Implementation and adaptation in Colombia of the Communities That Care

Implementación y adaptación en Colombia del sistema preventivo Communities That Care

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Abstract

For more than two years, Corporación Nuevos Rumbos (Colombia) has been carrying out, in eight Colombian communities, a preventive system called *Comunidades Que se Cuidan (CQC)*, an adaptation of *Communities That Care (CTC)*, created at the University of Washington (Seattle), developed for more than 25 years in the United States of America and implemented in eight countries of America, Oceania, and Europe. The system is based on the public health approach, and the social development strategy for community empowerment. The core idea is to teach communities how to make decisions based on data regarding drugs and alcohol consumption and the identification of protective and risk factors, on the basis of the original survey validated in Colombia: these will allow communities to choose the best preventive interventions, tailored for each of them according to their needs. This paper describes the process of implementation of CQC in Colombia, its differences with CTC, the creation of Colombian cut-points, the main difficulties and how these were solved. CQC seems to be a preventive system with a wide potential applicability in other Latin American countries.

Key Words: Communities That Care (CTC), prevention, drug use, risk factor, protective factors.

Resumen

La Corporación Nuevos Rumbos (Colombia) viene implementando hace más de dos años en ocho comunidades de Colombia, el sistema preventivo *Comunidades Que se Cuidan (CQC)*, adaptación de *Communities That Care (CTC)*, creado en la Universidad de Washington en Seattle, que ha sido desarrollado por más de 25 años en los Estados Unidos y en ocho países de América, Oceanía y Europa. El sistema busca que, a través del empoderamiento comunitario y empleando el enfoque de la Salud Pública y en la estrategia de desarrollo social, las comunidades tomen las mejores decisiones basadas en los datos de prevalencias de consumo y en la identificación de los factores protectores y de riesgo (basada en la utilización de la encuesta original validada en Colombia) y puedan escoger las estrategias de intervención probadas que más se ajusten a sus necesidades. Este documento describe el proceso de implementación en Colombia, sus diferencias con CTC, la creación de *puntos de corte propios* para el país, las principales limitaciones en el proceso de adaptación y cómo se abordaron. CQC aparece como un sistema preventivo que puede tener amplia aplicabilidad en otros países de América Latina.

Palabas clave: Comunidades Que se Cuidan, prevención, consumo de drogas, factores de riesgo, factores protectores.

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Emergence of Communities That Care (CTC)

At the end of the 1980's, J. David Hawkins and Richard Catalano, professors at the University of Washington in Seattle, created a preventive system known as *Communities That Care (CTC)*. This system, based on the social development strategy and on the approach to public health, is also supported by the integration of three major elements: work aimed towards community empowerment, the regular application of the "Youth Survey", and a "Menu" of proven and effective programs available to communities (Catalano, Arthur, Hawkins, Berglund & Olson, 1998; Hawkins, Catalano & Arthur, 2002).

CTC has enjoyed nearly 25 years of permanent implementation and evaluation, which support its development conceptually and theoretically with high quality empirical data collection, which has generated its recognition as being one of the best preventive systems in the western world (Brown, Hawkins, Arthur, Briney & Abbot, 2007; Brown, Hawkins, Arthur, Briney & Fagan, 2011; Feinberg, Greenberg, Osgood, Sartorius & Bontempo, 2007; Hawkins, Catalano & Miller, 1992; Rhew, Brown, Hawkins, & Briney, 2013; Social Development Research Group, 2014). Likewise, CTC is being implemented in the United States (more than 400 communities), Canada, Australia, Netherlands, Germany, United Kingdom, Croatia, and Cyprus. In Spain, one of its main instruments, the survey to measure the prevalence of drug consumption and risk and protective factors, has been used (López & Rodríguez, 2010) and it is being validated in Chile and Brazil, India, Sweden, and countries of Central America (Guatemala, Honduras, and El Salvador) have shown interest or are using certain elements of the system.

CTC as a preventive system

This system is based on the concept of *Community Coalitions*, leading to the reduction of social disorganization, the promotion of effective community rules against the consumption of psychoactive substances, delinquency, and other adolescent problem behaviors (violence, academic failure, and pregnancy), and the appropriation by the community of preventive activities (France & Crow, 2005). Having the community as its main axis, a number of objectives are focused on its organization and the training of members of the Community Boards; other goals are related to the implementation of effective programs and the permanent evaluation of protective and risk factors of problem behaviors. It has the following main objectives:

- To provide training to communities about concepts related to the science of prevention and data-based planning exercise;
- To identify, prioritize, assess, and monitor protective and risk factors in each community, through the application of an instrument and the use of local file data, for a focused planning;
- To create inter-institutional networks and a common language of prevention;
- To implement tested and effective *programs* focused on priority protective and risk factors in the communities, to reduce problem behaviors in adolescents;
- To assess the existing community resources and the interventions carried out from the viewpoint of the action plan.

The reason why CTC is a *system* and not a program refers to the articulation of the processes of community empowerment, the development of community profiles, and the construction of a menu of proven and effective programs. These elements are explained below:

- *A process of community empowerment i*n which, throughout the first four phases, the notions related to the science of prevention, and also the individual and institutional relationships necessary to support the implementation and monitoring of an action plan, are strengthened among community members;
- The development of a *community profile* based on community file data and a diagnostic tool called the "Youth Survey", which was tested in seven states of the United States, with a sufficient sample of students (n = 172.628; Briney, Brown, Hawkins & Arthur, 2012; Brown, Graham, Hawkins, Arthur, Baldwin, Oesterle, Briney, Catalano & Abott, 2009; Glaser, van Horn, Hawkins, Arthur & Catalano, 2005). The original CTC questionnaire is aimed at evaluating 25 risk factors (RF) and 13 protective factors (PF) in the four domains proposed by CTC (family, community, school and peers, and individual; Arthur, Hawkins, Brown, Briney, Oesterle & Abbott, 2010; Arthur, Hawkins, Pollard, Catalano & Baglioni, 2002; Hawkins, 2006), and it places students at high and low risk or protection by means of cut-points. In the United States, the psychometric characteristics of the questionnaire have been widely studied; the results have shown that this instrument has high reliability, as well as good construct and predictive validity both for men and for women, as well as in different ethnic groups, including Latinos (Arthur et al, 2002; Briney, Brown, Hawkins & Arthur, 2012; Glaser, Van Horn, Arthur, Hawkins & Catalano, 2005). In the Colombian case, the Youth Survey assesses with 103 items psychoactive substance consumption behaviors and the risk and protective profile, divided into 11 of the 23 risk factors of the original survey, and three protective factors (see Table 1);
- Construction of a *"menu" of preventive programs* that have been assessed, and are used by each Community Board in order to deal with priority risk factors, the result of the development of the community's profile.

Goal

To describe the process of implementation and adaptation of the CTC to the sociocultural conditions of Colombia, indicating why it is not possible to use the system in the same way as it was used in the country where it was created.

CTC Phases

The system is divided into five cyclical phases:

1. *Beginning*: the community's disposition toward change is assessed, actors are identified, leaders are recruited, and the support of the schools to apply the survey of protective and risk factors is obtained.
2. *Organize, introduce, and involve*: A coalition is formed that will extend over the five phases, and the main adult actors are trained. A vision of the future is developed for the children of the community, and a structure is organized to be able to move in that direction. Two trainings are carried out: leaders' orientation on prevention, and how to organize a Community Committee, which will be the highest authority when making decisions.
3. *Development of a community profile*: A phase in which the Youth Survey is administered to the young people; the chosen leaders receive training on how to interpret the protective and risk factors, and on that basis, they suggest which ones are the priorities. The community programs, policies, and resources concerning the existing risk and protective factors are also evaluated.
4. *Action plan:* The Community Board reviews the results of Phase 3 and develops an action plan, based on a training in community planning. Programs, practices, and policies that can change the risk factors and problem behaviors are chosen. Goals and measurable objectives are proposed.
5. *Implementation*: Training for the implementation of the community plan is offered, considering the importance of sticking to the guidelines of the system, of the financial aspects of the implementation, and of the elements that will allow the adequate assessment of the results.

The implementation of CTC in Colombia 2011-2014

Colombia is a country in which the problem of drug abuse has had a major impact, which has increased due to phenomena such as drug trafficking and guerrillas (Pérez Gómez, 2013). Also, as demonstrated by the Pan American Health Organization (PAHO) (Monteiro, 2013), and national studies (Ministry of Justice and the Law, Ministry of National Education, and Ministry of Health and Social Protection, 2011), the country presents a high consumption of alcohol, which particularly affects very young populations.

Although there have been no major developments in the field of prevention in the country, significant changes in this area that grant great importance to community and neuropsychological dimensions (Sloboda, 2014) have attracted the attention of the national authorities and institutions dealing with prevention.

In 2007, Nuevos Rumbos (hereafter, New Directions) established contact with the Social Development Research Group (SDRG) of the University of Washington, in order to learn more about the preventive system and to determine the conditions to carry it out in Colombia. This contact led to creating a version in Spanish of the Youth Survey and to the translation of all the material available from CTC by the team of New Directions, with the permanent support of the creators of the system. The efforts were rewarded in the year 2011, when the PAHO and the Ministry of Health and Social Protection (MSPS) invited the Corporation to pilot the system in two communities in the country, under the name "Comunidades Que se Cuidan" (CQC; Communities That Care). One of the communities was made up of a group of neighborhoods from the city of Bogota, and another was a municipality 25 km away. Eight months later, a third community from the department of Cundinamarca was added to the pilot experience, and this time, the system was included in the Committee of psychoactive substances of the municipality. One and one half years after the first experience, with the support of the Colombian Institute of Family Welfare, the implementation of the first four phases of the CQC was initiated in five municipalities of the coffee region, where high levels of consumption of alcohol and drugs among adolescents are observed, as well as other social problems.

In general, we attempted to maintain high fidelity to the CTC, but given the sociocultural differences of communities in comparison with the United States, we introduced some changes that are described below:

1. In Phase 1, to ensure the adequate implementation of the system, New Directions decided to personally coordinate, train, and accompany the communities, whereas in CTC, the trainer is hired by an entity, usually an NGO, and fulfills the functions of coordinator and person in charge of the process in that community (Brooke-Weiss, Haggerty, Fagan, Hawkins, & Cady, 2008). Although the Municipal Administrations, as a local contribution, appointed some of its officials as coordinators, their functions were far from those expected by the system, as New Directions was in charge of the convocation, the meetings with the key leaders, the meetings of the Community Board, and the definition of strategies to attract new members to the group, among other aspects. When the first cycle of the system was implemented, the coordinators began to assume functions that were much more committed and responsible, this time with the accompaniment, but not the leadership, of New Directions.

Another important element in the development of Phase 1 was the construction of a flexible and effective measurement instrument of *readiness to change*, as, in the initial meetings, much interest in participating is always expressed by the Community Board, but its members may not represent all the sectors of the community, they may not be true leaders who support the process in the future, or the community's present moment may not be optimal to start a CQC in its municipality. This instrument mainly measures the disposition of the leaders, of the community in general, and the strength of the community ties, and it is based on a simpler instrument designed by the University of Washington (Arthur, Hawkins, Catalano & Olson, 2002)

2. The second part of Phase 2 (Orientation of the Community Board - OCB) was performed a few weeks after introducing the system to the key leaders, whereas in CTC, this is done between one and three months later. The goal is to give the leaders, together with the contracted coordinator and the contracting agency, enough time to invite and enhance the process of convocation of the people who will become members of the Community Board (Brooke-Weiss et al., 2008; SDRG, 2014).

   Additionally, during its pilot study, the CQC did not divide the general group into subgroups because the small number of people (12-15) permanently attending the meetings was insufficient for the development of the six working groups proposed by CTC (data, funding, evaluation, public relations, maintenance of the coalition, and youth involvement: SDRG, 2014). Once Phase 4 had ended, due to the even closer knowledge of the experience and to our contact with the Masters of Trainers of the United States, three of the eight community boards constituted to date formed working subgroups in order to ensure the continuation of the system when New Directions leaves the communities; the working groups were Maintenance, Financing, and Evaluation. The first group is concerned with attracting new members and training in the basics of CQC; the second group, with permanent funding for the implementation of the action plans; and the third group is in charge of designing and implementing the evaluation plans of the programs and practices selected in Phase 4 and of the system in general.

3. The construction of community profile in Phase 3 began from the moment in which we contacted the local authorities, so that we had all the data when the communities, between 2 and 3 months after the process started, were developing the community map, in terms of consumption of psychoactive drugs and of protective and risk factors in the four prevention areas. This training phase included the entire group of the Community Board and not subgroups, as foreseen in CTC, which, in most cases, prompted a delay in its development because not all the members could or were interested in taking over the data collection and analysis on an ongoing basis. The division into subgroups would ensure that these tasks would remain in the hands of epidemiologists or those responsible for the follow-up of the social phenomena of each community, and would be adequately handled and used.

4. A menu of programs should be developed to carry out the process of planning in Phase 4 (Fagan, van Horn, Hawkins & Arthur, 2007; Ringwalt, Vincus, Hanley, Ennett, Bowling & Haws, 2010). The construction of our menu did not include experimental assessments because neither in Colombia nor in Latin America are this type of evaluations common. In contrast, we performed quasi-experimental assessments and with these, we constructed the menu of programs used by the communities to select the programs to be implemented in Phase 5, with the following result: there are 15 programs used nationwide, but only one (Anímate [Cheer up!]) has conducted systematic assessments for 13 years with nine measurements (Aja Eslava & Gómez Avila, 2013); seven programs have some sort of monitoring (perception of risk, information about assessment tools, systematizations or baselines and closure lines; these programs are: Consentidos, Sanamente, Familias Fuertes, Leones Educando, Habilidades para la Vida, CEMA-PEMA/NEF-PIP, Zonas de Orientación Escolar [Spoiled, Healthily, Strong Families, Educating Lions, Life Skills, CEMA-PEMA/NEF-PIP, School Orientation Areas]), and seven perform no evaluation (Colombia Joven, Experiencias para Vivir y Convivir, ACJ-YMCA, Fundación CreSer, Caminos, Retomemos [Young Colombia, Experiences to Live and Coexist, ACJ-YMCA, CreSer Foundation, Pathways, Retake, and DARE])[1]. At the time of formulating the action plan, the communities chose to implement the two programs with the most developed assessment (Anímate and Consentidos [Cheer up! and Spoiled/With meanings]). To overcome this difficulty, the Boards also identified other practices that could respond to the priority factors identified in Phase 3, and some strategies were considered to change the methodology and facilitate the implementation of the selected programs and practices. Likewise, New Directions offered a set of strategies to

1 At the end of 2014, New Directions received training in a program of proven effectiveness with Hispanic population in the United States, Familias que se cuidan: encaminándolos hacia buenas decisiones" [Families that care: Guiding Good Choices]. There are contacts with the GIZ in Germany, whose program, Thousands of Hands, is being used in Central America.

support those that were already available in the community:

- Training sessions for community leaders, parents, and teachers, in order to clarify and unify concepts related to prevention; in these sessions, they described protective and risk factors, the importance of coalitions to solve social problems, and of addressing the use of alcohol and drugs among adolescents from a public health perspective.
- Strategies for adequate use of leisure time: the community develops options for adolescents to occupy their time productively, in moments in which they are more prone to consume alcohol and other psychoactive drugs, for instance, sports and cultural activities created by the communities in accordance with the inhabitants' interests.
- Brief interventions:
  - BIMI (Brief Intervention with Motivational Interviewing): this is implemented with adolescents at school, mostly in the eighth and ninth grades. The program consists of a first intervention, two follow-ups, and two interventions with the parents, inspired by motivational interviewing, and accompanied by a screening instrument (CRAFFT/CARLOS) (Harris et al., 2012; Knight, Sherritt, Harrys, Gates & Chang, 2003; Pérez-Gómez & Scoppetta, 2011; Substance Abuse and Mental Health Services Administration, 1999). This latter instrument places the student at a level of risk so that each one of the participants will consider a goal of decreased consumption or delay in their age of onset. Follow-ups are carried out on the basis of this self-imposed goal, and interventions with parents are conducted based on the risk factors that were most predominant in each school.
  - "Capsules of humor": are short videos (3 minutes), in which a known actor ridicules situations related to the consumption of alcohol or other substances. The videos stimulate reflection based on identification with the character and also serve to demystify consumption-related issues and to clarify doubts.
- *Profession: being a parent*: This book is designed for parents, with information about alcohol and drugs, sexuality, eating disorders, bullying, and other problems of adolescence, as well as tips for handling specific situations and small questionnaires that help parents identify and respond to these situations.
- Basic training of the community in assessment processes, so they will be able to carry out or monitor the assessment of their programs and practices, as one of the pillars of CQC.
- The use of 'the Mystery Shopper' practice in order to prevent the sale of alcohol to minors and as a form of social control.

In CTC guidelines, each phase has lasts between one and three days, with an approximate intensity of eight hours per day; in CQC, the trainings are performed according to the specific agreements reached in each community, and are usually scheduled weekly or biweekly, with a duration of each meeting of two and four hours, respectively. This is proposed because a large number of the Community Board members are not volunteers, and they must comply with public functions that do not allow them several free days each month to attend the training sessions.

Throughout the implementation of CQC in eight communities, it was observed that the communities whose Phase 5 could be financed immediately, with their own or with external resources, were more successful. Ideally, during the first four CQC phases, the communities restructure and optimize the budget allocated to prevention, but this time, focusing on the priority factors identified by the instrument used to construct the community profile.

The lack of file data in the small municipalities of Colombia, the potential communities to implement CQC, is one of the greatest difficulties. Therefore, the data about juvenile delinquency, drugs, or incidents associated with the consumption of alcohol in these municipalities have been replaced with unofficial information or indirect indicators.

Instrument

Currently, the reliability and construct validity of the CQC questionnaire (available at www.nuevosrumbos.org) has been analyzed with data from 33.790 students. The results showed a high and moderate internal consistency in the risk factors and high in the three protective factors (see Table 1). Construct validity analysis is currently being conducted through confirmatory factor analysis for ordinal data. This process is carried out in the framework of a project with the University of Washington and NIDA, and the results will be revealed in future publications. So far, the fit of the measurement models of each risk and protective factor has been adequate, with values less than or equal to .08 for the *root mean square error of approximation* (RMSEA) and equal to or greater than .95 for the *comparative fit index* (CFI) and the *Tucker Lewis index* (TLI).

Cut-points

As mentioned above, the CTC Youth Survey has cut-points that place students at a high or low level of risk and protection. These cut-points, developed by the Social Development Research Group of the University of Washington (Arthur, Briney, Hawkins, Abbott, Brooke-Weiss & Catalano, 2007), were found to have high sensitivity and specificity in U.S. population and ethnic minorities.

Table 1
Reliability Coefficients of the Risk and Protection Factors assessed in the CQC Youth Survey

Risk factors	**Cronbach's alpha**
Perception of drug availability	0.81
Rules and regulations favoring drug use	0.69
Parents' attitudes towards drug use	0.57
Poor family management	0.83
Low commitment to school	0.70
Youth perceived risks of drug use	0.70
Favorable attitudes of youth towards drug use	0.79
Favorable attitudes of youth toward anti-social behavior	0.86
Drug use in friends	0.76
Antisocial behaviors in friends	0.76
Parents' favorable attitudes towards antisocial behavior	0.67
Protective factors	
School rewards for prosocial involvement	0.76
Family opportunities for prosocial involvement	0.92
Family rewards for prosocial involvement	0.89

Note. We could not perform factor analysis of the risk factors that have no values in the fit indices because of the low number of items in these two factors (three items each).

Initially, the cut-points of the United States were used to establish the profiles in Colombian communities; however, in some cases, the data seemed counter-intuitive: risk decreased with age, and lower grade students (sixth grade) seemed to be at higher risk in some factors. For this reason, we decided to calculate the cut-points for the Colombian population using the 33.790 surveys.

We calculated the cut-points for these communities using the methodology of Arthur et al. (2007). The procedure was performed for each risk and protective factor on an individual basis, as well as for each grade level.

In comparison with the cut-points of the United States, their calculation for the CQC communities revealed: (a) differences in the profiles of nine risk factors; (b) the cut-points of CTC and CQC tend to become more similar as the school grade increases for the community risk factor, "Rules and regulations favoring drug use"; and, (c) a community risk factor that was not very different, "Perception of drug availability", was found. Figure 1 shows an example of three community risk factors, using the preliminary cut-points calculated by the New Directions Corporation for CQC and those of CTC.

It is important to highlight that these cut-points have been used only to submit the data to the CQC communities because these data are adapted to the distribution of the data, and they do not correspond to a representative sample of the country. The New Directions Corporation is gathering new data to calculate cut-points that can be standardized for the Colombian population.

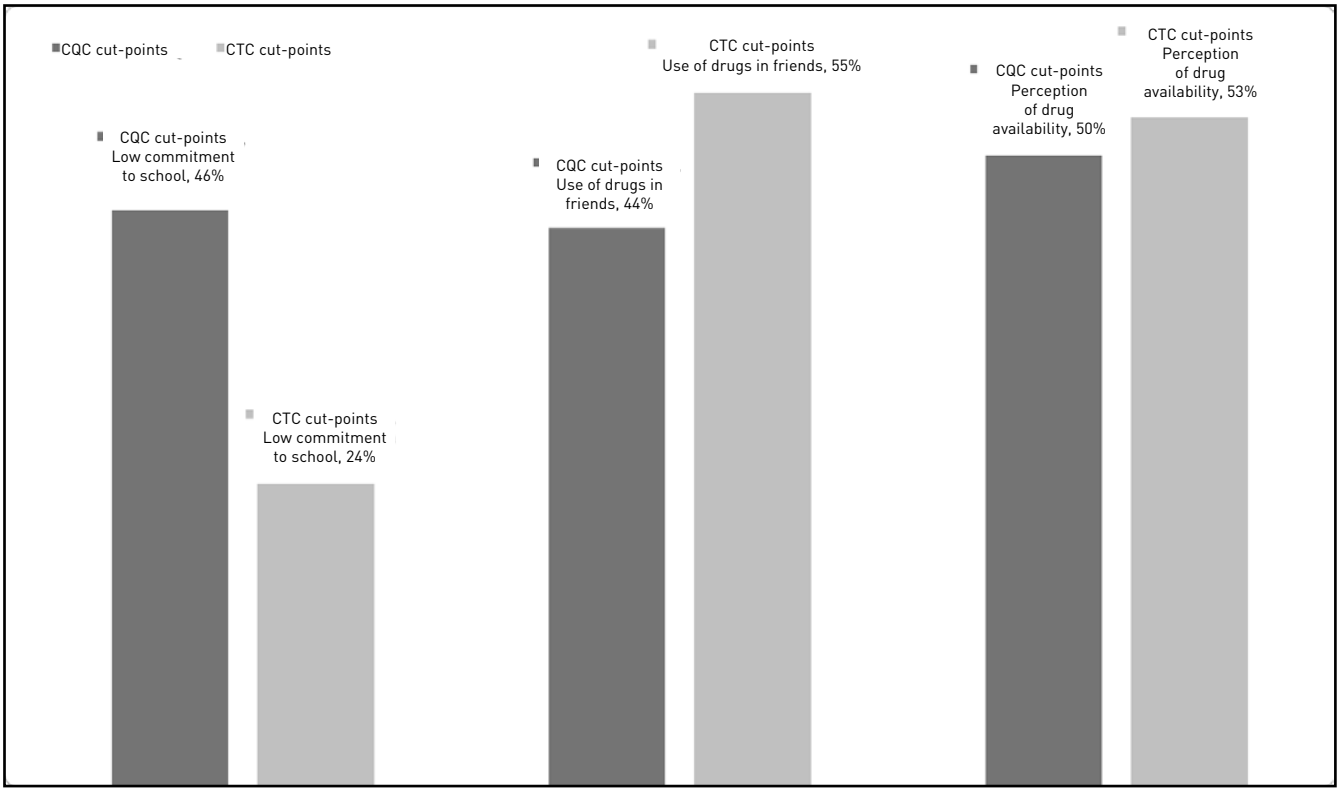

Figure 1

Table 2
Comparison of lifetime, yearly, and monthly prevalence rates of consumption of psychoactive drugs from the data of the CQC Youth Survey and from the national prevalence of drug consumption among students

Psychoactive substances	Prevalence rates					
	Lifetime		Yearly		Monthly	
	EJCQC[a]	National	EJCQC	National	EJCQC	National
Alcohol	76,9%	63,4%	72,9%	56,7%	40,0%	39,8%
Tobacco	31,0%	24,3%	24,9%	16,1%	11,3%	9,8%
Marihuana	14,2%	7,0%	12,1%	5,2%	5,7%	2,8%
Cocaine	1,7%	2,4%	1,2%	1,9%	0,3%	1,0%
Basuco	0,6%	0,7%	0,4%	0,5%	0,1%	0,2%
Inhalants	5,1%	3,1%	3,5%	1,8%	0,9%	0,9%
Ecstasy	1,4%	1,2%	0,9%	0,8%	0,1%	0,4%
Mushrooms	2,2%	N/a	1,5%	N/a	0,3%	N/a
Acids	1,9%	1,5%	1,3%	1,0%	0,3%	0,4%
Tranquilizers	1,2%	1,1%	0,9%	0,8%	0,2%	0,4%
Poppers	1,9%	2,5%	1,2%	1,4%	0,3%	0,6%
Amphetamines	0,2%	N/a	0,1%	N/a	0,0%	N/a
Heroin	0,3%	0,5%	0,1%	0,4%	0,0%	0,2%
Dick	5,8%	4,1%	3,7%	2,7%	0,7%	1,3%

Note. [a] Youth Survey for CQC.

Risk and Protection Profiles of the CQC Communities

Information about almost 37,000 high school students, aged between 11 and 18 years, from six municipalities of Quindío and three of Cundinamarca, were collected in a total of 31 schools, of which 28 were public and 3 were private. Fifty-two percent of the students were female and 48% were male. After refining the sample, 33.790 surveys were retained. The survey was applied in grades sixth to eleventh, to all of the students who attended class on the day of the application.

As shown in Table 2, the population studied with the CQC Youth Survey presented a lifetime and yearly prevalence greater than the one shown by the national study (Ministry of Justice and Law, Ministry of Education and Ministry of Health and Social Protection, 2011) in alcohol, tobacco, marijuana, and inhalants. It is important to highlight that the consumption of marijuana in the population studied by CQC presents a lifetime, yearly, and monthly prevalence that is twice that of the national data.

The students' risk and protection profiles of the communities studied as a function of grade level can be observed in Table 3. In general, it was found that the parents' attitudes towards drug use was the lowest risk factor, that community risk factors seem to be homogeneous, especially as the school grade increases. On the other hand, the youngest people appear to be at increased risk compared with the participants of higher school grades in the risk factors of poor family management, low commitment to school, anti-social behaviors in friends, and in the two community risk factors.

Regarding protective factors, 40 to 50% of the participants were found to be at a high level of protection. Another finding was that the protective factors are relatively homogeneous in all grades and tend to decrease as the grade increases, with the exception of the family protective factor acknowledgment of prosocial involvement.

Discussion

The prevention of the use of psychoactive substances has come a long way in its 45 years of existence. The complexity of the problem has led a growing number of researchers to explore a large number of variables and relationships among them, generating a greater understanding of the phenomenon, the factors that determine it, and ways to influence them through proven and effective prevention programs (Bukowski, 2003; Hawkins et al, 2002; O'Connell, Boat & Warner, 2010; Sloboda, 2014).

CTC/CQC seems to be a highly promising preventive system for the countries of Latin America. Even though

Table 3
Risk and Protection Profile per Grade

CQC Domain	Risk factors	Percentage of students at risk by grade					
		6	7	8	9	10	11
Community	Perception of drug availability	47%	49%	45%	44%	41%	44%
	Rules and regulations favoring drug use	47%	47%	45%	39%	43%	46%
Family	Parents' favorable attitudes towards antisocial behavior	42%	36%	43%	42%	40%	40%
	Parents' attitudes towards drug use	31%	39%	31%	36%	40%	44%
	Poor family management	49%	45%	42%	43%	43%	45%
School	Low commitment to school	47%	50%	49%	40%	43%	49%
Peers and individual	Youth perceived risks of drug use	41%	47%	40%	38%	48%	48%
	Favorable attitudes towards youth drug use	39%	41%	37%	45%	49%	37%
	Favorable attitudes toward youth anti-social behavior	41%	42%	48%	49%	47%	47%
	Drug use in friends	42%	49%	44%	42%	48%	47%
	Antisocial behaviors in friends	48%	44%	38%	48%	45%	41%
	Protective factors	Percentage of protected students by school grade					
		6	7	8	9	10	11
School	School rewards for prosocial involvement	46%	39%	45%	43%	41%	40%
Family	Family opportunities for prosocial involvement	51%	49%	45%	45%	41%	44%
	Family rewards for prosocial involvement	36%	49%	44%	37%	34%	35%

the authors (David Hawkins & Richard Catalano) have always considered that the key to success is the correct selection of the prevention programs in Phase 5 (Haggerty & Shapiro, 2013; Haggerty, McGlynn-Wright & Klima, 2013; Hawkins et al., 2002; Shapiro, Hawkins, Oesterle, Monahan, Brown & Arthur, 2013; Steketee, Oesterle, Jonkman, Hawkins, Haggerty & Aussems, 2013), the experience in Colombia shows that the first four phases consolidate processes in the community that no other preventive strategy has achieved: solidarity, awareness of responsibility for the future of our youth, the need to identify risk and protective factors and to change them whenever possible and necessary, and to systematically evaluate problem behaviors and ways to deal with them. This is the necessary condition for the successful implementation of the action plans.

Even when fidelity is undoubtedly an essential element to ensure the smooth functioning of the system and the programs (Fagan, Hanson, Hawkins & Arthur, 2008; Fagan, Arthur, Hanson, Briney & Hawkins, 2011; Quinby, Hanson, Brooke-Weiss, Arthur, Hawkins & Fagan, 2008), the Colombian experience, like that of some other countries (Jonkman, Junger-Tas & van Dijk , 2005; Jonkman, Haggerty, Steketee, Fagan, Hanson, & Hawkins, 2009; Steketee et al., 2013), shows that there are a series of adaptations that must be implemented due to cultural reasons, to the communities' functioning, or to unforeseeable conditions and special circumstances. In the case of Colombia, although the elements introducing variations in the system structure were not changed, numerous changes were carried out in training routines, in some contents (elements were removed or added according to the needs), the timing was modified (for example, the profiles were presented at the beginning of the process to awaken the communities' interest), and public employees were involved as members of the Community Boards. The only point that

can be considered a structural change was the beginning of Phase 5, with very few tested and effective programs, and our helping the communities to grant more importance (temporarily) to the activities that they defined as suitable. New Directions also offered a set of practices which are being assessed at the present time and that are based on principles that are currently considered universal (NIDA, 2003; OPS, 2010).

The results showed that the psychometric analysis of the instrument and of the cut-points is essential to ensure an accurate diagnosis. This process contributes to the generation of measurement technologies in the area of prevention in the Latin American context.

The prevalence of use of drugs such as alcohol, tobacco, marihuana, and inhalants was much higher than the national averages in populations in which the implementation of CQC has been requested. The rest of the substances have very similar consumptions; the exception is cocaine, which presents lower consumption rates than the national average (MJD, MEN & MSPS, 2011).

Most communities consider community risk factors— the availability of drugs, and rules and regulations favoring substance use— to be a priority. In this case, a confounding factor is the very high prevalence of alcohol and the marked tolerance in most of the country with regard to its consumption in minors. This should lead to an analysis in which legal and illegal psychoactive drugs are separated.

A final reflection emerges from having been immersed for more than two years in the study of CTC: although CTC/CQC is a highly flexible *system*, in general, the preventive *programs* are not. The best proof of this may be what happened with the most famous of all, Life Skills Training (LST). A recent study (Luna-Adame, Carrasco-Giménez & Rueda-García, 2013), carried out with extreme rigor to avoid the criticism of lack of fidelity, showed null results in Spain in the prevention of the onset of smoking in adolescents, which supposedly is the area in which LST is more effective. This fact is not surprising: LST was created 30 years ago, and has not suffered any kind of modifications, whereas the world has changed enormously during this period, especially for adolescents. Its authors , Gilbert Botvin, and Kenneth Griffin (2004), have maintained that their program is very efficient, and they have rejected criticism, refusing to introduce changes. Other authors have reported similarly poor results (Gorman, 2011; Johnson, Shamblen, Ogilvie, Collins, & Saylor, 2009; Vicary et al., 2004, 2006). This same outcome is probably occurring with many other prevention programs.

However, logic leads to thinking that this way of proceeding means that all prevention programs will be very outdated with regard to reality within a few years, which would jeopardize the entire functioning of CTC. This means, in short, that:

1. Preventive programs must be updated constantly, which creates some difficulties with regard to assessments;
2. We need to develop preventive programs that are easily modifiable without altering their core structure, which is responsible for the achievements. They should also contain flexible and reliable evaluation processes.

Limitations

The following can be considered the main limitations of this study:

The collected surveys do not constitute a representative sample of the country, so we require new calculations in other regions. Also, new adaptations may be needed in different communities, such as the Pacific region, the Eastern Plains, or the Caribbean coast.

The very limited availability of tested and effective prevention programs advises taking the results obtained in Phase 5 with caution. There are currently five programs, and we will very likely soon have Miles de Manos (Thousands of hands], GIZ -Deutsche Gesellschaft für Internationale Zusammenarbeit) and United Families (University of Miami).

There are no reliable data outside of the big cities.

This work should be considered an invitation to try out one of the best existing systems of prevention in Latin America and the Caribbean. In addition to all the benefits mentioned above, implementation costs are modest, and it has its own assessment strategy, which will facilitate the adjustments and allow making comparisons and accurately identifying what may or may not be modifiable.

Conflicts of interest

There are no conflicts of interest.

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