DRUG-FREE COMMUNITIES (DFC) SUPPORT PROGRAM

END-OF-YEAR 2022 REPORT
NATIONAL CROSS-SITE EVALUATION

PUBLISHED AUGUST 2023

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Executive Summary

Administered by the Office of National Drug Control Policy (ONDCP), the Drug-Free Communities (DFC) Support Program grant funds community coalitions to build the capacity needed to prevent and reduce youth substance use. The contributions of DFC coalitions constitute a critical part of the Nation's drug prevention infrastructure, as they are a catalyst for building capacity to implement local solutions to effect change. This summary of findings is based on national evaluation data regarding implementation from February to August 2022 and core measures data from 2002 to 2022. Additional details about the program and findings are presented in full in the report.

DFC coalitions met the goal of significantly decreasing the percentages of middle school and high school youth in their communities who reported using/misusing substances (See Figure ES1 for findings for the most current DFC cohort). Significant decreases in past 30-day prevalence of use are presented as percentage change in Figure ES2, with the largest decrease for tobacco use. Among high school youth, prescription drug misuse had the next highest decrease (-34%), a promising finding in line with coalitions' focus on addressing opioids in their communities. Youth's perceptions of risk associated with using substances was generally unchanged or decreased, except for an increase in perceived risk associated with prescription drug misuse among high school youth. Perceived risk associated with marijuana use was lower than the other substances. High school youth reported increased perception of peer and parental disapproval for substance use over time, except for no change in perceived parental disapproval of marijuana use. Among high school youth, those in DFC communities reported significantly lower past 30-day use of alcohol and marijuana in 2021 as compared to a national sample (Youth Risk Behavior Survey).

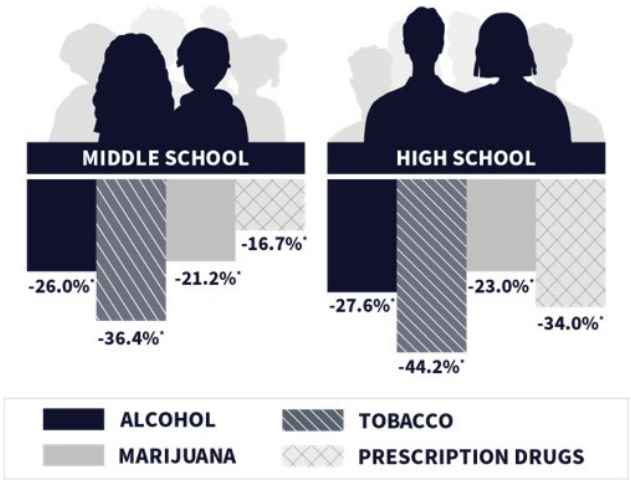
FIGURE ES1. OVERVIEW OF CORE OUTCOMES FINDINGS

FY 2021 DFC GRANT RECIPIENTS

MIDDLE SCHOOL					HIGH SCHOOL				
OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS	OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓	PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	↓	NC	↓	↓	PERCEPTION OF RISK	NC	NC	NC	↑
PARENTAL DISAPPROVAL	NC	NC	↓	NC	PARENTAL DISAPPROVAL	↑	↑	NC	↑
PEER DISAPPROVAL	NC	NC	NC	NC	PEER DISAPPROVAL	↑	↑	↑	↑

Source: DFC 2002–2022 Progress Reports, core measures data
Note: Up arrows indicate significant increases; down arrows indicate significant decreases; NC=No Change

FIGURE ES2. PERCENTAGE CHANGE IN PAST 30-DAY SUBSTANCE USE/MISUSE: FY 2021 DFC COALITIONS



Source: DFC 2002–2022 Progress Reports, core measures data
Note: *$p < .05$

DFC coalitions are successful at building community capacity serving a diverse range of communities. Approximately 1 in 5 Americans (20%) lived in a community with a DFC coalition in 2022, and nearly 35,000 people were successfully mobilized to engage in prevention efforts. Close to two-thirds of coalitions (65%) focus at least some of their prevention efforts toward specific demographic subgroups of youth/people (i.e., Hispanic /Latino; Black/African American, lesbian, gay, bisexual, or transgender [LGBTQ+], American Indian/Alaska Native, Asian/Asian American, Native Hawaiian/Pacific Islander), an increase

from 2021 when 59% did so. The Youth and School sectors contributed the highest median number of sector members.

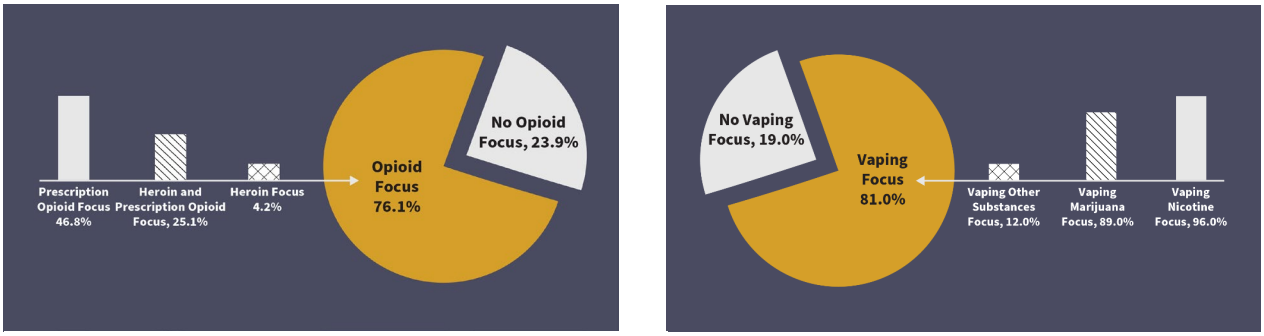
Engagement with the school sector is central to DFC coalitions prevention efforts. Almost all coalitions (99%) report working with at least one school, with most (83%) working with multiple schools either in a single or multiple districts. Just under one-fifth of coalitions (17%) reported that schools were the coalition's lead sector.

Two-thirds of DFC coalitions (67%) reported hosting a youth coalition, an effective strategy for increasing youth sector engagement. Coalitions who hosted a youth coalition rated youth as among the most engaged with their coalition, significantly higher than youth engagement in coalitions without a youth coalition. Youth coalitions provide opportunities for youth to act as leaders in their community and to serve as mentors to their peers and/or students in lower grades. Just under half (46%) of DFC coalitions have youth members who attend coalition meetings and have a vote/say in coalition decision making. Hosting a youth coalition appears to be one way coalitions support youth in being better connected to their families, schools, and communities—connections that are correlated with lower likelihood of substance use engagement.[1] This is in line with coalition overall efforts focused on strengthening protective factors including the connections of youth to their community (75%), family (66%), peers (64%), and school (63%).

More than two-thirds (69%) of DFC coalitions implemented at least five of the seven strategies for community change. Coalitions are encouraged to engage in evidence and practice-based strategies within the seven strategies and most activities implemented are evidence-based, although there is also room for coalitions to engage in implementation of innovative activities. *Providing Information*, an individual strategy, remains the most common strategy type. *Changing Access/Barriers* was the most engaged in environmental/community level strategy, with 82% of coalitions implementing at least one activity of this type (e.g., reducing home and social access; increased access to substance use services). DFC coalitions (69%) reported that having a DFC grant enabled coalitions to put culturally relevant materials related to substance use and social norms campaigns into the community, assets that might not otherwise have been possible.

Most DFC coalitions (73%) reported that they implemented activities to address opioids and/or methamphetamine (See Figure ES3). Similarly, 81% implemented activities to address youth vaping. The primary focus of opioid-related work was to address issues around prescription drug misuse. Coalitions also engaged in harm reduction activities such as training on the use of naloxone. Of those coalitions who addressed vaping, 96% reported that their work focused on vaping nicotine/tobacco, and 89% reported that their work addressed vaping marijuana.

FIGURE ES3. FY 2021 DFC COALITIONS FOCUS ON OPIOIDS/METHAMPHETAMINE AND VAPING



Source: DFC August 2022 Progress Report

[1] See for example Rose, I.D., Lesesne, C.A., Sun, J. et al. (2022). The relationship of school connectedness to adolescents' engagement in co-occurring health risks: A meta-analytic review. Journal of School Nursing, 2022 Apr 28;10598405221096802. doi: 10.1177/10598405221096802.

DFC Program

Created through the Drug-Free Communities (DFC) Act of 1997, the DFC Support Program funds community coalitions to prevent and reduce youth substance use emphasizing local solutions for local problems. DFC is funded and directed by the Office of National Drug Control Policy (ONDCP). The DFC National Cross-Site Evaluation Team prepared this report to provide findings related to DFC coalitions' progress on meeting the two key grant program goals:[2]

- Establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and Tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth (individuals 18 years of age and younger).
- Reduce substance use among youth and, over time, reduce substance use among adults by addressing the factors in a community that increase the risk of substance use and promoting the factors that minimize the risk of substance use.

Key findings presented in this report from the DFC program national evaluation include:

- **DFC coalitions serve a diverse range of communities across the United States and its territories to address local problems with local solutions:**
  - Approximately one-fifth (20%) of Americans lived in a community with one of 743 DFC-funded coalitions.[3] Over half (55%) of Americans lived in a community with a DFC coalition since 2005.
  - Two-thirds (65%) of coalitions reported working to tailor prevention efforts to serve a diverse range of community types and demographics, including working to effectively engage with and implement activities for Hispanic/Latino (43%), LGBTQ+ (34%), and/or Black/African American (24%) youth/people. [4] Just over half (54%) were working in rural and/or frontier communities.
  - In line with youth substance use, coalitions focused prevention efforts on core measure substances (alcohol [97%], marijuana [90%], tobacco [79%], and/or prescription drug misuse [75%]).
  - Coalition efforts were focused on strengthening protective factors including the connections of youth to their community (75%), family (66%), peers (64%), and school (63%). Coalitions also focused on addressing community risk factors including community and individual youth norms accepting of substance use (89% and 82% respectively) and the availability of substances (89%).
- **DFC is meeting its goal of building community capacity to prevent and reduce youth substance use as evidenced by the following accomplishments as of August 2022:**
  - DFC coalitions successfully mobilized approximately 35,000 community members to engage in evidence-based youth substance use prevention/reduction efforts.
  - Most coalitions (90%) report having at least one member from each of twelve sectors, although fewer reported active members from all sectors (73%).

[2] ICF, an independent third-party evaluator, was awarded this contract from ONDCP.

[3] During FY 2021, the DFC program awarded 745 coalitions; however, one coalition did not accept their FY 2021 award and another rescinded their grant afterwards, bringing the new total to 743 coalitions. Some coalitions that were awarded in October or December had a shortened period of performance in 2022 (i.e., 10/31/21 to 9/29/22 and 12/31/21 to 9/26/22).

[4] LGBTQ+ stands for lesbian, gay, bisexual, transgender, questioning youth/people, with the plus representing other sexual identities. Coalitions also worked with American Indian /Alaska Native (8%), Asian/ Asian American (7%) and Native Hawaiian/ Pacific Islander (3%) youth/people.

- Just under 1 in 5 (17%) DFC coalitions are being led by the school sector. Almost all coalitions (99%) reported conducting work directly in schools, with schools serving a crucial role in connecting the coalition to youth and families and vice versa. Some schools noted effectively working with the school sector to address mental health challenges that may contribute to youth substance use.
- Two-thirds of coalitions (67%) hosted a youth coalition, a promising practice associated with significantly higher levels of sector involvement, particularly Youth sector involvement. About half (54%) of DFC coalitions who host a youth coalition include youth members at coalition/leadership meetings, with 41% reporting youth representatives have a say in decision making.

- **DFC coalitions work to bring about change by implementing a comprehensive mix of strategies, with more than two-thirds (69%) implementing at least one activity in at least five of the seven strategy types. DFC coalitions were generally implementing activities at higher levels than during the first year of COVID-19 and approaching levels similar to prior to the start of the pandemic. Coalitions are encouraged to engage in evidence and practice-based strategies within the seven strategies and most activities implemented are evidence-based, although there is also room for coalitions to engage in innovation.**
  - *Providing Information* remains the most common strategy with virtually all coalitions conducting at least one activity of this strategy type. *Changing Access/Barriers* was the most engaged in environmental strategy, with 82% of coalitions implementing at least one activity of this type.
  - Coalitions were able to put in place a range of community assets following DFC awards including culturally competent materials around substance use (69%), social norm campaigns (69%), town halls (58%), and prescription drug disposal programs (49%).
  - Just under three-fourths (73%) of DFC coalitions implemented activities to address opioids and/or methamphetamine, with most implementing activities to address prescription drug misuse and/or fentanyl (98% and 74%, respectively).
  - Similarly, 81% of DFC coalitions implemented activities to address youth vaping. Of those coalitions who addressed vaping, 96% reported that their work focused on vaping nicotine/tobacco, and 89% reported that their work addressed vaping marijuana.
- **DFC coalitions met the goal of preventing and reducing youth substance use in their communities.**[5] **This is true for the DFC program collectively (all coalitions ever funded) and for the most recent DFC cohort (awarded in Fiscal Year (FY) 2021) highlighted in this report.**
  - Among high school youth in each of the samples, there were significant decreases in past 30-day use across *all* core measure substances (alcohol, marijuana, tobacco, prescription drug misuse).
  - The same was true for middle school youth for all DFC coalitions since inception. In the most recent DFC cohort, past 30-day alcohol, marijuana and tobacco use, and prescription misuse reported by middle school youth all declined significantly.
  - Prescription drug misuse remained relatively low for youth in both middle and high school.
  - Based on data collected in 2021, past 30-day use of alcohol and marijuana among high school youth in DFC communities were significantly lower than rates in the national Youth Risk Behavior Survey (YRBS). There were no differences in the DFC versus national YRBS samples in high school youth use of tobacco.

[5] Throughout this report, middle school and high school youth are referenced. For this report, middle school youth are those in grades 6 through 8 and high school youth are those in grades 9-12.

- While decreases were seen in substance use, middle school youth perceptions of risk associated with substance use generally decreased in communities with a DFC coalition. There was no change in high school perception of risk for alcohol, tobacco, and marijuana use; however, perceived risk associated with prescription drug misuse significantly increased. The decrease in perceived risk was largest for marijuana use among both middle and high school youth.

DFC Program Partners and Funding

ONDCP provides supports to DFC coalitions to help them succeed by funding and working in collaboration with the following Federal and community partners.

- **Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC)** provides grant management services and government project officer support and monitoring.
- **CADCA**, a nonprofit organization, provides training and technical assistance to strengthen the capacity of DFC coalitions. This is accomplished through the National Coalition Academy, which is a grant funded by ONDCP.
- **DFC National Cross-Site Evaluation Team** conducts the national evaluation and provides related technical assistance (e.g., data collection and reporting) to DFC coalitions. In addition to high level annual reports such as this, additional evaluation information is shared in issue briefs on specific topics.

DFC grant award recipients receive up to $125,000 annually for up to 5 years per award, with a maximum of 10 years of grant award funding per grant recipient.[6] Since 1998, DFC grants have been awarded to community-based coalitions that represent all 50 States and several Territories and Tribal communities. Each year, some grants end while new grants are awarded. This report primarily focuses on the efforts and outcomes associated with the 743 community coalitions awarded DFC grants in Fiscal Year (FY) 2021. Of these, 415 (56%) were funded through an initial 5-year grant; the remaining 328 (44%) were in Years 6 to 10 of funding. As of 2022, over 3,300 DFC grants have been awarded in over 2,200 communities.[7]

Background

National data consistently suggests that middle school and high school youth (ages 12-18), the focus of DFC prevention efforts, are at risk for both initiating substance use, engaging in regular substance use and, in some cases, developing substance use disorders. For example, findings from the 2021

[6] DFC coalitions must demonstrate they have matching funds from non-Federal sources. In Years 1 through 6, a 100% match is required. In Years 7 and 8, this increases to a 125% match; in Years 9 and 10 it increases to a 150% match. For further information see the most current notice of funding opportunity here: https://www.cdc.gov/drugoverdose/drug-free-communities/funding-announcements.html. For information on the FY 2021 awards please see CDC-RFA-CE21-2102 and CDC-RFA-CE20-2004CC21 at https://www.grants.gov/.

[7] Based on available data through FY 2021, 2,202 communities have received DFC grant awards, with 1,023 communities receiving a Year 1 to Year 5 award and 1,179 communities receiving an additional Year 6 to Year 10 award. Combined, these total 3,381 DFC grant awards. This is a conservative estimate of awards through FY 2021 as much award data pre-2009 were not available.

Youth Risk Behavior Survey (YRBS) suggest that among high school youth, 22.7% reported current (past 30-day) alcohol use, 15.8% current marijuana use, 6% current prescription opioid misuse, and 13% reported ever using illicit drugs.[8] The 2021 National Survey on Drug Use and Health (NSDUH) reported that among youth aged 12-17, 14.1% reported any past year illicit drug use, including 10.5% who reported past-year marijuana use.[9] Data collected during the first six months of 2021 from the Adolescent Behaviors and Experiences Survey (ABES) suggest that just under one-third (31.6%) of high school students reported current use of any tobacco product, alcohol, or marijuana or current misuse of prescription opioids.[10] Alcohol is the most commonly used substance among youth and remains a leading cause of preventable death in the United States. Research suggests from 2015-2019, an estimated 1 in 5 deaths among adults aged 20 to 49 years in the United States were attributed to excessive alcohol use.[11] Excessive drinking contributes to more than 3,900 deaths among people below the age of 21 in the U.S. each year. Youth alcohol use is linked to alcohol dependence later in life, death from alcohol poisoning, unintentional injuries, such as car crashes, falls, burns, and drownings. Prevention may reduce premature death and other consequences related to alcohol use.[12]

DFC Program Model

DFC coalitions are required to bring together community representatives from 12 sectors (see the Progress Report data section) that organize as community-based coalitions to meet the local prevention needs of the youth and families of their community. The coalition is expected to work together to develop and implement an action plan rooted in identifying local solutions to local problems. By working together to engage in prevention efforts, community coalitions can bring about synergistic change, rather than change occurring only in siloed activities engaged in by each sector. DFC coalitions may also bring about change in how each sector engages in their own efforts as well as their engagement in the collective efforts. That is, there is a sum effect of collaborative change occurring based on coalition efforts as well as enhanced individual sector efforts.

DFC coalitions develop an action plan as part of their grant application and then are expected to update these plans at least annually, driven in part by ongoing understanding of youth substance use

[8] Hoots, B.E., Li, J., Hertz, M.F. et al. (2023). Alcohol and other substance use before and during the COVID-19 pandemic among high school students – Youth Risk Behavior Survey, United States, 2021. MMWR Suppl 2023;72(suppl-1:84-92. doi: http://dx.doi.org/10.15585/mmwr.su7201a10. See also, CDC (2023). Youth Risk Behavior Survey: Data Summary & Trends Report. Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 (cdc.gov)

[9] See Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (samhsa.gov). Note that NSDUH changed methodologies in 2020, which prevents comparisons to prior years data.

[10] Brener ND, Bohm MK, Jones CM, et al. Use of Tobacco Products, Alcohol, and Other Substances Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):8–15. DOI: http://dx.doi.org/10.15585/mmwr.su7103a2.

[11] Esser MB, Leung GL, Sherk A, et al. (2022). Estimated Deaths Attributable to Excessive Alcohol Use Among US Adults Aged 20 to 64 Years, 2015 to 2019. *JAMA Network Open.* 2022;5(11):e2239485. doi:10.1001/jamanetworkopen.2022.39485. https://pubmed.ncbi.nlm.nih.gov/36318209/

[12] CDC - Fact Sheets-Minimum Legal Drinking Age - Alcohol. (2020, September 3). Centers for Disease Control and Prevention. https://www.cdc.gov/alcohol/fact-sheets/minimum-legal-drinking-age.htm

patterns and underlying causes in their community. Additionally, each DFC recipient determines how best to operate/function as a coalition in implementing this plan. DFC coalitions may make decisions that drive implementation based on input from all coalition members (e.g., during coalition meetings), coalition task force recommendations, and/or key personnel/leadership direction. They may choose to host or not to host a youth coalition. Coalitions may carry out activity implementation directly, primarily led by coalition staff, or may call upon sectors to implement activities individually or collaboratively. For example, Law Enforcement sector members may be called on to lead in implementing activities such as prescription drug take-back events.

A central focus for DFC coalitions is to understand what factors in the community may be contributing to youth substance use. That is, substance use is seen as being associated with a range of potential social determinants, which are conditions in each of the places where youth/people live, learn, work and play. [13] Coalitions may be able to implement activities by addressing negative social determinants or enhancing positive ones, which contributes to the increased likelihood of youth making positive choices (in this case not to engage in substance use). These social determinants are often described as risk and protective factors. Risk factors are included in adverse childhood experiences (ACEs), along with a range of other risk factors.[14] Experiencing ACEs, particularly multiple risk factors, has been associated with a range of negative outcomes including an increased risk of substance use problems, both during adolescence and into adulthood. Conversely, exposure to a range of protective factors may contribute to youth avoiding substance use and other negative outcomes. Some DFC coalitions work to address ACEs by engaging in activities intended to increase the likelihood that youth experience protective factors, including helping connect youth with their family, school, and/or community. Research suggests that youth who feel connected are far less likely to engage in substance use than those who are not, a protective factor that was also seen as helping youth to positively address stress associated with the ongoing COVID-19 pandemic.[15]

In sum, DFC coalitions bring together a diverse range of community members who identify and work to prevent and reduce youth substance use through building capacity of those engaged with the coalition and through implementation of a wide range of prevention activities. These prevention activities have the potential to directly impact current participants but may also bring about long-term change as social determinants in the community are altered.

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[13] For more on social determinants of health, see Social Determinants of Health Workgroup - Healthy People 2030 | health.gov and Social Determinants of Health | CDC.

[14] See the CDC's Preventing Adverse Childhood Experiences for more information on this topic: https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

[15] See for example Rose, I.D., Lesesne, C.A., Sun, J. et al. (2022). The relationship of school connectedness to adolescents' engagement in co-occurring health risks: A meta-analytic review. Journal of School Nursing, 2022 Apr 28;10598405221096802. doi: 10.1177/10598405221096802. and Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):16–21. DOI: http://dx.doi.org/10.15585/mmwr.su7103a3.

Data

DFC coalitions receive guidance from the national evaluation team throughout the year regarding data collection and submission of required reporting: progress reports, core measures, and coalition classification tool (CCT) guidance during report submission windows. This report includes all core measures data submitted through August 2022, as well as detailed analysis of coalition efforts reflected in the coalitions' submission of their August 2022 progress report and CCT.[16]

Progress Report

DFC coalitions collect and submit a broad range of data through biannual progress reports including information about the community context, building capacity, and implementation of prevention activities. The progress reports support grant monitoring as well as the national evaluation. Throughout the progress report, DFC coalitions answer specific questions but also report qualitatively about their work, successes, and challenges during the reporting period in open-text response fields.[17]

- *Coalition Structure & Process* includes information regarding the potential reach of the program (associated with ZIP codes served), community context (e.g., geographic setting, HIDTA collaboration), focus of coalition efforts (e.g., substances focused on), and key protective and risk factors found in the local community which coalitions are building on or working to address (e.g., availability of substances, positive school climate).
- *Building Capacity* includes data on the number of members (total and active) and level of member involvement by sectors. Coalitions also report on hosting (or not) a youth coalition and their capacity building activities. The 12 required community sectors[18] are:
    - Youth (age 18 or younger), Parent, School, Law Enforcement, Healthcare Professional or Organization (e.g., primary care, hospitals), Business, Media, Youth-Serving Organization, Religious/Fraternal Organization, Civic/Volunteer Group (e.g., a member from a local organization committed to volunteering), State, Local, or Tribal Governmental Agency with expertise in the field of substance use, and Other Organization involved in reducing substance use.
- *Strategy Implementation* includes details and descriptions of activities implemented during the reporting period. For each completed activity type within a given strategy, DFC coalitions provide information (e.g., number of completed activities, number of youths/adults participating). Activities are grouped into the Seven Strategies for Community Change, which

[16] 740 of the 743 FY 2021 coalitions (99.5%) submitted reports in time to be included in this report. Additional coalitions completed reports after data were pulled for the evaluation.

[17] Throughout this report, when incorporating qualitative anecdotes with findings, DFC coalitions will be identified by their FY 2021 funding year (1–10) and by the U.S. census region where they are located (see 2010 Census Regions).

[18] As per the notice of funding opportunity. For further information see the most current notice of funding opportunity here: https://www.cdc.gov/drugoverdose/drug-free-communities/funding-announcements.html. For information on the FY 2021 awards please see Archived DFC Funding Announcements | Drug Overdose | CDC

are divided into individual-focused strategies and environmental-focused strategies.[19] DFC recipients are encouraged to prioritize implementing environmental strategies as most effective for long-term, community-level change (e.g., efforts that result in a policy change such as drug-free school zones potentially impacts both current and future cohorts of youth).

Individual Strategies

Providing Information
Enhancing Skills
Providing Support

Environmental Strategies

Changing Access/Barriers
Changing Consequences
Changing Physical Design
Educating/ Informing about Modifying/Changing Policies or Laws

Coalition Classification Tool

DFC coalitions complete the CCT based on reflecting on coalition efforts over the past year. In the CCT, coalitions identify prevention assets that have been put into place in the community as a result of DFC funding. Other sections focus on the extent to which coalitions engaged in a range of coalition activities (e.g., referring to action plans to make decisions about activities and having youth members share the coalition's message with the community) and the extent to which coalition staff and members are responsible for carrying out some key activities.

Core Measures Data

DFC coalitions are required to collect and submit new youth core measures data at least every 2 years from at least three grades.[20] Briefly, the core measures are defined as follows (see Appendix A for specific wording for each of the core measure items):

Past 30-Day Prevelance of Use

Percentage of respondents who reported misusing prescription drugs or using alcohol, marijuana, or tobacco at least once within the past 30 days.

Perception of Risk

Percentage of respondents who perceived people who misuse prescription drugs or use alcohol (binge use), marijuana, or tobacco risk harming themselves to a moderate or great extent.

Perception of Parent Disapproval

Percentage of respondents who perceived their parents would feel misuse of prescription drugs or regular use of alcohol, marijuana, or tobacco is wrong.

Perception of Peer Disapproval

Percentage of respondents who perceived their peers would feel misuse of prescription drugs or regular use of alcohol, marijuana, or tobacco is wrong.

[19] CADCA derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see https://www.cadca.org/resources/implementation-primer-putting-your-plan-action. DFC grant funds may not necessarily fund all the indicated examples provided for each of the 7 Strategies for Community Change. For the most recent description of DFC grant funding limitations, see https://www.cdc.gov/drugoverdose/drug-free-communities/funding-announcements.html

[20] DFC coalitions are encouraged to collect data from at least one grade in middle school (Grades 6 through 8) and at least one in high school (Grades 9 through 12), with data from a total of data collected in at least three grades. A few core measures were revised in 2012, at the same time as the addition of new core measures (i.e., perception of peer disapproval and misuse of prescription drugs) were added. For unchanged core measures, data have been collected since 2002.

Given the DFC focus on prevention, past 30-day prevalence of use data are also reported here as prevalence of non-use (non-misuse). Reporting on prevalence of non-use emphasizes increases in youth engaging in decision making not to use substances. Data associated with each core measure are summarized by substance and time of report (first versus most recent report), allowing for the calculation of change in response patterns over time.

Community Context

Key Findings

In 2022, one-fifth (20%) of Americans lived in a community with a DFC-funded coalition, with prevention efforts tailored to a diverse range of demographics and community types. Almost two-thirds of DFC coalitions (65%) reported focusing building capacity or prevention efforts to one or more specific demographic subgroups including Hispanic/Latino, Black/African American, American Indian/Alaska Native, Asian/Asian American, Native Hawaiian/Pacific Islander and/or LGBTQ+ youth/people. In line with youth substance use, coalitions primarily focused prevention efforts on core measure substances (alcohol, marijuana, prescription drug misuse, and/or tobacco). Coalition efforts were focused on strengthening protective factors including the connections of youth to their community, peers, family, and school. Coalitions also focused on addressing community risk factors including community and individual youth norms accepting of substance use and the availability of substances.

The following sections summarize DFC coalitions' responses to questions pertaining to the communities with whom they work on prevention.

DFC Reach

In 2022, there were DFC coalitions in each of the 50 states, as well as in the District of Columbia and three United States territories (Guam, Puerto Rico, and Virgin Islands). Given the number and broad geographic distribution of DFC coalitions, many Americans potentially benefit from the program as they live in communities served by grant recipients. An estimated 67 million people (20% of the U.S. population) lived in communities served by DFC coalitions receiving funding in 2022. [21] This included approximately 2.6 million middle school students ages 12 to 14 (20% of all middle school youth) and 3.5 million high school youth ages 15 to 18 (21% of all high school youth). Since 2005, approximately 184 million, or 55% of the U.S. population, has lived in a community with a DFC coalition.

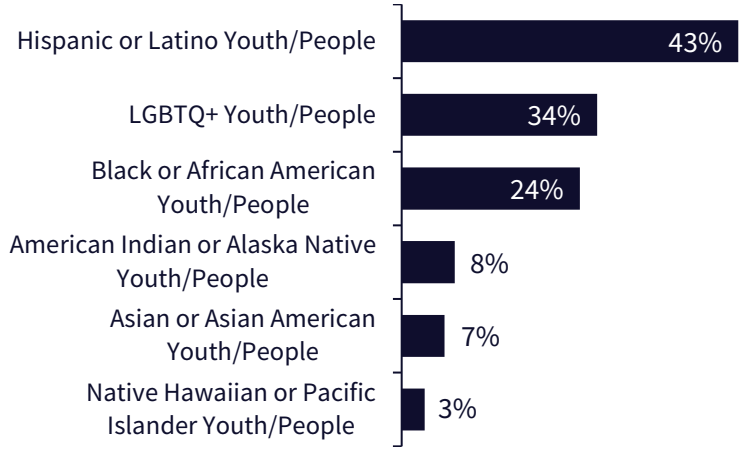
[21] DFC coalitions identify catchment areas by ZIP codes, indicating all ZIP codes in which grant activities are conducted. These ZIP codes were merged with 2020 United States (U.S.) Census data to provide an estimate of DFC coalitions potential reach and impact. DFC coalitions provide ZIP codes while the U.S. Census 2020 Age Groups and Sex table uses ZIP Code Tabulation Area (ZCTA). These are similar but not identical (see https://www.census.gov/topics/population/age-and-sex/data/tables.html. and https://www.census.gov/programs-surveys/geography/guidance/geo-areas/zctas.html). Some ZIP codes reported by DFC coalitions are not found in the U.S. Census ZCTA, typically because they represent smaller communities. Census estimates reported here are likely a conservative estimate of potential reach of the DFC grant. Estimates excluded a coalition that serves the entire state of New Jersey. Including this coalition increases the percentage to about 22%.

Community Type and Demographics Served

On average, DFC coalitions reported serving one or two of the five community types (frontier, rural, suburban, urban, and inner city). Most coalitions identified as working in rural (51%) or suburban (47%) communities, followed by urban (27%) inner-city (10%) or frontier (3%) communities. [22]

Almost two-thirds of coalitions (65%) reported focusing on building capacity or prevention efforts to one or more specific demographic subgroups, an increase of 6 percentage points from what was reported in August 2021. DFC coalitions were most likely to report that they focused some efforts on working with Hispanic or Latino Youth/People, followed by LGBTQ+ and Black or African American Youth/People (see Figure 1).

FIGURE 1. DEMOGRAPHIC(S) FOCUSED ON

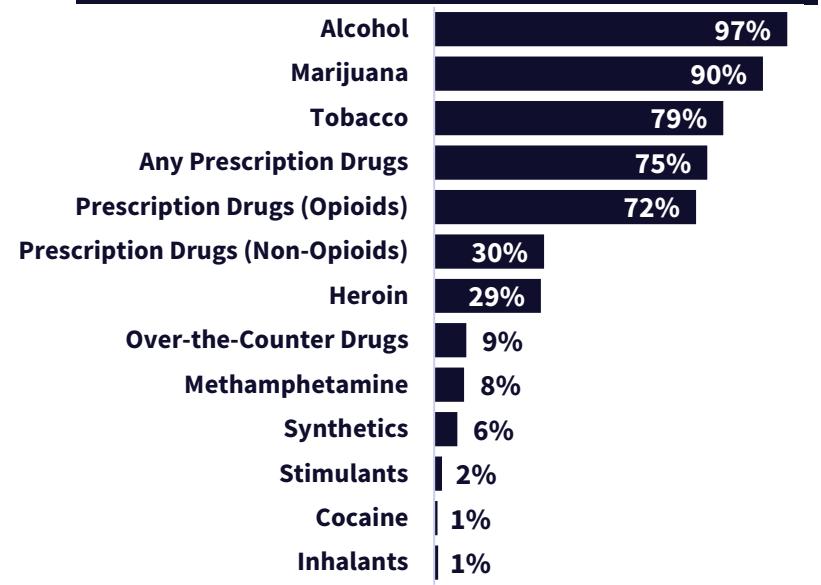


Source: DFC August 2022 Progress Report
Note: Coalitions could select more than one demographic.

Substance Focus

DFC coalitions were asked to select up to five (of sixteen) substances on which their coalition focuses prevention efforts in their community (see Figure 2). On average, DFC coalitions reported focusing on 4.2 substances. Nearly all coalitions reported addressing alcohol (97%) and at least three-fourths focused on the remaining core measure substances, with declining percentages across the remaining substances. [23]

FIGURE 2. SUBSTANCE(S) FOCUSED ON



Source: DFC August 2022 Progress Report
Note: Coalitions could select more than one substance. Only substances with ≥ 1% displayed.

[22] DFC coalitions selected all geographic settings that applied. For additional information, see: Methodology for designation of frontier and remote areas, 79 Fed. Reg. 25599 (May 5, 2014). Retrieved from https://www.federalregister.gov/documents/2014/05/05/2014-10193/methodology-for-designation-of-frontier-and-remote-areas

[23] The Any Prescription Drugs category refers to the total percentage of DFC coalitions who chose at least one type of prescription drugs.

Community Protective and Risk Factors

Protective factors are the characteristics of individuals, families, or community that *decrease the likelihood* of substance use and its associated harms while risk factors are the characteristics that may *increase the likelihood* of substance use and its associated harms or may increase the difficulty of mitigating these dangers. DFC coalitions may focus on building upon or strengthening protective factors or reducing or addressing important risk factors in their community. On average, DFC coalitions selected 8 (of 14) protective factors and 9 (of 17) risk factors. The most selected protective and risk factors can be found in Table 1 (see Table B.1, Appendix B for a complete list).

TABLE 1: TOP PROTECTIVE AND RISK FACTORS SELECTED BY COALITIONS

Protective Factors		Risk Factors	
Pro-social community involvement	75%	Perceived community norms of acceptability of substance use	89%
Opportunities for pro-social family involvement	66%	Availability of substances that can be misused	89%
Positive contributions to peer group	64%	Individual youth having favorable attitudes towards substance use/misuse	82%
Contributions to the school community	63%	Perceived peer acceptability of substance use	80%
Advertising and other promotion of information related to substance use	63%	Perceived parental acceptability of substance use	75%

Source: DFC August 2022 Progress Report Data, n=740

Building Capacity to Prevent and Reduce Substance Use

Key Findings

In 2022, DFC coalitions successfully mobilized approximately 35,000 community members to engage in youth substance use prevention/reduction efforts. Most (90%) coalitions report having at least one member from each of twelve sectors, although fewer (73%) reported active members from all sectors. **Two-thirds (67%) of coalitions reported hosting a youth coalition, a promising practice associated with significantly higher levels of Youth sector involvement.**

Comprehensive community collaboration is a fundamental premise of effective community prevention and the DFC program.[24] Building capacity in the community to address prevention work is an ongoing process aligned with the DFC goals. The average coalition in 2022 had 43 active members, with two paid and two unpaid staff. Extrapolating from the median across the 743 DFC coalitions, these DFC coalitions are estimated to have engaged approximately 32,000 active sector members and a total of approximately 35,000 community members including staff.[25] When asked to select the three most common activities they had engaged in during the reporting period to build capacity, coalitions most frequently selected outreach (47% of coalitions), recruitment (43%), and engaging the general community in substance use prevention initiatives (42%). The following provides additional details on sector membership and involvement as well as building capacity by hosting youth coalitions.

Sector Level of Involvement and Active Sector Members

While almost all (90%) DFC coalitions report compliance with having at least one member from each of the twelve sectors, fewer (73%) reported at least one active member in all sectors. DFC coalitions rated each sector's average level of involvement with the coalition. Schools, Other Organizations with Substance Use Expertise, and Youth-Serving Organizations were rated as the most highly involved sectors, although all sectors averaged ratings of medium or higher involvement (see Figure 3). On average, coalitions reported 1 to 6 active members per sector, with the median number of active members highest for the Youth and Schools sectors (see Figure 4).

[24] See CADCA (2019). Community Coalitions Handbook https://www.cadca.org/sites/default/files/resource/files/community_coalitions.pdf and NIDA (2020, May 25). How can the community implement and sustain effective prevention programs? Retrieved from https://nida.nih.gov/publications/preventing-drug-use-among-children-adolescents/chapter-3-applying-prevention-principles-to-drug-abuse-programs/implement-sustain on 2022, March 1

[25] The median is used here as the average rather than the mean because a small percentage of DFC coalitions reported very large numbers of active members. Extreme outliers (above 3 standard deviations from the mean) were excluded from these analyses prior to identifying the median. The median is the midpoint in a frequency distribution. Note that when the number of total active members is first summed, the median is larger (43) than if the median number of active members by sector is summed (32), as in Figure 4.

FIGURE 3. AVERAGE RATINGS OF ACTIVE MEMBER SECTOR INVOLVEMENT

Source: DFC August 2022 Progress Report
Note: 1 = Very Low, 2 = Low, 3 = Medium, 4=High, 5 = Very High

FIGURE 4. MEDIAN NUMBER OF ACTIVE MEMBERS BY SECTOR

Source: DFC August 2022 Progress Report

Engagement with the School Sector

Individual schools and school districts are important partners for DFC coalitions and almost all coalitions (99%) report working with at least one school with most (83%) working with multiple schools either in a single or multiple districts (see Table 2).[26] DFC coalitions not working with schools may still be working on building a relationship or may be working at broader regional/state levels. Just under one-fifth of coalitions (17%) reported that schools were the coalition's lead sector. Through schools, coalitions can reach students/youth, as well as their parents and families. The coalitions implemented each of the Seven Strategies for Community Change with/within the school sector. Much of this work focused on the nexus of substance use and mental health in youth.

TABLE 2: ENGAGEMENT WITH SCHOOLS

DESCRIPTION OF SCHOOLS AND DISTRICTS THAT COALITIONS WORKED WITH	PERCENTAGE OF DFC COALITIONS ENGAGING WITH SCHOOLS IN THIS WAY
Single school in a single district	**16%**
Multiple schools in multiple districts	**41%**
Multiple schools in a single district	**42%**
Not applicable/Not working directly with schools	**1%**

Source: DFC August 2022 Progress Report Data, n=740

Many coalitions successfully collaborated with schools to implement *Providing Information* activities to students and their families by providing handouts, disseminating messaging through weekly programming, and teaching classes about the misuse of drugs and their associated risks. Coalitions used interactive events like vaping trivia to engage students in vaping education. DFC coalitions were able to connect with the parent sector and *Provide Information* to parents through the school sector by holding meetings with parents of middle and high school students, sending educational flyers to parents about keeping teens safe and drug-free and providing parents with talking points and conversation starters. For example, a Year 3 coalition in the Midwest reported, "We continued our use of parent/caregiver letters to 8th and 12th graders, informing them about the risks of substance use on the developing brain, and coincided this with a radio and social media campaign. We were also featured at a local elementary school's night dedicated to creating strong family relationships and they brought in multiple items featured in our "Meaningful Meal" educational kit. We distributed new fentanyl information as a result of a regional youth's death this spring. These were highly successful areas and lead to greater distribution of our information and reach."

Coalitions worked with schools to enhance student and parent skills. Coalitions partnered with schools to host activities, programs, and training for students to reduce drug use, train on cessation

[26] District is a broad term here that may not reflect local language. In this context, it refers to schools that are grouped together under a single higher-level administration.

tactics, and enhance refusal skills for middle and high school students. For example, a Year 10 coalition in the Northeast region reported, "We provide vape education prevention training to students as well as parents and teachers, and we work with schools who have caught students vaping to assess their use and help support them in reducing their use or quitting." Coalitions also worked directly with school administrators to build staff knowledge on drugs and implement referral processes for treatment services within schools. A Year 3 coalition in the Southeast region described, "We met with school nurses, teachers, and staff to review the latest trends in vaping devices and worked with administrators on developing a referral process for treatment services."

Schools also played an important role in implementing environmental strategies for community change. These activities often reflected both educating about policy and changing consequences For example, several coalitions worked with schools to modify and change punitive consequences for students caught in possession of drugs while at school. A Year 9 coalition in the Midwest Region, along with a county-wide community organization, "worked in conjunction with a local school system to modify vaping policy and move from punitive policies to more educational and intervention-based policies." Coalitions enhanced access to drug-free prevention information and harm reduction kits for schools. They also worked with schools to change the physical design by introducing signage at school entrances as well as signage to indicate smoke-free areas.

School Sector Engagement and Mental Health

Since 2011, increasing numbers of youth have reported experiencing mental health challenges with 42% of high school youth in 2021 reporting feeling persistently sad and 29% reporting poor mental health.[27] Mental health challenges can contribute to youth engagement in risky behaviors such as substance use/misuse, which is linked to poor school performance and other negative outcomes for youth. Many DFC coalitions described working to build capacity and to implement activities in schools around addressing mental health alongside substance use among adolescents. Coalitions prioritized strengthening partnerships with key mental health informants inside and outside the school system. These partnerships provided coalitions with a deeper understanding of the overlap between substance use and the mental health needs of students and their families. For example:

- "One of our newest members, [a] Project Coordinator with [the local] Medical Center, joined our coalition in November 2021. [She] brings great insight and resources for parents that struggle with teen substance use. [She] has been working in our schools to offer mental health and substance education and has recently written a grant for naloxone in the schools. [She] works close with [a] Children's Hospital Network and has become a great asset to our coalition." (Year 5, Northeast Region)
- "Our coalition began on-campus as a joint venture between the Department of Psychology and that of Health Promotion and Wellness. Within these departments we have been able to

[27] See https://www.cdc.gov/healthyyouth/mental-health/index.htm and CDC (2022). Youth Risk Behavior Surveillance Data Summary & Trends Report: 2011-2021. Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 (cdc.gov)

forge new partnerships with several teams working on projects which align with our community-building and substance-prevention foci. Some of the most impactful partnerships have been with teams of clinicians working with youth and other community stakeholders to provide free mental health services. These partnerships have been fundamental to the coalition's recent successes in expanding into the local public schools as the coalition has been able to leverage their established connections with school administrators and counselors." (Year 3, South Region)

Key sector member access helped coalitions coordinate, and disseminate information, resources, and training to staff, students, and parents in schools. For example, one school leader provided buy-in from school mental health service providers to co-coordinate strategies. The coalition described, "We also added a new Assistant Superintendent of High Schools for one of our school districts. She has already helped increase capacity in the school buildings. She has welcomed and sought out our programs and initiatives for their buildings, students, and parents." (Midwest Region, Year 6). A Year 3 coalition (West Region) leveraged a shared vision with a student services administrator to establish sustainability and broaden equity in schools. "We have established a deeper relationship with the school district over the last few months as we continue to support and expand services at the district. With the establishment of the Family Resource Center (FRC) … we have developed a close relationship with the … Student Services Administrator …. This is an important connection for [our coalition] as the student services department deals with the most vulnerable youth population in the district including unaccompanied youth asylum seekers, students in foster care or who are suffering from homelessness, youth who have been caught with controlled substances, mental health issues, etc. As we work to establish the FRC we have collaborated to ensure students and their families' needs are met in order to address the underlying issues of substance abuse in youth as well as establish prevention strategies and protocols within the district."

Other coalitions were successful at implementing and supporting strategies directly within schools. Reports of school activities at the intersection of vaping and mental health were frequently reported. One coalition shared, "We expanded our capacity with schools with more in-school access to students via 3 planned lunch-time tabling events on mental health and vaping risks. It has been difficult to have direct connection to students during the school day, so this is an important expansion. We now have a new liaison to ESL teachers to help us better engage with the Latino population. For the first time, we delivered Mental Health First Aid training to 37 private school parents. We have a commitment from the county-wide YMCA to collaborate on delivering prevention messaging and potentially mental health support programs to their membership, especially their sport teams." (Northeast Region, Year 5). School activities at the intersection of other drugs, especially opioids, and mental health were also reported often. For example:

- "Our school-based Prevention Coordinator provided education to our middle school and high school students (grades 7-12) on facts and myths on opioid use/abuse and their impact on physical and mental health." (Year 7, Northeast Region)

- "While youth 18 and under have not been found to be using opioids in [local community], we are very aware of the use in the surrounding area, as well as the emerging danger of counterfeit pills and Fentanyl. We addressed this multiple times in our newsletter that goes out monthly to over 800 subscribers. To that end, the schools also hosted "Sullivan's Message", a presentation that addresses addiction to opioids, mental health and binge drinking through the personal story of a local family. All of our high school students saw this presentation and were very moved by it. It was also presented to the community in the evening to an audience of 30 adults. (Year 4, Northeast Region)

Hosting a Youth Coalition

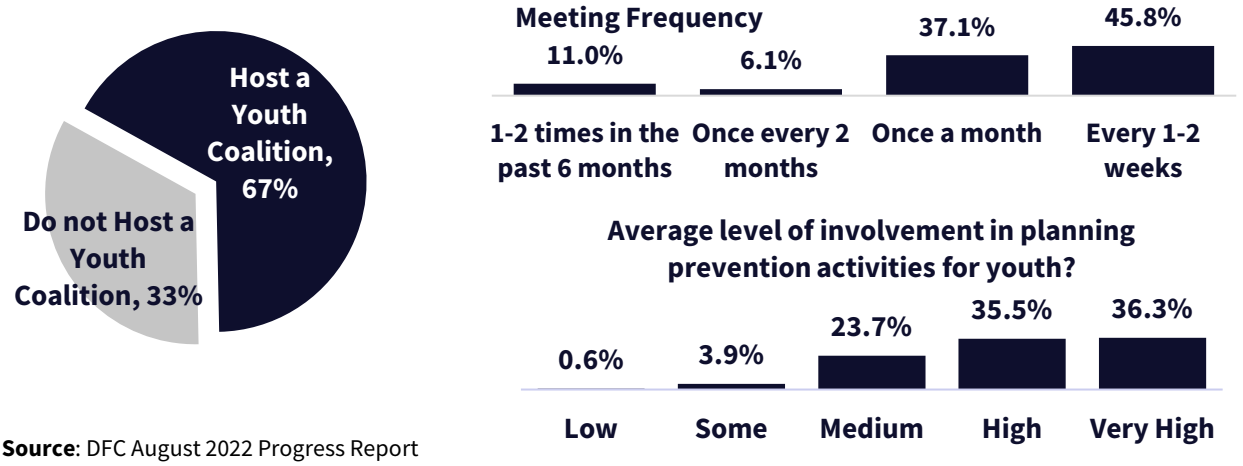
One strategy adopted by DFC coalitions to engage with youth and achieve grant goals is to host a youth coalition. A *youth coalition* is defined as:

> A group of youth who work together to plan and implement activities related to the mission of the full coalition. An adult coalition member serves as a mentor or leader, but the youth have key leadership roles. The youth coalition is integral to the full coalition, but generally meets independently.

In August 2022, two-thirds (67%) of DFC coalitions reported hosting a youth coalition (see Figure 5).[28] Most (83%) reported the youth coalition met at least once a month and rated involvement in planning prevention activities as high or very high (72%).[29] Of the coalitions not hosting a youth coalition (33%), more than two-thirds (68%) were working to host a youth coalition within the next six months, while the remaining had no plans to host a youth coalition.

Hosting a youth coalition continues to be a promising practice particularly for engaging youth. DFC coalitions hosting a youth coalition reported youth sector involvement as significantly higher on

FIGURE 5. DFC COALITIONS REPORTING HOSTING A YOUTH COALITION, MEETING FREQUENCY, AND LEVEL OF INVOLVEMENT OF THE YOUTH COALITION



Source: DFC August 2022 Progress Report

[28] This has slightly increased from February 2022, when 65% of DFC coalitions reported hosting a youth coalition.

[29] Of these coalitions, 45.8% met once every 1- or 2 weeks while 37.1% met once a month, for a total of 82.9%. Another 6.1% met once every 2 months while 11% of those with youth coalitions reported they met only one or two times in the past 6 months.

average (4.2, high to very high) as compared to those not hosting a youth coalition (3.0, medium involvement).[30] That is, for those coalitions hosting a youth coalition, their average youth sector level of involvement was higher than the other most highly rated sectors. This level of engagement was similar to that of schools (4.1) who overall were rated highest on engagement (see Figure 3).

Making it clear that youth coalitions are central to the work of DFC coalitions who host them, just under half (41%) of these coalitions indicated that a youth coalition representative attended leadership meetings and had a say in coalition decision making while 13% indicated that youth members attended leadership meetings but did not have a say in coalition decisions. Just under half (46%) indicated that no youth members attended these meetings. This engagement in decision making by youth may contribute to the overall higher level of involvement by youth coalitions.

Youth Involvement and Youth Coalitions

Among coalitions with high youth sector engagement, youth engagement spanned a variety of activities including meeting attendance, volunteering, peer mentoring, and serving as camp counselors. Youth were also involved in the development and creation of PSAs and other information distribution activities. For example, a Year 7 coalition (Northeast Region) reported an increase in youth participation, where youth were: "attending meetings, joining task forces, and … participating on our first ever video PSA about the Social Host Law." Other coalitions report engaging youth and youth coalition members in leadership and peer mentoring opportunities to meet the needs of the community. As reported by one Year 5 coalition (West Region), after assessing the racial diversity among the youth in the community, "the coalition decided that it would be a good idea to start a camp, where young campers would learn the cultural traditions of our area and would allow the youth coalition to serve as camp counselors and mentors."

Youth Recruitment, Retention and Leadership Development

Coalitions that benefit from high youth engagement report using incentives to increase youth interest. An example of incentives comes from a Year 3 coalition (West Region), "We continue to engage and recruit youth though various sources. We are working to launch a youth project grant program. $500 grants will be awarded for 6-month projects. Our goal of this activity is to engage and recruit youth in our coalition work, build their skills through mini grant management, and create a youth leadership base in the community."

Coalitions also recommended including youth voice to raise awareness of the coalition mission and recruit more youth participants. A Year 3 coalition (Northeast Region) included youth in the development of recruitment strategies saying, "Youth met with program coordinator, adult community leaders regularly to plan the event and most importantly come up with a marketing

[30] Mann-Whitney-Wilcoxon $X^2(4) = 144.98$, $p < .0001$

strategy to recruit youth participation in the event. Youth voice was important to helping select the speaker who would tell their story of addiction and mental health struggles, to selecting the food, and recruiting their schools' participation."

Several coalitions acknowledge that initial youth involvement is the first step in recruiting additional youth members and sustaining youth engagement. "It has been a challenge recruiting new youth members," reported one Year 2 coalition (South Region). "We are currently working with the youth we have, to put together a youth advocacy group. Our youth will help with the recruiting process at their schools. Our youth are still in the recruiting and replanning stages of building the youth coalition and are planning a Red Ribbon Week event which will serve as a recruitment platform."

Engaging Youth without a Youth Coalition

Coalitions that do not have a youth coalition but are in the process of forming one look to other ways to engage youth. A Year 1 coalition (South Region) notes, "Our coalition is new, but we are working in the community to engage youth in other ways to build a strong youth coalition. The coalition recently took 2 youth members to [youth conference] this summer. The youth are planning on helping recruit youth for the coalition when school begins in Fall 2022." Similarly, a Year 4 coalition (Northeast) acknowledges low youth participation but provides insight into how they intend to build youth engagement after a positive experience bringing a speaker to the school. "This speaker was a former student of the school and graduated less than 10 years ago. Her powerful testimony of her own experience at the school, with the same teachers and coaches, and her personal story about substance use was extremely relatable and engaging for the students and teachers … Evaluations of the program showed over 170 students participated and most of the feedback was positive, indicating that the youth would like more interactive activities like this in the future."

Established Youth Coalitions Benefit Youth Programing and Policy Impact

Coalitions benefit from having an established youth coalition. In these coalitions, youth are engaged as leaders in the community. Youth coalitions are integral in developing youth-focused programming such as a mental health awareness art fair, hashtag social media campaigns, and drug-free e-gaming events. A Year 5 coalition (Northeast) reported, "The youth coalition planned a community event which offered yoga sessions, rock painting, yard games, artwork of the butterfly logo done by a local recovery graffiti artist, ice cream, mental health and substance use resources, and swag, all of which were free." And a Year 3 coalition (South Region) reports, "the Youth Council planned and executed Drug-Free Youth Future Self Campaign. Email/text example: 'Dear Me, I'm sorry if sometimes I held you back with self-doubt. Don't be so hard on yourself. You're doing fine!'"

Having an established youth coalition leads to positive impacts on policy development and implementation. For some coalitions, their youth coalition is instrumental in engaging legislators and school administrators on important coalition objectives. For example, one Year 4 coalition (Midwest Region) reported that the youth coalition is "working with coalition partners to advocate for policy change. The youth coalition hosted an activity which encouraged people and legislators from all over

the state to identify the positive characteristics they see in their home communities." Similarly, a Year 5 coalition (Northeast Region) reported that in addition to leading campaigns and social media engagement' their youth coalition have "spoken to school administration on the work being done and why it is important to support within the school system."

Youth Engagement and Mental Health

Youth mental health was an important topic among coalitions and a priority among youth members. "Youth members identified mental health as an issue of concern among students in their school. [Youth recognized] the impact of mental health on substance use (and vice versa) and are passionate about the health and wellbeing of their peers. Youth members partnered with County Mental Health Services to develop strategies to address this issue. As a result, members engaged in multiple activities to equip all high school students and staff with information and skills helpful to coping with life's demands, pressures and traumas." (Year 5, Midwest Region)

Both coalitions and youth coalitions are taking steps to raise awareness and bring resources to their communities regarding mental health. For example, a Year 4 (Northeast Region) reported, "as part of the youth coalition strategy to work on mental health promotion, we have a subgroup that is open to any 10th to 12th grade high school student. For these meetings, they focus on skills to help them cope with stress, mindfulness skills, time management, and others. In addition to learning these skills to help promote positive mental health, the student leaders are developing their hard-set skills."

Youth mental health is recognized as a challenge in many communities and the coalitions are grateful to be able to raise awareness and provide resources. "The county we serve has minimal mental health resources for families in the community. The educators in the districts are also overloaded and suffering from stress from the pandemic. The ability to focus on mental health issues in addition to substance use through the DFC funding opportunity has been a true asset for our coalition and the community" (Year 1, South). Coalitions also engaged youth around these topics in line with addressing risk factors. For example, one Year 5 coalition (Midwest Region) reports, "The youth coalition is looking at ways to support teens who feel stressed, lost or are dealing with mental health challenges. We are hopeful that our youth will guide us in these efforts." Similarly, a Year 1 coalition (Midwest Region) reported, "our members have spent considerable time discussing mental health and specifically youth mental health. Conversation routinely brings up ACEs and resiliency. Our Youth Risk Behavior Survey, 2019 points to social isolation and lack of emotional support caused by undeveloped coping skills that lead to poor mental health that may increase the likelihood of youth alcohol and marijuana use."

Strategy Implementation

Key Findings

DFC coalitions implemented a comprehensive mix of strategies, with more than two-thirds (69%) implementing at least one activity in at least five of the strategy types. Over 70% of DFC coalitions implemented activities to address the emerging drug issues of opioids/methamphetamine and youth vaping (73% and 81%, respectively).

Each DFC coalition is expected to develop and implement an annual action plan to meet grant goals. DFC coalitions focus on selecting and implementing activities from the range of the Seven Strategies for Community Change that best address local needs and challenges, including enhancing or addressing local protective and risk factors. A primary purpose of collaboration across sectors is to leverage skills and resources in the innovative planning and implementation of prevention. DFC coalitions vary in the extent to which the range of sectors is involved in the development and implementation of the action plan. This section of the report provides an overview of the activities and strategies implemented by DFC coalitions as reported in their August 2022 Progress Report.[31] This is followed by information on community assets put into place in the community as a result of DFC funding. Next, strategies implemented to address emerging drug issues are described.

Comprehensive Strategy Implementation

To assess how DFC coalitions are implementing their action plans, 41 unique prevention activities were linked to one of the Seven Strategies for Community Change.[32] Over two-thirds (69%) of DFC coalitions implemented at least one activity in at least five of the seven strategy types (see Figure 6A). This continues the pattern of increased strategy implementation since the first year of the pandemic, when only 49% of DFC coalitions reported this level of strategy implementation, as coalitions continue to approach pre-pandemic implementation levels (80%). An examination of implementation of at least one activity by strategy type (see Figure 6B) presents a similar picture. For five strategy types (*Providing Information*, *Enhancing Skills*, *Changing Access/Barriers, Providing Support,* and *Changing Physical Design*), the rates of engagement are within five percentage points of what they were prior to COVID-19. For the two remaining strategy types (*Educating/Informing about Modifying/Changing Policies and Laws* and *Changing Consequences*) while there were increases in implementation between COVID-19 Years 1 and 2, implementation in these strategies in 2022 were still lower by 10 or more percentage points as compared to prior to COVID-19.

[31] Coalitions were asked to report on activities that were implemented from February 1st, 2022 through July 31st, 2022. The tables provide comparisons from February 2020 (pre-pandemic activities from August 1st, 2019 to January 31st, 2020) and August 2020 (pandemic year 1 activities from February 1st, 2020 to July 31st, 2020) as comparisons.

[32] The activities were identified based on coding of coalition descriptions of activities during an earlier phase of the DFC National Evaluation. DFC coalitions also have the option to add 'Other' activities for each of the seven strategies, bringing the total to 48 activities. Community Anti-Drug Coalitions of America (CADCA) derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see https://www.cadca.org/resources/implementation-primer-putting-your-plan-action.

FIGURE 6A. PERCENTAGE OF DFC COALITIONS IMPLEMENTING THE SEVEN STRATEGIES FOR COMMUNITY CHANGE BY NUMBER OF STRATEGIES ENGAGED IN PRE AND DURING COVID-19

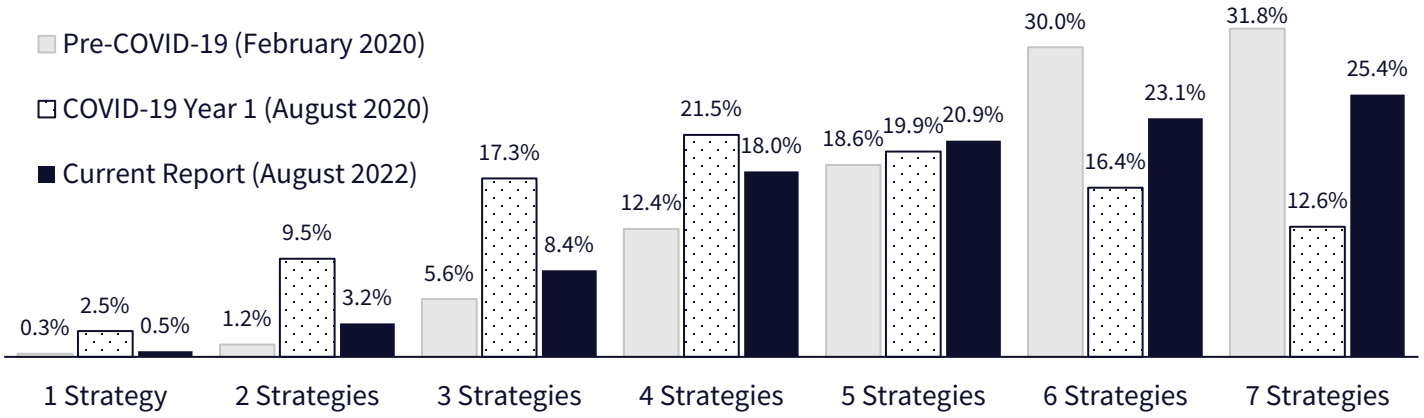
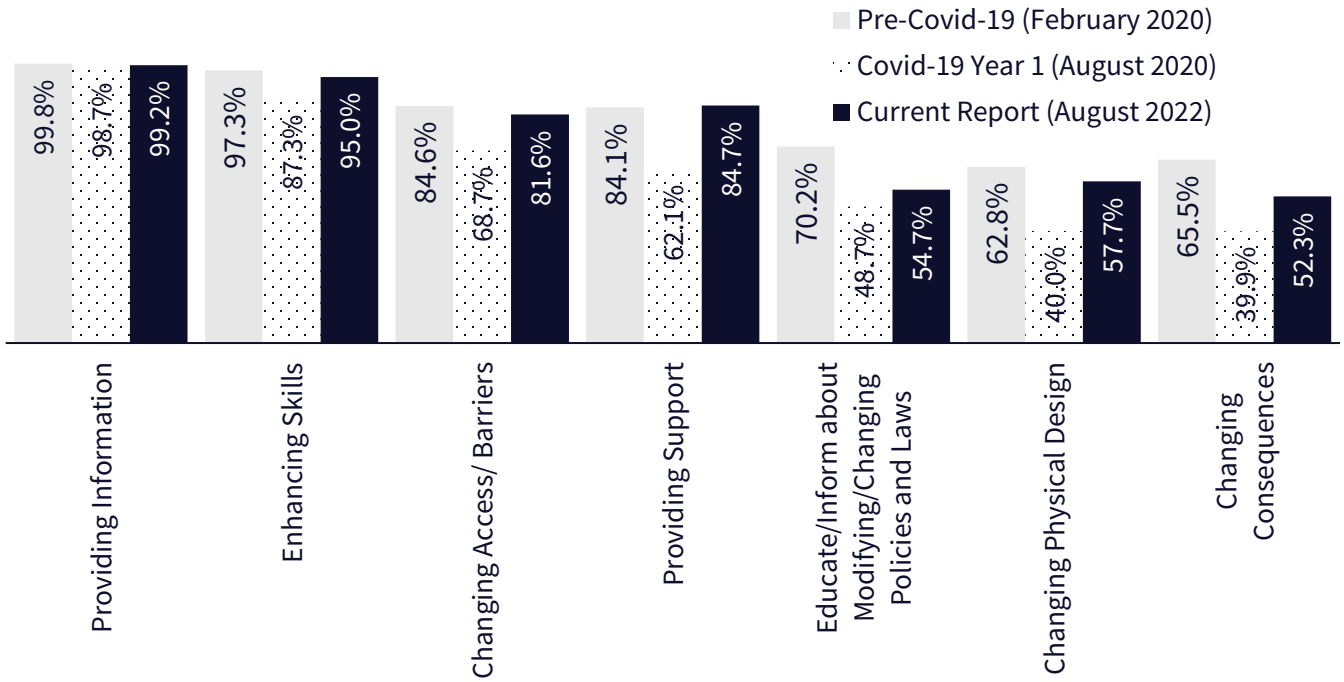


FIGURE 6B. PERCENTAGE OF DFC COALITIONS ENGAGED IN ANY ACTIVITY WITHIN EACH OF THE SEVEN STRATEGIES FOR COMMUNITY CHANGE PRE AND DURING COVID-19



Source: DFC February 2020, August 2020, and August 2022 Progress Reports
Notes: n=740 coalitions reporting in August 2022; n=715 coalitions reporting in August 2020; n=661 coalitions reporting in February 2020.

Activities Implemented by Strategy and Strategy Type

Table 3 provides an overview of the most common activities engaged in by DFC coalitions by strategy (see also Appendix C, Tables C.1 to C.7).[33] In addition to coalitions being generally more likely to have implemented individual strategies as compared to environmental strategies, activities within each of these strategy types were generally also implemented by high percentages of coalitions. Working in the community to *Change Access/Barriers* was the most common environmental strategy, and the most common activity in this strategy included efforts to reduce home and/or social access of substances, implemented by 65% of DFC coalitions.

TABLE 3: TOP TWO ACTIVITIES BY STRATEGY AND STRATEGY TYPE

INDIVIDUAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***Providing Information*:** activities provide community members with information related to youth substance use, including prevention strategies and the consequences of use.		
Informational Materials Disseminated: Brochures, flyers, posters, etc. distributed	90.3%	"The coalition continued to engage in a wide variety of information provision-focused activities throughout this reporting period, using both traditional media modalities as well as social media platforms. Information dissemination activities included the distribution of the County DFC Core Data infographic throughout the community and via online formats, distribution of the monthly Newsletters which include a wide readership across agencies, organizations, and sectors with excellent reach, implementation of prevention social marketing/media campaigns with content included in local newspapers, display on four billboards across the county to increase visibility and saturation of messaging, regional magazine promoting the Student of the Month, and on school district websites. Further, the coalition implemented a series of fun, engaging, and diverse Social Media Challenges for students and families to inform them about prevention resources and approaches… The coalition also participated in National Drug & Alcohol Facts Week and implemented multiple online activities swag giveaways in addition to providing prevention information for youth and families, and sponsored a youth poster design contest, with posters promoting prevention that were designed by youth and printed and distributed in the community." (Year 6, Midwest Region)
Social Networking: (e.g., Facebook, Twitter, etc.)	89.7%	

[33] DFC coalitions are legally prohibited from using Federal dollars for lobbying and are informed of this in their grant terms and conditions. As such, costs for lobbying cannot be calculated as contributing to the required match. For detail, see New Restrictions on Lobbying, 45 CFR 93 (2004). See Lobbying Restrictions on Grant Recipients | HHS.gov. DFC coalitions must comply with all Federal policies and regulations describing allowable and unallowable grant expenditures. In addition, the DFC Support Program has specific funding restrictions. DFC grant funds may not necessarily fund all of the activities indicated in examples provided for each of the Strategies for Community Change. For the most recent description of DFC grant funding limitations, see https://www.cdc.gov/drugoverdose/drug-free-communities/funding-announcements.html.

TABLE 3: CONTINUED

***Enhancing Skills*:** activities designed to increase the skills of participants.		
Youth Education and Training Programs: Sessions focused on providing information and skills to youth	78.9%	"Our greatest accomplishment was leading our community's effort to recognize Mental Health Awareness Month. We hosted the virtual webinar The Dangerous Truth about Today's Marijuana: Johnny Stack's Life & Death Story and the in-person parent workshop "Supporting Teens Mental Health" with the school's SEL/Counseling Director and an [county] Mental Health Counselor. We supported the webinar with supplemental marijuana prevention materials and supported the teen mental health workshop with our Parenting for Prevention tip sheets and mental health resources." (Year 9, Northeast Region)
Community Member Education and Training Programs: Sessions directed to community members (e.g., law enforcement, landlords)	53.9%	
***Providing Support*:** activities to support community members participating in activities that reduce risk or enhance protection.		
Alternative/Drug-Free Social Events: Drug-free parties, other alternative events supported by the coalition	59.3%	"The youth coordinator and the steering team's youth member/coalition intern coordinated the Live Your Why Passport Edition which encouraged youth and their families to participate in local learning events and activities while building protective factors. This included creating booklets and activity sheets to track participation, maintaining a calendar of community events, and promoting the program through schools and community centers. The youth member created an explainer video and created her own webpage updated with activities that kids participated in and wanted to share with others. The steering team's youth member/coalition intern coordinated a basketball clinic for middle school girls at her high school. Feedback from participants in the program was positive." (Year 3, Northeast Region)
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	37.4%	

ENVIRONMENTAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION EXAMPLES**
***Changing Access/Barriers*:** activities designed to improve systems and processes to increase the ease, ability, and opportunity to utilize those systems and services or designed to create systemic barriers to accessing substances.		
Reducing Home and Social Access to Alcohol and Other Substances (e.g., prescription drug disposal)	64.9%	"We continually promote the permanent drug drop boxes in our service area, and we hold Drug Take Back events regularly, although we did not hold any this period. We consistently provide resource materials through our outreach in the community and at our offices, where we also do intake for persons seeking help... We do court ordered drug testing at our headquarters, and advocate for rehab/treatment centers, focusing now on Oxford House. We provide naloxone at trainings, in our offices, to partners, and in the Gifting Box outside our office... Through our Cherokee Nation partner, we are able to provide naloxone free of charge as well as lock boxes and other safe storage/disposal items." (Year 8, South Region)
Increased Access to Substance Use Services (e.g., court mandated services, assessment and referral, EAPs, SAPs)	32.4%	

TABLE 3: CONTINUED

***Changing Consequences*:** activities designed to increase or decrease the probability of a specific behavior that reduces risk or enhances protection by altering the consequences/incentives for performing that behavior.		
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap, open container laws)	24.9%	"Local law enforcement is continuously looking at how to reduce access to opioids and methamphetamine in the community. [Our coalition] has worked with law enforcement on utilization of OD mapping. As noted earlier, … the alternative sentencing program, works with a small group of individuals to wrap services around those in need of treatment versus incarceration. We have also started work in the community around Recovery Friendly Worksites." (Year 10, Northeast Region)
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	22.4%	
***Changing Physical Design*:** activities to change the physical design or structure of the environment to reduce risk or enhance protection.		
Identifying Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	23.5%	"[Our coalition] has a contract with [the] County Human Services to address opioid prevention. [We are] involved in the Substance Misuse Task Force and a staff member from [our coalition] chairs the Environmental Strategies sub-committee which conducts environmental scans of locations known as 'hot spots'. The subcommittee took part in a Parks Clean Up around Earth Day where they went to local parks to clean up waste and report any drug use evidence back to the Task Force. The committee also provided Park Clean Up buckets to the City … Parks Department which include a sharps container, protective gloves, a grabber, and information on resources within the community. Naloxone kits have also been installed throughout the county where an individual has direct access to naloxone. The task force is made up of key leaders in law enforcement, treatment, recovery, and prevention. [The coalition] also coordinates Rx Drug Take Back events and provides community members with home medication lockboxes through this contract." (Year 10, Midwest Region)
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups)	23.4%	
Educating/Informing about Modifying/Changing Policies or Laws: activities to educate and inform with the goal of creating formal change in policies or laws.		
School: Policies promoting drug-free schools	19.2%	"[Our coalition] was successful in leveraging state opioid response grant funds to assist the … [local school] in the purchase of a Halo detection system for their restrooms. Students and staff had reported nicotine and tetrahydrocannabinol (THC) vaping occurring in those areas. Once funded, [key coalition] staff and coalition members met with the … School Board to solicit their support in moving from a hard suspension penalty to a mitigated educational discipline that involves offending students attend awareness and preventative programming. The school board overwhelmingly voted to support the new policy that will take effect in the 2022/2023 school year." (Year 1, West Region)
Underage Use: Laws/public policies targeting use, possession, or behavior under the influence for minors	15.5%	

Source: DFC August 2022 Progress Report Data, n=740

Note: Percentages by activity reflect the percentage of DFC coalitions who conducted the given activity out of all coalitions who conducted any activity within the strategy type.

Community Assets

Once a year, DFC coalitions complete the Coalition Classification Tool (CCT), a survey that asks them to provide information on coalition structure, performance, objectives, and local characteristics.[34] In the CCT, DFC coalitions select which of 22 specific community assets commonly associated with youth substance use reduction and prevention were in place in their coalitions before they received the DFC grant, those that were put into place after receiving the grant, and those not yet in place in the community to date. While each of these community assets may enhance the coalition's capacity to prevent or reduce youth substance use, those that were implemented after coalitions received their DFC grant awards provide an additional source of information about the local impact of the grant. Table 4 presents the top five community assets put into place after receiving the DFC grant award. All community assets can be viewed in Appendix D.1. Coalitions (69%) putting into place culturally competent materials aligns with coalition focus on meeting the needs of diverse groups of youth/people in their communities. Table 5 provides sample activities of each of the most frequently implemented community assets.

TABLE 4: COMMUNITY ASSETS MOST FREQUENTLY IMPLEMENTED AFTER DFC GRANT AWARD

COMMUNITY ASSET	PERCENTAGE OF DFC COALITIONS WITH ASSET PUT IN PLACE AS A RESULT OF DFC GRANT AWARD	PERCENTAGE OF DFC COALITIONS WITH ASSET IN PLACE BEFORE DFC GRANT	PERCENTAGE OF DFC COALITIONS WITH ASSET NOT IN PLACE IN COMMUNITY
Culturally competent materials that educate the public about issues related to substance use.	**69.1%**	**19.1%**	**11.8%**
Social norms campaigns.	**68.5%**	**15.5%**	**16.0%**
Substance use warning posters.	**62.1%**	**24.3%**	**13.6%**
Town hall meetings on substance use and prevention within the community.	**58.1%**	**21.8%**	**20.2%**
Prescription drug disposal programs.	**49.2%**	**45.4%**	**5.4%**

Source: DFC August 2022 Coalition Classification Tool Data
Note: n= 710 coalitions reporting CCT data in August 2022.

[34] In August 2022, 710 DFC coalitions completed the CCT in time for inclusion in this report (95% of all DFC coalitions).

TABLE 5: SAMPLE IMPLEMENTATION ACTIVITIES OF MOST FREQUENTLY IMPLEMENTED COMMUNITY ASSETS

COMMUNITY ASSET	SAMPLE IMPLEMENTATION ACTIVITY
Culturally competent materials that educate the public about issues related to substance use.	"During this period, the Coalition published in the local [Hispanic] newspaper… an infographic in Spanish, 'Maneras de motivar a tus hijos para dejar de vapearâ', (Ways to motivate your children to stop vaping). …The target population for our articles published are mainly parents. [This newspaper] is a valuable media outlet for our Coalition [and] is distributed in more than 40 cities around the state. … thanks to the collaboration with Spanish Radio-Latino, we presented vaping, and we shared with the audience, valuable information about this important topic in the communities." (Year 9, South Region)
Social norms campaigns.	"Social Norms nicotine/vaping poster campaigns (The Real Deal on Vaping) and activities in the Middle and High Schools reached approximately 3700 students. Lunch time prevention activities targeted vaping of nicotine and marijuana, bringing education and awareness of the issues, and distribution of messaging materials to grades 6-12. Banners at 1 middle school, 2 high schools and a county park advocating #endteenvaping were on display for prevention promotion to youth and the community. A Summer Camp Middle School group was shown a film "Vaping: More Dangerous Than You Think" and then participated in activities/games that reinforced that message and information. Also messaging materials were distributed, like wristbands and T-shirts as reminders. Even snacks had vaping messages added to the packaging." (Year 7, South Region)
Substance use warning posters.	"Our coalition partnered with 23 other community coalitions statewide to develop and implement a toolkit that includes radio PSA's, posters, PowerPoint presentations, posters, cards, etc. to educate adults and youth statewide on fentanyl and methamphetamine use and to provide information on naloxone." (Year 8, West Region)
Town hall meetings on substance use and prevention within the community.	"Coalition staff and volunteers worked in collaboration with Public Health, the recovery community, and other community members to plan and conduct a town hall meeting focusing on the dangers of opioid and fentanyl in our community. The evening event was held May 18, 2022, for the general public with special invitations sent to school staff and parents. Fifty-five people attended the event which featured six presenters including representations from mental health, treatment, prevention, education, and two parents who had lost a child to drug abuse. The evening concluded with a panel for questions and answers." (Year 2, West Region)
Prescription drug disposal programs.	"In June 2022, [our coalition] properly disposed of 228 Electronic Nicotine Devices (ENDs)/Vapes through the …County Hazardous Waste Collection Day. ENDs/Vapes that were disposed of at the hazardous waste day had been collected throughout the school year in the SAFE Vape Disposal boxes at schools in [three] counties. The SAFE Vape Disposal boxes are used throughout the school year as a receptacle for confiscating ENDs/Vapes and youth who would like to quit vaping and place them in the disposal box. Disposal of ENDs/Vapes in our area was of significant concern, as ENDs/Vapes, including rechargeable batteries and the cartridges and bottles that contain e-liquids (liquid nicotine mixtures), can pose a threat to human health and to the environment if they are not disposed of properly." (Year 7, Midwest Region)

Source: DFC August 2022 Coalition Classification Tool Data and August 2022 Progress Report data.

The CCT also asked coalitions to describe the extent to which they engaged in specific coalition activities in the past year to grow as a coalition and to bring about change in their community. Activities were grouped into 7 categories (see Appendix D, Table D.2 for all activities). Table 6 shows the individual activities coalitions engaged in most. In line with grant expectations, coalitions rated referring to action plans to guide decision making the most highly.

TABLE 6: TOP FOUR COALITION ACTIVITIES MOST HIGHLY ENGAGED IN BY DFC COALITIONS TO GROW AS A COALITION

CATEGORY	ACTIVITY	Mean Score
Strategic Prevention Framework Utilization	**Referred to our action plan to make decisions about activities.**	**2.6**
Data, Evaluation, and Outcomes Utilization	**Increased awareness of harmful consequences associated with substance use by youth.**	**2.5**
Data, Evaluation, and Outcomes Utilization	**Increased awareness of substance use (e.g., prevalence, types of substances) in the community.**	**2.4**
Building Sustainability	**Identified community organizations or members the provided support services for coalition activities.**	**2.4**

Source: DFC August 2022 Coalition Classification Tool Data
Note: n=710 coalitions reporting CCT data in August 2022. Extent of Engagement Scale: 0=Not at all, 1=To a slight extent, 2=To a moderate extent, 3=To a great extent

Finally, the CCT asked coalitions to indicate who is primarily responsible for carrying out coalition tasks. The tasks that were most likely to be mainly carried out by staff were developing communications sent to coalition members and community partners, making budget and expenditure decisions, and organizing committees and work groups (See Table D.3, Appendix D for full listing). Two tasks were identified by at least half of DFC coalitions as being the responsibility of coalition staff and members equally: identifying and recruiting new coalition members, and both planning coalition activities.

Addressing Emerging Drug Issues

DFC coalitions had the opportunity to answer items focused specifically on addressing two current emergent drug issues. The first section asks coalitions to indicate if they have been working locally to address opioids and/or methamphetamine while the second asks coalitions about addressing vaping. In each case, coalitions addressing the issue were asked to provide additional information.

Opioids and Methamphetamine

The CDC has identified opioid use and opioid overdose deaths as an epidemic.[35] From 2020-2021, drug overdose deaths involving synthetic opioids other than methadone increased 22%.[36] In 2021,

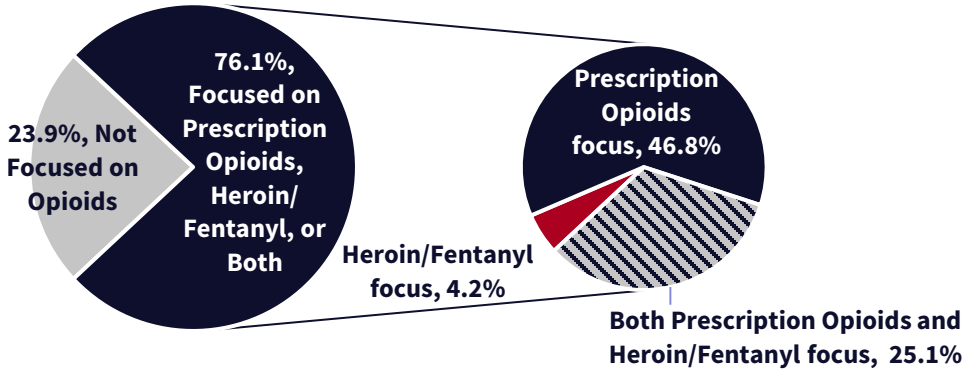
[35] See Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. MMWR Morb Mortal Wkly Rep 2021;70:202–207. DOI: http://dx.doi.org/10.15585/mmwr.mm7006a4 and https://www.cdc.gov/drugoverdose/deaths/index.html

[36] See CDC Drug Overdose Deaths in the United States, 2020-2021, https://www.cdc.gov/nchs/products/databriefs/db457.htm Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021. NCHS Data Brief, no 457. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:122556.

81.9% of overdose deaths involved at least one opioid (e.g., prescription opioids, heroin, fentanyl, illicitly manufactured fentanyl) and 54.2% involved at least one stimulant. Illicitly manufactured fentanyl alone or in combination with other substances was the most common opioid and cocaine the most common stimulant involved in overdose deaths.[37] Overdose deaths involving any opioid increased 17% between 2020 and 2021.[38] Recent analyses of trends over time in overdose deaths among youth aged 10-19, suggest that while a relatively small number of all overdose deaths, deaths in this age group also increased from July 2019 to December 2021. Specifically, median monthly overdose deaths increased 109%, from 32.5 to 68 during this timeframe and, particularly concerning, overdose deaths involving fentanyl increased 182% from 22 to 62.[39]

In August 2022, just over three-fourths of DFC coalitions (76%) selected prescription opioids, heroin, or both as among their top five substances focused on (see Figure 7).[40] This remained the same as the percentage of coalitions selecting prescription opioids, heroin, or both as among their top five substances in August 2021 (76%). However, of those, there was a decrease in the percentage of coalitions who selected only prescription opioids as their focus substance (55% in 2021 to 47% in 2022), while there was an increase in the percentage of coalitions selecting heroin and prescription opioids as their focus (19% in 2021 to 25% in 2022) and of coalitions selecting heroin as their focus substance (2% in 2021 to 4% in 2022).

FIGURE 7. PERCENTAGE OF DFC COALITIONS FOCUSED ON OPIOIDS



Source: DFC August 2022 Progress Report

[37] See the SUDORS Dashboard: Fatal Overdose Date, https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

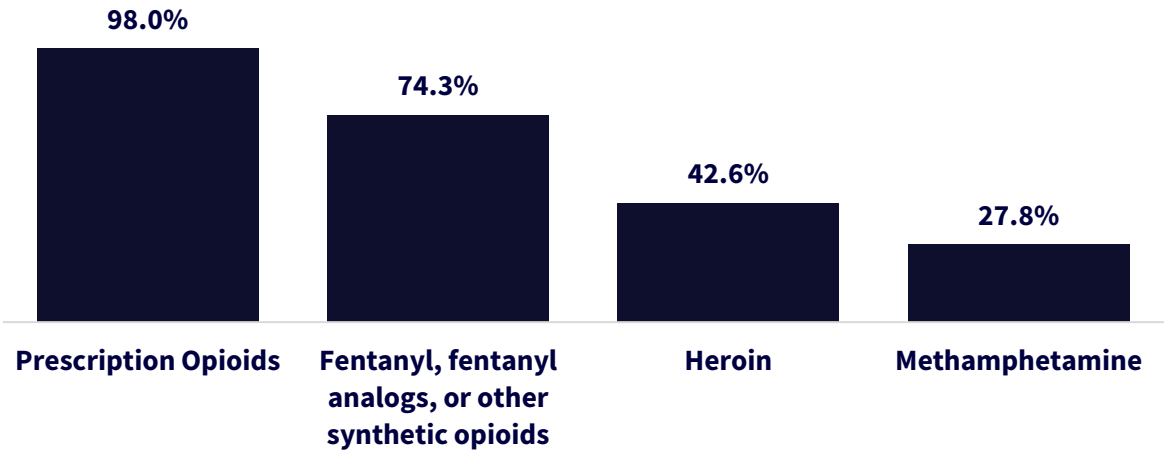
[38] See NIDA Drug Overdose Death Rates, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=In%202021%2C%20the%20number%20of,(Source%3A%20CDC%20WONDER).

[39] Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. (2022). Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:1576–1582. DOI: http://dx.doi.org/10.15585/mmwr.mm7150a2

[40] Heroin/fentanyl in this context refers to heroin, fentanyl, fentanyl analogs or other synthetic opioids. Beginning in August 2017, DFC coalitions could select prescription opioids or prescription non-opioids specifically. In February 2020, heroin was expanded to include Heroin, Fentanyl, Fentanyl analogs or other Synthetic Opioids. Drug-Free Communities Support Program National Cross-Site Evaluation END-OF-YEAR 2020 REPORT (whitehouse.gov)

In comparison to selecting opioids as a focal substance, slightly fewer DFC coalitions (73%) indicated they engaged in activities to address opioids and/or methamphetamine, with almost all indicating they had addressed prescription opioids (98%; see Figure 8). Almost three-fourths (74%) indicated their work addressed fentanyl or other synthetic opioids, close to half addressed heroin (43%), and just over a quarter (28%) indicated their work focused on methamphetamine. This primary focus on prescription opioids was also illustrated by the combination of substances the coalitions addressed with less than 2% of coalitions focused on substances that did not include prescription drugs and only two coalitions indicated a focus solely on methamphetamine.

FIGURE 8. SUBSTANCES SELECTED BY COALITIONS WHO IMPLEMENTED ACTIVITIES SPECIFICALLY TO ADDRESS OPIOIDS/METHAMPHETAMINE

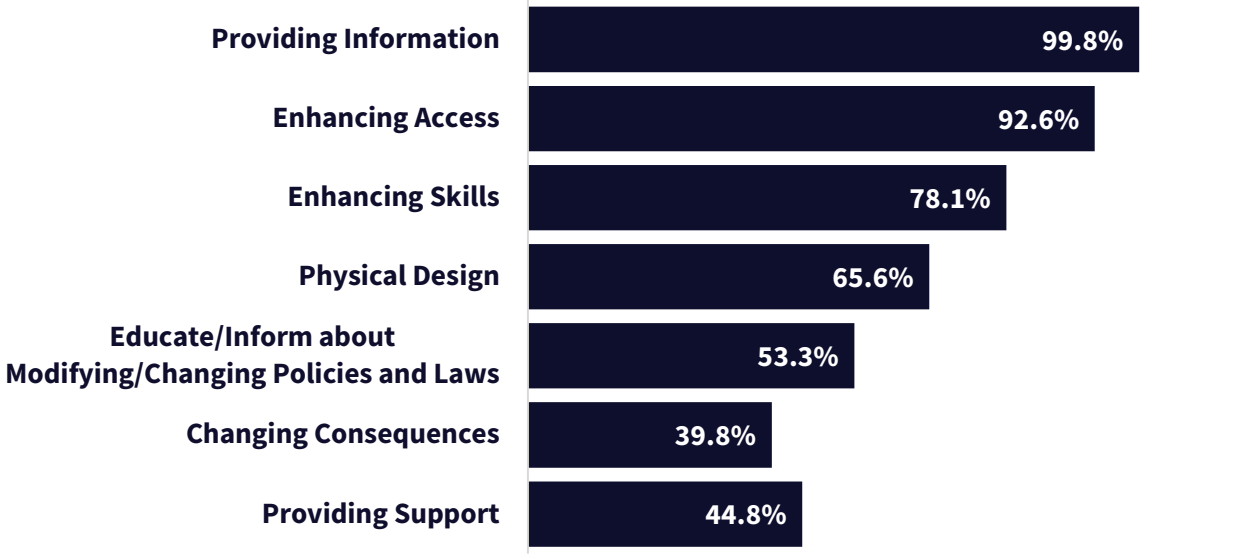


Source: DFC August 2022 Progress Report
Note: Totals do not add to 100% because DFC coalitions could select more than one substance.

DFC coalitions also indicated if they engaged in specific activities addressing opioids/ methamphetamine grouped by the Seven Strategies for Community Change. Figure 9 shows the percentage of DFC coalitions who indicated implementing at least one of the activities within each strategy (see Table E.1, Appendix E for full table). The top three activities implemented to address opioids and/or methamphetamine were all categorized as *Providing Information* followed by three *Changing Access/Barriers* activities (see Table E.1, Appendix E). While the top activities emphasized information regarding prescription opioids and their proper disposal as well as increasing availability of take-back events and prescription collection boxes, DFC coalitions were also focused on providing information about opioids more generally to their community (including synthetic opioids) and on increasing availability of naloxone, an evidence-based harm-reduction strategy. While less universal, over 40% of DFC coalitions reported *Educating and Informing* regarding naloxone policies and/or Good Samaritan Laws.[41]

[41] Good Samaritan laws offer legal protection to people providing reasonable assistance to those who are incapacitated, in this case calling for help or administering naloxone to overdose victims.

FIGURE 9. STRATEGY TYPES IMPLEMENTED BY DFC COALITIONS TO ADDRESS OPIOIDS/METHAMPHETAMINE



Source: DFC August 2022 Progress Report Data

Building Capacity for Opioids

Coalitions continued to develop and leverage their training and activities across sectors to build capacity at the state, local, and federal levels. Opioid settlement funding, work groups, and task force groups allowed coalitions to collect data, create shared visions, and strengthen new and old partnerships. For example, a Year 8 coalition (Midwest Region) noted, "The coalition was approached by local public health to help gather input from a variety of sectors that represent the county demographically and geographically on how to most effectively, efficiently, and equitably spend the Opioid Settlement funds awarded to [this] County." This coalition had success partnering with police and first responders in a county-wide campaign that resulted in the disposal of nearly 1,500 pounds of unused household pharmaceuticals. As a result of sharing data within workgroups, two coalitions discovered the presence of Xylazine and Kratom emerging in their community.[42] For example, a Year 6 coalition (Northeast Region) described, "Data from state health officials and local law enforcement indicates that fentanyl is highly prevalent in our geographic region and accounts for most of the fatal opioid overdoses. The conference planning committee is also planning to educate attendees about the emerging issue of Xylazine; this drug is being seen in our area. Xylazine is a veterinary medicine drug used as a sedative and the concern around it being in the local drug supply is that it does not respond to naloxone." Similarly, a Year 7 coalition (Midwest Region) reported, "In the last 6 months the coalition has just started to research and learn about Kratom and how it is affecting our community. We have only just become aware of it in this reporting period and have had preliminary

[42] For information on Xylazine see https://nida.nih.gov/research-topics/xylazine. For information on Kratom see https://www.dea.gov/sites/default/files/2020-06/Kratom-2020_0.pdf.

conversations with partner agencies with expertise in drug use about how to research and collect data surrounding this drug and its local impacts." Intensifying their capacity and engagement across multiple sectors enabled coalitions to use data-driven lead, support, and promote a broader range of opioid prevention strategies relevant in their communities.

Implementation of Strategies focused on Preventing Opioid Use

Coalitions implemented a number of strategies to raise awareness of opioid usage and its impact. Coalitions continued to use the virtual communication skills they acquired during the pandemic. For example, "Our coalition has a weekly radio show that builds community awareness by bringing on professionals from the community discussing various topics with our coalition coordinators. We have brought on naloxone educators, College professors and pediatricians from local hospitals to discuss opioid addiction and recovery. The show is played on several social media platforms, radio tune in app, spreaker.com and apple podcast. During the show we provide resources and stories to help the community learn from experience and real-life stories." (Year 1, South Region). Fewer COVID-19 health restrictions allowed coalitions to create, lead, and support in-person community education activities. Virtual and in-person special events were targeted to parents, students, and sector stakeholders to increase their awareness of opioids used individually or in combination with other drugs. For one Year 9 coalition (West Region), multiple substances of focus were bundled as part of a broader media campaign highlighted by local media outlets.

Coalitions also focused on enhancing skills through evidence-based curricula in schools and community-based events that focus on identifying the signs of opioid use, naloxone training, and stigma reduction. A Year 10 (Northeast Region) coalition reported, "During this reporting period we have organized one in person, one hybrid and one virtual naloxone training. Each training has been fully attended and well received. Most notably we partnered with our local chamber of commerce to host the hybrid training, reaching over 80 people trained in one day. All trained were offered naloxone kits to take home along with knowledge on addiction, how to reverse an opioid overdose and how to properly dispose and lock medication."

To enhance access and reduce barriers, coalitions worked to improve the availability, access, and usage of opioid prevention and care resources. Coalitions facilitated or supported take-back events and lockbox/dug disposal bag distribution to reduce home and school access to opioids. A Year 7 coalition (South Region) reported, "[Local] Behavioral Health Services, the sector that serves as the Other Substance Use Provider, and also the fiscal agent for the grant, has a prevention department that implements the strategies listed in this project. Staff at the agency have given out over 1,000 boxes of naloxone over the past year, held multiple prescription take-back events, hand out hundreds of medication disposal packets and lockboxes, provide Medication Assisted Treatment at no cost to most clients, provide transportation to increase access to services, are a part of a local Coordinated Effort group that works to reduce opioid use in a hotspot area of the county, utilizes ODMAP to identify hotspots of overdoses in the county, participates (and has for years) in SBIRT, has placed a

drop box at a local police department, and distributed hundreds of pieces of educational material to the community."[43]

Vaping

In 2022, national trends showed that about 2.55 million students (14.1% of high schoolers and 3.3% of middle schoolers) used e-cigarettes in the past 30 days, compared to 2.06 million (11.3% of high schoolers and 2.8% of middle schoolers) in 2021.[7] Of those using, approximately 4 in 10 (42%) reported frequent use and one in four (28%) reported daily use. Among middle and high school students who currently use e-cigarette products, most (85%) reported using flavored e-cigarettes.[44] Over three-fourths (81%) of DFC coalitions reported their coalition engaged in activities to address vaping locally (increased from 69% in August 2021). Of those coalitions who addressed vaping, 96% reported their work focused on vaping of nicotine/tobacco, and 89% reported their work addressed vaping marijuana. Additionally, 73 coalitions (12% of those who addressed vaping) reported addressing another substance. Of all coalitions that reported addressing vaping locally, 86% reported addressing both nicotine and marijuana, 10% of coalitions addressed nicotine/tobacco only, and 3% of coalitions addressed marijuana only. Youth who use vapes for nicotine have almost five-time-higher odds of using vapes for cannabis use. Cannabis and nicotine vaping has been associated with a higher frequency of engaging in other substance use, including cigarettes, alcohol, and illicit or prescription drug misuse.[45]

Leveraging Community Partners

To reduce and prevent the use of tobacco, THC, cannabis, and flavored vaping products, many coalitions reported building capacity with local businesses, schools, and civic agencies. A Year 3 DFC grantee from the South Region reported, "The school, business, other substance abuse agencies, volunteer organizations, and law enforcement agencies were essential in building awareness about the program in the community." Coalitions also trained key school staff to build human and organizational partnerships. For example, a Year 9 coalition in the Northeast Region reported,

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[43] ODMAP is the overdose detection mapping application program developed and managed by the Washington/Baltimore HIDTA. See https://www.odmap.org:4443/. SBIRT is SAMHSA acronym for screening, brief intervention, and referral to treatment; see https://www.samhsa.gov/sbirt.

[44] Cooper M, Park-Lee E, Ren C, Cornelius M, Jamal A, Cullen KA. Notes from the Field: E-cigarette Use Among Middle and High School Students — United States, 2022. MMWR Morb Mortal Wkly Rep 2022;71:1283–1285. DOI: http://dx.doi.org/10.15585/mmwr.mm7140a3Park-Lee, E., Ren, C. Sawdey, M.D. et al. (2021). Notes from the Field: E-Cigarette Use among Middle and High School Students – National Youth Tobacco Survey, United States, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1387–1389. DOI: http://dx.doi.org/10.15585/mmwr.mm7039a4. See also, Wang, T. W., Neff, L. J., Park-Lee, E., Ren, C., Cullen, K. A., & King, B. A. (2020). *E-cigarette Use Among Middle and High School Students — United States, 2020.* Morbidity and Mortality Weekly Report. *69,* 1310–1312. http://dx.doi.org/10.15585/mmwr.mm6937e1 and Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2020). *Monitoring the Future. National Survey Results on Drug Use 1975-2020. 2020 Overview Key Findings on Adolescent Drug Use.* Bethesda, MD: National Institute on Drug Abuse. Retrieved from: http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2020.pdf

[45] Saran, S. K., Salinas, K. Z., Foulds, J., Kaynak, Ö., Hoglen, B., Houser, K. R., Krebs, N. M., Yingst, J. M., Allen, S. I., Bordner, C. R., & Hobkirk, A. L. (2022). A Comparison of Vaping Behavior, Perceptions, and Dependence among Individuals Who Vape Nicotine, Cannabis, or Both. International Journal of Environmental Research and Public Health, 19(16), 10392. https://doi.org/10.3390/ijerph191610392

"Coalition staff trained 65 guidance counselors, social workers, and support staff [in schools] … focused on youth vaping trends and strategies to reduce use and access to vape products…[The] staff was tasked to return to their school to strategize actionable steps with the building administrator."

Building community partnerships emerged as another important capacity-building strategy. A year 4 Northeast Region coalition experienced success engaging with retailers, stating, "In addition we have helped make the compliance checks more reliable and are re-educating the retailers on the dangers of minors vaping." Another coalition described partnering with the local Health Department, "As of these discussions, our initial work will focus on Point of Sales marketing practices of convenience stores and gas stations. Both Coalitions recognize the potential for a strong alliance …and have agreed to work in partnership to: (a) Research tobacco related policies; (b) Develop youth advocacy and (c) Provide health related data" (Year 9, South Region).

Securing Additional Funding

New and experienced coalitions reported taking advantage of funding and prevention campaigns from outside sources to encourage vaping cessation among adolescents and adults. For example, "[Our coalition] also secured additional local prevention council funding to supplement and expand our original vaping prevention media campaign, … by hiring a social marketing consultant" (Year 4, West Region). Other coalitions leveraged these additional resources to enhance strategy implementation. "Through another funding source, the coalition conducted a Vaping Forum. Although the forum is not in the DFC grant, it complements the coalition's work addressing Vaping issues by engaging members and elected officials on the harms of vaping devices including nicotine or marijuana content, and the results of the environmental scans funded by the DFC grant." (Year 4, South Region)

Education & Awareness

To counteract marketing campaigns used to normalize vaping behavior among adolescents, coalitions created, disseminated, and publicized information on the prevalence and the risks of vaping to youth and their caregivers. According to a Year 6 coalition in the West, "This is a tough subject to share with high school students as the perception of harm is decreasing significantly following [this state's] legalization. We are establishing a social norms committee with our county substance abuse prevention partners to coordinate countywide social norms activities, messaging and strategies." Other coalitions reported altering social norms by offering alternative vape free events such as a "Vape Escape Room" (Year 2, Midwest Region). Others supported alternative events sponsored by sector partners. For example, "2 UPD officers attended the teen movie night to talk with youth about vaping prevention. The Youth Council had about 60 patrons attend this event. They recruited 3 new youth council members as a result of this event." (Year 5, West Region)

Beyond education and awareness campaigns, coalitions coordinated training programs to develop vaping cessation skills among youth and their parents. Low perception of harm was named as a barrier for at least one coalition who shared, "With the expansion of the Youth Action Committee, we

are working with key youth to change the overall low youth perception of harm when it comes to vaping (a barrier for us)." (Year 2, Midwest Region). Other coalitions reported facilitating or supporting special events to build parent skills. For example, "[the Program Director], [a local] High School and the Parent Action Team hosted a Vaping Resource Night for parents and families, featuring anti-vaping activist [name] as keynote speaker. The night provided parents with resources to help their children quit vaping and access free mental health services, educated parents and youth about the negative effects of nicotine vaping, and trained attendees to identify the insidious ways that companies like Juul target youth." (Year 4, Northeast Region). To help parents understand how schools are identifying substance use behavior one coalition took a proactive approach. "We provided our vaping tip sheet (in addition to our tip sheets on alcohol, tobacco, opioids, marijuana, and' what is SBIRT' as part of the SBIRT packet that is emailed to all parents of 7th grade and 9th students [who] participate in SBIRT. This reaches approximately 250 parents" (Year 9, Northeast Region).

Changing Environments & Policies

Finally, coalitions reported opportunities to promote vaping policy, practice, and environmental design changes in schools and in workplaces while implementing strategies. In schools, some coalitions promoted and helped design less punitive policies for students who vape. A year 6 coalition reported, "We continue to use our vaping intervention tool created in 2018 for students who have violated the policy or athletic code. …We are connected to PAVE (Parents Against Vaping/e-cigarettes) and have provided our policy and restorative approach to other states through our PAVE connection." (Year 6, Northeast Region). For greater impact, some coalitions involved students to inform and advocate for policy change. "Our teens have taken the lead regarding vaping. They gathered local data by conducting an environmental scan to see how vape products were displayed, priced, and promoted. With that data and their personal experiences, they put together a presentation for the local school board, state legislators, and other community leaders and encouraged better enforcement at the school level. We also learned of some of the weak spots in our retail stores which provided opportunities for teens to purchase products. We will be taking this information to our business [community] and encouraging better oversight." (Year 8, Midwest Region).

Core Measures

Key Findings

DFC coalitions (all and most recent cohort) reported significant decreases in past 30-day use across all substances among middle and high school youth. In the most recent DFC cohort, perception of risk measures for alcohol, marijuana and prescription drug use by middle school youth all declined significantly, whereas perceived risk at the high school level did not change (except for alcohol which increased significantly).

This section provides a summary of the core measures data reported by DFC coalitions.[46] Core measures data were analyzed with all available data from DFC coalitions since the inception of the grant and then analyzed including only data from the most recent (FY 2021) cohort of DFC coalitions.[47] The first set of analyses provides information regarding changes in community outcomes since DFC was first funded, whereas the second set seeks to emphasize outcomes associated with more recent DFC coalitions. Key data are presented in the body of this report (see Appendix F for full tables).[48]

Core Measures Findings Summary

Figure 10 provides a high-level summary of the core outcomes results for the sample of all coalitions since inception and for this cohort of coalitions. A green 'up' arrow indicates that the most recent measure significantly increased from the earliest measure, a positive finding; a green 'down' arrow indicates that the most recent measure significantly increased from the earliest measure, a positive finding; a red 'down' arrow indicates the most recent measure significantly decreased from the earliest measure, a negative or undesired outcome. A value of 'NC' or No Change indicates there was no significant difference between the most recent and earlier measures for that outcome. This table utilizes past 30-day use; for all four core measures significant decreases (green arrows) reflect findings in line with DFC goals. Notably, in both samples (all DFC coalitions since inception and this sample), past 30-day use decreased significantly across all substances and for both middle and high school youth.

[46] DFC coalitions have reported data from 2002 to 2022. For core measures changed or introduced in 2012, including peer disapproval and all measures for misuse of prescription drugs, data have been reported from 2012 to 2022. Data were analyzed using paired *t*-tests. The first and the most recent outcomes were weighted based on the number of students surveyed by DFC grant award recipients. Outliers with change from first report to most recent report scores greater than three standard deviations were excluded from the analyses. Significance is indicated when the statistical significance reached a value of $p < .05$.

[47] For core measures in place only since 2012, most of the DFC grant award recipients in the all DFC since grant inception sample are also in the FY 2021-only sample. For example, to date, 772 DFC coalitions since grant inception have two data points reported on past 30-day prevalence of use of prescription drugs for middle school youth. Of these 772, 393 (51%) also were in the FY 2021-only sample. In comparison, 422 of the 1,535 (28%) DFC coalitions that have reported past 30-day prevalence of alcohol use among middle school youth were in the FY 2021-only sample.

[48] The greater the disparity between the two bars, the more likely it is the difference was statistically significant; whereas the more equivalent the bars are, the more likely it is the difference was not significant. Significant differences at the $p < .05$ level are indicated with an asterisk.

FIGURE 10. OVERVIEW OF CORE OUTCOMES FINDINGS

ALL DFC GRANT RECIPIENTS SINCE INCEPTION

MIDDLE SCHOOL

OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	NC	NC	↓	NC
PARENTAL DISAPPROVAL	NC	↑	↑	NC
PEER DISAPPROVAL	↑	↑	NC	↑

HIGH SCHOOL

OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	NC	↑	↓	↑
PARENTAL DISAPPROVAL	↑	↑	NC	↑
PEER DISAPPROVAL	↑	↑	↑	↑

FY 2021 DFC GRANT RECIPIENTS

MIDDLE SCHOOL

OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	↓	NC	↓	↓
PARENTAL DISAPPROVAL	NC	NC	↓	NC
PEER DISAPPROVAL	NC	NC	NC	NC

HIGH SCHOOL

OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	NC	NC	NC	↑
PARENTAL DISAPPROVAL	↑	↑	NC	↑
PEER DISAPPROVAL	↑	↑	↑	↑

Source: DFC 2002–2022 Progress Reports, core measures data

Note: Arrows indicate significant increases (up arrows) or decreases (down arrows); **NC**=No Change

Past 30-Day Prevalence of Use/Non-Use and Percentage Change

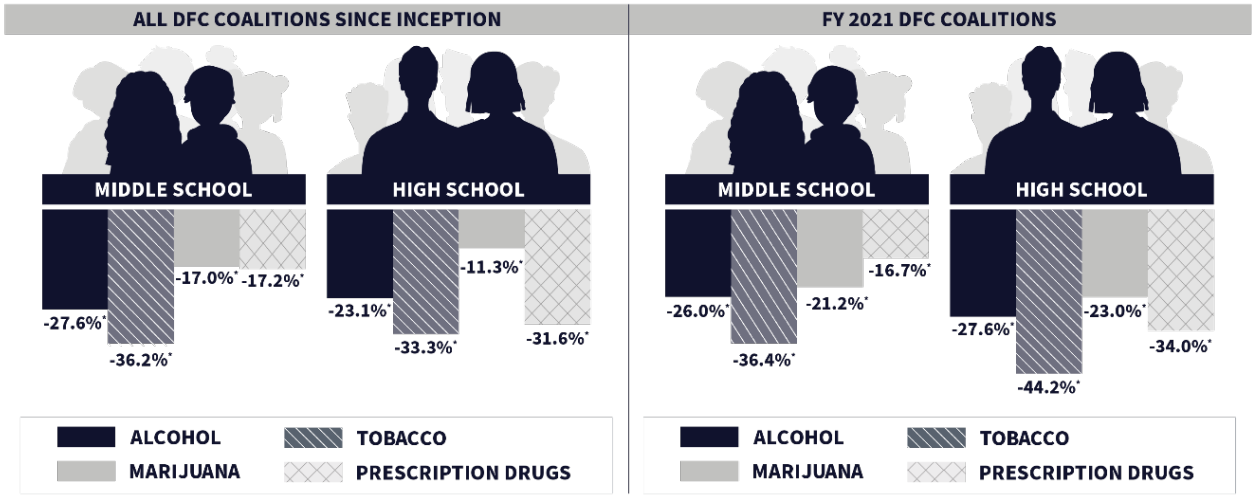
In general, past 30-day use decreased/non-use increased between middle school and high school levels (see also Tables F.1 and F.2, Appendix F). Alcohol was the most used substance at both school levels, followed by marijuana. Prescription drug misuse remained relatively low for both school levels. For all coalitions since inception, past 30-day *use rates decreased significantly* across all substances at both the middle and high school levels, evidence that DFC coalitions are meeting the goal of preventing youth substance use. That is, there were significant decreases in past 30-day use across substances. This same pattern held true for the FY 2021 cohort. The perception of risk and parental disapproval for marijuana use significantly decreased in both samples at the middle school level, but only parental disapproval of marijuana use significantly decreased for this sample at the high school level.

Figure 11 presents the percentage change in past 30-day prevalence of use.[49] The largest percentage change has been in past 30-day use of tobacco. Extrapolating non-use percentages based on census

[49] Percentage change (i.e., relative change) demonstrates how much change was experienced relative to the baseline. It is calculated as the percentage point change (most recent report minus first report) divided by first report (multiplied by 100 to report as a %).

data reflecting the potential reach of DFC, the estimated reductions in the number of middle and high school youth reporting past 30-day use of each substance are quite large (see Table 7).

FIGURE 11. PERCENTAGE CHANGE IN PAST 30-DAY PREVALENCE OF USE



Source: DFC 2002–2022 Progress Reports, core measures data
Note: * indicates $p < .05$

TABLE 7. FY 2021 DFC COALITIONS ESTIMATED INCREASES IN THE NUMBER OF YOUTH REPORTING PAST 30-DAY NON-USE BY SUBSTANCE

SUBSTANCE	MIDDLE SCHOOL	HIGH SCHOOL
Alcohol	52,000	242,000
Tobacco	31,000	159,000
Marijuana	18,000	131,000
Prescription Drug (misuse)	10,000	55,000

Source: DFC 2002–2022 Progress Reports, core measures data
Notes: Number of estimated youth based on extrapolating percentage change to potential reach based on census estimate (see DFC Reach section for details).

Perception of Risk

Following are highlights of the findings related to perception of risk (see Table F.3, Appendix F):

- At the middle school level, across both samples, perceived risk associated with marijuana use declined significantly from first to most recent report. For this cohort of coalitions, perceived risk associated with alcohol and prescription drugs also decreased significantly.
- At the high school level, across both samples, the perceived risk associated with prescription drug misuse significantly increased. Among all coalitions since inception, risk associated with tobacco use also increased significantly.
- The decrease in perceived risk was largest for marijuana use, with reported rates at the most recent time point dipping below 70% at middle school and approximately 51% at high school.

Perception of Parental Disapproval

Highlights of findings related to perception of parent disapproval include (see Table F.4, Appendix F):

- Generally, the reported rates of perceived parental disapproval were high across samples and substances, with middle school rates of at least 94% and high school rates of at least 86%.
- The FY2022 middle school rate of parental disapproval for marijuana significantly decreased, though rates were at least 95%. The middle school sample including all DFC coalitions since inception posted a significant increase in parental disapproval for marijuana and tobacco.
- Among high school youth from both this cohort and all DFC coalitions since inception samples, perceived parental disapproval for alcohol, tobacco and prescription drugs all increased significantly (disapproval for marijuana was unchanged).

Perception of Peer Disapproval

Highlights of findings related to perception of peer disapproval include (see Table F.5, Appendix F):

- Perceptions of peer disapproval were generally lower than perceptions of parental disapproval across substances and for both middle and high school youth. That is, while most youth report not using substances, they also report not perceiving of their peers disapproving should they use substances.
- Rates of middle school peer disapproval *increased* significantly for alcohol, tobacco, and prescription drugs for the sample of all DFC coalitions since inception. For this sample, rates of peer disapproval across all substances were unchanged.
- Rates of high school peer disapproval *increased* significantly from first to most recent report, though overall they were lower when compared to middle school youth. Rates increased significantly across all substances for both samples at the high school level.
- Both middle school and high school youth reported the lowest levels of perceived peer disapproval for engaging in regular marijuana use.

Comparison with National Data

Past 30-day use data from DFC coalitions were compared to national data where appropriate (see Table F.6, Appendix F):[50] Based on data collected in 2021, past 30-day use of alcohol and marijuana

[50] . For more information on YRBS data see https://www.cdc.gov/healthyYouth/data/yrbs/index.htm and https://www.cdc.gov/healthyyouth/data/yrbs/data.htm. Comparison between DFC and Youth Risk Behavior Survey data at the high school level were possible as the two use the same wording. Comparisons examine confidence intervals (95%) for overlap between the two samples. CDC YRBS data corresponding to DFC data are available only for high school students on the past 30-day use measures and only for alcohol, tobacco, and marijuana. YRBS data from 2021 are not yet available. Some DFC coalitions report using YRBS data to track local trends and thus may be included in the national YRBS data. That is, some change in YRBS data may occur in part due to efforts from DFC coalitions. Comparisons with the national sample also are influenced by the range of survey instruments that DFC coalitions use to collect core measures data and the year in which DFC coalitions collect their core measures data. Although surveys must use appropriate DFC core measures wording to be included in the DFC National Evaluation data, the order of core measure items and the length of the surveys can vary widely across DFC coalitions. While DFC coalitions are required to report core measures data every 2 years, each coalition may determine their own data collection schedule, further limiting the comparison between the two national samples. Because there is likely some overlap between samples, these comparisons are conservative estimates of the difference that DFC is making in communities.

among high school students in DFC communities were significantly lower than rates in the national Youth Risk Behavior Survey (YRBS). Rates of tobacco use were not statistically different between the DFC and YRBS samples.

Limitations and Challenges

Based on the 2022 data, DFC coalitions still continued to struggle with implementing some types of strategies (i.e., *Modifying/Changing Policies and Laws* and *Changing Consequences*), although most strategies are at or approaching pre-pandemic implementation rates. In addition, fewer coalitions were able to submit new core measures data in 2022 than submit this data in a typical year (only ~39% of coalition in 2022 compared to ~50% in an average non-pandemic year, though an increase from ~20% in 2021). In describing their challenges both in implementation and data collection, coalitions often referenced that schools were still facing capacity challenges during the post-COVID-19 period, a challenge shared by education researchers.[51] Many schools now are primarily focused on education recovery efforts and education goals, as opposed to initiatives that they may perceive as ancillary to the primary purpose of educating students. DFC coalitions focused on maintaining and rebuilding positive relationships with the school sector during this time both in order to be able to again implement activities with youth in this setting and to collect data from them.

Given that the most recent core measures data for the FY 2021 cohort were collected primarily in 2020 and 2021, COVID-19 may also be a contributing factor in youth substance use. That is, for those coalitions able to collect data in 2020 and 2021, youth use rates may be impacted by coalition efforts but also by broader context of living with COVID-19. Data on exactly how youth substance use was impacted remains mixed, suggesting that in some communities at least at some points in time, youth use may have been influenced by shifts in both risk and protective factors during that time frame.

More generally, although grant activities of DFC coalitions were designed and implemented to prevent and/or reduce youth substance use, it is not possible to establish a causal relationship in core measure changes over time because there is not an appropriate comparison or control group of communities from which the same data are available. Overall, multiple years of findings from the DFC National Evaluation support the conclusion that DFC coalitions are associated with decreased youth substance use across a range of substances providing evidence for this community-based approach to prevention.

Another challenge related to core measures is that each DFC coalition makes local decisions regarding how to collect core measures data, such as where to administer the survey, what grades to collect data from, the length of the survey used, and the order in which survey items are presented. These decisions were also likely impacted by COVID-19 (e.g., some coalitions may have shifted from in-person data collection to virtual data collection). While surveys vary, all surveys are reviewed by the DFC National Evaluation Team for core measures, and core measures data may only be entered if the item has been approved on the survey. Small variations are allowed (e.g., coalitions may ask youth to report on how many days in the past 30 days they used a given substance [from 0–30] rather than just a yes-or-no question on past 30-day use). Some coalitions collect all core measures, whereas others have been approved for only some of the core measures. These variations across

[51] See https://ies.ed.gov/blogs/research/post/conducting-education-research-during-covid-19

surveys may influence how youth respond to a survey. However, because most DFC coalitions make only small changes to their survey over time and because change from first report to most recent report are calculated in each DFC coalition to generate the national average, this challenge is somewhat addressed.

Although most coalitions report collecting core measures data in schools, this is not always the case. Additionally, youth not currently in school may report different experiences with substance use than youth attending school. Few, if any, DFC coalitions collect data from youth not attending schools, in part because these individuals are harder to locate and may be less willing to complete surveys. In addition, data are reported by school level, emphasizing that data collection is predicated on school attendance. Each DFC coalition's survey also varies in length and content. Youth responding to longer surveys or surveys in which core measures appear later, for example, may respond differently than youth whose surveys are shorter or in which core measures appear earlier. Finally, DFC coalitions are encouraged to collect representative data from their area of focus; however, each coalition is ultimately responsible for their own sampling strategies.

Appendix A. Core Measure Items

The following is the recommended wording for each of the core measure items, in place since 2012. DFC coalitions submit surveys for review to ensure they are collecting each given core measure item. For example, many DFC coalitions collect past 30-day prevalence of use by asking the number of days (0 to 30) in the past 30 days the youth used the given substance. Any use is counted as "yes," and therefore the data are to be submitted.

TABLE A.1. CORE MEASURE ITEMS RECOMMENDED WORDING (2012 TO PRESENT)

PAST 30-DAY PREVALENCE OF USE		
	Yes	**No**
During the past 30 days did you drink one or more drinks of an alcoholic beverage?		
During the past 30 days did you smoke part or all of a cigarette?		
During the past 30 days have you used marijuana or hashish?		
During the past 30 days have you used prescription drugs *not prescribed to you*?		

PERCEPTION OF RISK				
	No risk	**Slight risk**	**Moderate risk**	**Great risk**
How much do you think people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?				
How much do you think people risk harming themselves physically or in other ways if they smoke one or more packs of cigarettes per day?				
How much do you think people risk harming themselves physically or in other ways if they smoke marijuana once or twice a week?				
How much do you think people risk harming themselves physically or in other ways if they use prescription drugs that are not prescribed to them?				

PERCEPTION OF PARENTAL DISAPPROVAL				
	Not at all wrong	**A little bit wrong**	**Wrong**	**Very wrong**
How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?				
How wrong do your parents feel it would be for you to smoke tobacco?				
How wrong do your parents feel it would be for you to smoke marijuana?				
How wrong do your parents feel it would be for you to use prescription drugs not prescribed to you?				

PERCEPTION OF PEER DISAPPROVAL	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?				
How wrong do your friends feel it would be for you to smoke tobacco?				
How wrong do your friends feel it would be for you to smoke marijuana?				
How wrong do your friends feel it would be for you to use prescription drugs not prescribed to you?				

DFC coalitions also are permitted to collect and submit perception of risk and peer disapproval alcohol core measures associated with the Sober Truth on Preventing Underage Drinking (STOP) Act grant. These may be collected instead of or in addition to the respective DFC core measure. These data were not included in the current report. For perception of risk of alcohol use, the alternative item is: “How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks of an alcoholic beverage nearly every day?” For peer disapproval, the item is worded as attitudes toward peer use: “How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?”

Appendix B. Risk and Protective Factors Focused on by Coalitions

TABLE B.1: PERCENTAGE OF DFC COALITIONS FOCUSED ON GIVEN PROTECTIVE AND RISK FACTORS

Community Protective Factors	Percent
Pro-social community involvement	75.1%
Opportunities for pro-social family involvement	66.2%
Positive contributions to peer group	64.3%
Contributions to the school community	63.4%
Advertising and other promotion of information related to substance use	63.1%
Positive school climate	63.0%
School connectedness	61.9%
Family connectedness	60.7%
Recognition/acknowledgement of efforts	58.2%
Laws, regulations, and policies	51.2%
Cultural awareness, sensitivity, and inclusiveness	51.2%
Strong community organization	49.9%
Parental monitoring and supervision	43.9%
Family economic resources	26.1%
Other protective factor	5.3%
Community Risk Factors	**Percent**
Perceived acceptability (or lack of disapproval) of substance use/Community norms favorable toward substance use	89.3%
Availability of substances that can be misused	89.1%
Individual youth have favorable attitudes towards substance use/misuse	82.4%
Perceived peer acceptability (or lack of disapproval) of substance use	80.3%
Perceived parental acceptability (or lack of disapproval) of substance use	75.4%
Parents lack ability/confidence to speak to their children about substance use	64.6%
Family trauma/stress	64.2%
Early initiation of the problem behavior	60.1%
Low commitment to school	38.9%
Parental attitudes favorable to antisocial behavior	36.9%
New laws/ordinances allowing substance use/access	33.4%
Inadequate laws/ordinances related to substance use/access	31.8%
Lack of local treatment services for substance use	30.1%
Inadequate enforcement of laws/ordinances related to substance use	29.3%
Available treatment services for substance use insufficient to meet needs in timely manner	26.4%
Low Levels of active coalition engagement among community members	26.1%
Academic failure	24.6%
Other challenge	9.1%

Appendix C. Strategies Tables

TABLE C.1: *PROVIDING INFORMATION* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES	NUMBER OF ADULTS SERVED	NUMBER OF YOUTH SERVED
Informational Materials Disseminated: Brochures, flyers, posters, etc. distributed	668	90.3%	335,012	6,993,690	900,263
Social Networking: (e.g., Facebook, Twitter, etc.)	664	89.7%	62,938	9,058,033 followers	2,988,731 followers
Informational Materials Prepared/Produced: Brochures, flyers, posters, etc. prepared	586	79.2%	39,162		
Direct Face-to-Face Information Sessions	564	76.2%	6,004	141,252	167,939
Special Events: Fairs, celebrations, etc.	543	73.4%	2,201	287,104	269,306
Media Campaigns: Television, radio, print, billboard, bus or other posters aired/placed	537	72.6%	7,636		
Media Coverage: TV, radio, newspaper stories covering coalition activities	466	63.0%	3,186		
Information on Coalition Website: New materials posted	444	60.0%	5,086	766,773	
Other Providing Information activities	146	19.7%	836	343,310	114,687
Summary: Providing Information	*734*	*99.2%*	*462,061*	*8,532,129*	*1,452,195*

TABLE C.2: *ENHANCING SKILLS* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES	NUMBER OF ADULTS SERVED	NUMBER OF YOUTH SERVED
Youth Education and Training Programs: Sessions focused on providing information and skills to youth	584	78.9%	5,896		186,983
Community Member Education and Training Programs: Sessions directed to community members (e.g., law enforcement, landlords)	399	53.9%	1,473	53,843	
Parent Education and Training Programs: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.	365	49.3%	1,442	48,806	
Teacher/Youth Worker Education and Training Programs: Sessions on drug awareness and prevention strategies directed to teachers or youth workers	230	31.1%	685	15,452	
Business Training (e.g., responsible beverage server/vender training [voluntary or mandatory])	137	18.5%	615	7,343	
Other Enhancing Skills Activities	120	16.2%	825	8,044	6,057
Summary: Enhancing Skills	*703*	*95.0%*	*10,936*	*133,488*	*193,040*

TABLE C.3: *PROVIDING SUPPORT* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES	NUMBER OF ADULTS SERVED	NUMBER OF YOUTH SERVED
Alternative/Drug-Free Social Events: Drug-free parties, other alternative events supported by the coalition	439	59.3%	1,725	105,038	140,471
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	277	37.4%	893	73,437	57,184
Organized Youth Recreation Programs: Recreational events (e.g., athletics, arts, outdoor activities) supported by coalitions	170	23.0%	1,081	6,142	25,059
Youth/Family Support Groups: Leadership groups, mentoring programs, youth employment programs, etc., supported by coalitions	132	17.8%	1,579	8,808	6,463
Youth Organizations/Drop-In Centers: Clubs and centers supported by coalitions	122	16.5%	1,177	5,710	18,550
Other Providing Support Activities	99	13.4%	763	86,492	11,681
Summary: Providing Support	*627*	*84.7%*	*7,218*	*285,627*	*259,408*

TABLE C.4: *CHANGING ACCESS/BARRIERS* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF ADULTS SERVED	NUMBER OF YOUTH SERVED
Reducing Home and Social Access to Alcohol and Other Substances (e.g., prescription drug disposal)	480	64.9%	1,157,376	137,971
Increased Access to Substance Use Services (e.g., court mandated services, assessment and referral, EAPs, SAPs)	240	32.4%	64,319	33,563
Improved Access Through Culturally Sensitive Outreach (e.g., multilingual materials)	229	30.9%	344,115	104,811
Improved Supports for Service Use (e.g., transportation, childcare)	92	12.4%	22,885	11,665
Other Enhancing Access Activities	62	8.4%	5,899	7,124
Summary: Changing Access/Barriers	*604*	*81.6%*	*1,594,594*	*295,134*

TABLE C.5: *CHANGING CONSEQUENCES* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap, open container laws)	184	24.9%	
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	166	22.4%	3,109
Strengthening Surveillance (e.g., monitoring "hot spots," party patrols)	146	19.7%	
Other Changing Consequences Activities	72	9.7%	3,993
Publicizing Non-Compliance (e.g., advertisements highlighting businesses not compliant with local ordinances)	53	7.2%	1,384
Summary: Changing Consequences	*387*	*52.3%*	*8,486*

TABLE C.6: *EDUCATING/INFORMING ABOUT MODIFYING/CHANGING POLICIES OR LAWS* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF LAWS/POLICIES PASSED/MODIFIED	NUMBER OF LAWS/POLICIES PROMOTED
School: Policies promoting drug-free schools	142	19.2%	84	202
Underage Use: Laws/public policies targeting use, possession, or behavior under the influence for minors	115	15.5%	58	170
Citizen Enabling/Liability: Laws/public policies concerning adult (including parent) social enabling or liability (e.g., social host ordinances)	97	13.1%	27	114
Supplier Promotion/Liability: Laws/public policies concerning supplier advertising, promotion, liability (e.g., server liability, product placement, happy hours, drink specials, mandatory compliance checks, responsible beverage service)	82	11.1%	41	116
Sales Restrictions: Laws/public policies concerning restrictions on product sales (e.g., methamphetamine precursor access, alcohol at gas stations)	76	10.3%	42	96
Outlet Location/Density: Laws/public policies concerning limitations and restrictions of location and density of alcohol or marijuana outlets	71	9.6%	35	80
Treatment and Prevention: Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use offenders)	71	9.6%	46	91
Other Educating and Informing about Modifying/Changing Policies Activities	56	7.6%	0	0
Cost: Laws/public policies concerning cost (e.g., alcohol, tobacco, or marijuana tax, fees)	49	6.6%	21	66
Workplace: Policies promoting drug-free workplaces	36	4.9%	28	54
Summary: Educating and Informing about Modifying/Changing Policies or Laws	*405*	*54.7%*	*382*	*989*

TABLE C.7: *CHANGING PHYSICAL DESIGN* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES
Identifying Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	174	23.5%	770
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups)	173	23.4%	426
Promote Improved Signage/Advertising Practices by Suppliers (e.g., decrease signage or advertising, change product locations)	135	18.2%	1,075
Other Physical Design Activities	80	10.8%	8,214
Encourage Business/Supplier Designation of “no alcohol” or “no tobacco” zones	66	8.9%	183
Improved Visibility/Ease of Surveillance in Public Places and Substance Use Hotspots (e.g., improved lighting, surveillance cameras, improved line of sight)	54	7.3%	217
Identify Problem Establishments for Closure (e.g., close drug houses)	31	4.2%	65
Summary: Physical Design	*427*	*57.7%*	*10,950*

Appendix D. Coalition Classification Tool

TABLE D.1: COMMUNITY ASSETS

COMMUNITY ASSET	PERCENTAGE OF DFC COALITIONS WITH ASSET PUT IN PLACE AS A RESULT OF DFC GRANT AWARD	PERCENTAGE OF DFC COALITIONS WITH ASSET IN PLACE BEFORE DFC GRANT	PERCENTAGE OF DFC COALITIONS WITH ASSET NOT IN PLACE IN COMMUNITY
Culturally competent materials that educate the public about issues related to substance use.	69.1%	19.1%	11.8%
Social norms campaigns.	68.5%	15.5%	16.0%
Substance use warning posters.	62.1%	24.3%	13.6%
Town hall meetings on substance use and prevention within the community.	58.1%	21.8%	20.2%
Prescription drug disposal programs.	49.2%	45.4%	5.4%
Billboards warning youth about/against substance use.	41.8%	17.6%	40.6%
Recognition programs for businesses that comply with local ordinances.	38.2%	13.3%	48.5%
Formalized school substance use policies.	32.0%	57.5%	10.5%
Drugged driving prevention initiatives.	31.9%	33.9%	34.3%
Vendor/retailer compliance training.	31.2%	34.3%	34.5%
Media literacy training.	30.9%	10.9%	58.2%
Compliance checks: Alcohol.	27.7%	50.8%	21.5%
Responsible beverage server training.	26.7%	36.4%	36.8%
Compliance checks: Tobacco.	22.6%	51.1%	26.3%
Alcohol restrictions at community events.	20.8%	44.5%	34.7%
Prescription monitoring program.	20.2%	50.3%	29.6%
Social host laws.	16.0%	51.1%	32.9%
Secret shopper programs for alcohol outlets.	14.8%	24.7%	60.5%
Ordinances on teen parties.	13.7%	32.7%	53.6%
Compliance checks: Marijuana.	12.9%	13.0%	74.1%
Party patrols.	12.1%	19.8%	68.1%

TABLE D.2: EXTENT OF ENGAGEMENT IN COALITION ACTIVITIES

ACTIVITY	AVERAGE CCT SCORE	PERCENTAGE OF COALITIONS IMPLEMENTING TO A GREAT EXTENT	PERCENTAGE OF COALITIONS IMPLEMENTING TO A MODERATE EXTENT	PERCENTAGE OF COALITIONS IMPLEMENTING TO A SLIGHT EXTENT	PERCENTAGE OF COALITIONS NOT IMPLEMENTING	PERCENTAGE OF COALITIONS NOT APPLICABLE
Building Sustainability						
Identified community organizations or members that provided support services for coalition activities.	2.4	48.5%	38.5%	12.0%	0.8%	0.3%
Identified community organizations or members that provided facilities supporting coalition activities.	2.3	48.1%	37.0%	12.4%	0.9%	1.6%
Developed strategies that coalition sectors will continue to support after DFC funding ends.	1.8	27.6%	30.9%	28.9%	8.1%	4.6%
Developed effective strategies to recruit adult participants for coalition activities and events.	1.8	20.4%	42.1%	33.1%	3.4%	1.1%
Established plans to continue meeting after DFC funding ends.	1.8	28.1%	26.2%	28.2%	9.5%	7.9%
Improved sector members willingness to collaborate on new funding opportunities.	1.6	18.8%	29.2%	32.7%	9.9%	9.4%
Established procedures for continuing to share information across agencies after DFC funding ends.	1.5	20.4%	25.7%	27.4%	18.0%	8.5%
Transitioned responsibility for at least one coalition activity to a specific sector.	1.5	16.8%	30.5%	33.1%	15.7%	3.9%
Secured funding to continue prevention efforts after DFC funding ends.	1.2	10.8%	18.1%	32.9%	25.9%	12.2%
Built Capacity/ Strengthened Collaboration						
Increased members' knowledge of the work (e.g., services or programs offered) of other sector member organizations.	2.3	44.1%	40.1%	15.2%	0.4%	0.3%
Increased community perception of our coalition as the go to resource for addressing youth substance use.	2.1	38.6%	36.4%	22.7%	1.5%	0.8%
Had a strong feeling of cohesiveness across sectors.	2.1	33.3%	45.6%	19.0%	1.5%	0.7%
Made decisions on the allocation of coalition resources in an open and participatory manner.	2.1	36.2%	38.2%	20.3%	2.6%	2.8%

Facilitated opportunities for members to collaborate with one another in new ways.	2.1	35.6%	38.0%	23.3%	2.4%	0.7%
Relied upon multiple sectors to reduce barriers to planning strategies.	2.0	32.0%	37.8%	23.8%	4.3%	2.2%
Recruited new sector members who have the ability to take action in the community.	1.9	30.1%	36.8%	28.8%	3.5%	0.8%
Increased availability of tools, best practices, and/or other information that has informed the work of individual organizations/agencies.	1.9	25.5%	39.4%	29.7%	2.8%	2.6%
Increased the likelihood of a cross-system/sector approach in strategies to address emerging drug issues in our community.	1.9	24.9%	41.7%	25.7%	5.4%	2.4%
Developed shared understanding across sectors that promoted innovative strategy implementation by our coalition.	1.8	21.6%	42.2%	31.6%	3.2%	1.3%
Coalition Cultural Competence						
Considered the cultural makeup of the community when planning and implementing a strategy.	2.3	45.0%	35.3%	16.8%	1.3%	1.5%
Identified the demographic composition of the coalition's service area (from recent census data, local planning documents, statement of need, etc.) including, but not limited to, ethnicity, race, and primary language spoken as reported by the individuals	2.1	43.4%	29.4%	19.8%	5.2%	2.2%
Arranged to provide materials (e.g., brochures, billboards) in the home language(s) of English language learners in the community.	1.8	33.7%	20.3%	18.4%	14.7%	12.9%
Arranged to provide services/activities (e.g., training, town halls) in the home language(s) of English language learners in the community.	1.3	17.6%	17.9%	19.6%	26.7%	18.1%
Created a coalition cultural competence outreach plan to address cultural diversity from demographics to economic class, religion, customs, and beliefs.	1.3	10.8%	23.5%	33.9%	22.3%	9.5%
Involved sector members of targeted cultural groups in developing coalition materials for their community.	1.2	9.7%	21.8%	33.3%	23.8%	11.4%
Had a workgroup/subcommittee/task force dedicated to monitoring progress on the coalition cultural competence plan.	0.8	6.9%	10.6%	24.6%	40.9%	17.1%

Coalition Formalization						
Followed our written description of procedures for decision-making.	2.1	33.1%	32.4%	17.2%	3.5%	13.8%
Followed our written description of procedures for leader selection.	2.0	29.4%	23.4%	16.1%	6.9%	24.2%
Followed our written description of procedures for resolving conflicts among members.	1.9	18.7%	14.2%	8.3%	7.0%	51.7%
Maintained a current organizational chart showing coalition structures and relationships.	1.8	30.8%	24.9%	22.0%	16.0%	6.3%
Utilized a structure that primarily relied on the coalition as a whole (as compared to subcommittees/work groups reporting to the coalition) to complete the work of the coalition.	1.7	22.8%	31.7%	32.3%	11.2%	2.0%
Utilized a structure that primarily relied on subcommittees/work groups (as compared to the coalition as a whole) to complete the work of the coalition.	1.7	22.4%	32.7%	30.4%	11.8%	2.7%
Followed our written expectations for member participation (e.g., policy on missed meetings).	1.5	17.1%	24.5%	27.3%	15.5%	15.7%
Community Leadership Engagement						
Had community leaders present at coalition events.	2.3	47.8%	30.2%	18.5%	2.3%	1.1%
Had community leaders actively involved in coalition committees.	2.2	44.1%	37.0%	15.3%	2.6%	1.1%
Data, Evaluation, and Outcomes Utilization						
Increased awareness of harmful consequences associated with substance use by youth.	2.5	57.8%	33.5%	7.7%	0.5%	0.5%
Increased awareness of substance use (e.g., prevalence, types of substances) in the community.	2.4	54.4%	34.4%	11.0%	0.0%	0.1%
Identified data needs to inform future program planning.	2.2	37.8%	41.3%	18.1%	1.7%	1.1%
Collaborated across sectors to share data in a timely manner.	2.1	33.9%	39.5%	20.8%	3.1%	2.7%
Increased incidence of at least one specific protective factor against youth substance use in our community.	1.8	22.8%	38.8%	31.2%	3.8%	3.4%
Regularly used evaluation results to inform the community about coalition efforts.	1.8	24.2%	33.6%	31.7%	5.9%	4.6%
Collected a range of outcomes data to track progress towards coalition goals.	1.8	24.1%	36.8%	30.2%	6.9%	2.0%
Updated its action plans based on evaluation results.	1.8	25.8%	29.6%	25.9%	11.2%	7.5%

Decreased incidence of at least one specific risk factor for youth substance use in our community.	1.7	16.0%	37.4%	33.6%	5.2%	7.8%
Decreased prevalence of substance use in at least one specific target population (e.g., minority youth).	1.6	15.6%	29.8%	33.5%	7.0%	14.1%
Successfully shifted youth social norms related to youth use of at least one substance.	1.5	12.2%	30.9%	41.4%	7.9%	7.5%
Successfully shifted adult social norms related to youth use of at least one substance.	1.3	7.1%	24.1%	47.0%	12.8%	9.0%
Decreased prevalence of specific youth use of at least one substance other than the core measures (e.g., meth, cocaine, inhalants).	1.2	9.3%	17.7%	30.0%	20.8%	22.2%
Member Empowerment						
Placed the responsibility for what activities to implement on members.	1.7	15.1%	43.1%	37.0%	4.2%	0.7%
Placed the responsibility for implementing coalition activities on members.	1.6	15.3%	38.3%	40.3%	5.5%	0.5%
Placed the responsibility for setting the agenda for coalition meetings on members.	1.1	8.2%	19.5%	39.8%	30.0%	2.6%
Strategic Prevention Framework Utilization						
Referred to our action plan to make decisions about activities.	2.6	61.8%	32.7%	4.6%	0.5%	0.4%
Completed the activities stated in our action plan.	2.3	35.5%	54.4%	9.1%	0.5%	0.4%
Emphasized practices supported by research in our action plan.	2.2	42.3%	37.8%	16.4%	2.2%	1.3%
Relied on the findings of our ongoing needs assessment to guide our action plan.	2.2	42.7%	36.0%	19.0%	1.2%	1.1%
Used feedback on the quality of implementation of activities to make improvements.	2.1	32.3%	41.7%	21.4%	2.7%	2.0%
Sought feedback on the quality of implementation of activities.	2.0	34.8%	37.2%	21.4%	5.0%	1.6%
Followed a systematic process for assessing community needs.	2.0	33.3%	34.3%	24.2%	5.2%	3.0%
Followed a plan to address identified gaps in capacity.	1.8	19.4%	40.6%	30.5%	5.9%	3.6%
Engaged in focus groups/interviews with key stakeholders to inform assessment of community needs.	1.6	19.8%	30.4%	31.5%	14.0%	4.4%

Youth Involvement						
Had youth members who shared the coalition's message with the community.	2.0	35.8%	27.8%	26.2%	7.1%	3.1%
Successfully increased youth participation in coalition activities.	1.9	36.4%	25.8%	27.3%	9.3%	1.2%
Had organized youth members who implemented many of the coalition activities.	1.7	28.4%	24.6%	30.8%	11.4%	4.8%
Had organized youth members who planned many of the coalition activities.	1.6	25.9%	24.5%	30.0%	15.1%	4.6%
Had youth members who played a key role in developing our action plan.	1.4	17.3%	21.5%	32.7%	21.9%	6.6%

TABLE D.3: RESPONSIBILITY FOR IMPLEMENTING COALITION TASKS

COALITION TASK	AVERAGE CCT SCORE	PERCENTAGE IMPLEMENTED PRIMARILY OR OFTEN BY STAFF MEMBERS	PERCENTAGE IMPLEMENTED BY STAFF AN COALITION MEMBERS EQUALLY	PERCENTAGE IMPLEMENTED PRIMARILY OR OFTEN BY COALITION MEMBERS
Identifying and recruiting new coalition members	2.9	25.5%	57.3%	17.2%
Implementing coalition activities	2.7	37.1%	48.7%	14.2%
Planning coalition activities	2.7	34.1%	56.3%	9.5%
Leading committees and work groups	2.6	49.2%	32.9%	17.9%
Developing the coalition action plan	2.4	52.7%	41.1%	6.2%
Organizing committees and work groups	2.4	57.9%	32.9%	9.1%
Making budget and expenditure decisions	1.9	74.7%	20.8%	4.4%
Developing communications sent to community partners	1.9	75.7%	19.4%	5.0%
Developing communications sent to coalition members	1.7	83.5%	13.7%	2.8%

Appendix E. Activities Implemented to Address Opioid/Methamphetamine Use

TABLE E.1: PERCENTAGE OF COALITIONS IMPLEMENTATING ACTIVITIES TO ADDRESS OPIOIDS AND/OR METHAMPHETAMINE

STRATEGY TYPE	ACTIVITY	PERCENTAGE OF DFC COALITIONS
Providing Information	Promotion of prescription drug drop boxes/take back events	96.5%
	Information about sharing/storage of prescription opioids	90.2%
	Information about opioids (heroin, fentanyl, fentanyl analogs or other synthetic opioids) currently identified as an issue in the community or surrounding community	88.5%
	Distribution of treatment referral cards/brochures/stickers	56.1%
	Information about methamphetamines currently identified as an issue in the community or surrounding community	30.4%
	Information about methamphetamines risks	29.4%
	Prescribing guidelines	23.1%
	Promotion of Prescription Monitoring Program	22.8%
	Information delivered via a town hall forum or conference related to methamphetamines	12.2%
Enhancing Skills	Community education and training on opioid risks for various community stakeholders (e.g., train youth/parents on risks associated with taking prescriptions not prescribed to you, train school athletic staff/players/families on addressing pain following injury or surgery, train realtors on working with clients to properly store medications prior showing homes)	65.6%
	Community education and training on signs of opioid/methamphetamines use (e.g., Hidden in Plain Sight trainings)	55.4%
	Education and training to reduce stigma associated with opioid dependency	53.0%
	Prescriber education and training	13.5%
	Education, training, and/or technical assistance on monitoring compliance for the Prescription Monitoring Program	10.9%
Providing Support	Recovery groups/events	40.7%

	Youth/family support groups for individuals affected by opioid/methamphetamines dependency	26.5%

STRATEGY TYPE	ACTIVITY	PERCENTAGE OF DFC COALITIONS
Enhancing Access	Make available or increase availability of local prescription drug take-back events	79.6%
	Make available or increase availability of naloxone	69.4%
	Make available or increase availability of local prescription drug take-back boxes	67.4%
	Improving access to opioid methamphetamine prevention, treatment, and recovery services through culturally sensitive outreach (e.g., multilingual materials, culturally responsive messaging)	34.3%
	Make available or increase availability of substance use screening programs (e.g., SBIRT)	21.1%
	Make available or increase availability of medication assisted treatment for opioid dependency (e.g., suboxone, Vivitrol, methadone)	19.4%
	Drop-in events/centers to connect people addicted to opioids/methamphetamines and/or their families to treatment/recovery opportunities	19.4%
	Make available or increase availability of judicial alternatives for individuals with an opioid/ methamphetamines dependency who are convicted of a crime (e.g., drug court, teen court)	19.3%
	Make available or increase availability of transportation to support opioid prevention, treatment, or recovery services (e.g., medication assisted treatment, counseling, drug court)	15.2%
	Home visit follow-ups after an overdose/overdose reversal (e.g., safety official and healthcare provider visit to share and connect to treatment options)	14.4%
Changing Consequences	Drug task forces to reduce access to opioids/methamphetamines in community	29.1%
	Identify and/or increase monitoring of opioid/methamphetamine use "hot spots"	24.6%
	Recognition programs (e.g., physicians exercising responsible prescribing practices, individuals in recovery from opioid/methamphetamine dependency)	11.7%
Educate/Inform about Modifying/Changing Policies and Laws	Policies regarding naloxone administration	40.2%
	Good Samaritan Laws	39.6%
	Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use offenders)	19.6%
	State policies supporting a Prescription Monitoring Program	12.4%
	Crime Free Multi-Housing Ordinances	1.9%

Physical Design	**Increase safe storage solutions in homes or schools (e.g., lock boxes)**	**62.2%**
	Clean needles and other waste related to opioid use from parks and neighborhoods	**14.4%**
	Identify problem establishments for closure (e.g., close drug houses, "pill mills")	**6.1%**

Appendix F. Core Measure Data Tables

TABLE F.1. CHANGE IN PAST 30-DAY PREVALENCE OF USE[A]

SCHOOL LEVEL AND SUBSTANCE	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2021 DFC GRANT AWARD RECIPIENTS n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol	1487	11.6	8.4	-3.2*	398	7.7	5.7	-2.0*
Tobacco	1474	5.8	3.7	-2.1*	387	3.3	2.1	-1.2*
Marijuana	1468	4.7	3.9	-0.8*	387	3.3	2.6	-0.7*
Prescription Drugs	734	2.9	2.4	-0.5*	364	2.4	2	-0.4*
HIGH SCHOOL								
Alcohol	1586	33.3	25.6	-7.7*	439	25.4	18.4	-7.0*
Tobacco	1567	16.2	10.8	-5.4*	424	10.4	5.8	-4.6*
Marijuana	1569	17.7	15.7	-2.0*	434	16.5	12.7	-3.8*
Prescription Drugs	814	5.7	3.9	-1.8*	408	4.7	3.1	-1.6*

Source: Progress Report, 2002–2022 core measures data

Notes: * $p < .05$; *n* represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding.

[a] Outcomes represent weighted averages for each DFC coalition based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed for the first observation to the number surveyed for the most recent observation). Outliers beyond three standard deviations were removed. All numbers were rounded; percentage point change was rounded after taking the difference score.

TABLE F.2. CHANGE IN PAST 30-DAY PREVALENCE OF NON-USE[A]

SCHOOL LEVEL AND SUBSTANCE	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2021 DFC GRANT AWARD RECIPIENTS			
	n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change	n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol	1487	88.4	91.6	3.2*	398	92.3	94.3	2.0*
Tobacco	1474	94.2	96.3	2.1*	387	96.7	97.9	1.2*
Marijuana	1468	95.3	96.1	0.8*	387	96.7	97.4	0.7*
Prescription Drugs	734	97.1	97.6	0.5*	364	97.6	98	0.4*
HIGH SCHOOL								
Alcohol	1586	66.7	74.4	7.7*	439	74.6	81.6	7.0*
Tobacco	1567	83.8	89.2	5.4*	424	89.6	94.2	4.6*
Marijuana	1569	82.3	84.3	2.0*	434	83.5	87.3	3.8*
Prescription Drugs	814	94.3	96.1	1.8*	408	95.3	96.9	1.6*

Source: Progress Report, 2002–2022 core measures data

Notes: * $p < .05$; *n* represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding.

[a] Outcomes represent weighted averages for each DFC coalition based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed for the first observation to the number surveyed for the most recent observation). Outliers beyond three standard deviations were removed. All numbers were rounded; percentage point change was rounded after taking the difference score.

TABLE F.3. CHANGE IN PERCEPTION OF RISK/HARM OF USE[A]

SCHOOL LEVEL AND SUBSTANCE	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2021 DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	778	71.1	71.2	0.1	377	72.9	71	-1.9*
Tobacco[c]	1413	81.1	80.6	-0.5	384	80.8	80.1	-0.7
Marijuana[d]	749	70.7	68	-2.7*	375	71.5	67.4	-4.1*
Prescription Drugs[e]	704	81.3	80.8	-0.5	375	82.1	80.8	-1.3*
HIGH SCHOOL								
Alcohol[b]	834	71.7	71.5	-0.2	408	71.4	71.1	-0.3
Tobacco[c]	1482	81.1	81.8	0.7*	412	81.3	80.6	-0.7
Marijuana[d]	806	52.9	50.9	-2.0*	406	50.6	51	0.4
Prescription Drugs[e]	772	82.2	82.9	0.7*	405	82.3	83.4	1.1*

Source: Progress Report, 2002–2022 core measures data

Notes: * $p < .05$; *n* represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding.

[a] Outcomes represent weighted averages for each DFC coalition based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed for the first observation to the number surveyed for the most recent observation). Outliers beyond three standard deviations were removed. All numbers were rounded.

[b] Perception of risk of five or more drinks once or twice a week

[c] Perception of risk of smoking one or more packs of cigarettes per day

[d] Perception of risk of smoking marijuana one or two times per week

[e] Perception of risk of any use of prescription drugs not prescribed to user

TABLE F.4. CHANGE IN PERCEPTION OF PARENTAL DISAPPROVAL[A]

SCHOOL LEVEL AND SUBSTANCE	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2021DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	689	94.3	94.5	0.2	361	95.1	95	-0.1
Tobacco[c]	1327	92.7	94.6	1.9*	369	96.7	96.7	0.0
Marijuana[c]	1356	93.2	93.9	0.7*	382	95.9	95	-0.9*
Prescription Drugs[d]	688	95.9	95.7	-0.2	363	96.6	96.5	-0.1
HIGH SCHOOL								
Alcohol[b]	754	88.1	89.5	1.4*	398	88.9	89.9	1.0*
Tobacco[c]	1418	86.7	90.2	3.5*	397	92.3	94.5	2.2*
Marijuana[c]	1429	86.5	86.2	-0.3	409	86.9	86.7	-0.2
Prescription Drugs[d]	755	93.8	95	1.2*	396	94.5	95.9	1.4*

Source: Progress Report, 2002–2022 core measures data

Notes: *$p < .05$; *n* represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding.

[a] Outcomes represent weighted averages for each DFC coalition based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed for the first observation to the number surveyed for the most recent observation). Outliers beyond three standard deviations were removed. All numbers were rounded.

[b] Perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

[c] Perception of disapproval of any smoking of tobacco or marijuana

[d] Perception of disapproval of any use of prescription drugs not prescribed to user

TABLE F.5. CHANGE IN PERCEPTION OF PEER DISAPPROVAL[A]

SCHOOL LEVEL AND SUBSTANCE	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2021 DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	689	86	87.1	1.1*	369	87.4	87.7	0.3
Tobacco[c]	692	88.7	89.5	0.8*	367	90.4	90.5	0.1
Marijuana[c]	702	86	86.5	0.5	369	86.8	87.4	0.6
Prescription Drugs[d]	681	90.8	91.3	0.5*	362	91.9	92.1	0.2
HIGH SCHOOL								
Alcohol[b]	755	65.6	72	6.4*	402	67.2	73.4	6.2*
Tobacco[c]	753	71.9	77.4	5.5*	394	74.3	79.5	5.2*
Marijuana[c]	760	56.4	59.3	2.9*	402	56.2	61.8	5.6*
Prescription Drugs[d]	736	81	85.6	4.6*	394	81.8	87.2	5.4*

Source: Progress Report, 2002–2022 core measures data

Notes: *$p < .05$; *n* represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding.

[a] Outcomes represent weighted averages for each DFC coalition based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed for the first observation to the number surveyed for the most recent observation). Outliers beyond three standard deviations were removed. All numbers were rounded.

[b] Perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

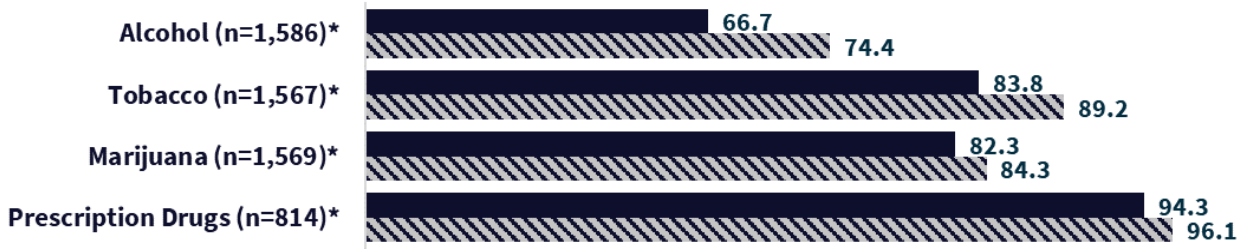
[c] Perception of disapproval of any smoking of tobacco or marijuana

[d] Perception of disapproval of any use of prescription drugs not prescribed to user

FIGURE F.1. PAST 30-DAY NON-USE, BY SUBSTANCE AND SCHOOL LEVEL
All COALITIONS SINCE INCEPTION

MIDDLE SCHOOL

HIGH SCHOOL



FY 2021 COALITIONS

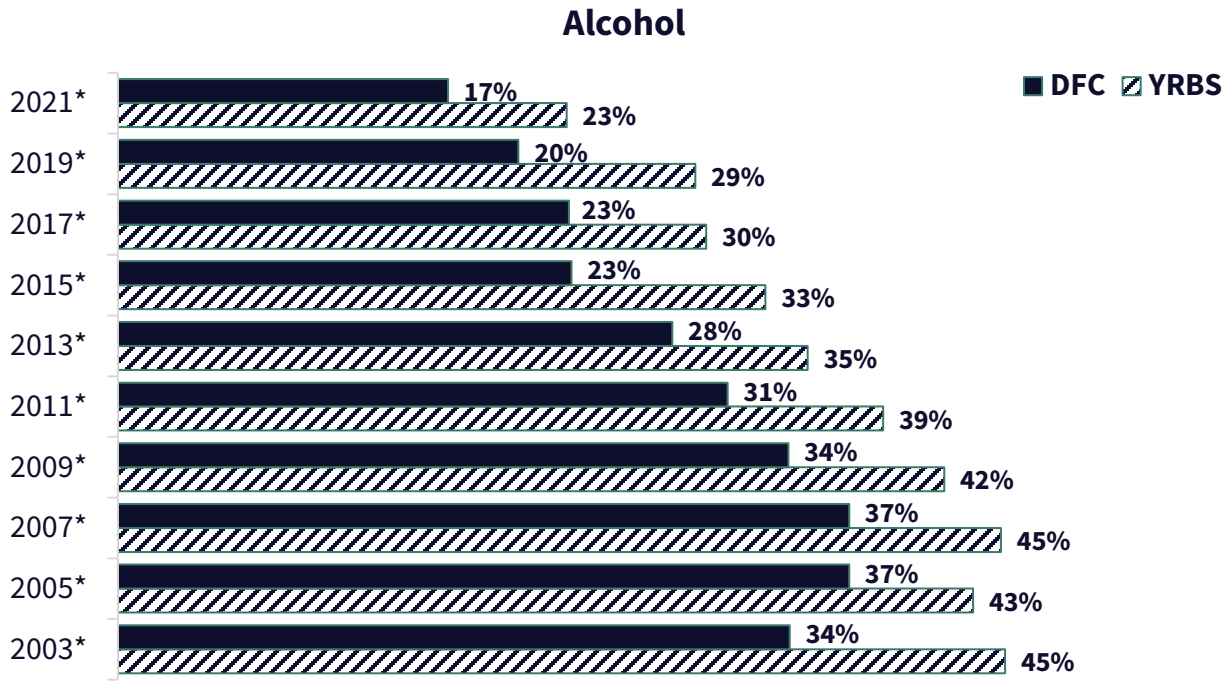
MIDDLE SCHOOL

HIGH SCHOOL

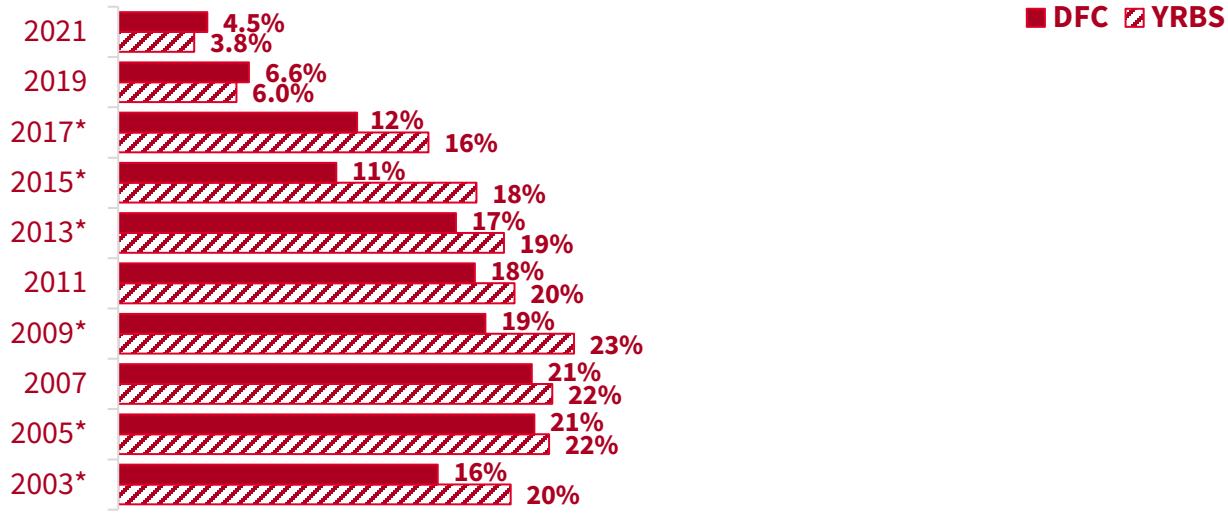
= First Report/Baseline = Most Recent Report

FIGURE F.2. DFC COMPARISON TO NATIONAL YRBS PAST 30-DAY ALCOHOL, TOBACCO & MARIJUANA USE AMONG HIGH SCHOOL STUDENTS

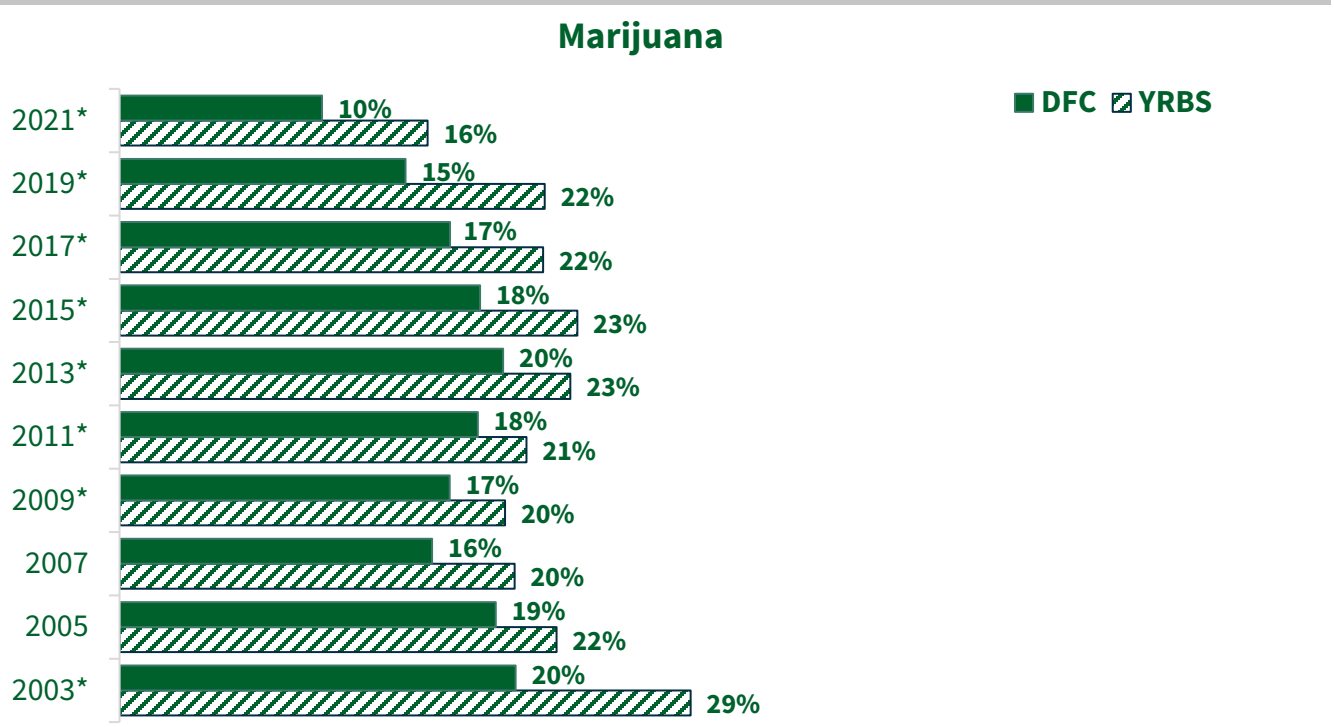
ALCOHOL



TOBACCO



MARIJUANA



Source: DFC Progress Report, 2003–2021 core measures data; CDC 2021 Youth Risk Behavior Survey Data (YRBS) downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm

Notes: Comparisons are between YRBS and DFC data examining confidence intervals for overlap between the two samples; * indicates $p < .05$ (significant difference)**;** numbers are percentages of youth reporting past 30-day use.

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