

**Report on Community Level Indicators for the
Guilford County Substance Abuse Coalition
4 April 2008**

Vincent T Francisco, PhD
Greer B Cook, BS BA
Mekia Barclift, MPH
Chad Schaben, MPH
Caitlin Brandt

Department of Public Health Education
University of North Carolina at Greensboro
437a Health and Human Performance Building
Greensboro, NC 27402-6170

Introduction

Overall History of the Project

Our interest in this project began subsequent to the initial invitation by then chair of the surveillance committee, Caroline Moseley. Ms Moseley requested the assistance of Dr Francisco due to his extensive experience with community coalitions and partnerships for a wide variety of community improvement and health-related outcomes, and especially for his prior work on community partnership evaluation that included the development of comprehensive surveillance systems. Subsequent meetings with the surveillance committee revealed that the approach offered by Dr Francisco would be of use to the Guilford County Substance Abuse Coalition (GCSAC). Additional meetings with the GCSAC Executive Director, George Coates, and a team of professionals put together by Dr Francisco led to the development of this project.

Project Purpose and Objectives

Based on this initial round of meetings with leadership from the coalition, the following mission, broad objectives, and specific next steps were developed pursuant to the drafting of a contract.

MISSION:

In collaboration with GSAC, to enhance the development of community capacity to prevent drug use through the development of community-level indicators related to locally-salient dimensions of illicit drug use.

BROAD OBJECTIVES:

- Facilitate the identification of potential community-level indicators with GSAC leadership, members and associated community partners.
- Help GSAC develop a plan to use the data to facilitate a prevention agenda.
- Develop a proposal to investigate the connection of new and modified programs, policies, and practices relating to community development and drug use prevention to changes in outcomes at the community level.

II. Components/Objectives:

- A. Facilitate the identification of potential community-level indicators with GSAC leadership, members and associated community partners.

Scope of Work:

1. Starting with the GSAC strategic plan and broad knowledge of the current science, brainstorm potential indicators.
2. Convene several meetings to discuss indicators and data sources.
3. Collect as much data as is available publicly, and analyze the data by accuracy and sensitivity.
4. Provide a report, to include recommendations for next steps to continue this process for as long as may be useful.

- B. Help GSAC develop a plan to use the data to facilitate a prevention agenda.

Scope of Work:

1. Based on the data collected at the community-level, and the summary report generated, convene a series of meetings to discuss next steps related to drug use prevention in Guilford County.

2. Provide a report that makes recommendations for what additional work can be done in Guilford County to facilitate a prevention agenda.
- C. Develop a proposal to investigate the connection of new and modified programs, policies, and practices relating to community development and drug use prevention to changes in outcomes at the community level.

Scope of Work:

1. Based on earlier work in this project, and on previous work with communities in this area, facilitate a conversation among GSAC leadership, members and related community organizations about how to work together to enhance the prevention agenda related to drug use.
2. Work to develop a funding proposal that might allow this level of collaboration and evaluation that would facilitate community goals in this area.

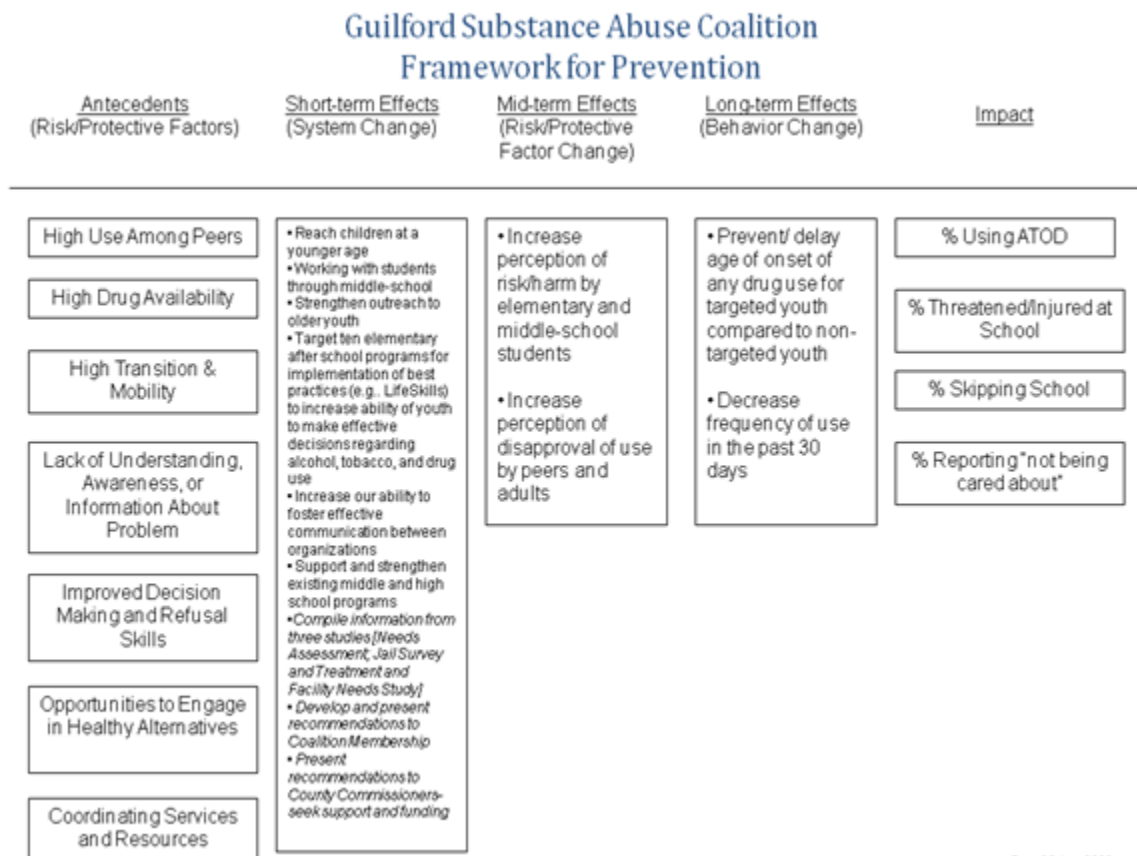
A contract was executed in June of 2007, and work began on the project. It was anticipated that the first year of the project would specifically focus on the development and analysis of initial indicators, and that the rest of the work would happen subsequent to the initial objective which would likely extend to subsequent years of the project.

Approaches to Developing and Using a Surveillance System

There are at least 3 approaches (or purposes) to developing and using a surveillance system. One is the development of broad community goals and accountability. This is often seen as a community “report card.” A second is for the grounding of initiatives pursuant to program evaluation and planning. A third is the development of new priorities for systems change in the community as they relate to the mission of the community partnership or coalition. While these are not mutually exclusive, it was clear from initial conversations that all three purposes were important to the leadership of the GCSAC.

Review of Materials and Logic Model Development

We began this project with a comprehensive review of documents associated with GCSAC. These documents included grant proposals, evaluation reports, strategic planning and other communication materials from the Coalition. Several meetings with Executive Director allowed us to clarify our understanding of the contents of these documents, and the following draft “implicit” logic model was developed to further aid us in narrowing down the list of indicators to those that might be helpful.



The framing of this logic model was solely to aid our research team, and was not meant to represent all of the purposes of the coalition. As we continued to work on the development and analysis of indicators, the coalition continued to clarify its work and develop an action plan that would be broader than the initial purpose from the Drug Free Communities grant proposals. Current goals of the GCSAC include:

- Establish and maintain a stable and functioning coalition.
- Conduct a comprehensive needs assessment that includes an inventory of resources and identification of gaps.
- Encourage the implementation of best-practice principles for substance abuse prevention, treatment and after-care programs.
- Establish and maintain an ongoing monitoring and planning of services system; and
- Raise community awareness of substance abuse through social marketing, education and advocacy.

The development of this report proceeded with all of this in mind.

Best Practices and Processes related to Community Mobilization for Substance Abuse Prevention

Before summarizing and discussing the community level indicators, we felt it important to consider several best practices and processes that would be useful in developing recommendations and next steps in this project.

Community Engagement

Community engagement involves the mobilization of resources and organizations with the sole purpose of creating policy, practice, or program changes within a given community (Fawcett et al, 1995). Individuals and organizations working towards community engagement are often unified by geographic proximity, shared interests, or other commonalities that preclude their ability to impact health in a successful manner. Previous studies have utilized several frameworks to conceptualize community engagement. These frameworks have included social ecology, cultural influences, community participation, and capacity building (Hatcher, 1997).

The social ecological perspective postulates that individuals operate within systems, which exert influence over their ability to change behavior. Behavior is thought to be a function of one's larger social or cultural context, with community engagement efforts being focused on multiple strategies. Community engagement efforts seek to target the individual, social networks and support systems, organizations, and policies (Goodman et al, 1996).

Because behavior is influenced by culture, culturally sensitive strategies must be employed by community engagement efforts if they are to be received by the community. Cultural sensitivity includes understanding how culture influences one's perceptions towards health and health-related decision-making, particularly if it is different from that of the researcher's.

Community participation is vital to the community engagement process. Community participation encourages ownership and personal control over one's environment, involvement in the process, and interaction with others sharing similar interests. Additionally, it builds the community's capacity to deliver environmental changes for existing problems. Community participation allows communities to be a catalyst for change.

The community engagement process embodies empowerment among individuals, organizations, and communities (Hatcher, 1997). Community empowerment is the mobilization and organizing of individuals, organizations, and communities in order to create action, influence, and decision-making on important issues. Empowerment enables improved decision-making ability and the likelihood of desired outcomes in that empowerment that occurs at any one level is likely to influence other levels (Fawcett et al, 1995).

Finally, community capacity building is essential to community engagement in fostering individuals and organizations with resources, knowledge, and skills beyond their current capacity. The community engagement process provides the opportunity for researchers to address the needs of the community, while improving the sustainability of community engagement through collaborative action and problem-solving.

Community Mobilization

Collaborative engagement aims to improve population-level health by creating and sustaining change within different sectors of the community (Roussos & Fawcett, 2000). Several assumptions exist to facilitate such community change. Namely, collaborative engagement assumes that the collective goal is unattainable to individuals or groups working alone. Community change works best when there is a diversification of membership, whereby ideas that are essential to achieving goals are shared and when consensus has been obtained by the group.

Risk and protective factors have been used to evaluate the effectiveness of community engagement in addition to more distant health outcomes measures. Community engagement could result in widespread changes to many risk and protective behaviors, although the magnitude of change is often unanticipated (Roussos & Fawcett, 2000).

Community change refers to new or modified programs, policies, and practices that are facilitated by the community engagement process. Community engagement aimed at establishing community change has been criticized for its inconsistent collection, making it difficult to compare the rate of change over time. There are also significant challenges in estimating the public health significance of change. Because change can have varying degrees of success, more emphasis is needed to understand how communities can choose changes with greater public health significance. According to *The Community Toolbox* (2007), changes that have been shown to promote sustainable community change include:

1. Analyzing information relating to the problem, goal, or factor
2. Clarifying the group's vision and mission
3. Developing an organizational structure and operating mechanism
4. Developing a framework or model of change
5. Developing and using strategic and action plans
6. Arranging for community mobilization
7. Developing leadership
8. Implementing effective interventions
9. Assuring technical assistance
10. Documenting progress and using feedback
11. Making outcomes matter
12. Sustaining the work

Vision, Mission, Objectives, Strategies, and Action Planning (VMOSA)

Community engagement can be achieved through the establishment of a strategic plan or VMOSA. VMOSA is an acronym for vision, mission, objective, strategy, and action planning intended to assist communities in accomplishing their plans for change. Vision describes how a group sees the ideal conditions for a community. Mission reflects what will be done and why these steps will be taken to accomplish these goals. The mission should be concise, outcome-oriented, and inclusive. Objectives are specific and measurable results intended to achieve one's broad goals. Strategies explain how the objectives will be accomplished and action plans are specific changes and steps necessary to meeting the mission (*Community Tool Box*, 2007).

Because this process also aids in the development of systematic processes that can increase the overall efficiency of programs and prioritization of other community actors, the following steps could be used to develop VMOSA:

1. Collect information about problems in community (CLIs)
2. Engage key leaders and stakeholders to develop community change plan
3. Engage others in the community to become involved with GCSAC
4. Document the specific changes that GCSAC wants to see within the community and what steps are required to reach this objective

7 Factors Related to the Success of Community Coalitions and Partnerships

The success of community partnerships can be measured by changes that occur within the community. Community improvement can also result from the work of these partnerships. There are seven modifiable factors that can influence partnership success and community improvement (Fawcett, S., Francisco, V., Paine-Andrews, A., and Shultz, J. 2000).

1. **Clear vision and mission-** When objectives are clearly defined by the partnerships higher rates of community change may occur.
2. **Action planning-** Through this strategy, plans for community changes are developed and the steps required to create the changes are identified.
3. **Leadership-** The ongoing process of creating and supporting leadership efforts enables the opportunity for community changes to develop.
4. **Resources-** Identification of available resources is vital for healthy communities as well as the development of additional resources.
5. **Documentation and feedback-** Collecting and assessing relevant community-level indicators is necessary to create community change. The feedback process allows for recognition of accomplishments in the community.
6. **Technical assistance-** Provides capacity partnership members to understand community issues, acquire new skills, and to develop resources.
7. **Making outcomes matter-** After collecting and analyzing community changes, progress reports can be created and disseminated to stakeholders.

Social Capital

Social capital is a key building block in producing high-functioning communities, neighborhoods, and organizations, just as financial capital, physical capital and human capital allow firms to produce goods and services (Community Foundation of Greater Greensboro, 2007). Social capital is measured by surveying communities nationwide and Greensboro was selected for both the baseline survey in 2000 and in 2006. Social connectedness and community engagement are the two areas that are considered to have an impact on social capital.

Social connectedness is measured by relationships with family, friends, and strangers in the community. Community engagement is measured through active participation within the community and in activities that promote community well-being (Community Foundation of Greater Greensboro, 2007). The results of the 2006 survey found that Greensboro residents are active in community engagement, enjoy good social networks, but there is a lack of trust with outsiders to their community. The report concluded that engagement without trust results in contentiousness and this is remedied by greater community engagement (Community Foundation of Greater Greensboro, 2007).

Collaborative Empowerment

The implementation of an empowerment model and framework can assist collaborative partnerships develop and improve the health of a community (Fawcett, S., Paine-Andrews, A., Francisco, V., Schultz, J., Richter, K., Lewis, R., Williams, E., Harris, K., Berkley, J., Fisher, J., and Lopez, C. 1995). The first dimension of the model involves individual or group factors. These factors include recruiting new members for the partnership, understanding the community, and embracing the diversity of the members as it relates to community change. The second dimension involves environmental factors. Barriers to this factor may influence the rate of community change and support from the community in the form of collaboration will enhance

positive outcomes. Empowerment capacity and outcomes is the final dimension. This dimension may vary over the life of the coalition and the partnerships that are created, directly effecting community change.

The framework for collaborative partnerships consists of five components: collaborative planning; community action; community change; community capacity and outcomes; and adaptation, renewal, and institutionalization (Fawcett, S., et al. 1995). Encouraging community involvement with the planning process contributes to implementing change. Community actions are activities in which the collaborative partnerships make changes in the community. Community changes are new or modified programs, practices, or policy changes. Community capacity is built when the efforts of communities to implement change occur. Adaptation, renewal, and institutionalization refer to the ability of collaborations to adjust strategies, seek new funding opportunities, and create long-term capacity building opportunities.

Description of Community-Level Indicators

The following section offers a summary and analysis of community level indicators that were selected from a much larger set available. There are three important considerations for community level indicators. Accuracy refers to how well the indicators represent the world at large. Many indicators were available but were not accurate due to biases inherent in the data collection and/or summary process. Sensitivity refers to how likely the indicators are to move with the kinds of interventions put into place in the community. Feasibility refers to the

Outcome 1: Alcohol availability and use (Table 1 and Figures 1-7)

There are approximately 20 Alcohol Beverage Control (ABC) retail locations in Greensboro and High Point According to North Carolina Crime Control and Public Safety, in 2007, there were 17,500 licensed restaurants and night clubs in North Carolina (2007). As of March 28, 2008, there were 1,440 active permits in Guilford County for all alcohol sales requiring a permit by the ABC (ABC, 2008). Since 2001, the numbers of liquor law violations in Greensboro have fluctuated yearly with a notable increase in 2003 (Figure 1). According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), North Carolina residents age 14 years of age and older consumed 1.99 gallons of alcohol per capita in 2005.

We examined data generated from the Youth Risk Behavior Survey (YRBS) for Guilford County and North Carolina and when Guilford County data was unavailable, we collected data from the United States to assess alcohol use among adolescents. In 2003, 40% of all students in both Guilford County and North Carolina reported using alcohol during the last 30 days. When students were asked about binge drinking, there was a significant difference between them, 8% of Guilford County students, and 21% of North Carolina students. In 1995, youth were asked about their lifetime use of alcohol, this was the last year this question was asked in North Carolina. 68.9% of students in North Carolina and 80.4% of students in the United States reported lifetime use of alcohol. Data for lifetime alcohol use among students is not available for Guilford County. In Guilford County 19.9% and 22.2% of North Carolina students used alcohol before the age of 13.

Data from the Behavioral Risk Factor Surveillance System (BRFSS) was collected and analyzed for alcohol usage trends among adults from 2001 through 2006 in Guilford County and North Carolina. When Guilford County adults were asked about heavy drinking (males more than 2 drinks a day/females more than 1 drink a day), the data fluctuated from year to year. The highest rate for Guilford County was 5.4% in 2001, which dropped to 2.1% in 2002, and in 2006 increased to 4.7%. In North Carolina, heavy drinking rates fluctuated from 4.1% in 2001 and in 2006 decreased to 3.4%. Binge drinking is defined as drinking more than five drinks on one occasion and the data for Guilford County and North Carolina fluctuated from 2001-2005. Overall, Guilford County rates were higher than North Carolina (except for 2002), in 2001, the rates were 10.6%, and this increased to 15.3% by 2006.

According to the North Carolina Department of Revenue (2006), the following excise taxes are imposed upon alcoholic beverages. Beer: 5¢ per can or 12 ounce bottle, unfortified wine is taxed at 21¢ per liter, fortified wine is taxed at 24¢ per liter, and excise tax on liquor room ABC stores is 25%. Additionally, for restaurants that sell liquor “by the drink”, an additional tax of \$20 on each four liters is levied on liquor purchased by restaurants or clubs for sale by the drink (NCDOR, 2006). According to the ABC, approximately \$2,007,353 in alcohol taxes paid for alcohol treatment or other public health programs (2005).

Outcome 2: Tobacco availability and use (Figures 8-12)

The YRBS, which was administered in 2003 asked students about tobacco use and we collected data for Guilford County and North Carolina. Among high-school students, 26.7% in Guilford County and 24.8% in North Carolina reported the use of tobacco over the past 30 days. When asked about tobacco use on school property, 13.1% in Guilford County and 10.1% of students in North Carolina responded with “yes”. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports substance abuse data at the state level through National Outcome Measures (NOMs). According to SAMHSA, the NOMs *have defined embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities*” (2006). The NOMs for North Carolina surveyed 12-17 year-olds who disapproved of their peers smoking one or more packs of cigarettes a day. In 2004, the NC NOMS found that in North Carolina 86.4% of students disapproved of peers smoking, which was slightly lower when compared to 88.1% of students in the United States. This question is not asked on the YRBS and Guilford County data is not available.

Among adults, data was collected through the BRFSS about tobacco use in Guilford County and North Carolina. When we analyzed the data from 2001-06 we found that overall North Carolina had higher rates of smokers when compared to Guilford County. However, since 2001, the rates of adult smokers in Guilford County and North Carolina have decreased. The number of worksites that prohibit smoking in public and private areas is also surveyed. From 2001 to 2006, the rates of worksites prohibiting smoking in Guilford County and North Carolina have fluctuated. Overall, the rates have varied from 70% to 79% with North Carolina showing slightly higher rates than Guilford County. From 2001-2006, the number of adults that smoke in North Carolina has decreased by just over 3%. However, in Guilford County the rates increased then decreased and went back to the same rates as found in 2001.

In North Carolina, the amount of money that is spent on tobacco marketing increased steadily from 1999 through 2003. In 2004, tobacco marketing expenditures began decreased by 4.46%. When looking at the data over this seven year period, an increase of 104.12% has occurred with tobacco marketing. Currently, there is an excise tax of 35¢ per pack of cigarettes and products other than cigarettes are subject to a tax of 3% of the wholesale price (NC Department of Revenue, 2006).

In North Carolina, strict regulations are in place for vending machines, they must be under control of the manager or licensee of the premises or employee to activate the sale of any tobacco products and vending machines are permitted in establishments open to persons 18 years of age and older (North Carolina Crime Control and Public Safety, 2005). In 1997, Governor Hunt designated Alcohol Law Enforcement (ALE) to reduce the rate of tobacco products that underage youth through retail outlets and vending machines by 20% in 2001 (NCDHHS, 2008). In 2005, the Red Flag Enforcement Campaign was launched, now the Department of Motor Vehicles color coded driver's licenses. If a driver is underage their license has a red background, this is to help retailers comply with the prohibition of selling tobacco products to minors (NCDHHS, 2008).

According to 100% Tobacco-Free Schools, Guilford County schools are 100% smoke-free and 105 North Carolina school districts are 100% smoke-free (2008). In Guilford County, 67.6% high school students in this region are exposed to secondhand smoke at least one day or more per week (NCDHHS, 2005). Also, it is estimated that 40 million children are exposed to secondhand smoke at home (Campaign for Tobacco Free Kids, 2000). In the United States, more than 4,000 teenagers try their first cigarette with half of them becoming regular smokers (Campaign for Tobacco-Free Kids, 2007).

Outcome 3: Substance abuse related crime data (Figures 14-20, Tables 2-3)

We obtained crime data for the city of Greensboro from the Greensboro Police Department (GPD) related to driving while intoxicated (DWI), drug incidents and charges, and general crime reports. From 2005 to 2006, the number of alcohol related accidents increased by 19.5%, alcohol related accidents with injury increased by 11.2%, and DWIs increased by 13.6% (2006). The rate of drug incidents increased 9.7% and drug charges increased by 8.9% from 2005 to 2006 (GPD, 2006).

In 1995, the Governor's Highway Safety Program began the Booze It and Lose It campaign in North Carolina. Through this initiative, sobriety checkpoint and saturation patrols are organized state wide to reduce the numbers of drunk drivers in North Carolina. A variety of local law enforcement officials are involved with each campaign, which are usually scheduled around holidays in which alcohol is usually consumed (e.g. New Years, St. Patrick's Day). From 2002 through 2007, the Booze It and Lose It campaign led to the arrest of 1,034 persons driving while intoxicated (DWI) in Guilford County (GHSP, 2007).

From 2001 to 2007 in Greensboro, the number of violent offenses and property crimes appeared to be consistent with each other with the trends following both categories. Violent offenses include murder, rape, robbery, and aggravated assault. Property crimes include burglary, larceny, and auto theft. In 2001, there were 1,951 reports of violent offenses and 14,005 reports of property crime. In 2002, these numbers decreased and continued to decrease until 2004 when they rose and fluctuated until 2007. In 2007, there were 2,028 reports of violent offenses and 14,701 reports of property crime.

In Guilford County, the number of violent offenses and property crimes fluctuated from 1996 to 2006. In 2006, violent offenses were slightly higher than the numbers in 1996 and property offenses had decreased considerably from 1996 to 2006 (North Carolina State Bureau of Investigations [NCSBI], 2008). Data for the number of arrests categorized by age (e.g. juveniles and adults) was also examined for 2000- 2006. The numbers for violent offenses and property crimes decreased substantially during this time frame for both populations (NCBSI, 2008).

In 1998, the National Institute on Alcohol Abuse and Alcoholism implemented the Arrestee Drug Abuse Monitoring Program (ADAM). In an effort to look at the relationship between substance abuse and violent crime, arrestees were surveyed about their use of alcohol or drugs and asked to submit a urine specimen for testing. Arrestees who reported using alcohol were more likely to have been booked for a DWI or a public disorder charge. Arrestees who tested positive for cocaine were more likely to have been charged with property related offenses.

Outcome 4: Illicit Drug Use- Figures (23-26)

To assess the rates of substance abuse in Guilford County, we collected available data from the last YRBS, which was administered in 2003. This data was compared with North Carolina YRBS data for that year as well. When students were surveyed about ecstasy, 7.2% of Guilford County and 9.2% of North Carolina reported using the drug. The rates for heroin use were almost the same at 2.9% Guilford County and 3.0% in North Carolina. Students in Guilford County who have used methamphetamines reported in at 5.2% and 6.6% of students in North Carolina reported using the drug.

The percentage of high-school students that reported being offered, sold, or given illegal drugs on school property was slightly higher in Guilford County when compared with North Carolina at 31.9%. Guilford County surveyed both middle and high-school students in 2003; we were unable to locate data for North Carolina middle school students regarding drug use. Over twice as many Guilford County students reported cocaine use, 7% compared to 3% in North Carolina. The use of inhaled solvents was the same for both Guilford County and North Carolina at 15%. The rates for marijuana were much higher in Guilford County as well, 43% compared to 24% in North Carolina. Steroid use was also the same for both Guilford County and North Carolina at 5.2%. Among middle-school students in Guilford County, 4% have used cocaine. 12% inhaled solvents, 10% marijuana, and 3.7% have used steroids.

In North Carolina, data was collected for SAMHSAs NOMs from 2002-2006 about the percentage of youth who disapprove of peers using marijuana. When compared with the United

States the rates were similar over the four year period at around 80%. This question is not asked at the county level, only at the state level.

Outcome 5: Treatment availability and use (Figures 27-30)

In Guilford County, there are over 50 organizations that offer substance and alcohol abuse treatment (GCSAC, 2008). In North Carolina, data was collected for SAMHSAs NOMs from 2002-2006 about treatment and substance and alcohol abuse. The population with the highest number of persons needing but not receiving treatment was age 18-25. The rates were consistently higher than the other age groups (12-17 and 26+) from 2002-06 for both illicit drug use and alcohol abuse.

In 2005, the NOMs survey inquired about two separate questions related to alcohol use: alcohol dependence and alcohol dependence or abuse. The 26+ age group numbers were substantially higher for both questions than the 12-17 and 18-25 age groups. Also, two separate questions were asked about illicit drug use: illicit drug dependence and illicit drug dependence or abuse, with the 26+ age group being substantially higher than the 12-17 year age group and slightly more than the 18-25 year age group. From both of these tables it appears that the participants reported higher levels of alcohol abuse or alcohol dependency than illicit drug use or dependence.

Outcome 6: Community Asset Data (Figure 31)

Data was collected through SAMHSAs NOMs in 2002 through 2006 to assess the percentage of youth who have reported exposure to substance abuse prevention messages. Data was compared between North Carolina and the United States. The variance between the two populations showed little change from the original 92% reporting exposure to prevention messages in 2002.

Outcome 7: Economic Related Data (Figure 32)

The BRFSS, which is conducted through random telephone surveys, features a series of questions dedicated to health care access. The rates of residents who do not have health insurance including health maintenance organizations or government plans like Medicare were compared between Guilford County and North Carolina. From 2001 through 2005, North Carolina had consistently higher rates of uninsured residents when compared with Guilford County. However, in 2006 both North Carolina and Guilford County had the same rate of uninsured residents. In North Carolina, approximately 1,772,068 people were enrolled in the Medicaid program in 2006 (NCDHHS). The number of children in North Carolina receiving Medicaid in 2006 was 34,058 (NCDHHS).

The North Carolina Department of Health and Human Services (NC-DHHS) reported that in 2006, the unemployment rate in Guilford County was 4.4% and 4.7% in North Carolina (2007). As of March 28, 2008, the unemployment rate in Greensboro and High Point had risen from 4.6% last fall to 5.4% in January 2008 (U.S. Department of Labor Bureau of Labor Statistics, 2008).

Outcome 8: Educational Attainment and Enrollment (Tables 6 - 7)

From 2003- 2007, schools in Guilford County and North Carolina reported attendance rates around 95% each year. This figure includes elementary, middle, and high school data. The dropout rate for Guilford County for 2004-05 was 2.98% and for 2005-06, the rate increased to 3.41%. In North Carolina, the 2004-05 dropout rates were 4.74% and in 2005-06 increased to 5.04%.

Outcome 9: Gang Activity (Figure 33)

In 2006, the Greensboro Police Department began collected data related to gang activity in the city. The largest number of offenses was found to be in the category of vandalism. This included auto vandalism, graffiti, and malicious damage of residential or non-residential locations. Other offenses that increased from 2006 to 2007 were burglary and drug possession and sales.

Recommendations

There are six (6) recommendations for next steps offered by this research team. These recommendations reflect most of the 7 Factors associated with the success of initiatives similar to the GCSAC.

1. Develop greater clarity about substance abuse issues across the lifespan, and how the problems associated with substance abuse changes over time. It will be important to be as targeted as possible in the further development of the GCSAC mission so that success will be likely.
2. Develop an Action Plan for systems changes (e.g. new and modified programs, policies and practices) that taken together will contribute significantly to the resolution of substance abuse and problems associated with substance abuse. It will be important that these planned systems changes reflect the diversity of populations (esp. those most at-risk), sectors (or channels of influence) in the community, strategies for behavior change, and durations (e.g., short term, long term) to effect enough change in the environment so that widespread behavior change will result. This research team has extensive experience in leading and coordinating the development of this kind of plan with diverse communities.
3. Develop and make use of a documentation system to track the accomplishments of GCSAC and related organizations in accomplishing the mission of GCSAC. While the basic elements of such a system can be found at the Community Tool Box (<http://ctb.ku.edu/>) in the Table of Contents (Chapter 38, Section 3), an online system is already developed and can be used by GCSAC through the Community Tool Box. This online system has features that include a high level of security, a high level of data integrity across systems changes and community level indicators, and can automate the development and deployment of monthly, quarterly and annual evaluation reports for the coalition.

4. Enhance Current Data Systems

It will be important to work with the Guilford County Public Schools on the implementation of the Youth Risk Behavior Survey, and get additional youth data important to the understanding of how youth risk for substance abuse is changing over time. These additional data can be obtained in a variety of ways, including the addition of questions to the schools' YRBS administration, or strategic random sampling of youth in the community. It will be important to also work with the Police and Sheriff's offices to enhance their data reporting to be more geographic and longitudinal. We were not yet able to get data broken down by substance abuse issues, nor could we yet obtain data prior to 2005. These departments are working on the additional data requests, but it may take some time and advocacy to make sure that it is available to all interested parties in the future. It will be important to have longitudinal data to allow for the establishment of trends, and for evaluation of community initiatives.

5. Develop an Enhanced Logic Model for GCSAC

An example of this kind of logic model is offered earlier in this report. Given that the goals and purposes of GCSAC are broader than youth substance abuse prevention, developing clarity about these additional purposes will only enhance the work of the coalition.

6. Develop measurable health objectives using these (and other relevant) data.

It is important to hold the coalition and the community accountable using reliable benchmarks for progress. It is also important to establish clear and challenging goals to facilitate forward movement on difficult (and often intractable) problems such as substance abuse.

References

- 100% Tobacco Free Schools of North Carolina. (2008). Select a district. Retrieved February 13, 2008, from <http://www.tobaccofreeschoolsnc.com/SelectedDistrict.aspx>
- Campaign for Tobacco-Free Kids. (2008). State cigarette excise tax rates and ranking. Retrieved February 13, 2008, from <http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf>
- Campaign for Tobacco-Free Kids. (2008). State-specific tobacco company marketing expenditures 1998-2005. Retrieved February 13, 2008, from <http://tobaccofreekids.org/research/factsheets/pdf/0271.pdf>
- Campaign for Tobacco-Free Kids. (2008). Where do youth smokers get their cigarettes? Retrieved February 13, 2008, from <http://tobaccofreekids.org/research/factsheets/pdf/0073.pdf>
- Cheadle, A., Sterling, T., Schmid, T., and Fawcett, S. (2000). Promising community-level indicators for evaluating cardiovascular health-promotion programs. *Health Education Research*, 15(1), 109-116.
- Easterling, D. and Foy, C. (2007). 2006 Social Capital Community Benchmark Report. Retrieved February 11, 2008, from <http://www.cfdg.org/page24752.cfm>
- Fawcett, S., Paine-Andrews, A., Francisco, V., Schultz, J., Richter, K., Lewis, R., Williams, E., Harris, K., Berkley, J., Fisher, J., and Lopez, C. (1994). Work Group evaluation handbook: Evaluating and supporting community initiatives for health and development, Lawrence, KS: Work Group on Health Promotion and Community Development, University of Kansas.
- Fawcett, S., Paine-Andrews, A., Francisco, V., Schultz, J., Richter, K., Lewis, R., Williams, E., Harris, K., Berkley, J., Fisher, J., and Lopez, C. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology*, 23, 677-697.
- Fawcett, S., Francisco, V., Paine-Andrews, A., and Shultz, J. (2000). A model memorandum of collaboration: A proposal. *Public Health Reports*, 115, 174-179.
- Focusing on what matters: Health and Human Services needs in Greater Greensboro. (2003). United Way.
- Goodman, R., Wandersman, A., Chinman, M., Imm, P., & Morrissey, E. (1996). An ecological assessment of community-based interventions for prevention and health promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology*, 24(1), 33-61.

- Greensboro Police Department: Crime Analysis Section. (2008). City of Greensboro Crime Report 1998-2007.
- Greensboro Police Department: Crime Analysis Section. (2008). City of Greensboro Gang Related Offenses Report 2006-2008.
- Greensboro Police Department: Departmental Review: Year to year comparison. (2006). Retrieved September 6, 2007, from <http://www.greensboro-nc.gov/NR/rdonlyres/17439802-71CC-423A-A961-B138AD041BBB/0/Annual06.pdf>
- Gruchow, W. (2003). Guilford County Teens Youth Risk Behavior Survey (2003). Table of comparisons to state-wide 2003 YRBS data. UNCG: Greensboro NC.
- Guilford County Schools. (2007). Friday Notes from Guilford County Schools. Retrieved September 10, 2007, from http://www.gcsnc.net/fridaynotes/2_2_07.aspx
- Guilford County Substance Abuse Coalition. (2008). Home page. Retrieved March 31, 2008, from <http://www.gcsac.org/index.html>
- Guilford Health Partnership and Guilford County Department of Public Health. (2005). Executive Summary. Retrieved July 5, 2007, from <http://www.co.guilford.nc.us/publichealth/divisions/wp-content/uploads/2006/12/executive-summary.pdf>
- Hatcher, M. (1997). Principles of community engagement: CDC/ ATSDR Committee on community engagement. Part 1: Community engagement: Definitions and organizing concepts from the literature. Retrieved March 24, 2008, from <http://www.cdc.gov/phppo/pce/part1.htm>.
- Howell, E., Petit, K., Ormond, B., & Kingsley, G. (2003). Using the national neighborhood indicators partnership to improve public health. *Journal of Public Health Management and Practice*, 9(3), 235-242.
- Join Together. (2005). How do we know we are making a difference: A community alcohol, tobacco, and drug indicators handbook. Retrieved July 5, 2007, from http://www.indicatorshandbook.org/Indicators_Handbook-v1.pdf
- Kids Count. (2007). Community-level information on kids state profile: North Carolina Retrieved July 5, 2007, from http://www.kidscount.org/cgi-bin/cliiks.cgi?action=profile_results&subset=NC
- National Community Anti-Drug Coalition Institute. (2008). Drug-Free Communities in North Carolina. Retrieved February 13, 2008, from <http://www.coalitioninstitute.org/Evaluation-Research/StateSurvey/NorthCarolina.pdf>

- National Institute on Alcohol Abuse and Alcoholism. (2008). Self-report alcohol use and abuse by arrestees in 1998 Drug Abuse Monitoring Program (ADAM). Retrieved February 13, 2008, from <http://pubs.niaaa.nih.gov/publications/arh25-1/72-80.htm>
- National Institute on Alcohol Abuse and Alcoholism. (2008). Total per capita alcohol consumption in gallons of ethanol by State, United States, 2005. Retrieved February 13, 2008, from <http://www.niaaa.nih.gov/Resources/GraphicsGallery/configs4text.htm>
- North Carolina Alcohol Beverage Control Commission. (2008). Advanced permittee search. Retrieved 28 March, 2008, from http://www.ncabc.com/search/advanced_search.aspx
- North Carolina Alcohol Beverage Control Commission. (2005). FY 2005 Annual Report: Revenues from Spirituous Liquor. Retrieved February 13, 2008, from <http://reports.ncabc.state.nc.us/uploads/resources/0bab6aac576e43f5be3b3c36f6adefe1.pdf>
- North Carolina Alcohol Beverage Control Commission. (2007). Store locations. Retrieved September 6, 2007, from <http://www.ncabc.com/stores/Default.aspx>
- North Carolina Alliance for Health. (2005). Cigarette excise tax. Retrieved July 16, 2007, from <http://www.ncallianceforhealth.org/tax.html>
- North Carolina Crime Control and Public Safety. (2008). Alcohol Law Enforcement Statistics. Retrieved March 28, 2008, from <http://www.nccrimecontrol.org/Index2.cfm?a=000003,000005,000271>
- North Carolina Crime Control and Public Safety. (2005). North Carolina Tobacco Law. Retrieved February 13, 2008, from <http://www.nccrimecontrol.org/Index2.cfm?a=000003,000005,000996,000378>
- North Carolina Department of Health and Human Services. (2008). Division of Medical Assistance. Retrieved February 13, 2008, from <http://www.ncdhhs.gov/dma/>
- North Carolina Department of Health and Human Services: Division of Medical Assistance. (2007). Guilford County Report. Retrieved February 13, 2008, from <http://www.ncdhhs.gov/dma/countyreports/GuilfordCounty.pdf>
- North Carolina Department of Health and Human Services: Tobacco Prevention and Control. (2001). Guilford County Tobacco Use Prevention and Control: Status and Need. Retrieved February 13, 2008, from <http://www.tobaccopreventionandcontrol.ncdhhs.gov/data/Documents/CountyProfiles/GUILFORD.pdf>
- North Carolina Department of Health and Human Services: Tobacco Prevention and Control. (2008). Resources. Retrieved February 13, 2008, from <http://www.tobaccopreventionandcontrol.ncdhhs.gov/about/resources.htm>

- North Carolina Department of Health and Human Services: Tobacco Prevention and Control. (2007). Training Opportunities. Retrieved February 13, 2008, from <http://www.tobaccopreventionandcontrol.ncdhhs.gov/about/training.htm>
- North Carolina Department of Health and Human Services: Tobacco Prevention and Control. (2008). Youth tobacco use prevention. Retrieved February 13, 2008, from <http://www.tobaccopreventionandcontrol.ncdhhs.gov/youth/index.htm>
- North Carolina Department of Revenue. (2006). North Carolina State and Local Taxes: 2006. Retrieved September 6, 2007, from <http://www.dornrc.com/publications/stateandlocal.pdf>
- North Carolina Department of Transportation: Governor's Highway Safety Program. (2007). Booze It and Lose It data archives. Retrieved September 6, 2007, from <http://www.ncdot.org/programs/ghsp/news/anews.html>
- North Carolina School Report Cards: School Safety and Access to Technology. (2008). School Attendance 2003-04. Retrieved March 20, 2008, from <http://www.ncreportcards.org/src/distDetails.jsp?Page=3&pLEACode=410&pYear=2003-2004&pDataType=1>
- North Carolina School Report Cards: School Safety and Access to Technology. (2008). School Attendance 2004-05. Retrieved March 20, 2008, from <http://www.ncreportcards.org/src/distDetails.jsp?Page=3&pLEACode=410&pYear=2004-2005&pDataType=1>
- North Carolina School Report Cards: School Safety and Access to Technology. (2008). School Attendance 2005-06. Retrieved March 20, 2008, from <http://www.ncreportcards.org/src/distDetails.jsp?Page=3&pLEACode=410&pYear=2005-2006&pDataType=1>
- North Carolina School Report Cards: School Safety and Access to Technology. (2008). School Attendance 2006-07. Retrieved March 20, 2008, from <http://www.ncreportcards.org/src/distDetails.jsp?Page=3&pLEACode=410&pYear=2006-2007&pDataType=1>
- North Carolina State Bureau of Investigations. (2008). Crime in North Carolina: Guilford County 1995-2006. Retrieved March 31, 2008, from <http://sbi2.jus.state.nc.us/crp/public/Default.htm>
- North Carolina State Center for Health Statistics. (2007). BRFSS topics for Guilford County. Retrieved September 6, 2007, from <http://www.schs.state.nc.us/SCHS/brfss/2006/guil/topics.html#rf>
- Roussos, S. and Fawcett, S. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*, 21, 369-402.

Substance Abuse and Mental Health Services Administration. (2007). Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMs) Retrieved July 16, 2007, from http://www.nationaloutcomemeasures.samhsa.gov/outcome/index_2007.asp

Substance Abuse and Mental Health Services Administration. (2007). National Outcome Measures for North Carolina. Retrieved July 16, 2007, from <http://www.nationaloutcomemeasures.samhsa.gov/./Outcome/StateSummary/TRE/NC.pdf>

The Centers for Disease Control and Prevention. (1994). Examples of community-level indicators. Retrieved July 3, 2007, from <http://faculty.washington.edu/cheadle/cli/indlist.html>

The Centers for Disease Control and Prevention. (2007). YRBSS-Youth Online: Comprehensive Results. Retrieved September 6, 2007, from <http://apps.nccd.cdc.gov/yrbss/SelQuestyear.asp?cat=3&desc=Alcohol%20and%20Other%20Drug%20Use&loc=NC>

The Community Toolbox. (2007). Using promising approaches. Retrieved March 24, 2008, from <http://ctb.ku.edu/en/promisingapproach/>.

The Community Toolbox. (2007). An Overview of Strategic Planning or "VMOSA" (Vision, Mission, Objectives, Strategies, and Action Plans) Retrieved March 24, 2008, http://ctb.ku.edu/en/tablecontents/sub_section_main_1085.htm

United States Department of Health and Human Services. (2007). The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services. Retrieved February 13, 2008, from <http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet2.html>

U.S. Department of Labor Bureau of Labor Statistics. (2008). Bureau of Labor Statistics Data: Greensboro-High Point, North Carolina. Retrieved March 28, 2008, from http://www.bls.gov/eag/eag.nc_greensboro_msa.htm