comprehensive community mobilization strategy that focuses on empowerment stimulates community interest and ongoing self-sustaining community prevention initiatives.
- Considering racial and cultural characteristics of people of color in impoverished communities can enhance the appropriateness of a community mobilization strategy.

In conclusion, we offer our community practice experience in CLC in implementing a community mobilization strategy as guidance to others who desire to mobilize church communities to prevent AOD abuse problems. It is hoped that a clear understanding of our four-stage community mobilization strategy will enhance others' success in reaching out and engaging church communities in such prevention programming.

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