THE NATIONAL EVALUATION SURVEY OF THE COMMUNITY PARTNERSHIP DEMONSTRATION PROGRAM

James Trudeau, Lori Saunders, Christine Andrews, Rebekah Hersch, Cheryl Oros, ISA Associates
James Trudeau, 201 N. Union Street, Suite 360, Alexandria, VA 22314

KEY WORDS: Substance abuse, prevention, partnerships, coalitions

Introduction

Over the last quarter-century, as the use of alcohol and other drugs has gradually become recognized as one of our most injurious problems, a variety of programs designed to prevent alcohol, tobacco, and other drug (ATOD) use have been launched -- with mixed results. Recent evidence on ATOD prevention programs seems to point to the importance of a *comprehensive, coordinated* approach to the problem. Under the Anti-Drug Abuse Act of 1988, The Center for Substance Abuse Prevention (CSAP), U.S. Department of Health and Human Services, in 1990 began the Community Partnership Demonstration Program to address the need for a coordinated, long-range, community-wide approach to ATOD prevention.

Under this program, Partnerships have been formed in 251 communities across the nation. Each local coalition of public and private entities serves as the central body to coordinate existing ATOD prevention activities and encourage or sponsor the creation of new efforts. The Partnership grants are not to be used to support substantial direct services or the general operating costs of prevention agencies. Rather, the funds are intended to be used to identify service needs in the community, establish community-wide priorities and systems changes, and promote and coordinate drug abuse prevention programs.

This paper summarizes the results of the first survey of these Partnerships, providing an early look at a type of entity that -- while not new -- is becoming an ever more common means of addressing many of America's social ills.

Overview of the National Evaluation. In October of 1990, ISA Associates was awarded a contract to conduct the national evaluation of the Community Partnership Demonstration Program. The national evaluation is currently funded as a three-year effort focused on the assessment of program implementation and processes, accompanied by the development of an impact evaluation methodology. The evaluation began in October, 1990, when the first round of demonstration sites began, and is scheduled to be completed in September, 1993. The impact evaluation project will follow and will extend until 1997.

The on-going process evaluation has two central purposes: (1) to document and describe the processes by which Partnership programs are implemented and operated; and (2) to identify factors and forces associated with effective implementation and operation. The process evaluation is proceeding along two tracks: (1) basic information on implementation processes and proximal outcomes is being gathered from all sites via the National Evaluation Survey; and (2) more detailed information on programs and partnership dynamics is being collected in up to 39 intensive sites via site visits. (Findings from the intensive site visits, along with case studies of individual Partnerships, are presented in ISA's Annual Reports. The methodology for the entire process evaluation and the impact evaluation design are detailed in ISA's Evaluation Plan.)

Survey Methodology. The 30-item National Evaluation Survey was mailed to the directors of all 251 Partnerships in April, 1992. Six months later, 201 Partnerships, or 80% of the total, had returned the survey. Reminder letters were sent to 162 Partnerships, and follow-up phone calls were made to 108 partnerships. In some cases, respondents were also telephoned to complete missing data or clarify vague responses.

The partnerships who returned the survey were not significantly different from those who did not. Partnership type, age, and community population density did not significantly differ between those who did and did not respond. There was also no difference according to type of grantee organization (e.g., social services agency, university, non-profit, etc.) In terms of community ethnicity, the two groups only differed in percent Native American: sites with higher proportions of Native Americans were more likely to return the survey.

Overview of this paper. Most of the analyses presented in this paper are descriptive, and were designed primarily to provide an accurate documentation of the Partnerships in their early years. While a substantial amount of inferential analyses have also been conducted, they have focused on a *preliminary assessment* of how the Partnerships differ on major measures of implementation and operations

as a function of the principal taxonomic variables (described below) and stage of activity. In subsequent annual reports and other publications, ISA will present more extensive results of inferential analyses, such as how measures of Partnership characteristics (e.g., composition, cooperation) relate to the development of ATOD prevention strategies and, ultimately, to Partnership effectiveness.

In this paper we will look first at the characteristics of the communities in which the Partnership exist, the formation and focus of the Partnerships, and their membership, structure, and early functioning. Then we will turn to the problems they are targeting and the strategies and activities they are using or planning to use to achieve their goals.

Characteristics of the Partnerships and their Target Areas

A taxonomic classification of Partnerships was developed to provide meaningful and conceptually important dimensions that would help explain the experiences and effects of the Partnerships. This taxonomy was also used to select appropriate programs for intensive study. Two taxonomic dimensions relate to the Partnerships themselves (their age and type) and will be discussed below. The third dimension concerns the types of communities in which the Partnerships are located.

Target area characteristics. Communities of different sizes, characteristics, and locations around the country provide different environments for the operation of programs. Urbanicity (i.e., rural, suburban, or urban character) was chosen as the most important dimension of area type, with population density chosen as the best indicator of urbanicity. Three urbanicity categories were defined as follows: (1) *Low density*: population of less than 200 per square mile; (2) *Medium density*: population greater than 200 but less than 2000 per square mile; (3) *High density*: population greater than 2000 per square mile. Of the respondents to the National Evaluation survey, 28% of the Partnerships were in high density areas, 36% in medium density areas and 35% in low density areas.

Over half of the Partnerships are targeting a single county or city, while 17% target multiple cities and multiple counties. In fact, some Partnerships are targeting over five cities or five counties. In contrast, 8% of the Partnerships are addressing sub-areas (neighborhoods or city wards) with typically more than one listed. About 16% of the Partnerships are targeting an area defined in some other way or that is a mixture of areas.

The size and characteristics of the target area populations vary greatly across the Partnership communities. The typical Partnership targets a population of just over a quarter million people (259,016). In low density sites the mean population is 87,171, in medium density sites it is 288,945, and in high density sites it is 434,739. Community target populations vary widely from only 280 people to three and one-half million.

Across all the Partnerships responding to the survey, 68% of the total population is white, 12% is African American, 10% is Hispanic, 7% is Native American, and 3% is of some other racial/ethnic classification. Perhaps more interesting is the extent to which the Partnership communities have sizeable minority populations. Roughly 17% of the communities are at least 25% African American, with 12% being at least 25% Hispanic and 7% at least 25% Native American. Ten of the Partnership communities are at least 75% Native American, 10 are at least 50% Hispanic, and 6 are at least 50% African American.

Age of the Partnerships. Partnership age is one of three central variables included in the taxonomy of Partnership programs, and is thought to be one of the more influential characteristics of a Partnership. Partnerships are classified as either *old* (established before the 1990 announcement of CSAP's Community Partnership Program) or *new* (established after the 1990 announcement). Partnerships are also classified by whether they were funded during Round I (94 were funded in 1990) or Round II (157 were funded in 1991).

The National Evaluation Survey data show that 65% of the programs are newly formed, and 35% are old (continuing or expanding) programs. Of the Round I Partnerships, about half are continuing or expanding programs and about half are new. By contrast, Round II Partnerships are 70% new. The progress of the Partnerships is a function of their age *and* their funding cycle, so our analyses considered round as well as Partnership age.

Size of the Membership. The typical Partnership has 50 members (after removing one atypical Partnership that has over 1,000 members). This figure should be interpreted with caution due to the differing definitions Partnerships have as to what constitutes being a member: For some Partnerships, only invited key players are considered Partnership members, while for others, any interested community resident is considered a member -- most Partnerships fall somewhere between these extremes. While this lack of uniform definition of membership makes it

difficult to discuss meaningfully the characteristics of Partnership membership, it underscores the diversity in approach among the Partnerships.

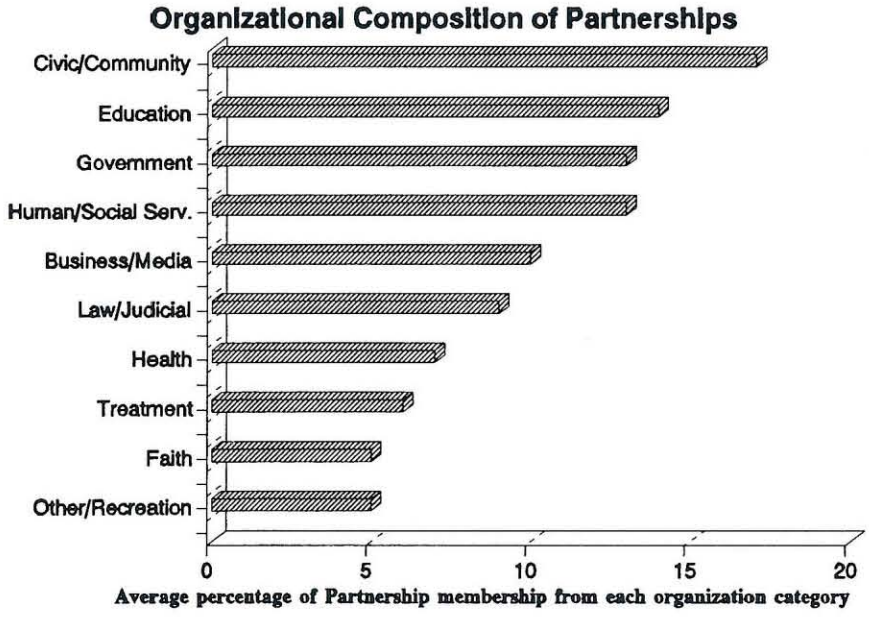
Type of Partnership. To address the last taxonomic dimension, Partnership type, we asked each respondent to classify his or her Partnership as *predominantly* comprised of 1) community leaders, 2) professionals, or 3) grassroots individuals or group representatives. Of the 201 Partnerships responding, 40% said they were professional, 28% leadership, 17% grassroots, and 14% felt they were an equal combination of these three types of members.

Membership Composition. Partnership programs are intended to bring together a wide variety of citizens and officials from all over the community. Based upon data from the National Evaluation Survey, it appears that most Partnerships have been successful in recruiting a broadly varied membership from many key agencies and groups.

One way to look at membership composition is in terms of the percentage of Partnerships with members from each of 11 key categories. Nearly all Partnerships reported members with backgrounds in education (97% reported having at least one member in this category), government (96%), civic groups (92%), and law enforcement (90%). Also very common were Partnerships with members in health (87%), social services (86%), business (79%), ATOD treatment (77%), and faith (71%) categories. The least represented categories were individual citizens (37%) and recreation (29%). The typical Partnership has members in 8 of these 11 categories.

Another way to view membership composition is to ask what percentage of the typical Partnership membership each of the 11 categories constitutes. The largest proportions of members within the Partnerships are civic or community organizations, education, government, and human or social services, (see Figure I). Partnership composition varies among the types of Partnerships and the community densities. Low density communities have a lower percentage (13%) of civic and community members, but have a higher percentage of members from education (18%). Representation from business and media is lowest in high density areas (8%). Grassroots Partnerships have the highest percentage of members from civic or community groups (22%), while leadership Partnerships have the most members from government (16%) and business or media (14%).

FIGURE I



Structure. Most Partnerships have a formal structure in addition to a designated leader, with defined committees. Most common are administrative (in 60% of Partnerships) and steering committees (49%), with a host of topical committees across the sites. The most common topical committees are marketing/media (in 45% of Partnerships), youth (41%), education/schools (38%), evaluation/research (38%), and workplace/business (33%).

About one-third of the Partnerships also reported having informal groups. These groups are significantly more common in grassroots Partnerships (41%) than leadership (30%) or professional types (30%).

Partnership Development and Targeted Problems

Almost half the Partnerships reported a major change affecting the Partnership, such as change in project director or staff, or a change in target area or focus. Round I/new sites were more likely to report such a change, which may be explained by the fact that they had been in the program longer than the Round II sites but were not as settled as the older (pre-program) Partnerships. Twenty-one Partnerships lost their project director, thirteen of which were Round I sites. More Round I sites had lost staff (22) than had gained staff (12), but more Round II sites had gained staff (19) than lost staff (7). The Round I sites had longer to experience turnover, while the Round II sites were still in a growth phase. Only 4 Round I and 3 Round II Partnerships had changed focus or target area, with most Partnerships demonstrating continuity in the face of the changes just described.

Internal Partnership Activities. During the first year or two, most Partnerships concentrated on a variety of internal development activities. Needs assessments have been completed in 15% of the Partnerships, but are still underway in 78% of the sites. Similarly, only 10% of the Partnerships have completed internal policy development, and 78% continue to be engaged in policy development. Most of the other activities (e.g., recruitment, planning sessions, etc.) are the type that may continue indefinitely: they are activities of Partnership *maintenance* as well as development. Strategy development was the least advanced of the planning activities: 43% have either not engaged in, or have only just begun, strategy development. For all planning activities, Round I sites reported being significantly further along.

ATOD Problems Targeted. Alcohol is by far the most common drug targeted across all sites. Of the 166 Partnerships that reported what drugs they are targeting, 98% named alcohol. Marijuana was named by 62%, and cocaine by 49%. These drugs are being targeted approximately equally across the density types, except that cocaine is less likely to be targeted in low density sites (34%). High density areas were significantly more likely to name crack (31%) and heroin (38%), whereas low density areas tended to be more likely to name inhalants (16%) and tobacco (21%).

Three in four Partnerships report that they are emphasizing alcohol equally with other drugs, with 17% targeting alcohol more than other drugs and only 8% targeting other drugs more than alcohol. In fact, of the Partnerships targeting alcohol more than drugs, most report that they are targeting alcohol *much* more, while those targeting drugs more than alcohol are mostly targeting drugs only *slightly* more.

FIGURE II

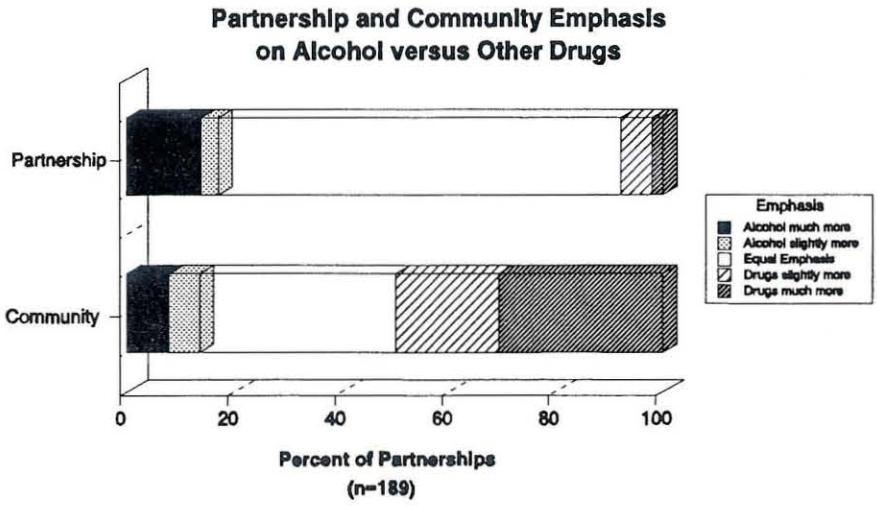
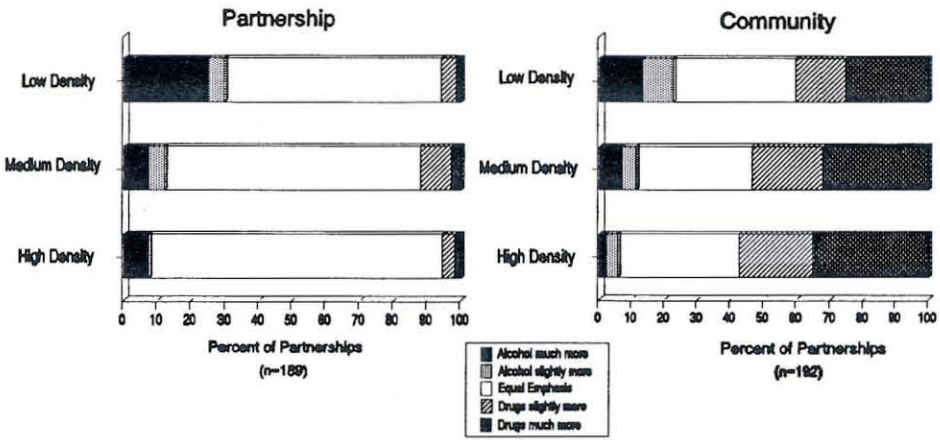


FIGURE III

Partnership and Community Emphasis On Alcohol Versus Other Drugs, By Population Density



This emphasis on alcohol by many Partnerships contrasts with the respondents' perceptions of the relative emphasis placed on alcohol versus other drugs by the target communities. (See Figure II). About half the respondents report that the community places more emphasis on drugs, with 20% saying "slightly more" and 30% saying "much more." Only 14% of the respondents report that the community places more emphasis on alcohol. About one-third (36%) of the Partnerships report that their target communities place equal emphasis on alcohol and other drugs. There appear to be two related reasons why the Partnerships' emphasis is different than their perceptions of the community emphasis: First, the general public is generally more alarmed about the use of illicit drugs than the use of alcohol; second, the partnerships are striving to increase the community's awareness of alcohol as a drug and of the seriousness of alcohol-related problems.

Figure III shows the different emphasis of Partnerships and communities in low, medium and high density areas. The tendency for communities to emphasize other drugs more than alcohol (at least in the Partnership directors' eyes) is increased as density increases. In contrast, the Partnerships' equal emphasis on alcohol and other drugs persists in all three density groups, with Partnerships in low density areas tending to emphasize alcohol more.

External Partnership Activities

The Partnerships have planned and implemented a wide variety of "external" activities targeting both entire communities and specific populations within those communities. These activities are the main work of the Partnerships in ATOD prevention. We use the term "external" here in contrast to the "internal" work the Partnerships carried out in creating, developing, and maintaining their action coalitions. These activities include broad-based community education and training, alternative activities for youth, workplace ATOD prevention programs, developmental funds for non-Partnership activities, resource centers, prevention program coordination, cultural and ethnic events, and focused programs aimed at specific groups (for example, the elderly, specific ethnic/racial populations, or teachers).

Although most of the Partnerships have moved beyond internal, coalition- strengthening activities to the implementation of external activities directed toward the community, only a few of the Partnerships have made significant progress on the development of comprehensive community-wide prevention plans or strategies. In many ways, this is not surprising; even the Round I sites were in only their second year of a five-year program at the time these data were collected. Once the internal structure of the Partnership is in place, most programs are anxious to begin implementing activities to address their communities' ATOD problems, even if a strategic plan is not yet in place.

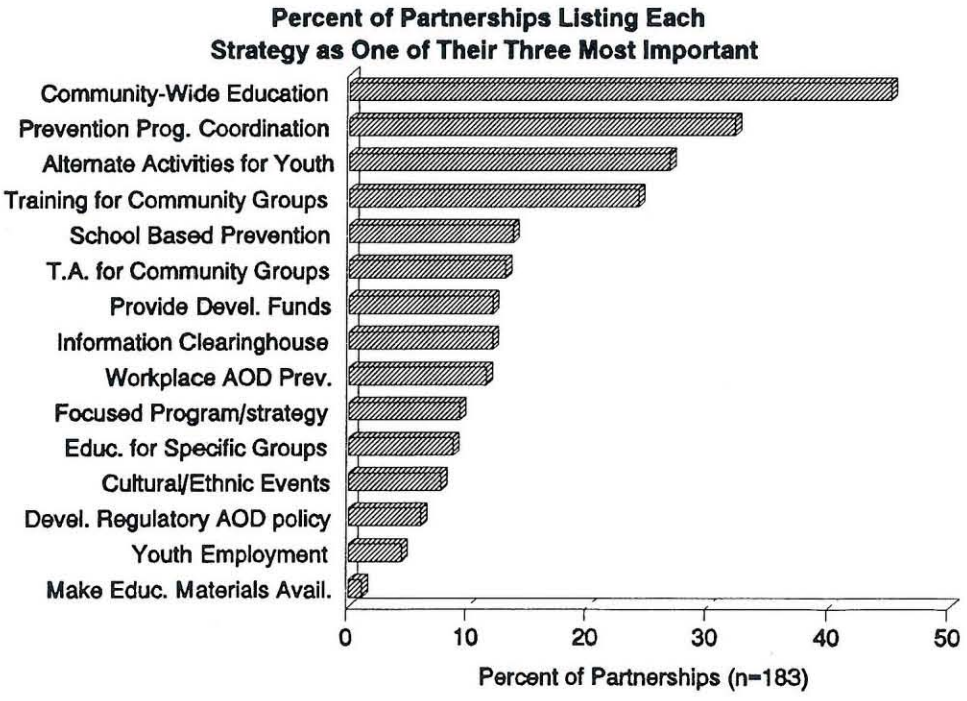
Both Round I and Round II Partnerships spent their first years focusing, understandably, on developmental tasks -- building and strengthening the Partnership, conducting needs assessments, recruiting and providing training to members, etc. To date, the external prevention activities of most Partnerships tend to be somewhat narrowly focused, one-time events; broad-based strategies with the potential for widespread community impact on ATOD use usually do not emerge until well into the second year. Typically, substantial progress on the development of a comprehensive, community-wide prevention plan

must also wait until the Partnerships' second year, after a strong internal structure has been developed. The general sequence of activities implemented in the intensive sites -- from ATOD prevention education to specific ATOD programs and finally to legislative or policy changes -- seems to be a natural progression. ATOD public education is a necessary activity for almost all the Partnerships and can be conducted with relative ease. More specific programming or legislative lobbying are generally more complex activities, requiring greater degrees of coordination and planning. It is not surprising then that these activities are more often conducted in older Partnerships.

Relative perceived importance of activities. Survey respondents were asked to rate the importance their Partnerships give to listed activities, whether or not they had yet implemented that activity. Coordination of community prevention programs, training for community groups, and alternative activities for youth were seen as extremely important by 60% or more of the Partnerships. Youth employment programs and the development of regulatory ATOD policy received the lowest ratings of importance and over 25% of the Partnerships indicated that they were not even using these strategies. Although many Partnerships stress the importance of attacking ATOD use among youth, these findings indicate that the focus of these Partnerships remains *community-wide* prevention. We found no relationship between the mean importance ratings and any of the taxonomic groups (Partnership type, age of Partnership, or density).

Primary strategy focus. After rating the importance of each activity, Partnerships were asked to list their *three most important strategies*, whether or not they had as yet implemented the strategies. As indicated in Figure IV, community-wide prevention education was listed by forty-five percent of the Partnerships. Prevention program coordination and alternatives activities for youth were the next most frequently cited, while making educational materials available (1%) and youth employment (4%) activities were least likely to be listed as one of the three most important strategies.

FIGURE IV



When Partnerships were asked to list their three most important activities/strategies, some patterns emerged. For example, grassroots Partnerships were more than twice as likely to list educational programs targeted at specific groups as the leadership or professional Partnerships. On the other hand, 25% of the leadership Partnerships listed workplace strategies as one of their three most important compared to 13% of grassroots and 7% of professional. Alternative activities and developmental funding were listed most often by Partnerships led by multiple organizations. One reason for the emphasis on distributing developmental funds by Partnerships led by multiple organizations is that the developmental funds are a mechanism by which the Partnership can spread its money around to different organizations. By contrast, focused programs and strategies were listed more often by Partnerships led by one organization.

The choice of the three most important strategies was also related to community characteristics. Workplace programs were listed more often in medium density areas (19%) compared to only 8% in low density and 6% in high density areas. School-based prevention programs were listed more often in low and medium density areas (19% and 16%) compared to only 6% in high density areas. Partnership-sponsored, school-based prevention programs may be less commonplace in high density areas because of the prevalence of police-sponsored, DARE programs in these larger communities.

Implemented strategies and activities. Partnerships were also asked to describe the three most important strategies they had *actually implemented*. About two-thirds of the Partnerships were able to describe activities they had implemented. Older Partnerships appear more advanced, as 100% of the Round I/old Partnerships described their strategies. Seventy-nine percent of Round I/new, 68% of Round II/old, and only 44% of Round II/new Partnerships described strategies they had implemented.

When asked to describe activities they had implemented, 129 Partnerships listed activities, with a few activities cited most frequently. Fifty-five respondents listed community-wide prevention education, 34 listed alternative activities for youth, and 33 listed prevention program coordination. These three activities are described below, following a summary of the strategies emphasized by various types of Partnerships.

Not surprisingly, there was a relationship between Partnership type and the three most important strategies implemented which was similar to the relationship seen earlier between Partnership type and the strategies listed as most important. Workplace prevention strategies were described as among the most important implemented strategies most often by leadership Partnerships, and alternate activities for youth were described most often by combination Partnerships. A greater percentage of grassroots Partnerships implemented education strategies targeting specific groups than either leadership or professional Partnerships. Developmental funding activities were described most often by Partnerships led by multiple organizations; by contrast, focused programs and strategies are more popular with Partnerships led by one organization.

In communities emphasizing drugs slightly more than alcohol, school-based prevention and community-wide prevention education strategies were described most often. In communities emphasizing alcohol much more than drugs, education strategies targeting specific groups were described most often. School-based prevention programs were implemented more often by continuing Partnerships, and cultural events and technical assistance for community groups were started more often by the Round I sites.

Community-wide prevention education. Twenty-six Round I and twenty-nine Round II Partnerships have implemented community-wide prevention education in their communities. The categories of organizations who were primarily involved in these activities were education, civic/community, business/media, and law enforcement/judicial. In Round I sites, volunteers/citizens were almost three times as likely to be involved as in Round II sites, showing that gaining the involvement of volunteers/citizens typically takes time. Over 50% of these community-wide prevention education efforts were either conducted monthly or on an ongoing basis; 31% were considered one time events. Not surprisingly, the outcome cited most often by Partnerships describing these activities was increased awareness (although 27% of these Partnerships indicated that the activity was not yet completed).

Alternative Activities for Youth. Eighteen Round I and sixteen Round II Partnerships described alternative activities for youth as a strategy. Education, law enforcement/judicial, community, and government organizations were most likely to be involved in the activities. These organizations were primarily involved in sponsoring events and activities, planning and development, as well as facilitating and coordinating groups and events. Alternative activities tended to be one time events or ongoing activities.

Many lasted one day, while other lasted over a week. Some types of early outcomes mentioned include increased youth involvement and awareness about ATOD use and abuse.

Prevention Program Coordination. The third most often cited activity, prevention program coordination, was implemented by twenty Round I and thirteen Round II sites. The primary organizations involved in this type of activity were education, law enforcement/judicial, health, civic/community, and government. These organizations were most involved in facilitating and coordinating the activity, planning and development, and providing training and education. Almost two thirds of the events described occurred monthly or on an ongoing/longterm basis, with another third occurring only once. The two most likely outcomes from the prevention program coordination activities were youth involvement and increased awareness.

Described Organizational or Governmental Policy Changes. Sites were also asked if they had considered or had implemented policy changes in their community, such as convenience stores requiring proof of age from anyone appearing 25 or younger or regulations to ban cigarette machines. If the sites had considered or implemented policy changes, they listed these and we categorized them.

About one-quarter of the Partnerships have implemented policy changes in their community. Law enforcement/judicial (12%) and workplace based (8%) policy changes are the most common. Local legislative or law enforcement changes were most likely to be under consideration. Round I sites are more advanced in this area of development: 45% of Round I Partnerships have implemented changes, compared to only 18% of Round II Partnerships. In addition, the age of the Partnership (regardless of Round) was also significantly related to whether the Partnership had implemented policy changes with 39% of old Partnerships implementing changes compared to 21% of new Partnerships. The planning and implementation of policy changes seems to require significant Partnership coordination and is therefore more likely to be conducted by Partnerships who have made greater strides in the development and strengthening of their internal structure (that is, Round I vs. Round II and older vs. newer Partnerships).

Conclusion

The Community Partnership Demonstration Program has spawned a wide variety of Partnerships in all types of communities; these Partnerships are addressing a range of ATOD issues through a variety of approaches. The Partnerships have successfully involved many facets of their communities, with the typical Partnership having the participation of 8 of 11 membership categories. While it is still premature to identify which Partnerships are more effective, it is clear that some have progressed more than others. Most of the Partnerships have, understandably, focused early work on internal developmental activities. Many Partnerships have implemented activities, though for the most part these activities have not resulted directly from a strategic plan. Most of the Partnerships have achieved a position from which they may reasonably expect to meaningfully impact the ATOD problem in their communities. It will be very interesting to see the extent to which that promise is realized in the next few years.