Fighting Back Against Substance Abuse
Are Community Coalitions Winning?

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Objectives: Federal initiatives continue to provide strong support for community antidrug coalitions, but whether this approach actually reduces substance abuse is not clear. This paper examines the strategies that coalitions in a large national demonstration program (Fighting Back) chose to develop, the degree to which they implemented these strategies, and evidence regarding their effects.

Methods: Coalition strategy implementation was coded and ranked for 12 Fighting Back sites. Effect sizes (intervention over time) for outcomes related to substance use, alcohol and other drug treatment, and community/prevention indicators were also ranked by site. Using rank order correlation, three directional hypotheses compared strategy dose to outcomes.

Results: None of the hypotheses were supported. Strategies aimed at either youth or community/prevention outcomes showed no effects, while strategies to improve adult-focused outcomes showed significant negative effects over time, compared to matched controls. Coalitions with a more comprehensive array of strategies did not show any superior benefits, and increasing the number of high-dose strategies showed a significant negative effect on overall outcomes.

Conclusions: Comprehensive community coalitions are intuitively attractive and politically popular, but the potential for adverse effects must be considered. Efforts to evaluate implementation processes as well as to correlate strategies with theoretically corresponding outcomes are a critical but neglected aspect of prevention research.

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Introduction

Federal policy continues to provide strong support for community antidrug coalitions. The federal government spent almost a half billion dollars during the 1990s to support local coalitions through the Center for Substance Abuse Prevention's (CSAP) Community Partnership Program and subsequent Community Coalition Program.[1] Since 1997, the Office of National Drug Control Policy has funded 464 antidrug coalitions with an additional $95 million, and the president's 2002 budget request would double funding for community antidrug coalitions to $350 million over 5 years, including an $11 million increase in 2002.[2] The private sector has also invested heavily in antidrug coalitions. The Robert Wood Johnson Foundation (RWJF) launched Fighting Back, its largest demonstration program ever, to reduce demand for drugs through community coalitions.[3] RWJF credits the Fighting Back concept as the origin of federal initiatives.

Supporting the activities of local coalitions is both intuitively attractive (bringing the community together to address local problems) and politically popular (spreading the money around). What is not clear is whether coalitions actually reduce substance abuse. This article presents data on the Fighting Back program, including the strategies that the coalitions chose to develop, the degree to which they implemented these strategies, and evidence of their effects. It also provides conclusions and recommendations about ways to improve the efforts of antidrug coalitions. This study is unique in categorizing the strategies that communities developed to reduce substance abuse and correlating strategy dose with corresponding outcomes.

Fighting Back followed several large-scale community trials for chronic disease prevention that had enormous

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influence in shaping community-based, health promotion programming.[4] Minnesota Heart Health is an example of one such comprehensive program, which included media messages; health education at work sites, churches, and other institutions; grocery and restaurant heart-health food labeling; school-based smoking prevention programs targeting youth; health practitioner training; and citizen task forces to develop annual risk-factor education campaigns.[5,6] An essential feature of the interventions was that they were comprehensive, seeking to simultaneously change community norms, institutional policies, and individual behaviors. From an evaluation standpoint, this means that there were actually multiple interventions going on throughout the community. Teasing out the elements of complex programs and considering dose measures is important, since the dose for any individual in a community program may be small and lead to modest or null overall results, a common problem with all of the major community health promotion trials.[7]

In Fighting Back, RWJF promoted the notion of a comprehensive approach in two ways. First, they insisted that local political, business, and grassroots leaders all come together around a community "table" to assess the substance abuse problems in their community and to develop a comprehensive, coordinated response.[3] They stressed the need for an inclusive process in which all players would provide their unique perspective about the nature of the problem, ideas about how to solve it, and commitment to work together in a coordinated way. This process was the key intervention expected to lead to reductions in substance use and harms.

See related Commentary on page 303.

Second, although communities were encouraged to devise their own programs based on local context and needs, they were required to develop a single, community-wide system of prevention and treatment, which at minimum included: (1) public awareness; (2) prevention, targeted especially at youth and children; (3) early identification and intervention; and (4) treatment and relapse prevention.[8] Later, the National Program Office, appointed by RWJF to oversee and support the program, added a fifth element: environmental improvement, which included empowerment and community development strategies, and policies to reduce the availability of alcohol and other drugs (AOD) and to promote "responsible" liquor sales.[9]

It should be noted, however, that Fighting Back differed from Minnesota Heart Health and similar prevention programs in one important aspect: the choice and development of strategies. In the cardiovascular disease prevention programs, communities were involved in customizing and implementing a variety of proven strategies for lowering blood pressure and reducing heart attack risk. In the Fighting Back and similar federal programs, community leaders chose, developed, and implemented strategies much more autonomously. As conceptualized, RWJF was actually testing the effects of an empowerment process, rather than a specific intervention. Nevertheless, it soon became apparent that it was critical to know what the sites were doing, and whether their particular activities were moving them closer toward related goals. This information is also critical to second-generation coalitions who wish to replicate successful strategies and to justify continued efforts.

Methods

Sample

A total of 14 communities participated in the Fighting Back program. Fighting Back's targets were mid-sized communities, both urban and rural, consisting of between 100,000 and 250,000 residents. They included areas ranging from large portions of mid-sized cities (e.g., Milwaukee, Wisconsin) to relatively small areas within a city (e.g., Washington, DC). The national evaluation collected implementation activity data and conducted telephone surveys in 12 Fighting Back sites; two communities were omitted from these evaluation activities due to the difficulties of conducting a telephone survey (northwest New Mexico) and a delay in program implementation (Oakland, California).

Each Fighting Back treatment site was paired with two or three demographically similar comparison communities within the same state (Table 1). Selection of comparison sites within a state controlled for differences in AOD use policies. Multiple controls provided several advantages: information regarding site-to-site variation in use rates and trends within a state, and alternative comparisons if a control site initiated a similar program or experienced significant economic or population changes.[10] In the first wave of the survey, AOD use rates in treatment and comparison sites were no different than would be expected by chance.[11]

Data and Measurement

Outcome data were from three waves of a large-scale random-digit-dial (RDD) telephone survey of individuals aged 16 to 44, conducted in study communities in spring 1995, 1997, and 1999.[12] The survey assessed AOD use behaviors and attitudes, knowledge about and use of treatment services, and neighborhood perceptions. A total of 12,113 interviews were completed in 12 treatment and 29 comparison sites in 1995, with roughly 500 interviews allocated to each site. The sample was increased in subsequent waves so that a total of 17,900 interviews were completed in 1997 and 17,469 interviews in 1999.

The effectiveness of the program was assessed by three sets of outcome measures: substance use, treatment indicators, and community/prevention indicators. Highly correlated items were excluded for the present analysis. For example, 12-month illicit drug use included both marijuana use and cocaine use; thus only the composite item was used. Fourteen indicators were selected, as outlined in Table 2.

Table 1. Fighting Back and comparison sites

Fighting Back sites	Comparison sites
Washington, DC (Marshall Heights)	Baltimore, MD Washington, DC (central)
Santa Barbara, CA	Carlsbad, CA Redondo Beach, CA
Vallejo, CA	San Bernardino, CA Stockton, CA
Little Rock, AR	Fort Smith, AR Pine Bluff, AR
New Haven, CT	Bridgeport, CT Hartford, CT Waterbury, CT
San Antonio, TX	Dallas, TX Fort Worth, TX Houston, TX
Kansas City, MO	Columbia, MO Springfield, MO St. Louis, MO
Milwaukee, WI	Madison, WI Racine, WI
Columbia, SC	Charleston, SC (north) Greenville, SC
Charlotte, NC	Greensboro, NC Raleigh, NC Winston-Salem, NC
Newark, NJ	Camden, NJ Jersey City, NJ
Worcester, MA	Fall River, MA Lowell, MA Springfield, MA

Process data were from several sources including an on-site management information system (MIS), site visits, and interviews with site directors, staff, and volunteer leadership. Activity data were collected from all Fighting Back sites by a full-time MIS specialist. These data were corroborated through evaluator interviews with Fighting Back directors, key staff, and coalition partners. Data were collected from the start of the project, March 1992, through December 1996. After this, RWJF discontinued the MIS and provided renewed funding to eight of the sites for up to 5 years. The other four sites either continued on unspent funding or local funding. One site (Worcester) had its activities absorbed into local prevention efforts of the state substance abuse agency.

Since sites chose their own initiatives for implementation, cross-site categories had to be developed as a first step for measuring program inputs. "Strategies" were standardized by problem addressed, target group, approach, and goal. After several refinements,[13] a set of 18 strategies was identified using the following criteria: (1) equivalent in level of abstraction and detail, (2) mutually exclusive, and (3) conceptually consistent with the continuum of care. Table 3 summarizes the 18 strategies, with examples of related activities.

Evaluators next developed a scale to rate the relative strength of strategy implementation within a site (i.e., the role of Fighting Back, level of effort/activity, and duration). Further details about the rating criteria are summarized in Table 4.

Using this scale and all available data, three raters independently judged strategy dose at each of four implementation time periods, and then met to discuss and determine a consensual rating. As a final check on accuracy, ratings were sent in a written report to site directors for their review. Directors could provide additional information or arguments about ratings, but they corroborated findings in most cases.

Hypotheses

The analyses were guided by three main hypotheses, with relevant variables and targets summarized in Table 2.

Hypothesis 1: Strategy outcomes will positively correlate with their specific targets. Strategies aimed at youth will improve substance use and treatment-related outcomes for respondents aged 16 to 20 years. Strategies aimed at adults will improve substance use and treatment-related outcomes for respondents aged 21 to 44 years. Strategies aimed at the whole community will improve community prevention–related outcomes.

Hypothesis 2: Sites that have more comprehensive programs, as evidenced by total score and rank across all strategies, will have better outcomes.

Hypothesis 3: Sites with more high-dose strategies will have better outcomes, because overall program efforts will be more potent.

Analysis

Average ratings (0 to 5) across three implementation time periods were calculated for strategies by individual site and across all sites. First-period strategy ratings were dropped because scores were universally low, reflecting the time needed by sites to recruit and consolidate coalition members, hire staff, and conduct planning. Individual strategies were compared for frequency of implementation by their average dose across sites. Then sites were compared and ranked by the average dose score on each strategy, and an average rank was calculated by grouping (e.g., youth strategies). Sites were also ordered by their average rank for all strategies and were separately ranked by the number of strategies that had received an average score of three or higher (number of high-dose strategies).

Outcome data were analyzed using SUDAAN software (Research Triangle Institute, NC), which adjusts for the potential bias in variance estimates due to clustered samples. All outcomes were dichotomous variables; thus, logistic regressions were used to test program effects. The basic program effects model compared the rate of change in a particular outcome (e.g., binge drinking) in control sites over the 4 years spanning the survey to the rate of change in that outcome in the Fighting Back site over the same period. Even though comparison sites were demographically similar to treatment sites, the respondent's demographic characteristics (race/ethnicity, gender, age, employment status, poverty status, and education) were included as covariates to control for potential differences in composition. Thus, the program effects model consisted of treatment and time variables, demographic covariates, and an interaction term representing the difference in trends over time between the treatment and control sites. Substance use and treatment outcomes were estimated for youth (aged 16 to 20) and adults (aged 21 to 44) separately, whereas community outcomes were estimated for all respondents (aged 16 to 44).

Next, the 12 Fighting Back treatment sites were ranked in terms of the program effect for each outcome. Table 5

Table 2. Hypothesized relationships between strategies and outcomes

Age-targeted strategies	Targeted population	Outcomes (limited to target population)
Youth-targeted strategies (n=6)	Youth outcomes (aged 16–20 years)	**Drug use indicators**
Youth AOD prevention training		Legal (at risk for alcohol dependence, alcohol dependence, 30-day binge drinking, current cigarette smoking)
structured activities		Illegal (12 months any illicit drug, drug dependence, 30-day combined marijuana use and binge drinking)
Youth access to a tobacco and alcohol		**Treatment indicators**
intervention with high-risk youth		Knowing about treatment facilities or knowing people in treatment
Enhanced treatment for youth		12 months receiving AOD treatment
School system		12 months attending meetings
Adult-targeted strategies (n=5)	Adult outcomes (aged 21–44 years)	Same as above
Enhanced treatment for adult		
Legal system		
Faith community		
Workplace/business community		
Healthcare system		
Community-targeted strategies (n=7)	Community outcomes (all population groups)	Seeing or hearing a drug-prevention message
Public awareness		Considering use of cocaine as great risk of harm
Community organizing		Knowing someone in community who uses heroin
Community policing		Frequently seeing drug sales in neighborhood
Community resource center		
Community grant		
Neighborhood cleanup		
Control of liquor outlets		
Overall strategies (n=18)	All population groups	All outcomes listed above
Cumulative score of all 18 strategies		
Number of high-dose strategies		

AOD, alcohol and other drugs.

provides an example of program effects for 30-day alcohol binging. Milwaukee is ranked in first place because it had the greatest decline in binge drinking relative to its control sites (logit=−0.27). Santa Barbara is ranked 12 because it had the greatest rise (logit=0.23). An average site rank was estimated for each set of outcomes (i.e., adult/youth substance use, adult/youth treatment, and community/prevention). A lower average rank indicated greater program success.

The principal analysis consisted of estimating the correlation between the program effect rank and the strategy rank to test each hypothesis. A two-tailed Spearman's rho was employed.

Results

Strategy Dose

Table 6 provides information about strategy dosage in each of the sites. As seen in the table, sites differed in their choice of strategies, and the dose with which they implemented them. When summed, cumulative strategy scores ranged from 32.7 to 51.4 across sites. The number of high-dose scores ranged from three to nine.

The bottom row of Table 6 shows average scores for each strategy. Of the 18 strategies, public awareness was consistently delivered with the highest dosage (average score=3.9) and by the most communities. Other high-dosage strategies were enhanced treatment for adults, community organizing, structured activities, and intervention with high-risk youth. Strategies delivered at the lowest dosage were treatment for youth, youth access to tobacco and alcohol, work/business community, control of liquor outlets, and youth AOD prevention training.

Relationship between strategy and outcome. Table 7 compares site strategy rankings with outcome rankings. First, we examined whether strategies targeting certain groups had an effect on corresponding outcomes. As seen in Table 7, there is little correlation between youth strategy and outcomes. The rho correlation showed an inverse relationship, but it was not significant (rho=−0.02, p=0.95).

Next, we examined whether adult-focused strategies showed outcome effects. This time, the correlation coefficient was negative and significant (rho=−0.69, p =0.01). Finally, we examined the relationship between community strategies and outcomes. There was no significant relationship between score and outcomes (rho=−0.02, p =0.95). As a further check, individual strategies were examined for unique effects when correlated against group outcomes related to Hypothesis 1, but no single strategy appeared to show exaggerated influence.

Hypothesis 2 examined whether coalitions that were more comprehensive in their strategy approach had more positive outcomes. The correlation coefficient was negative but not statistically significant

Table 3. Strategies of continuum of care categories

Continuum of care categories	Strategies	Activities
Public awareness	Public awareness	Development of mass media materials; public forums and presentations; campaigns to change alcohol and tobacco advertising practices; newsletters, PSAs and other projects with radio, TV, and print media
Youth prevention	Youth AOD prevention training	Classes or curricula aimed at teaching youth about refusal skills and the dangers of substance use
	Structured activities	Before/after/summer school programs, drug- and alcohol-free recreational activities, community service projects, job training/placement, leadership and media advocacy
	Youth access to tobacco and alcohol	New policies/enforcement of tobacco-free school districts, bans on vending machines and sale of single cigarettes; decoy or sting operations to enforce ban on alcohol sales to minors
	Intervention with high-risk youth	Court diversion programs, counseling, conflict resolution training, academic assistance, truancy and gang prevention, parenting classes and interventions with families
Early ID/Institutional norms	Legal system	Drug court, training of police and court personnel in identification and referral; efforts to pass DWI laws and public consumption laws
	Faith community	Efforts to foster acceptance (addiction as disease rather than moral failing), and provide church-based services such as pretreatment, referral, or aftercare
	Workplace/business community	Prevention training; "Drugs Don't Work" programs; employee assistance programs; and gathering support from businesses for community-based prevention activities
	Healthcare system	Instituting or improving AOD screening, assessment and referral procedures in healthcare settings, and improving managed care coverage for prevention and treatment
	School system	Identification and referral policies and programs, student assistance programs, other prevention or intervention programs implemented through the schools
Treatment and relapse prevention	Enhance treatment services: adults	Coordinate and integrate service provision; advocate or provide services for underserved, such as women and minorities; advocate for funding options for uninsured and underinsured
	Enhance treatment services: youth	Same as above, with focus on children and youth
Environmental improvement	Community organizing	Support, initiate, and develop grassroots organizations; leadership and AOD prevention training for residents; organize residents to support Fighting Back agenda; provide staff for local organizing efforts; provide case management services to neighborhood residents; bring services or improve the economic vitality of an area
	Community resource centers	Neighborhood-based centers that provide access to city or county services to residents
	Community policing	Partnerships with police to solve local crime problems; foot patrols; neighborhood crime watches
	Community grants	Small grants to local groups for prevention services or planning
	Neighborhood cleanups	Graffiti and trash cleanups; beautification projects, street lighting; housing renovation; closing crack houses; code enforcement; training residents to use code enforcement
	Control of liquor outlets	Responsible beverage service training; policies to restrict/close liquor outlets; local ban on fortified wines or 40-oz. malt; Sunday alcohol sales restrictions; attempts to increase alcohol tax

AOD, alcohol and other drugs; PSA, public service announcement.

(rho=−0.34, p =0.28). Hypothesis 3 examined the relationship between number of high-dose strategies and outcomes. This time, the correlation coefficient was negative and significant (rho=−0.59, p =0.02).

Discussion

Surprisingly, the data from this study did not support any of the study hypotheses. Not only were effects related to community and youth goals null, but coalitions that targeted adults actually did worse on related indicators over time compared to matched controls. Coalitions that were more comprehensive in their strategies did not show any superior benefit; when coalitions focused high doses of funding and staff time on specific strategies, this produced an inverse relationship with desired outcomes. How can we interpret these findings?

Table 4. Strategy rating criteria

Rating	Criterion
0	No activity; not a Fighting Back strategy.
1	Minimal activity or planning stages only. >3 mentions in MIS or meetings for discussion only with no implementation. May also signal peripheral partnership. Fighting Back staff may have attended meetings, but little commitment to implement or sustain.
2	Minimal activity, but an implemented initiative listed in the MIS. Low budget and staffing commitment (e.g., Fighting Back may be an active partner but did not initiate, or Fighting Back initiated but project was of brief duration (≤6 months).
3	More activity reflected in MIS and in project budget. Fighting Back had more of a leadership role, with committed staff and other resources to implement.
4	A sustained, extensive effort that Fighting Back initiated and led, devoting considerable resources to implementation and coalition building for institutionalization.
5	A flagship effort, with extensive resource commitment that defines the project in terms of focus.

MIS, management information system.

It is useful to consider that there are different ways to develop and evaluate public health programs. The most systematic approach starts with basic research and hypothesis development, followed by pilot applied studies and efficacy trials, and finally effectiveness and demonstration studies.[14] Each stage builds on findings from the previous stage. Efficacy trials, in particular, allow researchers to determine whether the program improves the condition of those exposed and whether there are any unanticipated harms associated with interventions. An alternative to this systematic process is program evaluation, in which the intervention is not standardized, is of unknown efficacy, or both, but is tested using an experimental or quasi-experimental design. Program evaluations are the least interpretable because a lack of program effects could be due to program inefficacy, poor implementation, low availability, or low acceptance.[14] Program evaluations, however, are quite common, and Fighting Back followed this model.

Table 5. Example of derivation of outcome ranks: 30-day alcohol binging

Site	Program effect (logit)	Rank
Charlotte, NC	−0.05	6
Columbia, MO	0.14	9
Kansas City, MO	−0.06	5
Little Rock, AR	−0.15	3
Milwaukee, WI	−0.27	1
Newark, NJ	0.07	8
New Haven, CT	−0.10	4
San Antonio, TX	−0.22	2
Santa Barbara, CA	0.23	12
Vallejo, CA	0.03	7
Washington, DC	0.14	10
Worcester, MA	0.22	11

With this in mind, several interpretations of the findings are possible. The first, which must be considered, is that coalitions have adverse effects. Without an efficacy trial, there was no opportunity to pilot test whether the Fighting Back concept was either efficacious or had a possibility of harm. Instead, there was a

Table 6. Strategy dose score by site

	Youth strategies						Adult strategies		
Fighting Back sites	AOD prevention training	Structured activities	Access to tobacco and alcohol	Intervention with high-risk youth	School system	Enhanced treatment service	Faith community	Legal system	Workplace/ business community
Charlotte, NC	0	3	0	2	2	0.7	4	1.3	0.7
Columbia, MO	2	3.7	2	3.3	2	4	3	2	1.7
Kansas City, MO	2.7	2.7	2.3	3	0	0	2.7	2	2.7
Little Rock, AR	0.3	2.3	0.7	1	1	2.7	0.7	0.7	1.3
Milwaukee, WI	1.3	3.3	2	4	2	0.7	3	2	0.3
Newark, NJ	3	3.3	0.7	3.3	4.3	0.7	2.7	0	1.3
New Haven, CT	3	2.7	1.7	2.7	2.3	1.7	1	1.3	1
San Antonio, TX	0.7	4.3	1.7	3.7	2	0.7	2	0.7	0
Santa Barbara, CA	2	4.7	1.7	4	5	0	2	2.7	3
Vallejo, CA	1	5	2	3	2	1	3	2	2.7
Washington, DC	2	3.3	0	3	2	0	2	2	1.3
Worcester, MA	1.3	3	1	5	2.3	1	3	3	0.7
Average by strategy	**1.6**	**3.4**	**1.3**	**3.2**	**2.3**	**1.1**	**2.4**	**1.6**	**1.4**

AOD, alcohol and other drugs
[a]Cumulative score.
[b]Number (n) of high-dose strategies.

5-year implementation period in which communities were given roughly $3 million to bring a wide variety of interest group representatives together, hire staff, develop a plan for interventions, and work in various committees. Although counterintuitive, it is possible that the resulting process tipped the political balance in such a way as to harm existing programs, raise conflicts, or attract new players who were more harmful than helpful.

As an example, coalition involvement might lead to the adoption of a popular school-based program, such as Drug Abuse Resistance Education (DARE), because a few influential members persuade the group to favor it over other more effective programs recommended by knowledgeable school staff. This, in fact, happened at one of the sites, although with input from evaluators, other programs were also subsequently adopted. DARE is a useful example because the program has been rigorously evaluated and found to have only minimal, short-term impact.[15] Most other strategy activities had no scientific testing, but were chosen in a similar fashion. Thus, bringing a broad coalition together could actually lead to less effective strategies because of the political need to acquiesce to various demands, making it harder to achieve a cohesive, targeted program.

It is similarly possible that coalitions require a lot of effort, but produce no appreciable effect. Public awareness provides an example of the problems that inclusive coalitions face in making any impact. Public awareness was the most consistent and highest-ranked activity across all Fighting Back sites. Yet there is little evidence that this strategy changed either beliefs or behavior related to substance use in Fighting Back sites.[16] Research shows that public awareness campaigns can be used to set the agenda for policy decisions and to change social norms,[17] but successful campaigns require leadership, consistency, repetition, power, and money. As an example, the Harvard Alcohol Project used Hollywood's clout to create the "designated driver" social norm in the United States.[18] The project was top-down, with a single focus and strong support from respected industry leaders. But such centralized campaigns are antithetical to coalitions like Fighting Back.

Another explanation for the findings is that the Fighting Back program was either poorly implemented or unacceptable to the individuals and institutions that coalitions were supposed to change. In terms of implementation, there is evidence that the Fighting Back communities did bring disparate community groups together and that coalitions attempted to coordinate and enhance the continuum of care.[19] Since the program itself was not standardized, evaluators had to devise some method for measuring dose and implementation of the "programs" developed. Although activities were reasonably categorized into the 18 strategies, the within-category variation was large, and specific programs and activities were often sporadic. Staff turnover often meant that a program would stop for a period and resume with very different content and process (although still with the same target and purpose). Rarely did any strategy follow a tested model of intervention; community members and agencies were encouraged to try any and all new ideas, sometimes with small mini-grants from the coalition. Thus, while the strategy rating process allowed a way to measure "dose," it was not able to capture "quality."

Institutions were least likely to change as a result of Fighting Back, even though they were clearly targeted

Table 6. (continued)

Adult strategies		**Community strategies**							**Overall (N=18)**	
Healthcare system	**Enhanced treatment service**	**Community organizing**	**Public awareness**	**Community policing**	**Community resource center**	**Community grants**	**Neighborhood cleanups**	**Control liquor outlets**	**Cuma**	**N**
1.3	4	4.7	3.3	2.7	3.7	3	3	3	**42.3**	**9**
2.7	3.7	3	4	1.3	0	3	1.7	0.7	**43.7**	**8**
0.7	3	5	3.7	4	2	1	3	3	**43.4**	**7**
1.3	5	2.7	4	2.3	5	1	2.7	0.7	**35.3**	**3**
2	2.7	4	5	1.3	2.7	1.3	2	2	**41.7**	**5**
0	4	5	2.7	3.3	4	1.3	3	0.7	**43.3**	**9**
1.3	4	5	4	3	0	3.3	1.7	1.3	**41**	**6**
0.7	3	4.3	4	2.7	4	4	3.7	1.7	**43.7**	**8**
4	3	2	5	1	0.3	0	2	0.7	**43**	**7**
2.7	4.7	3.7	5	2	2.7	3	2	4	**51.4**	**8**
1.3	4.7	2.7	2.7	1.7	1	0	1.7	1.3	**32.7**	**3**
1.3	3.7	2.7	3.3	2.3	0	2	2	0	**38.7**	**6**
1.7	**3.8**	**3.7**	**3.9**	**2.3**	**2.1**	**1.9**	**2.4**	**1.6**		

Table 7. Relationship between strategy ranking and outcome ranking[a] by site

Site	Average rank of youth strategies	Average rank of youth outcome	Average rank of adult strategies[b]	Average rank of adult outcomes	Average rank of community strategies	Average rank of community outcomes	Average rank of overall strategies	Rank of high-dose strategies[b]	Average rank of overall outcomes
Charlotte, NC	8.8	6.3	5.6	5.0	4.0	6.5	6.1	1	5.8
Columbia, MO	3.5	6.7	3.6	7.9	7.6	7.0	5.1	3	7.3
Kansas City, MO	7.2	7.9	6.0	5.9	4.3	4.8	5.7	6	6.5
Little Rock, AR	9.5	6.1	6.8	4.8	6.0	6.0	7.4	11	5.5
Milwaukee, WI	4.5	5.0	6.6	6.1	5.6	5.3	5.5	10	5.5
Newark, NJ	4.7	9.4	7.8	7.7	4.7	7.5	5.6	1	8.4
New Haven, CT	5.3	6.8	7.4	4.7	5.1	6.3	5.8	8	5.8
San Antonio, TX	5.5	7.1	9.8	4.4	3.1	8.5	5.8	3	6.2
Santa Barbara, CA	4.0	6.6	4.2	9.4	8.4	7.8	5.8	6	8.0
Vallejo, CA	4.7	5.3	2.2	6.9	4.4	5.8	3.9	3	6.0
Washington, DC	7.0	3.8	4.8	6.2	9.1	5.5	7.2	11	5.1
Worcester, MA	5.2	6.9	4.6	9.0	8.3	7.3	6.2	8	7.8

[a]Best rankings are associated with lowest numbers.
[b]rho $p < 0.05$.

by RWJF.[3] The proposed changes were difficult to achieve (e.g., coordination within the substance abuse treatment system) and were not acceptable to institutions who found little individual benefit in RWJF's goals of a coordinated, consolidated system of care.

A final alternative explanation is that the Fighting Back communities were at particularly high risk for substance use and its related harms. This argument suggests that the reason Fighting Back communities got selected for funding is because they showed evidence of high or escalating substance abuse-related problems. These communities chose particular strategies because they were concerned about the growing problems and lack of treatment for targeted groups. Outcomes would have been even worse if the coalition had not been at work. Comparison and intervention sites were quite similar on key outcomes at baseline, however, making such a pattern unlikely. In addition, this argument is weakened by the fact that there was a negative correlation broadly with high-dosage strategies, as well as in outcomes specifically related to adults.

This study has a number of limitations. The difficulties involved in evaluating both the activities and outcomes of community-based coalitions quantitatively are well known and have been documented elsewhere.[20–22] A major problem is small sample size when the community is the unit of analysis. The sample size in this study was limited to 12 matched sets. Multiple comparison sites were carefully selected within the same state (to control for state policies) for similar demographic profile. Nevertheless, it is extremely difficult to achieve equivalence in a quasi-experimental design.[20] Fighting Back sites were selected in an application process and so may have been different in some unknown way from comparison sites. Many of the comparison sites had coalitions formed under the CSAP coalition programs. Since most of these limitations would be expected to lead to null or random findings, it is surprising that there was such a strong and consistent negative correlation between strategies and outcomes.

As mentioned previously, measurement of strategies was limited to dose and not to quality. The study, however, contributes to the field by a very careful measurement of dose across multiple time points, despite the lack of program standardization across sites. The accuracy of strategy measurement was reviewed and confirmed by staff in each of the Fighting Back sites.

Given the findings, there are two main lessons learned in Fighting Back. First, broad goals do not lend themselves to effects on specific outcomes. Fighting Back had extremely broad goals to reduce demand for all drugs and alcohol among all groups and to prevent harms associated with use. Such broad goals required communities to work on many fronts at once and to have many competing programmatic priorities.

Second, coalitions are expensive to maintain and may not lend themselves to effective or well-implemented strategies. RWJF required coalitions to have broad-based involvement, including grassroots members as well as community elites. Money and strategy concessions were required to keep people at the coalition table. Demand reduction goals were not necessarily served well by these requirements. Policymakers need to carefully consider whether community coalitions are really a viable weapon in the war on drugs, at least as presently conceived.

Based on the Fighting Back experience, several recommendations can be made to help coalitions avoid negative outcomes and better gauge the success of their efforts. First, communities should keep their goals focused and manageable. The expected outcomes should be well defined, with high-quality corresponding data sources (e.g., school surveys). Since data collection is expensive, quality is to be preferred over quantity. Second, communities should be encouraged to choose research-based programs and get assistance

in effectively carrying them out. In the case of school-based programs, there are now several federal lists of programs[23–25] that have research evidence of efficacy, and there is also limited evidence on other specific community strategies.[26] No matter what communities choose, they should monitor implementation and pay attention to both dose and quality. Third, communities should consider environmental programs, and not just public awareness or individually focused strategies. There is now extensive evidence that certain policies and other environmental approaches can reduce substance abuse.[27] But as seen in Fighting Back, communities often tend to avoid environmental strategies (e.g., reducing youth access to alcohol and tobacco and control of liquor outlets).

Finally, communities should evaluate the impact of their programs. They should get technical help with evaluation, but also community participation in choosing outcomes, indicators, and benchmarks. Outcomes should be meaningful to the community and should be tightly tied to agreed goals, programs, and strategies. Sampling should be done carefully so that results are valid, and some type of comparison group (e.g., comparable state or nationwide data) must be used as a context for understanding results. Otherwise, "successful" findings may merely reflect nationwide declines in AOD use, or "failures" may indicate results that are actually better than expected trends.

Fighting Back continues to be a bold attempt to solve an extremely difficult problem. RWJF invested philanthropic funds to try out ideas that many thoughtful persons believed would hold the key to reducing demand for drugs and alcohol. Given the amount of research produced over the last decade since Fighting Back was conceptualized, the next generation of community sites could benefit from assistance in reviewing and selecting programs based on research findings, setting up and conducting formative evaluations, and interpreting results in a way that can guide further planning. Rather than expecting effective programs to emerge entirely from a political process, we must continue to find a way to bridge the gap between scientific knowledge and the desire to improve one's own community.

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