HIV and Substance Use Prevention Among
Charleston County African American Teens
Community Needs Assessment Report
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Prepared by: Carla Kmett Danielson, Ph.D., Director, EMPOWER Program
National Crime Victims Research & Treatment Center, Medical University of South Carolina
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Methods of Data Collection

1) Adolescent and Caregiver Focus Groups

Several focus groups were conducted with the following populations in Charleston County: African American adolescent girls (12-17 years), African American adolescent boys (12-17 years), and caregivers of African American adolescent boys and girls. Recruitment for the focus groups with the adolescents and caregivers took place through several urban and rural-based schools, churches, and community organizations. Written permission, provided on permission slips approved by the MUSC IRB, were collected from all participants. In all, 11 groups were run (8 youth groups and 3 caregiver groups), each lasting approximately 60-90 minutes. A total of 22 Boys, 38 Girls, 47 Parents/Caregivers participated in the groups. The average group size was approximately 8-9 youth participants; caregiver groups were larger. Caregiver participants consisted of mothers and grandmothers. The following questions were used to lead uniform discussions across groups:

Adolescent Questions:

- Have you ever heard of HIV/AIDS?
- Do you know what HIV or AIDS stands for?
- Do you know someone personally who has HIV or AIDS? (For example: A family member, friend, friend’s family member?)
- Do you know someone or are you related to someone who uses drugs and alcohol?
- Where do you get most of your information about HIV and AIDS? (for example: friends, parents, other family members, doctor, nurses, TV, Internet?)
- Where do you get most of your information about drugs and alcohol?
- Are there places in your community that offer HIV testing or treatment? Where are they?
- Are there places in your community that offer substance use treatment? Where are they?
- If you needed to get an HIV test, where would you go?
- If you needed to go to an HIV clinic or a substance use clinic, how would you get there
- Which ethnic group do you think has the highest rate of HIV/AIDS?
- Which gender do you think has the highest rate of HIV/AIDS?
- Which age group has the fastest growing rate of HIV/AIDS?
- Do you think that HIV/AIDS is a serious problem that you and your friends should worry about? Why or Why not?
- If you were HIV positive and you needed somewhere to go for help, where would you go? Who would you talk to, if anyone?
- If you wanted to get drugs and alcohol, how easy would it be for you to find drugs or alcohol in your community?
- How great is the peer pressure to use drugs or alcohol in your community or in your peer circle?
- How great is the peer pressure to engage in sexual behaviors among your peers?
- How many of your friends do you think are sexually active?
- Are there safe places for you and your friends to go to have a good time and not be faced with pressure to use drugs or alcohol? If so, where?
Caregiver Questions:

- Have you ever heard of HIV/AIDS?
- What does HIV or AIDS stands for?
- How aware are you of your child’s knowledge of HIV/AIDS?
- Do you know someone personally who has HIV or AIDS?
- Do you know someone or are you related to someone who uses drugs and alcohol?
- Where do you get most of your information about teaching your kids about HIV and AIDS?
- Where do you get most of your information about teaching your kids about drugs and alcohol?
- Are there places in your community that offer HIV testing or treatment? Where are they?
- Are there places in your community that offer substance use treatment? Where are they?
- Are you aware of their policies regarding testing and/or treating minors?
- If you or your child needed to get an HIV test, where would you go?
- If you or your child needed to go to an HIV clinic or a substance use clinic, how would you get there?
- Which ethnic group do you think has the highest rate of HIV/AIDS?
- Which gender do you think has the highest rate of HIV/AIDS?
- Which age group has the fastest growing rate of HIV/AIDS?
- Do you think that HIV/AIDS is a serious problem that you and your child should worry about? Why or Why not?
- If you or your child were HIV positive and you needed somewhere to go for help, where would you go? Who would you talk to, if anyone?
- If your child wanted to get drugs and alcohol, how easy would it be for him/her to find drugs or alcohol in your community?
- How great is the peer pressure to use drugs or alcohol in your community or in your child’s peer circle?
- How great is the peer pressure to engage in sexual behaviors among your child’s peers?
- How many of your child’s friends do you think are sexually active?
- Are there safe places for your child and his or her friends to go to have a good time and not be faced with pressure to use drugs or alcohol? If so, where?

A minimum of two facilitators were present at each group, such that at least one facilitator was able to record notes from the discussion. In addition, focus group members were given the questions on a written handout to follow during the discussion and to allow participants to write their answers if they preferred this to sharing their responses aloud with the group. Participant time was compensated through $10 gift cards.
2) Faith-Based Community Leader Focus Group

A Focus Group with faith-based community leaders was conducted in Fall, 2008, with faith-based community representatives from Hollywood, SC (rural area of Charleston). The group was held at a local Middle School for two hours. The purpose of the focus group was to provide faith-based community leaders an opportunity to discuss risky sexual behaviors (which lead to teen pregnancy) and youth sexuality issues in their community and to inform prevention services staff on the best ways to address these issues.

Nine pastors and community members were scheduled to participate in the focus group. A total of six individuals showed up on the day of the group to participate. The participants represented five churches and two denominations: four were African Methodist Episcopal (AME) and one was Baptist. A total of 15 questions were asked to address three broad areas:

- Perceptions of the risky sexual behavior/teen pregnancy and youth sexuality problem in the community;
- The role of the church in addressing teen pregnancy and youth sexuality issues;
- Perceptions of the low impact of existing HIV prevention programs among pastors and churches in the community.

3) Phone-Based Surveys

SAMHSA's Minority AIDS Initiative (MAI) National Outcome Measure (NOM) was administered through phone surveys and small group surveys to collect data about HIV and substance use risk behaviors among local youth and caregivers. Trained interviewers contacted potential participants by dialing phone numbers obtained through phone lists targeting areas with high prevalence of African American families in Charleston County. Calls were typically made in the early evening and Saturdays. Families were screened for eligibility to participate (inclusion criteria: African American adolescent between the ages of 12-17 years living in the home, verbal consent had to be provided by legal guardian and adolescent for participation). A brief description of the survey (focusing on HIV and substance abuse behaviors and prevention) was provided to families meeting inclusion criteria, whom were then offered the opportunity to participate. Gift cards in the amount of $10 were provided to participants who completed the phone survey. Given problems with slow recruitment through the phone list method, we were given permission by the IRB to pursue recruitment through public forums, including the local mall and the Black Expo (a large annual event in North Charleston in which a large portion of the local African American community participate). In these public forums, individuals were screened for eligibility, informed about the surveys, and asked whether they would be interested in participating. Interested adolescents and caregivers provided us with a phone number and best time of day to call. These individuals were then contacted that week by interviewers and the same aforementioned procedures were followed.
4) Epidemiological Data

EMPOWER staff met with the SEOW team multiple times and Charleston County Department of Alcohol and Other Drug Abuse Services (DAODAS), whom, as EMPOWER community partners, graciously shared the most recent county and state-wide epidemiological data collected regarding adolescent HIV and substance use-related behaviors. The most recently available epidemiological data from the Centers of Disease Control (CDC) and SC Department of Health and Environmental Controls (DHEC) was gathered per the respective websites as well.
Adolescent Focus Group Results

The following themes resulted from the adolescent focus group responses:

- Virtually no youth knew what HIV or AIDS stood for—although 1 answered, “As I Die Slowly”; many did not know the difference between HIV and AIDS

- Youth identified TV and internet—as well as peers and school—as the primary sources from which they learn about HIV/AIDS. **Virtually no youth identified parents as a source of information about sex and HIV/AIDS.**

- The great majority of youth said they would **not** go to their parents to discuss if they wanted to get tested for HIV; communication between youth and caregivers about substance abuse appears to be more prevalent—but still needs improvement

- Most youth believed substance abuse was prevalent among local young people

- Most youth were not aware of where and how to access substance abuse prevention and treatment services

- Transportation in general was a concern (for HIV testing, accessing services, accessing positive community activities)

- Youth noted that peer pressure was a ‘real thing’ when it came to substance use and sex

- Many youth noted the following as “safe places”: movies, mall, being a part of a sports team

- However, some communities did not have local movie theaters or community centers

- Almost all youth stated that a community center that did not cost money to join would be a good “safe place” for teens—most did not have this type of center in their community

- Many youth did recognize that African Americans were at highest risk for HIV infection
Caregiver Focus Group Results

The following themes resulted from the caregiver focus group responses:

- As with youth, no caregivers knew what HIV or AIDS stood for—although 1 caregiver also answered, “As I Die Slowly”; again, many did not know the difference between HIV and AIDS

- Almost all caregivers knew someone with HIV or AIDS, as well as others who were addicted to drugs and alcohol

- Parents identified the internet, the doctor’s office, media, and DHEC as sources on information

- Many parents believed their youth knew “some” but not “all” of the facts regarding HIV infection/risky sexual behavior (concerns whether youth recognized oral and anal sex as sex)

- Most caregivers were not aware of the SC laws regarding HIV testing of minors (mandatory reporting of positive results to DHEC and school superintendents)

- Many caregivers stated that African Americans, women, and young people in particular, were among the higher risk groups for HIV infection; however, information regarding method of transmission was not accurate (“fast women passing it on to their babies”)

- Caregivers recognized that alcohol and drugs were easily accessible to their teens—and that peer pressure was prevalent.

- Some parents did not believe there were easily-accessible substance abuse services
Faith-Based Community Leader Focus Group Results

The following themes resulted from the faith-based leader focus group responses:

- More resources are needed for prevention education within the churches:
  - Health Education (e.g. it would be ideal if each church could have its own health educator)
  - Increased funding for various prevention programs

- There needs to be a place where pastors can access HIV/AIDS information easily—and discreetly

- Include church leaders in advisory work groups and planning—BUT plan ahead and provide LOTS of reminders to the pastors—whom already have a lot on their plate

- Bring in the data/statistics regarding teen pregnancy, HIV/AIDS, etc among our African American youth to engage community members—"prove" this is a problem
  - Perhaps in the form of an Education Day/Forum

- If you’re going to "get" the youth, you need to "get" the parents

- Need to provide incentives to attend prevention workshops

- Outreach is key because transportation is always a problem

- Most folks just don’t know where to get the information. Many think it is too difficult to access their local health department—but many don’t know all it takes is a phone call to get the necessary information

- It would be great to have all of the information in one place

- Quote from participant: “We need outreach and to help bridge gaps. Part of the outreach program of the church is to give information. Funding is a motivator. But outreach is part of our mission…and again the role of the church is to fulfill its mission. And so the outreach program would be the result. The mission would be to have less sexually active children or less children having babies or less HIV. And the only way to know that is to look at it closely, study it, and evaluate it for success. I think the church does have a specific role, and that is to get the information to the people. We are definitely in a place where we are at the top of the list for HIV, African-American women. So we have a mission. Our purpose is to make sure that doesn’t rise and to educate our children. So the church’s mission for getting information out, it’s already been told. It’s already been…but we’re just not doing it enough. Why is beyond me! And, we might be doing it, but we might not be doing it effectively. And if we’re not doing it effectively, we don’t have a guide that is proven to work. Then we’re just spinning our wheels spending money, time and energy, and still not reaching the children.”
Adolescent Phone Survey Results

A total of 72 surveys were completed with African American adolescents (4.3% identified as Hispanic as well). Of these participants, 62.3% (n=43) were girls. With regard to sexual orientation, 92.8% identified as straight or heterosexual, while 2.9% identified as “gay or lesbian, another 2.9% identified as “bisexual” and 1.4% reported they were unsure. When asked to describe where they live, 75.4% endorsed their parent or guardian’s home, 14.5% lived in a group home, 4.3% lives with another relative, 2.9% reported they lived in a foster home, and 1.4% reported living in their own apartment. Youth ranged from 5th-12th grade, with the mean being in the 10th grade.

The following graphs represent responses on key items of the survey.

Alcohol Use

Percent of Participants Who Endorsed Alcohol Use in Last 30 Days
Tobacco and Marijuana Use

Percent of Participants Who Endorsed Tobacco and Marijuana Use in Last 30 Days

Use of Other Drugs

Percent of Participants Who Endorsed Using other Illegal Drugs in the Last 30 Days
Risky Behaviors

Percent of Participants Who Endorsed Risky Behaviors Associated with Using Alcohol and Drugs

Parent and Guardian Influence

Percent of Participants Who Talked With a Parent or Guardian in the Last 12 Months About Alcohol, Drugs, and Tobacco.
Family Influences/Family Dynamics

Percent of Participants Who Endorsed Positive Family Interactions

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm available when others want to talk to me</td>
<td>95%</td>
</tr>
<tr>
<td>I listen to others, even if I disagree</td>
<td>90%</td>
</tr>
<tr>
<td>We ask each other for help</td>
<td>85%</td>
</tr>
<tr>
<td>We like to spend free time together</td>
<td>75%</td>
</tr>
</tbody>
</table>

Peer Influence Cont.

Percent of Participants Who Have Friends Who Engage in Risky Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get Suspended From School or Drop Out</td>
<td>60%</td>
</tr>
<tr>
<td>Get Arrested</td>
<td>40%</td>
</tr>
<tr>
<td>Are Sexually Active</td>
<td>100%</td>
</tr>
</tbody>
</table>
Peer Influence Cont.

Percent of Participants Who Have Friends Who Participate In Positive Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer</td>
<td>60%</td>
</tr>
<tr>
<td>Participate in Religious Activity</td>
<td>80%</td>
</tr>
<tr>
<td>Exercise or Play Sports</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sexual Risk Behaviors

Percent of Participants Who Engaged In Risky Sexual Behaviors

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever Had Vaginal, Oral, or Anal Sex</td>
<td>70%</td>
</tr>
<tr>
<td>Had Sex In the Last 30 Days</td>
<td>40%</td>
</tr>
<tr>
<td>Had sex after using substances in the last 3 months</td>
<td>10%</td>
</tr>
</tbody>
</table>
Sexual Risk Behaviors Cont.

**Age at First Sex**
*(Including Oral, Anal, and Vaginal Sex)*

- Under 11 years
- 11-14 years
- 15-18 years

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**Percent Endorsing The Use of Condoms**
in the Last Thirty Days

- Yes
- No
- Refuse
Sources of Information Cont.

Where Do Participants Receive Information About HIV and Substance Use (Broken Down By Source)

Internet Services

Location of Internet Access Across Participants
Caregiver Phone Survey Results

A total of 59 parent/caregiver surveys were completed. Caregivers ranged in age from 34-74 years; 85.5% were women. Approximately 71% of the respondents were employed (full or part time) and 43% were married. Approximately 95% were African American and over 10% endorsed being of Gullah descent and another 11% responded that they were unsure whether they were of Gullah descent. A range of 1-4 children lived in the home of these caregivers. Age of the “designated child” (to whom the survey questions were focused) ranged in age from 12-17 years, with 55.9% of the youth being girls.

The following graphs represent responses on key items of the survey.

Parent/Guardian Attitudes on Teen Alcohol Use
Parent Behaviors Toward Preventing Teen Alcohol Use

Percent of Participants Who Engaged In Teen Alcohol Prevention Behaviors In The Last Six Months

![Graph showing percentage of participants engaged in specific behaviors]

Parent Behaviors Toward Preventing Teen Alcohol Use Cont.

Percent of Participants Who Endorsed Teen Alcohol Prevention Behaviors In The Last Six Months

![Graph showing percentage of participants endorsing specific behaviors]
Family Influences

Participant Responses to “How much does your family influence what your teen does?”

<table>
<thead>
<tr>
<th>Influence Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much</td>
<td>80%</td>
</tr>
<tr>
<td>Some</td>
<td>10%</td>
</tr>
<tr>
<td>Not very much</td>
<td>5%</td>
</tr>
<tr>
<td>None at all</td>
<td>5%</td>
</tr>
</tbody>
</table>

Family Communication

Participants Who Talk With Their Teens About Risky Behaviors At least Once a Month (By Behavior Category)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use</td>
<td>72%</td>
</tr>
<tr>
<td>Sex</td>
<td>68%</td>
</tr>
<tr>
<td>HIV</td>
<td>62%</td>
</tr>
</tbody>
</table>
Family Communication Cont.

**Percent of Participants Who Endorsed Confidence in Answering Their Teen’s Questions Accurately About Substance Use, Sex, and HIV**

- Substance Use: 94%
- Sex: 100%
- HIV: 96%

Family Communication Cont.

**Percent of Participants Who Endorsed Confidence That Their Teens Would Come To Them with Questions about Substance Use, Sex, or HIV**

- Substance Use: 96%
- Sex: 91%
- HIV: 95%
Parental Opinion of Current Services

Percent Who Reported On the Availability of Prevention Services for Teens in Charleston County

- Minimal to No Services
- Some Services
- Many Services

Parental Interest in New or Improved Services

Percent of Participants Interested in Workshops for Parents and Teens (By Category)
Parental Interest in New or Improved Services

Percent of Participants Interested in Future Services

Parental Interest in Web-Based Services

Percent of Participants Who Endorsed Interest in Web-based Services for Teen Substance Use and Risky Sexual Behaviors

Website that offered information to Parents  Website that offered information to Teens
Epidemiological Data Results (by Data Source)

The following represent the most recent available data from each of the following agencies:

Epidemiological Data from the SC State Epidemiological Outcomes Workgroup (SEOW) (as reported in South Carolina Profile on Alcohol, Tobacco, and Other Substance Related Indicators Report, March, 2008):

*Current Use*

Rates of current (past 30-day) alcohol use among youths in grades 9 through 12 have remained consistent over multiple years of reporting, with a subtle declining trend since 1999 (Figure 1). In three of the four years for which there were South Carolina YRBS data, 1995, 1997, and 1999, use rates were slightly lower in South Carolina compared to the US, with overlapping confidence bands in 1997 and 1999. In 2005 current alcohol use rates in the two geographic regions were indistinguishable. In 2007 the South Carolina rate declined to 36.8 percent (US data for 2007 were not yet available). Since there were approximately 204,000 students in grades 9-12 in South Carolina public schools in 2007-2008 (Source: SC Department of Education, Office of Research, Average Daily Membership files, Available: http://ed.sc.gov/agency/offices/research/DailyMembership.html), this translates to 75,072 students who were current alcohol users.

Figure 1. Current (Past 30-Day) Alcohol Use among Youths in Grades 9 through 12, South Carolina and US, 1995 to 2007
South Carolina current alcohol use rates by demographic groups in 2007 are shown in Figure 2. Although confidence bands are overlapping, there was a gradual increase across grade levels with highest use rates among 12th graders. African Americans reported lower use rates compared to whites.

Figure 2. Current (Past 30-Day) Alcohol Use among Youths in Grades 9 through 12, By Gender, Grade, and Race/Ethnicity, South Carolina and US, 2007

Among persons age 12 to 17, current alcohol use rates remained essentially unchanged between 2002 and 2003 in both South Carolina and the US but declined slightly in both regions in 2004-2005 (Figure 3). Current alcohol use rates among 12 to 17 year olds have been consistently lower in South Carolina compared to the US (e.g., 13.7% versus 17.1% in 2004-2005). Using 2004-2005 US Census population estimates for this age group in South Carolina (approximately 363,000), this translates into approximately 62,000 persons age 12 to 17 who were current alcohol users.
Figure 3. Current (Past 30-Day) Alcohol Use among Persons Age 12-17 and 18-25, SC and US, 2002-04

Figure 4. First Alcohol Use before Age 13, South Carolina and US, 1995-2007

*Early onset use*

First use of alcohol before age 13 is declining in both South Carolina and the US as a whole, from a higher 1995 starting point of roughly 40% in South Carolina and 33% in the US as a whole (Figure 4). Rates in the two regions were indistinguishable in 2005 at roughly 26%. The 2007 rate in South Carolina remained essentially unchanged at approximately 25% (US data for 2007 were not yet available), or roughly 51,000 students in grades 9 through 12.
Binge use

Binge alcohol use, defined as five or more drinks on a single occasion, has remained fairly constant across reporting years among youths in grades 9 through 12, with the suggestion of a recent decline in the US to about 28% (Figure 5). Rates have remained lower in South Carolina compared to the US as a whole, though by 2005, SC rates (at 25%) were not statistically different from US rates. South Carolina rates declined slightly in 2007 (US data for 2007 were not yet available). This rate (25%) translates to approximately 51,000 students in grades 9-12 who were binge drinkers.

Figure 5. Binge Alcohol Use* in the Past 30 Days among Youths in Grades 9 through 12, South Carolina and US, 1995-2007
Drinking and driving

Rates of past 30-day drinking and driving among youths in grades 9-12 declined over multiple reporting years in both South Carolina and the US, although South Carolina YRBS data are absent for 2001 and 2003, so whether the downward trend continued through those years is unknown (Figure 6). Drinking and driving rates in 2005 were roughly equivalent in South Carolina and the US as a whole at about 10-12%. In 2007 the South Carolina rate declined slightly to approximately 10% (US data for 2007 were not yet available). The South Carolina rate translates to roughly 20,400 persons.
Drinking and driving rates tended to be higher among males compared to females, and lower among 9th and 10th graders (who are barely of driving age) and African Americans (Figure 7).

**Dependence or Abuse**

Among persons age 12 to 17, alcohol dependence or abuse rates have remained relatively constant between 2002 and 2004 in both South Carolina and the US as a whole, with the
suggestion of a slight decline in 2004-2005 (Figure 8). The 2004-2005 death rate in this age group represents approximately 16,700 persons in South Carolina.

Figure 8. Percent of Persons Age 12 to 17 and 18 to 25 Meeting DSM-IV Criteria For Alcohol Dependence or Abuse in the Past Year, SC and US, 2002-2005

HIV/AIDS
HIV/AIDS is an important consequence of risky sexual behavior among youths. At the end of 2005 in South Carolina there were an estimated 179.7 adults and adolescents per 100,000 living with HIV and 181.9 per 100,000 living with AIDS (Figure 9). These rates compare less favorably to US rates of 137.0 per 100,000 living with HIV and 174.5 per 100,000 living with AIDS. For children less than 13 years of age, prevalence rates were 7.4 per 100,000 for HIV and 3.2 per 100,000 for AIDS in South Carolina. These rates were very similar to US rates of 7.4 per 100,000 for HIV and 2.7 per 100,000 for AIDS. Thus, compared to the US as a whole, South Carolina has very similar prevalence rates for children under age 13, but among adults and adolescents South Carolina has higher rates of both HIV (in particular) and AIDS. In South Carolina the leading mode of transmission for reported AIDS cases was male to male sexual contact (36% of cases), followed by heterosexual contact (24%), unreported or unidentified means (17%), and injection drug use (16%). For the US, these percents by mode of transmission were 45%, 23%, 2%, and 23%, respectively.

Figure 9. Estimated rates (per 100,000 population) for adults and adolescents living with HIV infection (not AIDS) or with AIDS, 2005—United States and dependent areas
a Includes persons whose area of residence is unknown.


**Current marijuana use**

South Carolina and US youth as a whole consistently report similar rates of past 30-day marijuana use, ranging from 20% to 25% (Figure 10). There has been a gradual decline in rates from 1999 to 2005. In 2007 the South Carolina rate was unchanged at 18.6% (US data for 2007 were not yet available). The 2007 rate of 18.6% represents about 38,000 youths in grades 9 through 12.

Figure 10. Current (Past 30-day) Marijuana Use among Youths in Grades 9-12, SC & US, 1995-2007
YRBS subgroup data suggest that males have higher rates of current use compared to females, and an upward trend in use across grade levels (Figure 11).

**Figure 11. Current (Past 30-day) Marijuana Use among Youths in Grades 9 through 12, By Gender, Grade, and Race/Ethnicity, South Carolina, 2007**
Looking at age groups in this survey data, South Carolina and US current marijuana use rates in both the 12- to 17- and 18- to 25-year-old age groups are gradually declining and are similar in South Carolina and the US (Figure 64). The South Carolina 2004-2005 rates of 6.4 and 14.4 percent represent approximately 26,000 and 79,000 persons in these two age groups, respectively.

Figure 12. Current (Past 30-day) Marijuana Use among Persons Age 12 and Over, By Age Group, South Carolina and US, 2002-2004

Age of first marijuana use
South Carolina and US youth report similar rates of first marijuana use before age 13 for all reporting periods (Figure 13). As with current use rates, early use rates have declined since 1999. In 2007 the South Carolina rate was essentially unchanged at 9.7% (US data for 2007 were not yet available). The 2007 rate represents about 20,000 youths in grades 9 through 12.
Figure 13. Youths in Grades 9-12 Reporting First Marijuana Use before Age 13, SC & US, 1995-2007

Other illicit substance use
Looking again at the same two age subgroups in this survey data, there was no change in self-reported past month illicit substance use other than marijuana among these subgroups across the three reporting years, both in South Carolina and nationally (Figure 14). South Carolina and US rates were comparable. The South Carolina 2004-2005 rates of 4.9 and 8.7 percent represent approximately 18,000 and 42,000 persons in these two age groups, respectively.

Figure 14. Other Illicit Drug Use in the Past Month among Persons Age 12 to 17 and 18 to 25, South Carolina and US, 2002-2005
Figure 15 shows past year cocaine use among persons age 12 to 17 years and 18 to 25 years from 2002 to 2005 for South Carolina and the US. Use rates in South Carolina and the US were very similar. Cocaine use appears to be a concern among 18- to 25-year olds, with use rates of about 6.5 percent, representing approximately 31,000 persons.

Figure 16 shows past year nonmedical use of pain relievers among persons age 12 to 17 and 18 to 25 for South Carolina and the US from 2003 to 2005. Rates have decreased very slightly in the former group and increased very slightly in the latter, and rates in South Carolina and the US have been similar. The South Carolina 2004-2005 rates represent approximately 27,000 and 62,000 persons in these two age groups, respectively.
Figure 16. Nonmedical Use of Pain Relievers in Past Year among Persons Age 12 to 17 and 18 to 25, South Carolina and US, 2003-2005

![Graph showing nonmedical use of pain relievers](Image)

Source: National Survey on Drug Use and Health

Dependence or Abuse

There were no differences across reporting years or between South Carolina and the US as a whole in reported rates of illicit drug dependency in the past year among persons ages 12 to 17 and 18 to 25 years old (Figure 17). The South Carolina 2004-2005 rates represent approximately 17,000 and 37,000 persons in these two age groups, respectively.

Figure 17. Illicit Drug Dependency or Abuse in Past Year among Persons Age 12 to 17 and 18 to 25, South Carolina and US, 2002-2004

![Graph showing illicit drug dependency or abuse](Image)
Summary of General Causa/Risk Factors:

General causal factors for the use and abuse of alcohol, tobacco and other drugs range from the characteristics of the community and home, to the impacts of school and peers. In particular, youth are more likely to use alcohol, tobacco, or other drugs if they do not perceive much harm from use, and do not believe that it is wrong for people their age to drink, smoke, or use other drugs; associate with peers who use or value alcohol; family and community attitudes do not discourage early use behavior; and substances are readily available.

The economic health of a community is a strong contributing factor to the use of alcohol, tobacco, and other drugs. From 1997 to 2005 the annual median household income for South Carolina was lower than the national average. In 2005, the median household income for South Carolina was $39,477, compared to a national average of $46,242. Between 1997 and 2005 a higher percent of households in South Carolina were considered to be in poverty, compared to the national average. In 2005, 15.6% of South Carolina households were in poverty, compared to 13.3% of US households. Related to this finding is the percent of South Carolina and US students qualifying for the Free and Reduced Price Lunch Program. In 2005, over half (52%) of South Carolina students qualified for this program, while 42% of students qualified nationally. For a family of four, annual income could be no more than $35,798 to qualify for reduced price meals in 2005. The annual income for free meals was $25,155. Unemployment is also a measure of statewide and national economic health. South Carolina’s 2007 average unemployment rate was 6.1 percent and peaked at 6.8 percent in 2004, while the national rate peaked at 6.0 percent in 2003 and was at 4.6 percent in 2007.

The makeup and dynamics of individual families play a significant role in both adult and youth behavior. Family disorganization is a leading cause of youths’ unhealthy habits regarding alcohol, tobacco and other drug use. Specifically, disruptive family characteristics include single parent families, births to unmarried mothers, households headed by a grandparent, and family
conflict. According to Census 2000 data, 2.7% more South Carolina households headed by a single parent compared to US households. Likewise, the rate of births to unmarried mothers from 1997 to 2005 has been about 15% to 20% higher in South Carolina compared to the state. Households headed by a grandparent are not considered to be the ideal family environment. Census 2000 data indicate that 4.4% of South Carolina households were headed by a grandparent, compared to 3.4 percent for the US as a whole. Finally, family conflict is a risk factor for inappropriate behavior among the community’s youth. South Carolina reported 37% fewer family assaults per 10,000 residents compared to the national rate.

**County vs. State Epidemiological Data from SC Department of Alcohol and Other Drug Abuse Services (DAODAS) (as reported in the Charleston County Alcohol, Tobacco, and Other Drug Data Assessment report, January, 2008):**

**County Overview**

Charleston County is located along the southeastern coast of South Carolina. It encompasses approximately 919 square miles of land, marshes, rivers and wetlands with a coast line that stretches nearly 100 miles along the Atlantic Ocean. Charleston County contains vital protected areas including the Francis Marion National Forest, Cape Romain National Wildlife Refuge, and ACE Basin National Wildlife Refuge.

Charleston County’s population has grown 7.1 percent since 2000 to an estimated 2006 population of 331,917, with a median age of 36. The labor force consists of around 155,555 workers, with a median household income of approximately $39,233. Around 88.3 percent of Charleston County residents have a high school degree or higher level of education, while 37.5 percent hold a bachelor’s degree or higher.

*Source: U.S. Census Bureau’s 2006 County Quick Facts and 2005 American Community Survey*

Charleston County has a wide range of industry including shipping, tourism and manufacturing. Total gross retail sales in the region set another record calendar year 2006, topping $13 million, and an increase of 8.5 percent from 2005. The top ten major employers in the county are: Medical University of South Carolina (MUSC), Charleston Air Force Base, Charleston county School District, Roper St. Francis Health Care, Piggly Wiggly Carolina Co Inc. Charleston county Government, Trident Health System, City of Charleston, Mead Westvaco Corp., and the College of Charleston.

*Source: Charleston Metro Chamber of Commerce, Center for Business Research*

Charleston County Government is composed of 43 departments and offices. A staff of over 2,300 serves the citizens of Charleston County. Charleston County also includes the manipulates of the City of Charleston, City of Folly Beach: City of Isle, of Palms, City of North Charleston, Town of Awendaw, Town of Hollywood, town of James Island, Town of Kiawah Island, Town of Lincolnville, Town of McClellanville, Town of Meggett, Town of Mount Pleasant, Town of Rockville, Town of Seabrook Island, and Town of Sullivan’s Island.
General Causal Factors

A majority of data in this assessment is organized by alcohol, tobacco, or marijuana and other drugs. However, some risk and protective factors (causal factors) for the county apply equally to substance use and other behaviors. We describe these below, organized by “domains,” the parts of an individual’s everyday environment (community, family, school, peers, and the individual themselves).

Community

One measure of risk in a community is the general economic situation. Data from the US Census Bureau indicate that median household income in Charleston County has remained from 1997 to 2004 about the same as the median household income for the state as a whole (Figure 2).

Figure 2. County and State Median Household Income, 1997-2004

Census Bureau data also indicate that from 1997 to 2004 about the same percentage of Charleston County households have been in poverty, compared to South Carolina households (Figure 3).
Source: U.S. Census Bureau, Small Area Income and Poverty Estimates

From 1998 to 2004, a slightly higher percentage of students living in Charleston County have qualified for the federal Free and Reduced Price Lunch Program, compared to students living in the state as a whole (Figure 4). The gap has narrowed over this time period.
Since 1997, fluctuations in Charleston County’s average unemployment rates have tended to mirror those of the state as a whole, but rates have consistently remained lower (Figure 5). The average unemployment rate in Charleston County, currently at 4.5%, has not exceeded 5.4% in the past decade, while the state rate peaked at 6.8% in 2004. Both county and state rates appear to be slowly declining.
Community disorganization can appear in many different ways. One measure is the extent to which there is adequate law enforcement protection for the population. In 2003 there were nearly twice as many police officers per 10,000 residents in Edisto Beach compared to the state as a whole. The remaining jurisdictions, however, had about fewer officers per 10,000 residents than the state had, with Lincolnville having nearly 50% fewer officers (Figure 6).
Figure 6. Number of Police Officers per 10,000 Residents, County and State, 2003

Source: Law Enforcement Census, 2004 Addendum, City and County Data, SC Department of Public Safety

In 2003 Charleston County was well-staffed with sheriffs’ deputies, having nearly three times as many officers per 10,000 residents compared to the state as a whole (Figure 7).
Family

Undoubtedly, characteristics of the family greatly influence the behaviors of both the adults and youth within that family. One of those characteristics, family disorganization, can be measured in several ways. Data from the 2000 US Census indicate that Charleston County had slightly more of its households headed by a single parent, compared to the state average (Figure 8).
Figure 8. Percentage of County and State Households with a Single (Unmarried) Head of Household, 2000

Source: 2000 U.S. Census
The percentage of live births to unmarried mothers has from 1997 to 2004 been between 10% and 30% higher in Charleston County compared to the state as a whole. Both state and county rates have gradually declined since 1999 (Figure 9).

Figure 9. Percentage of County and State Live Births to Unmarried Mothers, 1997-2004

![Graph showing percentage of live births to unmarried mothers from 1997 to 2004 for Charleston County and the state of South Carolina. The line for Charleston County is slightly higher than the line for the state, with both showing a gradual decline over the years.]

Source: SC Department of Health and Environmental Control, Vital and Morbidity Statistics

According to 2000 US Census data, 4.2% percent of Charleston County households are headed by a grandparent, compared to 4.4% for the state as a whole (Figure 10).
Family conflict is also a risk factor. In 2004 there were 20% fewer family assaults per 10,000 residents in Charleston County compared to the state as a whole (Figure 11).
Parental supervision is linked to youth substance use.

Truancy data from the SC Department of Education for the school year 2005 to 2006 indicate that truancy rates in Charleston County were much higher than state rates for all grades except grades 10 through 12 and peaked in 8th grade at about 33%, over three times the state average rate for 8th graders (Figure 12). Truancy rates for the state as a whole were around 10% of ADM or less and more stable due to the larger population numbers. State rates steadily declined in the high school grades.
Only youth are impacted by school risk and protective factors, but the influence on them is substantial. One protective factor related to the school environment is the extent to which students are bonded to the school. Data from the SC Department of Education indicate that from 1999 to 2003 the percent of public school students dropping out in Charleston County was similar to the state average rate of about three percent (Figure 13). However, in 2004 and 2005 county rates remained well above the state average.
School failure is another documented risk factor. One measure of this is the percentage of classes taught by teachers who are not highly qualified. SC Department of Education data for 2004 to 2005 indicate that Charleston County had nearly 50% more classes taught by teachers who were not highly qualified compared to the state as a whole (Figure 14).
Figure 14. Percent of District and State Classes Not Taught by Highly Qualified Teachers, 2004-2005

Source: SC Department of Education, School Report Card District Fact File

Schools with more comprehensive, strict, and sensible policies regarding ATOD issues should have a more positive impact on students’ use than schools with poor policies or poor implementation of policies.

**Charleston County School District current policy:**

**Alcohol Drugs and other Substances**

*No student shall be in possession of, use manufacture, sell, dispense, or distribute a controlled substance, a counterfeit controlled substance, an imitation controlled substance (as described by state law), an illegal drug or narcotic, or chemical inhalant, alcoholic beverage of any kind, or any medication not prescribed for the student by a physician.*

*A student shall not be under the influence of any kind of illegal drug, narcotic, controlled substance, chemical, inhalant, alcoholic beverage of any kind, or any medication not prescribed for the student by a physician.*

*The principal may refer to the office of Student Placement any student found to be using, under the influence of, or in possession of drugs or alcohol or paraphernalia. The principal shall recommend expulsion for all students involved in the distribution or drugs, alcohol or*
medication. The principal or other responsible administrator shall report drug and alcohol offenses by students to the appropriate police authority. The principal shall retain a copy of any written report filed with the police in a file established for that purpose.

For those students that commit the offense of drug possession, that in inclusive of being under the influence of a drugs or in possession of a paraphernalia, charged by local law enforcement with the offense of possession, the Office of Student Placement can recommend in lieu of explosion the student’s participation in and successful completion of an approved alcohol or drug intervention program. If the parent or legal guardian and the student choose to adhere to the above disposition or recommendation, the student may be provided with the opportunity to remain in school. Students who commit the drug offense of possession with the intent to distribute and are charged with this offense by local law enforcement are recommended for expulsion. (CCSD 2007)

The above policy is clear and thorough in it's consequences of violation of the rules related to alcohol and drug abuse, but there is little or no evidence of standardized education or prevention programming related to ATOD before an initial offense. The suspension rates and expulsion rates in Charleston versus the South Carolina average indicate a willingness to enforce rules around ATOD. There are 44,000 students at this time in Charleston County schools and there is currently only a handful of prevention staff to serve those children with risk factors of ATOD use. Progress needs to be made on reducing suspensions and expulsions over ATOD issues and increasing the prevention services that the students receive K-12th grade.

The impact of these policies and their enforcement can somewhat be reflected in the number of school expulsions and suspensions. Data from the SC Department of Education indicate that since 2003 rates of suspension or expulsion in Charleston County have been higher than the state average of about one percent and have trended upward since 2001 (Figure 15).
Figure 15. Percent of District and State Students Suspended or Expelled, 2000-2005

Source: SC Department of Education, School Report Card District Fact File

In 2005 rates of suspension or expulsion for violence or ATOD use were similar in Charleston County compared to the state (Figure 16). Rates in both regions were very low (less than one percent of ADM).
Individual/Peer

Other risk and protective factors are related to individuals themselves and their peer groups. Among these are psychological problems. Data from the SC Department of Mental Health indicate that the number of school age children served per 1,000 population of the same age was slightly lower in Charleston County compared to the state as a whole (Figure 17).
Psychological and substance abuse problems can also be quantified among a segment of the population dubbed “Safety Net” by the Office of Research and Statistics (ORS) of the Budget and Control Board. The Safety Net population is the under-served individuals who experience barriers to care due to any combination of economic, cultural, or lifestyle conditions. ORS creates the Safety Net population by combining unduplicated individuals from the Medicaid, Temporary Assistance for Needy Families, and Food Stamps recipient population from age 0 to 64. Therefore, the Safety Net population is primarily poorer and more likely to be female than the general population. The males that are included are typically under 18, but then they are no longer Medicaid eligible at that age. These findings for the Safety Net population, therefore, should likely not be generalized to the general population but may be more useful for making comparisons across counties or to state averages.
Figure 18 shows the percentage of the Safety Net population age 12 to 17 served by the Division of Mental Health in 2004, comparing Charleston County to other urban counties in the state. About the same percentage of the safety net population was served in Charleston County.

Figure 18. Percent of Safety Net Population Age 12-17 Served by the Division of Mental Health, 2004

Source: SC Budget and Control Board, Office of Research and Statistics

Another individual risk factor is early antisocial behavior. This is often an indicator of future ATOD use. Data from the Department of Juvenile Justice show that Charleston County has had a consistently higher rate of juvenile arrests for delinquent acts per 1,000 age-eligible juveniles, compared to SC as a whole, and this difference may be increasing (Figure 19).
Figure 19. Rate of Youth Arrested for Delinquent Acts per 1,000 Age-Eligible Juveniles, 2002-2006

Source: Department of Juvenile Justice County Datasheets

Table 1. Top Five County and State Referral Offenses in Juvenile Cases, 2005-2006

<table>
<thead>
<tr>
<th></th>
<th>Charleston County</th>
<th>State</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Disturbing School</td>
<td>Disturbing School</td>
</tr>
<tr>
<td>2.</td>
<td>Simple Assault</td>
<td>Simple Assault and Battery</td>
</tr>
<tr>
<td>3.</td>
<td>Shoplifting</td>
<td>Shoplifting</td>
</tr>
<tr>
<td>4.</td>
<td>Public Disorderly Conduct</td>
<td>Public Disorderly Conduct</td>
</tr>
<tr>
<td>5.</td>
<td>Simple Possession of Marijuana</td>
<td>Simple Possession of Marijuana</td>
</tr>
</tbody>
</table>

Source: SC Department of Juvenile Justice County Datasheets

Summary of General Causal Factors
Charleston often parallels South Carolina in its areas of strengths and weaknesses but a few areas are worth a brief discussion.

In the Domain of Community, Charleston does not deviate from the South Carolina average in families living below poverty as well as median household income. The rates of free and reduced school lunches are also very similar. This indicates the same level of influence on high risk behaviors as in the remainder of the state due to high rates of poverty and lack of familiar resources. An area of the Community domain that Charleston was especially above the State average was in law enforcement officers per 10,000 citizens. Despite this statistic however, the Charleston area ranks near the top of the state in violence.

In the Domain if Family, Charleston has a higher rate of single parent households than the South Carolina average. This area may contribute to many high risk behaviors. Nearly one third (30%) of all Charleston county residents live in a single parent household.

In the Domain of School, Charleston has a much higher rate than SC for dropouts and for suspensions/expulsions. In the analysis of the School District policy the need for ongoing and integrated ATOD education and Prevention was identified as a possible effective intervention to positively affect these statistics.

In the Domain of Individual and Peer, Charleston nearly doubles the rate of juveniles being arrested for delinquent acts. This strains all systems associated with these youth (DJJ, DSS, Schools, courts) and is most likely a strong indicator for future high risk choices, including ATOD use and abuse. Charleston indicates a strong need for services related to juvenile crime. Attractive activities for juveniles, job training programs, problem solving skills and increased parental involvement are all possible approaches.

Causes of Alcohol Use
Youth are more likely to use alcohol if they do not perceive much harm from use and do not believe it is wrong for people their age to drink.

Using the DAODAS Standard Survey to help identify the Perceived Risk of alcohol use, the results indicate that the perception of risk averages 1.92 out of a scale of 0-3 (0 begin “no risk” and 3 being “great risk”) (Figure 20). This rates them as an average less that a 2, which is rated as “moderate risk”. With the average age of the survey taker being 12 years old this indicates a definite permissive environment around alcohol use.

Using the DAODAS Standard Survey to help identify the Favorable Attitudes towards alcohol use, the results indicate that the perception of risk averages 2.43 out of a scale of 0-3 (0 begin “not wrong at all” and 3 being “very wrong”) (Figure 21). This rates them as an average between a 2 “wrong” and a 3 “very wrong”. With the average age of the survey taker being 12 years old this indicates a large area of growth as the reinforcement of the dangers and the inappropriateness of underage alcohol use is there, but could be much stronger.
Figure 20. Perceived Risk DAODAS Standard Survey Pre test results 2007

Source: DAODAS/PIRE 2007 Outcomes Report

Figure 21. Favorable Attitudes DAODAS Standard Survey Pre test results 2007

Source: DAODAS/PIRE 2007 Outcomes Report
Family and community attitudes are also influential upon youth’s early alcohol use behaviors.

The data from the DAODAS Standard Survey indicates that the adolescents do believe their parents and community disapprove of ATOD use among their age group (Figure 22). The numbers are high enough to indicate that among the small population surveyed; this area does not warrant a large use of resources to improve but could instead be maintained.

Figure 22. Perceived Parental Attitudes DAODAS Standard Survey Pre test results 2007

![Perceived Parental Attitudes](image)

Source: DAODAS/PIRE 2007 Outcomes Report

The environmental scans regarding alcohol have both positive and negative findings. While the amount of alcohol in receptacles like barrels or cooers to be bought as singles already ice cold was down from previous surveys, the consistent large selection and quantity of alcohol no matter what the size of the store or establishment speaks to the importance of alcohol to overall sales of the store. There was also a significant lack of proper signage regarding the 21 year old drinking age. The size of the alcohol drinks are also a problem area. The standard definitions of a drink when it relates to beer are a 12 ounce beer with an alcohol rate of 4-5%. There were beers available that would not only triple the size of the beer (40 ounce,) but also increase the alcohol content (ice beer, malt liquor, etc.). These surveys indicate the need for more merchant education around signage as well as efforts to reduce the emphasis on larger beers that will increase intoxication and impairment related problems.

Finally, ready availability of alcohol is also an important risk factor for use. Charleston is tourist town and the rates of alcohol outlets reflect that fact. Charleston County has over 15,000 licensed alcohol establishments, ranking second highest in the state, just behind Horry county (Figure 23).
Source: SC Department of Revenue Annual Report, 2006

Charleston County shows a significantly lower percentage of buy rates for alcohol compliance rates than South Carolina average (Figure 24). These numbers, however, may be misleading due to the small total numbers completed in FY 07. Charleston only completed 19 compliance checks for the year, however with the AET program funding for FY 08 these numbers will be significantly increased.
Alcohol Use

Current use
Youth Alcohol Use: Charleston County does not implement any county wide survey system but in a survey conducted at Wando High School among 157 9th graders, the current rates appear to be near state and national averages.

Among the 9th graders 42% had drunk alcohol before and 15% have drunk in the last 30 days. One in five students (19%) has felt pressured to drink in the last 30 days.

Adult Alcohol Use: Charleston County is the same as the rest of the country where alcohol is the most commonly used and abused substance. Charleston rates for binge use may be higher due to a strong college presence in the area as well as a heavy saturation of bars and restaurants due to the tourist business.

Binge use
Binge alcohol use, defined as five or more drinks on a single occasion. Binge drinking has been correlated to higher rates of problems than frequent drinking in small amounts. Binge drinking can result in higher rates of crime, DUI, motor vehicle accidents and sexual assaults.
Data from the CDC’s Behavioral Risk Factor Surveillance System indicate that rates of adult binge drinking were roughly the same in Charleston County and the state as a whole, except in 2004 and 2006, when county rates were significantly higher (Figure 25).

Figure 25. Percentage of County and State Adults Reporting Binge Drinking in the Past Month, 2004-2006

![Graph showing percentage of county and state adults reporting binge drinking in the past month, 2004-2006.]

Source: CDC Behavioral Risk Factor Surveillance System

Heavy use

Heavy alcohol use is defined as having more than two drinks per day for adult men and more than one drink per day for adult women. Data from the CDC’s Behavioral Risk Factor Surveillance System indicate that rates of adult heavy alcohol use in the past month were roughly the same in Charleston County and the state as a whole (Figure 26).

Figure 26. Percentage of County and State Adults Reporting Heavy Alcohol Use in the Past Month, 2004-2006
Drinking and driving

Youth are especially at risk for drinking and driving accidents. Youth are significantly more at risk for vehicle crashes overall, due both to their inexperience and their adolescent impulsivity. Charleston County has an above average percentage of youth that drive vehicles due to the increased per capita income allowing the purchase of second and third cars. Charleston also lacks a comprehensive public transportation network for adolescents to utilize. South Carolina, however, does have clear and enforceable underage DUI laws that are a positive deterrent to underage DUI.

ATOD Services Utilization

Using the data collected from the Knight Integrated Software, the intakes and admissions at the Charleston Center have appeared to remain fairly steady from 2005-2007 (Figure 30). The admissions and intakes, however, indicate the fact that we served only 1.15% of the Charleston County populations, a number far lower that the general estimation of ATOD problems as a percentage of overall citizens.

Figure 30. Intakes and Admits at Charleston Center, 2005-2007
Using the data collected from the Knight Integrated Software, the ratio of male to female admission has stayed relatively stable (Figure 31). The data indicates a much larger ratio of intakes are males. This trend indicates the need to engage and offer services to more females in an attempt to have the ratio more appropriately meet the demographics of Charleston County.

Using the data collected from the Knight Integrated Software, the drug of choice for admission to services from 2005-2007 was alcohol, cocaine was the next highest, followed by marijuana and finally opiates (Figure 32). There does appear to be an upward trend among Marijuana and Cocaine, while Alcohol and Opiates appear stagnant. These results indicate the need for
treatment services to be competent in addiction to many substances and make sure services illustrate that awareness.

Figure 32. Intakes per drug of choice at Charleston Center, 2005-2007

Source: Knight Integrated Software-Charleston Center 2007

Using the data collected from the Knight Integrated Software there appears little or no change among the ages admitted to Charleston Center over the last three years (Figure 33). The statistics illustrate that intakes are strongly weighted towards adult admissions and that the adolescent population may be underserved. It is also noted the much larger quantity if resources allocated to the personnel treating adult clients versus adolescents and children (Figure 34). This conclusion does tie into the lack of ATOD services at area schools, to further support the underserved status of those less than 18 years of age that experience ATOD problems.

Figure 33. Age of Intakes at Charleston Center, 2005-2007
Figure 34. Treatment Staff per population at Charleston Center, 2007
Violent crime
Violent crime, including aggravated assaults, sexual assaults, and robberies, is one consequence of alcohol abuse. Uniform Crime Reports (UCR) data for 1995 to 2005 indicate that rates of violent crimes per 1,000 residents have been higher in Charleston County compared to average rates for the state (Figure 35). While the overall trend over the ten year period for the state has been a slight decline, rates in Charleston County have been slightly increasing since 2002 (Figure 35).

Figure 35. County and State Violent Crimes per 1,000 Residents, 1995-2005

Causes of Marijuana and Other Illicit Drug Use
Youth are more likely to use illegal drugs if they do not perceive much harm from use and do not believe it is wrong for people their age to use illegal drugs.

Using the DAODAS Standard Survey to help identify the Perceived Risk of illegal drugs use, the results indicate that the perception of risk averages 1.92 out of a scale of 0-3 (0 begin “no risk” and 3 being “great risk”) (Figure 51). This rates them as an average less that a 2, which is rated as “moderate risk”. With the average age of the survey taker being 12 years old this indicates a definite permissive environment around illegal drug use.

Using the DAODAS Standard Survey to help identify the Favorable Attitudes towards illegal drugs use, the results indicate that the perception of risk averages 2.43 out of a scale of 0-3 (0 begin “not wrong at all” and 3 being “very wrong”) (Figure 52). This rates them as an average between a 2 “wrong” and a 3 “very wrong”. With the average age of the survey taker
being 12 years old this indicates a large area of growth as the reinforcement of the dangers and the inappropriateness of illegal drugs use is there, but could be much stronger.

Figure 51. Perceived Risk DAODAS Standard Survey Pre test results 2007

Source: DAODAS/PIRE 2007 Outcomes Report

Figure 52. Favorable Attitudes DAODAS Standard Survey Pre test results 2007

Source: DAODAS/PIRE 2007 Outcomes Report
Family and community attitudes are also influential upon youth’s early illegal drugs use behaviors.

The data from the DAODAS Standard Survey indicates that the adolescents do believe their parents and community disapprove of ATOD use among their age group (Figure 53). The numbers are high enough to indicate that among the small population surveyed; this area does not warrant a large use of resources to improve but could instead be maintained.

Figure 53. Perceived Parental Attitudes DAODAS Standard Survey Pre test results 2007

Source: DAODAS/PIRE 2007 Outcomes Report

Marijuana and Other Illicit Drug Use

*Current marijuana use*

County specific data is limited on Marijuana and other illicit drug use. Marijuana is the third leading drug of choice for referral into the Charleston Center. Marijuana is on the rise in total number of admissions and is the most common referral for those that are under the age if 18. Trends are difficult to gauge without multiple years of data and goals Charleston County lacks in this area.

Cocaine is continually a common drug of choice in Charleston, often exceeding the State average. Heroin and other opiates are also in use but again, numbers are small and trends are not valid with such small survey results.
**Consequences of Illicit Drug Use**

**Morbidity**
From 2003 to 2004 the rate of acute care hospital ER visits for alcohol- and/or drug-related diagnoses was similar in Charleston County compared to the state as a whole, but in 2005 the county rate was about half the state rate (Figure 54).

**Figure 54. Number of Persons Visiting the Emergency Room at Acute Care Hospitals for Alcohol- and/or Drug-Related Diagnoses, per 1,000 Residents, County and State, 2003-2005**

Source: SC Office of Research and Statistics

**Mortality**
Mortality data from 1990 to 2003 indicate that deaths from drug use, abuse, or dependence in Charleston County have been similar to the state average (Figure 55).

**Figure 55. County and State Deaths from Drug Use, Abuse, or Dependence per 1,000 Residents, 1990-2003**
Property crime

UCR crime data for 1995 to 2005 indicate that Charleston County property crime rates have been consistently much higher than those of the state as a whole, although county rates have declined more rapidly than the overall state average rates (Figure 56).

Figure 56. County and State Property Crimes Reported per 1,000 Residents, 1995-2005

Source: National Center for Health Statistics, National Vital Statistics System
Summary of Illicit Drug Use and Consequences

Charleston County is afflicted with problems related to illicit drug use as are other communities. Charleston again is notable in its high rate of property crime versus the state average and this trend has appeared in multiple charts. Marijuana and Cocaine make up significant portions of treatment admissions, and Heroin has small but significant use in the community.

CONCLUSIONS

Charleston County shows significant risk in multiple areas. While Charleston County has a high rate of Sheriff and Police officers per resident (275% of the state average), violent crime and property crime are still substantially higher than the state average (42% and 21% higher respectively). Juveniles are arrested at a much higher rate in Charleston County than in the state as a whole (80% higher than SC average) and homicide rates are 45% higher than the state average in Charleston and are on the rise.

The Charleston County School District has a firm and strictly enforced ATOD policy on their regulations. This policy results in the much higher suspension and expulsion rate of students in Charleston County than the state average (278% of the SC state average). These students are then out of school without structure, again fueling the increased violent and property crime seen throughout the area. CCSD also has high rates of truancy (78% above SC average). There are less than 12 ATOD school based counselor in the entire school district, which serves 44,000 students. This averages one ATOD counselor per 3,667 students.

Charleston is a tourism driven economy, and also has a large college population. The rates for establishments that serve alcohol are very high, and Charleston County alone accounts for 29% of the entire South Carolina licenses for alcohol sales. Accidents that involve a driver that was drinking are 13% higher than the SC average and are in the rise.

Many of the indicators for Charleston are of concern as even when the statistics are lower than state averages, South Carolina rates very high among the other states in these areas, such as smoking rates and high school dropout rates and teen pregnancy.

Epidemiological Data from the Centers for Disease Control (CDC) and South Carolina Department of Health and Environmental Control (SC DHEC):

At the state level, South Carolina currently ranks 9th for rate of new HIV/AIDS infections. The AIDS case rate for the state of South Carolina (SC) is approximately 15.7 per 100,000 people, with approximately 880 new cases of HIV/AIDS diagnosed each year (CDC). African Americans comprise 74.5% of the states’ AIDS cases (SCDHEC). Among metropolitan areas, HIV/AIDS cases in Charleston-North Charleston ranks 29th in the nation. In Charleston County, 68.7% of people with AIDS cases are African American, with a staggering AIDS case rate number of 43.6 per 100,000 (SCDHEC). With regard to vulnerable age groups, Charleston county adolescents appear to be at significant and increasing risk for HIV infection, as youth aged 13-19 years were the ONLY age group to consistently increase in HIV/AIDS rate in Charleston County between 1997 (3.6 per 100,000 at that time) and 2005 (12.9 per 100,000; SCDHEC). HIV/AIDS rate age breakdown is not available by racial/ethnic groups within the SC DHEC data. However, other
HIV/AIDS data sources indicate that adolescents with HIV/AIDS are no exception to the over-representation of African Americans within this population. For example, consistent with the escalating rate of HIV positive cases among adolescents, the Medical University of South Carolina (MUSC) Department of Infectious Diseases (located in Charleston County) is currently serving 734 HIV positive individuals in our area, with over 44% of these patients falling between the ages of 13-24 years. Among these HIV-positive individuals currently served, 70% are African American and 43% meet criteria for CDC-defined AIDS (Assey, 2008).
Needs, Resources, Gaps Summary

Based on extensive data collected through focus groups with local African American adolescents, caregivers, and faith-based leaders, phone and in-person surveys with local African American adolescents, and multiple epidemiological surveys (see below), several areas of gaps/needs were identified. The primary areas of need identified through our assessment efforts to be targeted through our services are three-fold. First, there is a need for a central place where youth, parents, and community leaders, including faith-based leaders, can easily access accurate information regarding HIV infection, testing, prevention, and treatment, as well as substance abuse prevention and treatment. Although some HIV prevention and substance use prevention services are currently available, few community members know where and how to access these services. Second, there is a need for assistance with transportation to access such services. Third, there is a desire for education-based and ethno-centered HIV and substance prevention services that target behavior change among adolescents. Adolescents, and particularly caregivers, identified the potentially need for/utility of internet as a mechanism by which such services and education could be easily (and confidentially accessed).

One need or barrier that was identified through this Community Needs Assessment process, was the need for our program and staff to build trust with both community members and organizations. Examples of mistrust include responses to the phone survey recruitment, which demonstrated high levels of suspicion—and concerns raised during the focus groups (e.g., “Are you targeting African Americans because you feel we are less educated?”). We are already working hard with our community partners and advisory work group to address this issue.

We also find it important to note our concern that the length of the MAI NOM is going to serve as a dis incentive. We “piloted” this measure through the phone surveys and many youth became bored with the length with some skipping or “quickly” answering to the point where we might worry about the validity of the data with some youth. It is strongly recommended that SAMHSA consider reducing the length of the measure. For example, if youth are already coming in for a 90 minute prevention workshop (e.g., for SIHLE) and are asked to complete a 45 minute questionnaire before even beginning the workshop—this can affect enthusiasm, interest, and engagement in the actual session—as well as participant retention over time. We recognize the strong importance of collecting outcome data—we merely suggest doing it in such a way that it does not hinder the service-providing process.
Overall Summary of Findings

- HIV infection among African American youth is a problem in the Charleston county area.
- There is a need for basic psychoeducation regarding HIV/AIDS to all youth and caregivers
  - Peers are a common source of information; it is important to make sure adolescents have accurate information; change the culture so that it is cool to be safe and such that it is recognized that teen pregnancy (which is widely accepted in the local African American population) is NOT the worst thing that can happen from unprotected sex
- There is need for targeted, evidence-based prevention services for at-risk adolescents
- It is very important to improve communication between parents and youth about sexual behavior, as well as substance abuse—there is a disconnect between what is reported. Caregivers report talking with their youth regularly about substances, sex, and HIV—youth, alternatively, report they almost never go to their parents about these issues.
- There is a need for an easily-accessible, common (education-based) resource for community leaders and members
- Transportation is a barrier for HIV and substance abuse prevention
- TV and Internet (for youth) and Internet, Media, and Primary Care Doctors (for caregivers) are likely the best avenues for providing information
- The great majority of youth and parents have internet access