Communities That Care
Youth Survey Report 2015

Supplement report:
Northern Bay College
Year 6, 8 & 10 students

Produced by the School of Psychology, Deakin University for Communities That Care Geelong.

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Contents

EXECUTIVE SUMMARY

This supplementary report was completed by the School of Psychology, Deakin University to support a collaborative project with Communities That Care Ltd. and Communities That Care Geelong, auspiced by Barwon Child, Youth and Family and supported through funding from the Department of Justice and Regulation. This report is a sub-profile of the Northern Geelong Region report:

Hall, J., Smith, R., & Toumbourou, J. (2015). 2015 Communities That Care Youth Survey Report: Norlane, Corio and Lara. Geelong: Deakin University.

This report presents basic demographic on Northern Bay College along with data collected from youth regarding the prevalence of alcohol and other drug use, the source of alcohol supply, antisocial behaviour, diet and exercise, depressive symptoms and associated risk and protective "influencing" factors that affect the healthy development of students in Northern Geelong.

The youth survey was based on the *Communities That Care Youth Survey* and adapted for online use in Australia. The *Communities That Care Youth Survey* is designed to provide information on rates of health and social problems experienced by young people and in addition to provide information on the risk and protective factors that predict these problems. These include factors within community, school, family and peer group environments that can be modified to reduce or prevent health and behavioural problems, and improve health outcomes.

Students in Years 6, 8 and 10 at Northern Bay College completed the survey.

1: PROJECT OVERVIEW

The Communities that Care Pilot Project across the Northern Geelong region (Norlane, Corio and Lara) is supported by funding through the Community Crime Prevention Unit within the Department of Justice and Regulation, Victorian Government and is delivered by Communities That Care Ltd. in partnership with Communities That Care Geelong and the School of Psychology, Deakin University.

Communities That Care (CTC) is a long-term, comprehensive, risk and protective-focused prevention strategy based on research of predictors of health and social problems. By using an early intervention and prevention framework, communities are guided towards understanding their local, identified needs, then refining, and/or developing and implementing tested, effective strategies to address those needs. In particular, the Communities That Care process provides an integrated approach to the prevention of problem behaviours, including harmful substance use, low academic achievement, early school leaving, sexual risk-taking, and violence.

The Communities That Care implementation phases are:

- *Phase 1 - Getting Started*: communities prepare for action by working to identify and recruit relevant community stakeholders and key decision-makers to the Communities That Care process.
- *Phase 2 - Getting Organised:* the Community Board, Key Leader Group and relevant governance structures are established to guide decision making and planning.
- *Phase 3 - Create a Profile:* a Community Profile Report is prepared using data gathered from youth surveys of health behaviours and risk and protective factors, archival data, and assessments of existing community resources and strengths.
- *Phase 4 - Create a Plan:* the Community Board goes through a process of identifying priorities for action, choosing relevant evidence-based programs for implementation, and creating a comprehensive Community Action Plan to guide program implementation and evaluation.
- *Phase 5 - Implement and Evaluate:* the strategies from the Community Action Plan are put in motion, and the Community Board and Key Leader Groups ensure that evidence-based programs and strategies are implemented and evaluated as planned.

The *Communities that Care Youth Survey* contributes to the CTC prevention planning efforts in Northern Geelong. The survey is designed to provide information on issues such as alcohol and drugs, mental health, diet and exercise and antisocial behaviour as well as a range of factors that can potentially impact adolescent development.

Findings from the youth survey in combination with other data sources will provide information which will help to demonstrate how local data can be used to better understand young people and develop programs that enhance their healthy development (Phase 3 of the Communities That Care process).

Participating schools and communities will directly benefit by having local data for use in planning prevention services.

For more information on the Communities that Care Pilot Project across the Northern Geelong region please contact:

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2: BASIC DEMOGRAPHIC PROFILE

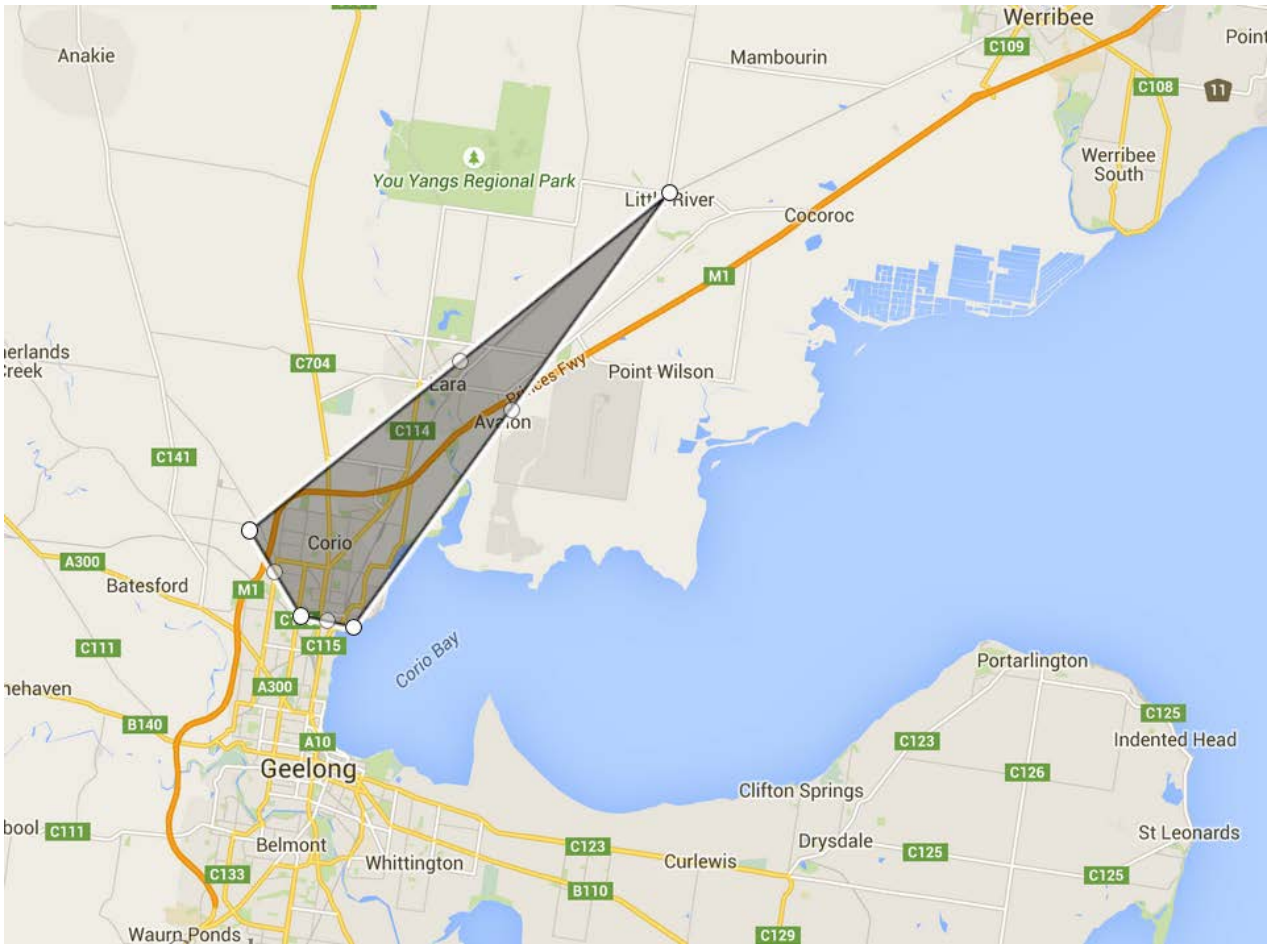
2.1 The Landscape and population

The City of Greater Geelong is located 75 kilometres south west of the Victorian capital city, Melbourne. Following Melbourne, Geelong is the second most populated area in Victoria and covers 115 square kilometres. In 2011, there were 173, 454 people residing in Geelong (significant urban area). Children and adolescents aged between 0-14 years made up 18.5% of the total population living in the region. This proportion is in line with the Victorian state 0-14 year old total population of 18.6%.

2.2 Socioeconomics

The City of Greater Geelong is relatively disadvantaged according to socioeconomic characteristics (SEIFA score = 980), in comparison to the Victorian state as a whole (SEIFA score = 1009). Geelong has a ranking of 39 in the level of disadvantage among the municipalities of Victoria.

Map 1: The highlighted section below shows the Northern region of Geelong on which the broader report is based, including: Corio, Norlane, Lara



3: THE COMMUNITIES THAT CARE YOUTH SURVEY

The survey of young people in Northern Geelong involved an online or paper-based questionnaire assessing a wide range of risk and protective factors and other behavioural outcomes. The survey took students around 45 minutes to complete.

3.1 The Survey Instrument

The survey is an Australian adaptation of the original *Communities That Care* Youth Survey developed in the United States. Adaptations were originally made to ensure the survey was culturally appropriate for young people in Australia and to broaden the scope of behaviours assessed by including measures of depressive symptoms, victimisation (Bond et al, 2000), physical activity and healthy eating. Adaptations to the original survey were also made to ensure suitability for a wide age range, from Year 5 to Year 12 students.

In 2006 and 2013 the survey was again adapted to cater for the changing needs of communities. The survey used to collect the data presented in this report has been designed to help achieve more integrated planning of prevention strategies for children and young people. The survey explores nine areas of adolescent life: About You, School experiences, Your Friends & Experiences, Your Opinions, Your Feelings, Tobacco, Alcohol & Other Drugs, Health & Personal Experiences, Your Family and Your Neighbourhood. The survey asks 326 questions.

This survey instrument measures a broad range of behavioural outcomes and risk and protective factors in four domains: Community, School, Family and Peer/Individual. Within these domains, there are approximately 30 scales with an average of 4 questions per scale.

Risk factors are factors that can predict negative behavioural and adverse outcomes, and protective factors are factors that can moderate and mediate risk factors for a range of adolescent health and behaviour problems. The following section details the risk and protective factors measured.

3.2 The Risk and Protective Framework

Risk factors are characteristics of school, community, and family environments, and characteristics of students and their peer groups, that are known to independently predict increased likelihood of harmful drug use, crime, violent behaviours, school dropout and mental health problems among youth (Hawkins, Catalano, & Miller, 1992; Hawkins, Arthur, & Catalano, 1995; Bond, Thomas, Toumbourou, Patton & Catalano, 2000; Brewer, Hawkins, Catalano, & Neckerman, 1995; Lipsey & Derzon, 1998). For example, children who live in disorganised communities with high rates of crime and drug use are more likely to become involved in crime and drug use than are children who live in areas that have low rates of these problems.

Protective factors exert a positive influence and buffer against the negative influence of risk, thus reducing the likelihood that children and young people will develop health and social problems. Protective factors identified through research include strong bonding to family, school, community and peers, and healthy beliefs and clear standards for behaviour. For bonding to serve as a protective influence, it must occur through involvement with peers and adults who communicate healthy values and set clear standards for behaviour. According to the social development model (Catalano & Hawkins, 1996) three conditions must be present in communities, neighbourhoods, schools, families and peer groups for young people to develop strong bonds to these social units:

Opportunities for active contribution and involvement in these units;

Skills to be successful in meeting the opportunities they encounter; and

Consistent **Recognition** or reinforcement for their efforts and accomplishments.

Risk Factor Definitions

COMMUNITY DOMAIN	**Low neighbourhood attachment**	Neighbourhoods where residents report low levels of bonding to the neighbourhood have higher rates of juvenile crime, violence and drug use. *Example question: 'I'd like to get out of my neighbourhood.'*
	Community disorganisation	Neighbourhoods with high population density, lack of natural surveillance of public places, physical deterioration, and high rates of adult crime have higher rates of juvenile crime, violence and drug use. *Example question: 'How much do you agree with the following statements? There are fights in my neighbourhood.'*
	Personal transitions & mobility	Young people without stability and strong personal relationships are more likely to use drugs and become involved in Anti-social behaviours. *Example question: 'Have you moved house in the past year (last 12 months)?'*
	Community laws/norms favourable to drug use	Communities where laws regulating alcohol and other drug use are poorly enforced have higher rates of youth alcohol and drug use, violence, and delinquency. Further, rates of youth alcohol and drug use and violence are higher in communities where adults believe it is normative or acceptable for minors to use alcohol or other drugs. *Example question: 'How wrong would most adults in your neighbourhood think it is for kids your age to drink alcohol?'*
	Perceived availability of drugs	The availability of cigarettes, alcohol, marijuana, and other illegal drugs is related to a higher risk of drug use and violence among adolescents. *Example question: 'How easy would it be for you to get marijuana?'*

FAMILY DOMAIN	**Poor family management**	Parents' use of inconsistent and/or unusually harsh or severe punishment with their children places the children at higher risk for substance use and other problem behaviours. *Example question: 'The rules in my family are clear.'*
	Family conflict	Children raised in families high in conflict are at risk for violence, delinquency, school dropout, teen pregnancy, and drug use. *Example question: 'We argue about the same things in my family over and over again.'*
	Parental attitudes favourable to drug use	In families where parents are tolerant of their children's alcohol or drug use, children are more likely to become drug abusers. The risk is further increased if parents involve children in their own drug or alcohol using behaviour; for example, by asking the child to light the parent's cigarette. *Example question: 'How wrong do your parents feel it would be for you to smoke cigarettes?'*
	Parental attitudes favourable to Anti-social behaviour	In families where parents are tolerant of their children's misbehaviour, including violent and delinquent behaviour, children are more likely to become involved in violence and crime during adolescence. *Example question: 'How wrong do your parents feel it would be for you to pick a fight with someone?'*
SCHOOL DOMAIN	**Academic failure**	Beginning in the late primary school grades (grades 4-6), children who fall behind academically for any reason are at greater risk of drug abuse, school dropout, teenage pregnancy and violence. *Example question: 'Putting them altogether, what were your marks like last year?'*
	Low commitment to school	Factors such as not liking school, spending little time on homework, and perceiving coursework as irrelevant are predictive of drug use, violence, delinquency and school dropout. *Example question: 'Now, thinking back over the past year in school, how often did you try to do your best work in school?'*
PEER-INDIVIDUAL DOMAIN	**Favourable attitudes to drug use**	Youth who express positive attitudes toward drug use are at higher risk for subsequent drug use. *Example question: 'How wrong do you think it is for someone your age to use marijuana?'*
	Friends use of drugs	Young people who associate with peers who engage in alcohol or substance use are much more likely to engage in the same behaviour. *Example question: 'In the past year (12 months), have any of your four best friends use marijuana?'*

Protective Factor Definitions

COMMUNITY DOMAIN	**Community rewards for prosocial involvement**	Recognition for positive participation in community activities helps children bond to the community, thus lowering their risk for problem behaviours. *Example question: 'My neighbours notice when I am doing something well and let me know.'*
	Community opportunities for prosocial involvement	When opportunities for positive participation are available in a community, children are more likely to become bonded to the community. *Example question: 'Which of the following activities for people your age are available in your community? -sports teams, scouts/guides, youth groups, community service.'*
FAMILY DOMAIN	**Family attachment**	Young people who feel strongly bonded to their family are less likely to engage in substance use and other problem behaviours. *Example question: 'Do you feel very close to your mother?'*
	Family opportunities for prosocial involvement	*Young people who have more opportunities to participate meaningfully in the responsibilities and activities of the family are more likely to develop strong bonds to the family.* *Example question: 'My parents ask me what I think before most family decisions affecting me are made.'*
	Family rewards for prosocial involvement	When parents, siblings, and other family members praise, encourage, and recognise things done well by their child, children are more likely to develop strong bonds to the family. *Example question: 'How often do your parents tell you they're proud of you for something you've done?'*
SCHOOL DOMAIN	**School opportunities for prosocial involvement**	When young people are given more opportunities to participate meaningfully in the classroom and school, they are more likely to develop strong bonds of attachment and commitment to school. *Example question: 'In my school, students have lots of chances to help decide things like class activities and rules.'*
	School rewards for prosocial involvement	When young people are recognised for their contributions, efforts, and progress in school, they are more likely to develop strong bonds of attachment and commitment to school. *Example question: 'My teachers praise me when I work hard in school.'*
PEER-INDIVIDUAL DOMAIN	**Belief in the moral order**	Young people who have a belief in what is 'right' or 'wrong' are less likely to use drugs or engage in delinquent or other problem behaviours. *Example question: 'It is important to be honest with your parents, even if they become upset or you get punished.'*
	Interaction with pro-social peers	Young people who interact with other young people who display pro-social behaviour are less likely to engage in substance use and other problem behaviours. *Example question: 'Think of your four best friends (the friends you feel closest to). In the past year (12 months), how many of your best friends have tried to do well in school?'*
	Stress/coping adaptive	When young people demonstrate positive coping strategies in stressful situations they are less likely to engage in substance use and other problem behaviours. *Example question: 'When I have a problem. I think about the best ways to handle the problem'*
	Emotional control	Young people who demonstrate emotional control are less likely to engage in substance use and problem behaviours and experience less depression. *Example question: 'I know how to calm down if I am feeling nervous'*

3.3 Method

The survey was carried out online or a paper-based version used if access to computers was limited. It was conducted in students' normal class time, taking approximately 45 minutes to complete.

3.4 Validity

To ensure survey accuracy respondents were eliminated if their surveys showed evidence that they had responded inaccurately or dishonestly. The criteria for elimination included reporting the use of a fictitious drug and self-reporting that responses had been dishonest (see Bond et al, 2000 for criteria).

3.5 Interpreting the data: *a word of caution*

As a high proportion of students in year 6, 8 and 10 in the participating schools completed the survey, the estimates presented in the following results section can be treated with relative confidence. However, estimates from student survey data should be interpreted by weighing them against other available information.

3.6 Interpreting the results

Source of alcohol: students are included in the sample if they reported they had consumed alcohol in the past year.
Risk and Protective factors: Each Risk and Protective factor item is developed based on scale (a combination of questions asked in the student survey - averaging 4 questions per scale). Students are included in the 'total valid response' if they responded to a minimum number of questions that make up this scale (e.g. if students only respond to one of four questions that make up the scale they are not included in the total valid responses).

3.8 Survey Demographics

Northern Geelong Sample

The 2015 data presented for Northern Bay College is sampled from five campuses located in Norlane and Corio. The total number of students surveyed is 287. The data was collected in May and June 2015.

Year 6 Demographics – Northern Bay College sample
Total number of students approached in year 6 = 166
Number of students surveyed* = 144
Percentage of students surveyed = 87%
Ages ranged from 11 to 13.
Males 49%; Females 51%.
Number of students who showed evidence of being dishonest** = 4

Year 8 Demographics – Northern Bay College sample
Total number of students approached in year 8 = 124
Number of students surveyed* = 89
Percentage of students surveyed = 72%
Ages ranged from 12 to 16.
Males 48%; Females 52%.
Number of students who showed evidence of being dishonest** = 1

Year 10 Demographics – Northern Bay College sample
Total number of students approached in year 10 = 80
Number of students surveyed* = 54
Percentage of students surveyed = 68%
Ages ranged from 15 to 17+.
Males 58%; Females 42%.
Number of students who showed evidence of being dishonest** = 14

*The main reason for non-participation was (a) absence from school on the day of the survey (19%) and (b) non-consent (4%).
**These students were removed from the analysis.

4: RESULTS

4.1 Behavioural Outcomes

a) Alcohol use

Adolescent alcohol use is highly prevalent in Australia, despite considerable evidence that adolescent alcohol use contributes significantly to societal suffering and burden. Patterns of alcohol use adopted in secondary school tend to strongly influence the likelihood of alcohol problems in adulthood (Loxley, Toumbourou, & Stockwell, 2004). Findings from a range of longitudinal studies have shown that the frequency of alcohol use in adolescence is strongly predicted by the age at which alcohol use is first initiated (Loxley, et al., 2004; Shortt, Hutchinson, Chapman, & Toumbourou, 2007). These findings emphasise the need to introduce alcohol prevention goals that include delaying the age that adolescents initiate alcohol consumption.

The Australian alcohol guidelines recommend that for people under the age of 18 years, not drinking alcohol is the safest option (National Health Medical Research Council, 2009).

The following section outlines the prevalence of substance use and source of alcohol supply.

Alcohol use	Year 6 (%)	Year 8 (%)	Year 10 (%)
Ever drank alcohol	21	37	53
Drank in the last 30 days	10	21	30
Binge drank in the past 2 weeks	3	9	20

b) Source of Alcohol

Student self-report data suggests adolescents access their alcohol through multiple sources (White & Bariola, 2012). These sources can be further categorised into social supply or retail supply. Social supply refers to obtaining alcohol through secondary sources, such as parents or guardians, siblings, taking it from home, friends or getting someone else to purchase for them (White & Bariola, 2012). Retail supply refers to the purchase of alcohol from an on-premise liquor venue or off-premise venue. An on-premise venue is a licensed venue where liquor can be consumed on-premise; this can include bars, pubs, clubs, sporting clubs or restaurants. An off-premise venue, otherwise referred to as a packaged liquor outlet, is a venue in which alcohol is pre-packaged and sold to be consumed off-premise, these include hotel bottle shops and liquor stores (White & Bariola, 2012). Students who reported they had consumed alcohol in the past year were asked how they accessed their last drink.

Alcohol use	Year 6 (%)	Year 8 (%)	Year 10 (%)
Student bought it	0	0	5
Parents gave it to them	50	19	56
Sibling gave it to them	14	8	6
Took it from home without permission	7	12	0
Friends gave it to me	14	8	13
They got someone to buy it for them	0	15	6
Other (supplied by relatives, stole, weddings etc.)	15	38	14

c) Antisocial behaviour and Depressive Symptomology

According to the youth survey, students in Northern Geelong are involved with a range of antisocial behaviours including carrying a weapon, being suspended from school, selling illegal drugs, attempting to steal a motor vehicle, attacking others with the intention to seriously harm, and being drunk or high at school.

Below shows the prevalence estimates of the above listed antisocial behaviours for students at Northern Bay College by year level in 2015. Below also outlines student reports of depressive symptomology during the past month.

Antisocial behaviour	**Year 6 (%)**	**Year 8 (%)**	**Year 10 (%)**
Carried a weapon	14	16	10
Threatened someone with a weapon	6	7	5
Suspended from school	9	15	15
Sold illegal drugs	2	2	10
Stolen a motor vehicle	3	3	8
Attacked someone	11	6	5
Stolen something worth more than $10	9	24	18
Been drunk or high at school	3	5	13
Been bullied recently	48	30	33
Bullied another student recently	11	17	25
Depressive symptomology (past month)	47	41	55

4.2 Risk Factors

Risk factors are common and important factors that can predict behaviour and health outcomes. An increase in levels of risk factors in a young person's environment can be associated with an increase in adverse outcomes. Risk factors can occur within the community, family, school and peer/individual domain.

The following section outlines the prevalence of *Community*, *Family*, *School* and *Peer/Individual* risk factors.

Risk Factor	Year 6 (%)	Year 8 (%)	Year 10 (%)
Community			
Low community attachment	53	53	52
Community disorganisation	30	47	47
Personal transitions & mobility	11	15	21
Community laws/norms favourable to substance use	35	55	79
Perceived availability of drugs	15	21	48
Family			
Poor family management	29	35	55
Family conflict	49	59	36
Parental attitudes favourable to drug use	12	27	49
Parental attitudes favourable to anti-social behaviour	20	36	39
School			
School failure	29	28	42
Low commitment to school	49	47	83
Peer/Individual			
Rebelliousness	14	20	18
Favourable attitude towards drug use	14	27	65
Friends' use of drugs	3	15	30
Sensation seeking	18	19	26
Rewards for antisocial behaviour	4	3	3

4.3 Protective Factors

Protective factors are key factors that can moderate or mediate potential risk factors. Similar to risk factors, an increase in levels of protective factors in a young person's environment can enhance protection against adverse outcomes. Protective factors can occur within the community, family, school and peer/individual domain.

Protective Factor	Year 6 (%)	Year 8 (%)	Year 10 (%)
Community			
Community opportunities for prosocial involvement	44	56	52
Community rewards for prosocial involvement	64	76	66
Family			
Family attachment	78	67	58
Family opportunities for prosocial involvement	71	40	39
Family rewards for prosocial involvement	60	40	36
School			
School opportunities for prosocial involvement	48	43	15
School rewards for prosocial involvement	46	44	23
Peer/Individual			
Religiosity	44	42	25
Belief in moral order	74	68	57
Interaction with prosocial peers	67	60	38
Emotional control	66	64	74
Coping with stress-Adaptive	58	59	48
Social competencies	46	43	33

4.4 Diet and Exercise

The following section outlines the diet and exercise behaviours of youth at Northern Bay College.

Physical Activity

Being physically active every day can have social benefits, emotional and intellectual benefits, and health benefits. Australia's Physical Activity and Sedentary Behaviour Guidelines for Young People (13 – 17 year olds) recommends for health benefits:

- Young people should accumulate at least 60 minutes (and up to several hours) of moderate to vigorous intensity physical activity every day, and include a variety of activities.

Australia's Physical Activity and Sedentary Behaviour Guidelines for Young People (13 – 17 year olds) recommends to reduce health risks:

- Young people should limit use of electronic media for entertainment to no more than two hours per day, and to break up long periods of sitting as often as possible.

Fruit and Vegetable intake

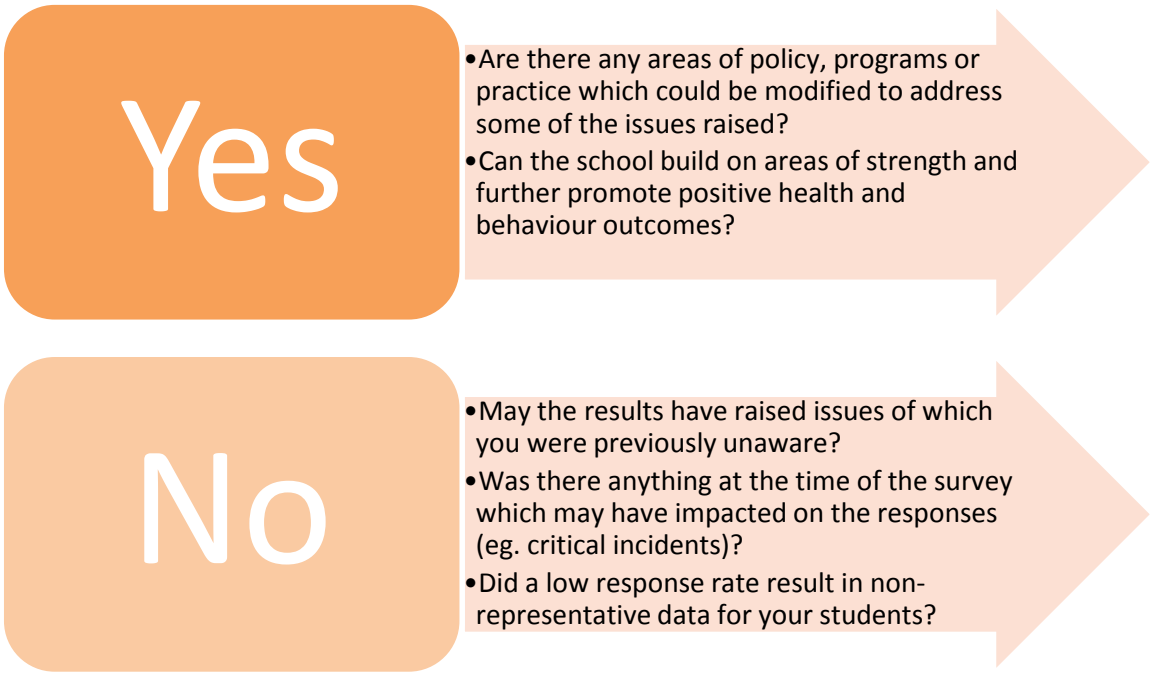
The Australian Dietary Guidelines provide recommendations based on scientific evidence that aim to promote health and wellbeing, reduce the risk of diet-related conditions, and reduce the risk of chronic diseases. These guidelines recommend for young people aged 9 to 18 years the daily intake of fruit is 2 serves and 5 serves of vegetables/legumes/beans per day. Young people are also encouraged to enjoy a variety of foods from the other three food groups each day, and to eat a healthy breakfast every day. Foods high in kilojoules, saturated fat, added sugars, and added salt should be limited.

Diet and Exercise	Year 6 (%)	Year 8 (%)	Year 10 (%)
Meet physical activity guidelines	26	12	6
Meet sedentary behaviour guidelines	59	28	26
Eat breakfast everyday	41	31	32
Meet recommended vegetable intake	28	20	9
Meet recommended fruit intake	46	35	22
Meet dietary guidelines fruit and vegetables	26	15	9

5: IMPLICATIONS

This report was prepared by Communities that Care Ltd. to support the Department of Justice and Regulation funded *Communities that Care Pilot Project* in Northern Geelong. The project is a collaboration between Communities That Care Ltd. and Communities That Care Geelong, auspiced by Barwon Child, Youth & Family.

Does this information fit with your own impressions of the health and behaviour issues effecting the students at your school?



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The Communities That Care Approach to Prevention

The current report has presented results from the Northern Bay College Youth Survey based on the *Communities That Care Youth Survey*; it is designed to complement the implementation of the Communities that Care process in Northern Geelong. Communities That Care (CTC) is a comprehensive, community wide, risk focused prevention strategy based upon research on predictors of health and social problems. The approach is theoretically grounded in the social development model (Catalano & Hawkins, 1996; Catalano, Kosterman, Hawkins, et al 1996). Professors David J Hawkins and Richard Catalano, from the University of Washington, Social Development Research Group, developed the CTC program to provide a framework for community intervention aimed at modifying factors that undermine healthy youth development (Hawkins, Catalano & Associates, 1992).

The process begins by identifying 'key leaders' with influence over organisational collaborations and/or resources in a specific community. These leaders participate in a training program explaining the CTC approach and its implications for directing resources into evidence-based prevention programs. With the support of key leaders, the CTC process is implemented and focuses initially on building local capacity for community prevention. The community mobilisation aspects of CTC are further developed through the establishment of a Community Prevention Board bringing together formal and informal community leaders and intervention personnel. The Community Board is provided with training and assistance to develop a local prevention strategy plan. Local prevention strategies are developed using a variety of information sources. School survey data assessing a comprehensive range of community risk and protective factors is an important information source, however, other information is also important to the assessment process including local community knowledge and values, demographic data and service analysis information. Local assessment information is used to diagnose community needs and set priority intervention targets aimed at reducing elevated risk factors and increasing depressed protective factors. A list of evaluated interventions that effectively target risk and protective factors is made available to inform the development of local intervention strategies.

Through these steps, CTC aims to assist local community boards to select evidence-based interventions tailored to fit local conditions. Once a local prevention plan has been approved, CTC then provides intensive training and support to ensure rigorous implementation of the selected community interventions (Hawkins, Catalano et al., 1992). Evidence for the effectiveness of the Communities That Care process comes from a large community randomised trial completed in the United States (Hawkins et al, 2008; Hawkins et al, 2009) and evaluations of the experience implementing the CTC process in Pennsylvania (Greenberg et al, 2005).

CTC Ltd. was formed through an initial partnership between the Royal Children's Hospital, Centre for Adolescent Health and the Rotary Club of Melbourne, Victoria, with the aim of providing advice and assistance implementing the CTC program in Australia. The CTC process has been successfully adapted and trialled in Australian communities since 2002 (Kellock, 2007). Previous Australian community re-survey results (Williams & Smith, 2007) have revealed population-wide improvements in youth reports of community social environments and reductions in problems such as alcohol and drug use.

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