Attachment 3:

Sample Evaluation Report

Drug-Free Communities (DFC) Support Program National Cross-Site Evaluation

End-of-Year 2021 Report

Published August 2022

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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 2021 and core measures data from 2002 to 2021. Additional detail about the program and findings are presented in full in the report.

DFC coalitions met the goal of significantly increasing the percentages of middle school and high school youth in their communities who reported choosing not to use substances (See Figure ES1 for findings for the most current DFC cohort). The only exception to this finding was for middle school youth past 30-day misuse of prescription drugs, with nearly all (97%) reporting choosing not to misuse prescription drugs and this remaining unchanged. Significant decreases in past 30-day prevalence of use are presented as percentage change in Figure ES2, with the largest decrease for tobacco use. Youth's perceptions of risk associated with using substances decreased significantly over time, an unexpected finding. Perceived risk associated with marijuana use was lower than for the other substances, especially among high school youth. High school youth did report 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 2019 as compared to a national sample (Youth Risk Behavior Survey).

FIGURE ES1. OVERVIEW OF CORE OUTCOMES FINDINGS

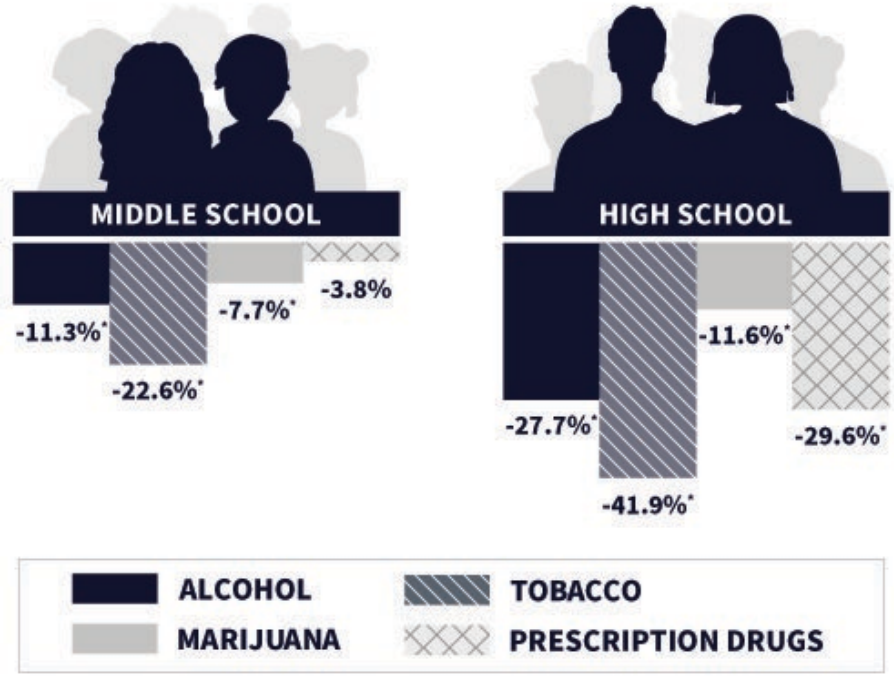
FY 2020 DFC GRANT RECIPIENTS

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

Source: DFC 2002–2021 Progress Reports, core measures data

Note: ↑ = significant increase; ↓ = significant decrease; **NC**=No Change

FIGURE ES2. PERCENTAGE CHANGE IN PAST 30-DAY SUBSTANCE USE/MISUSE: FY 2020 DFC COALITIONS



Source: DFC 2002–2021 Progress Reports, core measures data

Note: *$p < .05$

Approximately 1 in 5 Americans (20%) lived in a community with a DFC coalition in 2021, and nearly 30,000 people were successfully mobilized to engage in prevention efforts. Over half (59%) focus at least some of their prevention efforts toward specific demographic subgroups of youth/people (e.g., Hispanic /Latino; Black/African American, lesbian, gay, bisexual, or transgender [LGBTQ+]), an increase from 2020 when 48% did so. The Youth and School sectors contributed the highest median number of sector members.

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. 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. Youth coalitions also provide opportunities for youth to act as leaders in their community and to serve as mentors to their peers and/or students in lower grade levels.

Nearly two-thirds (63%) of DFC coalitions implemented at least one activity from 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* remains the most common strategy type while Changing Access/Barriers was the most engaged in environmental strategy, with 81% of coalitions implementing at least one activity of this type. Having a DFC grant enabled coalitions to put culturally relevant materials related to substance use (69%) and social norms campaigns (65%) into the community, assets that might not otherwise have been possible.

Most DFC coalitions (70%) reported that they implemented activities to address opioids and/or methamphetamine. Similarly, 69% implemented activities to address youth vaping. The primary focus of opioids work was related to addressing issues around prescription drug misuse, although coalitions also engaged in harm reduction activities such as trainings on the use of Naloxone. Of those coalitions who addressed vaping, 94% reported that their work focused on vaping of nicotine/tobacco, and 85% reported that their work addressed vaping marijuana.

In 2021, COVID-19 related challenges continued to impact the work of DFC coalitions, although to a lesser extent than in 2020. Many challenges related to implementation and youth data collections were described as due to COVID-19, particularly to challenges in working with schools who were focused on addressing their own ongoing pandemic related challenges.

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:[1]

- 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 increases 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 can be found across the United States and its territories serving a diverse range of communities to address local problems with local solutions:**
  - One-fifth (20%) of Americans lived in a community with one of 732 DFC-funded coalitions. Over half (54%) of Americans lived in a community with a DFC coalition since first awards.
  - 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, Black/African American, and LGBTQ+ youth/people. [2] Just over half (51%) were working in rural and/or frontier communities.
  - In line with youth substance use, coalitions focused prevention efforts on core measure substances (alcohol [98%], marijuana [87%], prescription drug misuse [78%], and/or tobacco [76%]).
  - Coalition efforts were focused on strengthening protective factors including the connections of youth to their community (72%), peers (69%), family (65%), and school (60%). 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 (85%).
- **DFC is meeting its goal of building community capacity to prevent and reduce youth substance use as evidenced by the following accomplishments in 2021:**
  - DFC coalitions successfully mobilized approximately 30,000 community members to engage in evidence-based youth substance use prevention/reduction efforts.
  - Most (94%) coalitions report having at least one member from each of twelve sectors, although fewer (76%) reported active members from all sectors.
  - Two-thirds (67%) of coalitions hosted a youth coalition, a promising practice associated with significantly higher levels of sector involvement, particularly Youth sector involvement.
- **DFC coalitions work to bring about change by implementing a comprehensive mix of strategies, with nearly two-thirds (63%) 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**

[1] ICF, an independent third-party evaluator, was awarded this contract from ONDCP.
[2] LGBTQ+ stands for lesbian, gay, bisexual, transgender, questioning youth/people, with the plus representing other sexual identities.

year of COVID-19, but still somewhat lower levels in 2021 than 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 81% of coalitions implementing at least one activity of this type.
- Just over two-thirds (70%) of DFC coalitions implemented activities to address opioids/methamphetamine, with most activities focused on prescription drug misuse.
- Similarly, 69% of DFC coalitions implemented activities to address youth vaping. Of those coalitions who addressed vaping, 94% reported that their work focused on vaping of nicotine/tobacco, and 85% reported that their work addressed vaping marijuana.

- **DFC coalitions met the goal of preventing and reducing youth substance use in their communities.[3] This is true for the DFC program collectively (all coalitions ever funded) and for the most recent DFC cohort (awarded in Fiscal Year (FY) 2020) 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 by middle school youth all declined significantly, but misuse of prescription drugs was low (less than 3%) and unchanged from first to most recent report.
  - Based on data collected in 2019, past 30-day use of alcohol and marijuana among high school students in DFC communities were significantly lower than rates in the national Youth Risk Behavior Survey (YRBS).
  - While decreases were seen in substance use, youth perceptions of risk associated with substance use generally decreased in communities with a DFC coalition. Perception of risk associated with regular marijuana use was particularly low.

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.
- **Community Anti-Drug Coalitions of America (CADCA),** a national non-profit provides training and technical assistance to strengthen the capacity of the DFC coalitions, including through the National Coalition Academy.
- **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

[3] 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.

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.[4] 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 732 community coalitions awarded DFC grants in Fiscal Year (FY) 2020. Of these, 424 (58%) were funded through an initial 5-year grant; the remaining 308 (42%) were in Years 6 to 10 of funding. As of FY 2020, just over 3,200 DFC grants have been awarded in over 2,100 communities.[5]

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 2019 Youth Risk Behavior Survey (YRBS) suggest that among high school youth, 29.2% reported current (past 30-day) alcohol use, 21.7% current marijuana use, 13.7% current binge drinking, and 7.2% current prescription opioid misuse.[6] The 2020 National Survey on Drug Use and Health (NSDUH) reported that among youth aged 12-17, 13.8% reported any past year illicit drug use, including 10.1% who reported past-year marijuana use.[7] Findings on youth substance use during the COVID-19 pandemic has varied, with some finding high school youth use of substances decreased, some finding increased use and some finding use unchanged. It is likely that how youth use was impacted by the pandemic was related to a range of social determinants such as whether access increased or decreased and whether family norms around substance use shifted. 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.[8] NSDUH 2020 data suggest that just

[4] 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 2020 awards please see CDC-RFA-CE20-2002 and CDC-RFA-CE20-2003 at https://www.grants.gov/.

[5] Based on available data through FY 2020, 2,153 communities have received DFC grant awards, with 1,027 communities receiving a Year 1 to Year 5 award and 1,126 communities receiving an additional Year 6 to Year 10 award. Combined, these total 3,279 DFC grant awards. This is a conservative estimate of awards through FY 2020 as much award data pre-2009 were not available.

[6] Jones CM, Clayton HB, Deputy NP, et al. Prescription Opioid Misuse and Use of Alcohol and Other Substances Among High School Students — Youth Risk Behavior Survey, United States, 2019. MMWR Suppl 2020;69(Suppl-1):38–46. DOI: http://dx.doi.org/10.15585/mmwr.su6901a5external icon.

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

[8] 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.

over a third (38.7%) of youth ages 12-17 reported using alcohol a little or much less than before the pandemic, while 14.5% reported using alcohol a little or much more.[9]

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 community 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 and changing understanding of youth substance use 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. [10] 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.[11] Experiencing ACEs, particularly multiple risk factors, has been associated with a range of negative outcomes including an increased risk of

[9] See footnote 6.

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

[11] 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

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. [12]

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.

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 2021, as well as detailed analysis of coalition efforts reflected in the FY 2020 coalitions submission of their August 2021 progress report and CCT.[13]

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.[14]

- *Community Context* includes information regarding the potential reach of the program (associated with ZIP codes served), community context (e.g., geographic setting), focus of coalition efforts (e.g., substances focused on), and key protective and risk factors found in the

[12] 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. Online ahead of print. 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.

[13] 693 of the 732 FY 2020 coalitions (94.6%) submitted reports in time to be included in this report. Additional coalitions completed reports after data were pulled for the evaluation.

[14] Throughout this report, when incorporating qualitative anecdotes with findings, DFC coalitions will be identified by their FY 2020 funding year (1–10) and by the U.S. census region where they are located (see 2010 Census Regions).

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[15] 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 are divided into individual-focused strategies and environmental-focused strategies.[16] 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).

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

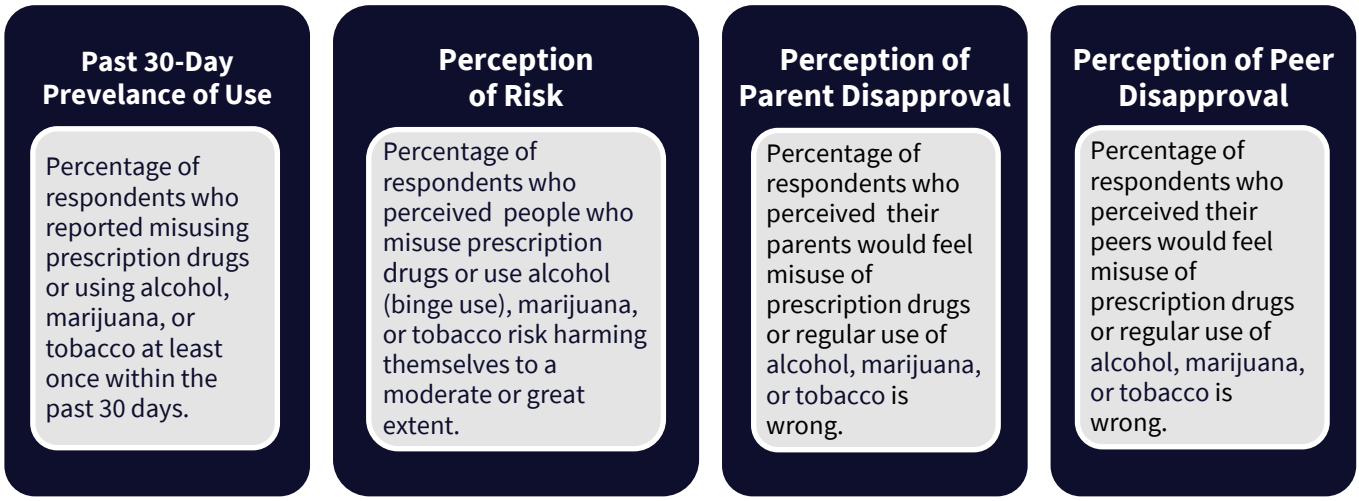
[15] As per the notice of funding opportunity. For further information see the most current notice of funding opportunity here: https://www.cdc.gov/drugoverdose/drug-free-communities/funding-announcements.html. For information on the FY 2020 awards please see CDC-RFA-CE20-2002 and CDC-RFA-CE20-2003 at https://www.grants.gov/.

[16] 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. 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

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 grade levels.[17] Briefly, the core measures are defined as follows (see Appendix A for specific wording for each of the core measure items):



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 is summarized by substance and time of report (first versus most recent report), allowing for the calculation of change in response patterns over time.

[17] DFC coalitions are encouraged to collect data from at least one grade level in middle school (Grades 6 through 8) and at least one in high school (Grades 9 through 12), with data from a total of at least three grade levels. 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.

Community Context

Key Findings

In 2021, one-fifth (20%) of Americans lived in a community with a DFC-funded coalition, with prevention efforts tailored to a diverse range of community types and demographics, including Hispanic/ Latino, Black/African American, and LGBTQ+ youth/people. Over half of DFC coalitions (59%) reported focusing building capacity or prevention efforts to one or more specific demographic subgroups, an increase of 11 percentage points from what was reported in August 2020. 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 addressed 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 2021, 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.[18] An estimated 67 million people (20% of the U.S. population) lived in communities served by DFC coalitions receiving funding in 2021.[19] This included approximately 2.7 million middle school students ages 12 to 14 (20% of all middle school youth) and 3.8 million high school youth ages 15 to 18 (20% of all high school youth).[20] Since 2005, approximately 169 million, or 54% of the U.S. population, has lived in a community with a DFC coalition.

DFC Potential Reach

In 2021, 20% of Americans lived in a community with a DFC-funded coalition.

Since 2005, 54% of the U.S. population has lived in a community with a DFC coalition.

[18] DFC coalitions identify catchment areas by ZIP codes, indicating all ZIP codes in which grant activities are conducted. These ZIP codes were merged with 2010 United States (U.S.) Census data to provide an estimate of DFC coalitions potential reach and impact (2020 data by ZIP were not yet available). DFC coalitions provide ZIP codes while the U.S. Census 2010 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). Note that 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.

[19] This excludes a coalition that serves the entire state of New Jersey. Including this coalition increases the percentage to about 22%.

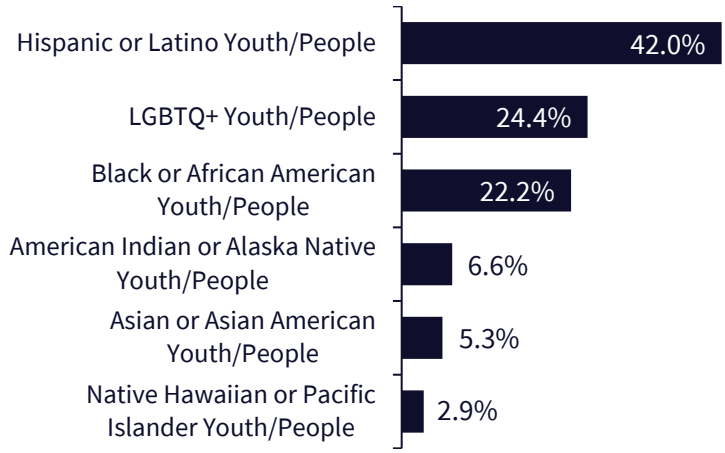
[20] Age is used as an indicator of school level here because U.S. Census data are not collected by grade level.

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 (49%) or suburban (44%) communities, followed by urban (28%) inner-city (9%) or frontier (2%) communities. [21]

Over half of DFC coalitions (59%) reported focusing building capacity or prevention efforts to one or more specific demographic subgroups, an increase of 11 percentage points from what was reported in August 2020. 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

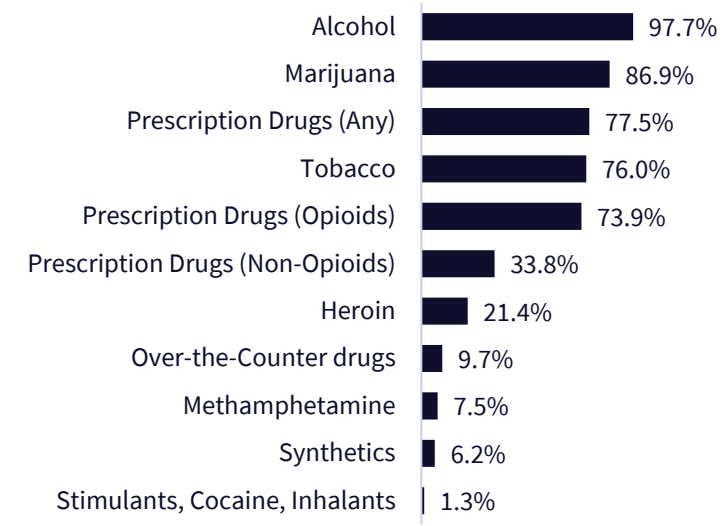


Source: DFC August 2021 Progress Report
Note: Coalitions could select more than one demographic.

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 (98%) and at least three-fourths focused on the remaining core measure substances, with declining percentages across the remaining substances.[22]

FIGURE 2. SUBSTANCE(S) FOCUSED ON



Source: DFC August 2021 Progress Report
Note: Coalitions could select more than one substance. Only substances with ≥ 1% displayed.

[21] 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

[22] 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 8 (of 13) 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	72%	Perceived community norms of acceptability of substance use	89%
Positive peer groups	69%	Availability of substances that can be misused	85%
Family connectedness	65%	Individual youth having favorable attitudes towards substance use/misuse	82%
Positive school climate	62%	Perceived peer acceptability of substance use	73%
Opportunities for pro-social family involvement	72%	Perceived parental acceptability of substance use	66%
School connectedness	60%		

Source: DFC August 2021 Progress Report Data, n=693

Building Capacity to Prevent and Reduce Substance Use

Key Findings

In 2021, DFC coalitions successfully mobilized approximately 30,000 community members to engage in youth substance use prevention/reduction efforts. Most (94%) coalitions report having at least one member from each of twelve sectors, although fewer (76%) 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.[23] Building capacity in the community to address prevention work is an ongoing process aligned with the DFC goals. The average coalition in August 2021 had 37 active members, with two paid and two unpaid staff. Extrapolating from the median across the 732 DFC coalitions, these DFC coalitions are estimated to have engaged approximately 27,000 active sector members and a total of approximately 30,000 community members including staff.[24] DFC coalitions reported engaging in a range of activities to build their capacity to serve their communities. When asked to select the three most common activities they had engaged in during the reporting period to build capacity, coalitions most frequently selected recruitment (52% of coalitions), engaging the general community in substance use prevention activities (46%), and strengthening strategies (46%). The following provides addition 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 (94%) DFC coalitions report compliance with having at least one member from each of the twelve sectors, fewer (76%) reported at least one active member in all sectors. DFC coalitions rated each sector's average level of involvement with the coalition. Schools and Other Organizations with Substance Use Expertise 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 5 active members per sector, with the median number of active members highest for the Youth and Schools sectors (see Figure 4).

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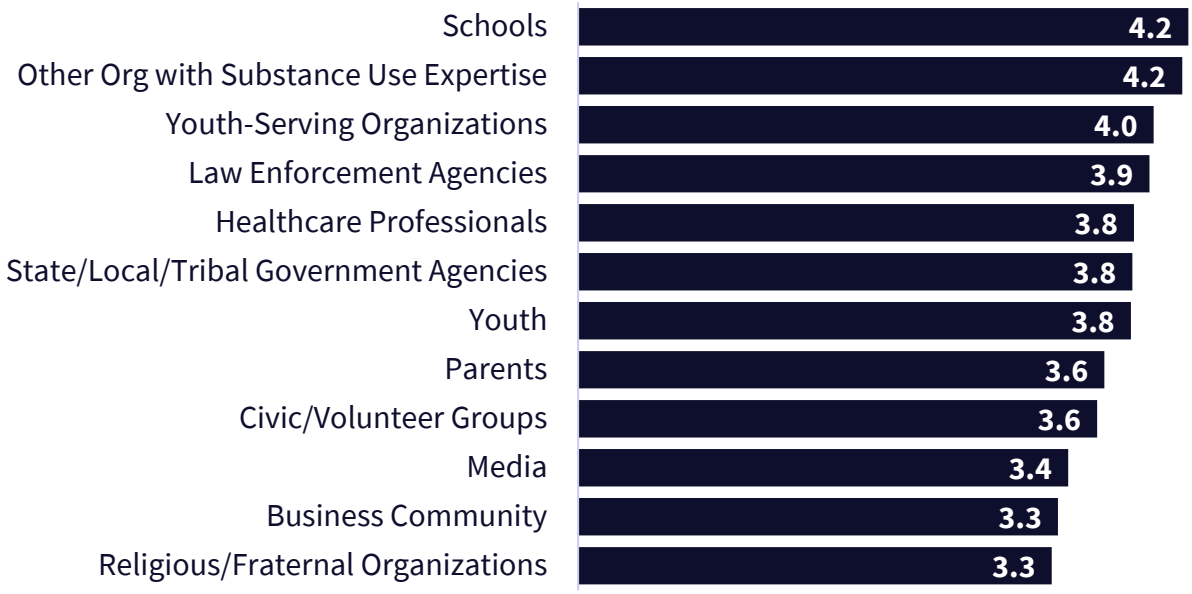
[23] See CADCA (2019). Community Coalitions Handbook https://www.cadca.org/sites/default/files/resource/files/community_coalitions.pdf and NIDA (2020, May 25). How can the community implement and sustain effective prevention programs? Retrieved from https://nida.nih.gov/publications/preventing-drug-use-among-children-adolescents/chapter-3-applying-prevention-pri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

[24] 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 (38) than if the median number of active members by sector is summed (29), as in Figure 3.

FIGURE 3. AVERAGE RATINGS OF ACTIVE MEMBER SECTOR INVOLVEMENT



Source: DFC August 2021 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 2021 Progress Report

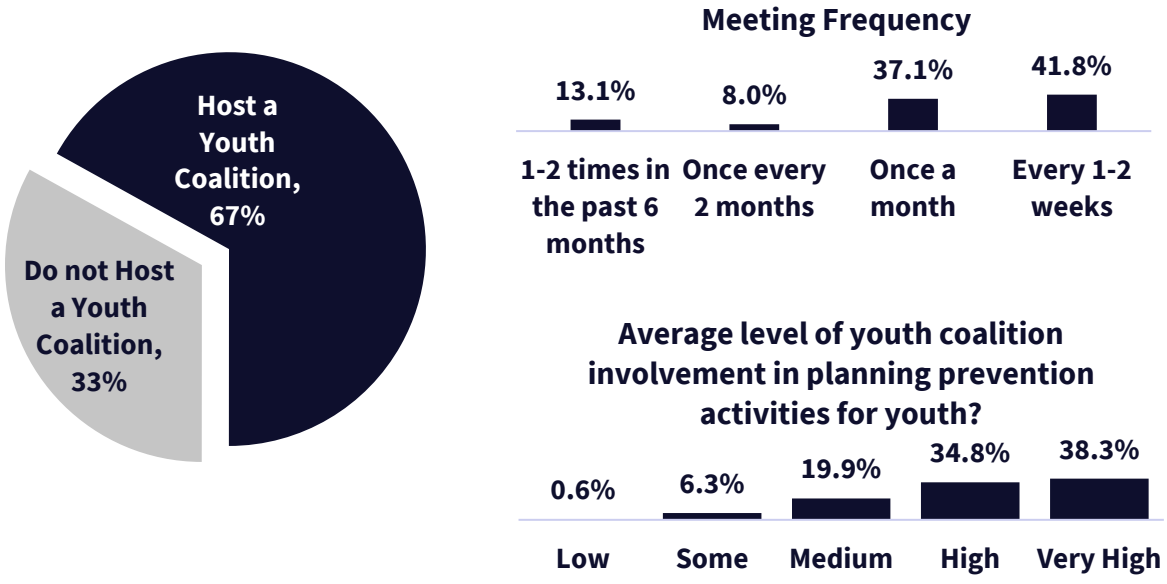
Hosting a Youth Coalition

While Youth had the highest median number of active members, on average the Youth sector was not rated highest on level of involvement. 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 2021, two-thirds (67%) of DFC coalitions reported hosting a youth coalition (see Figure 5).[25] 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 average (4.2, high to very high) as compared to those not hosting a youth coalition (3.0, medium involvement).[26] That is, for those coalitions hosting a youth coalition, their level involvement was as high as the other most highly rated sectors. Law Enforcement, Parent and School sector involvement were also rated significantly higher by DFC coalitions who did versus did not host a youth coalition, although the differences in involvement were smaller for these sectors. Most (79%) DFC coalitions who hosted a youth coalition reported the youth coalition met at least once a month and rated involvement in planning prevention activities as high or very high (73%).[27] Of the coalitions not hosting a youth coalition (33%), two-thirds (66%) were working to host a youth coalition within the next six months, while the remaining had no plans to host a youth coalition.

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



Source: DFC August 2021 Progress Report

[25] This has decreased from February 2020, when 72% of DFC coalitions reported hosting a youth coalition.

[26] Mann-Whitney-Wilcoxon $X^2(4) = 136.5$, $p < .0001$

[27] Of these coalitions, 41.8% met once every 1- or 2 weeks while 37.1% met once a month, for a total of 78.9%. Another 8.0% met once every 2 months while 13.1% of those with youth coalitions reported they met only one or two times in the past 6 months.

Making it clear that youth coalitions are central to the work of DFC coalitions who host them, just over half (55%) of these coalitions indicated that a youth coalition representative attended leadership meetings and had a say in coalition decision making while 10% indicated that youth members attended leadership meetings but did not have a say in coalition decisions.[28] The remaining third (36%) 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

A goal of hosting a youth coalition is to provide a space where youth can lead in an adult mentored/facilitated environment. DFC coalitions provided many examples of the types of activities engaged in with youth coalitions, particularly providing an environment for youth to engage in peer mentorship activities, to serve in leadership roles, and to educate decisionmakers on substance use issues. Youth coalitions were often mentioned as engaging in the mentoring of peers and near-peers.[29] As reported by one Year 6 coalition (Midwest Region), "The [youth coalition] developed a peer support program called SMILES (Support, Motivate, and Include for Lasting Engagement among Students) for incoming 9th graders, in which 46 upper classmates became SMILES partners providing mentoring support to create a more positive relationship and safe and supportive school climate." Another coalition (Year 7, Midwest Region) provided youth with the opportunity to participate in a similar peer mentorship program with a goal to "re-direct risky behaviors by their peers." In this program, peer mentors primarily relied on "educating their peers through unconventional workshops, cultural arts and sports gathering concentrating on the unhealthy aspects of marijuana, alcohol and opioid use." Youth coalitions also developed campaigns using the peer lens to communicate substance prevention messages most effectively to other young people, "The Youth Coalition created mental health and vaping PSAs with peer-to-peer messaging and provided resources for peers struggling with mental health issues" (Year 3, Northeast Region).

Youth coalition members also worked within their communities to educate and inform about policies. For example,

- One coalition reported efforts to educate about potential cannabis policy change through the Department of Motor Vehicles, "[…] the Youth are working with the State of Massachusetts Department of Motor Vehicles to mandate that marijuana impaired driving is a part of Drivers Education curriculum across the state. This policy change will not only impact Wakefield youth, but youth throughout the state of Massachusetts." (Year 9, Northeast Region).
- "[Youth coalition] virtually participated in a statewide recognition of Kick Butts Day where they spoke to [state representative], touching on topics such as youth mental health, and underaged

[28] This includes those coalitions (10%) where youth coalition's members were involved in decision making (10%) but noted their coalition does not have a board, steering committee, leadership team (i.e., the group that provides overall leadership to the coalition).

[29] Near-peers are slightly younger. They might be one grade level lower or may involve middle school students mentoring elementary students while high school students provide mentoring to middle school students.

substance use and met with [state senator] to speak about the effects of COVID on adolescent mental health, what they hope to accomplish in education and resources for students in the coming year." (Year 5, Northeast Region).

In some instances, youth coalitions used their voices to advocate for existing legislation, "Youth were successful in writing in for city council meetings regularly to express their concerns and attended in person to successfully advocate to keep our marijuana ordinance" (Year 7, West Region). One youth coalition (Year 5, Northwest), in addition to engaging their representatives also engaged the community by disseminating prevention materials throughout the community,

> "They distributed 20 lawn signs to residents promoting the Our Safe Home Campaign in honor of National Prevention Week . . . youth ambassadors took to the streets with the NPW awareness fliers they created and hung to various telephone poles throughout the Town to kick off NPW and raise awareness. They touched on where to get [drug deactivation kits], vaping facts, mental health helpline, and risks of opioids."

Mental health initiatives were an important tool for youth coalitions to prevent and reduce youth substance use. One coalition reported members performing peer-to-peer wellness checks, "the Youth Advisory Council contributed to the campaign [Mental Health Awareness Month] with the Peer-to-Peer Wellness Check-In project focused on the goals of building social connections during physically distancing circumstances, encouraging conversations about mental health and well-being as well as providing information and support" (Year 3, West Region). Mental health was a concern particularly in the context of the COVID-19 pandemic. Mental health among youth has reportedly declined during the COVID-19 pandemic, although youth with better connections such as to their school or community fared better[30]. Youth coalitions mobilized to prevent harmful behaviors, "The Youth Council focused on a Photovoice project that explores their pandemic journey, a social media campaign (called Mountain Project) to normalize talking about mental health and on two occasions spoke during student assemblies to students at the Middle School about coping with stress during the pandemic" (Year 2, Northeast Region). Another coalition shared a 31 days of mental health campaign that reduced "stigma around mental and behavioral health, encouraged help-seeking, and provided connection to mental and behavioral health resources" and provided students with an outlet to share "their experiences with the pandemic" (Year 6, Northeast Region). An additional activity that youth coalitions engaged in was trying to maintain normalcy and routine for students by hosting virtual events, "The Council also developed and hosted some pandemic appropriate alternative social activities, including virtual trivia and games nights" (Year 6, Northeast Region).

[30] 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.

Strategy Implementation

Key Findings

DFC coalitions implemented a comprehensive mix of strategies, with nearly two-thirds (63%) implementing at least one activity in at least five of the strategy types. DFC coalitions were generally implementing at higher levels than during the first year of COVID-19, but still somewhat lower than prior to the pandemic. Just over two-thirds of DFC coalitions implemented activities to address the emerging drug issues of opioids/methamphetamine and youth vaping (70% and 69%, respectively).

Each DFC coalition is expected to develop and implement an annual action plan to meet grant goals. DFC coalitions focus on selecting to implement 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 although 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 2021 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 the emerging drug issues of opioids, methamphetamine and/or vaping are described.

Comprehensive Strategy Implementation

To assess how DFC coalitions are implementing their action plans, 41[32] unique prevention activities were linked to one of the Seven Strategies for Community Change.[33] Nearly two-thirds (64%) of DFC coalitions implemented at least one activity in at least five of the seven strategy types (see Figure 6A). This was a large increase from the 49% of DFC coalitions who implemented at this level during the first year of COVID-19, although still well below pre-pandemic levels (80%). An examination of implementation of at least one activity by strategy type (see Figure 6B) presents a similar picture. For three strategy types (*Providing Information*, *Enhancing Skills*, and *Changing Access/Barriers*), the rates of engagement are similar to what they were prior to COVID-19. For the remaining strategy types, while there were increases in implementation between COVID-19 Years 1 and 2, levels are still lower by 10 or more percentage points as compared to prior to COVID-19.

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[31] Coalitions were asked to report on activities that were implemented from February 1st, 2021 through July 31st, 2021. 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.

[33] 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 DURING COVID-19

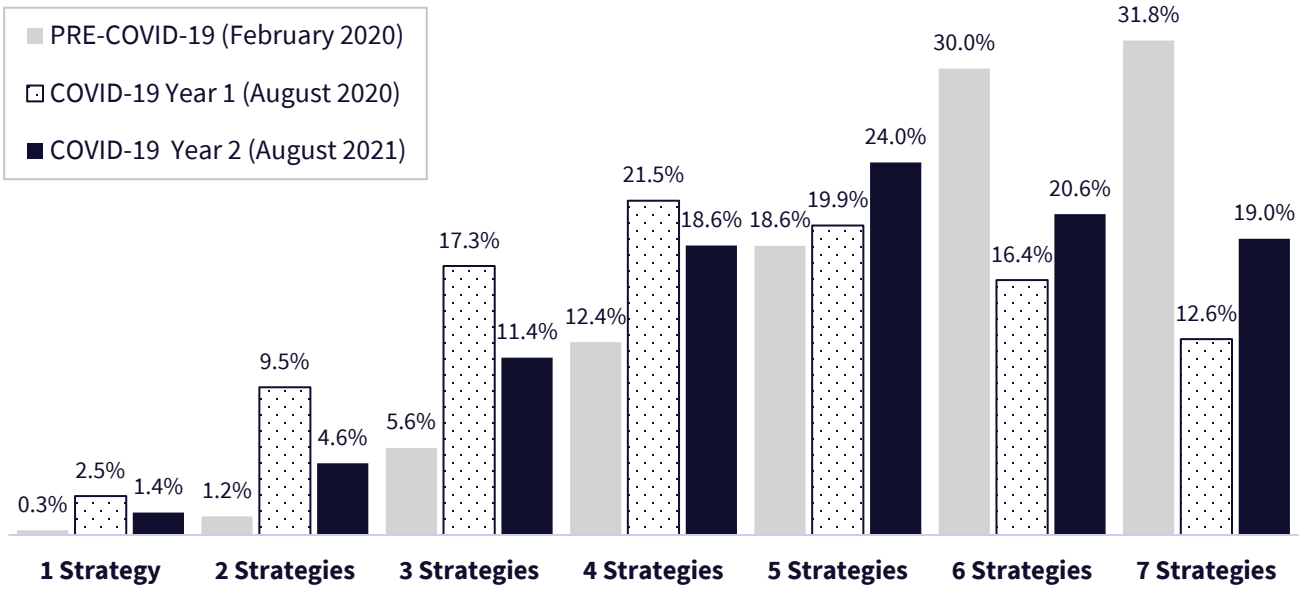
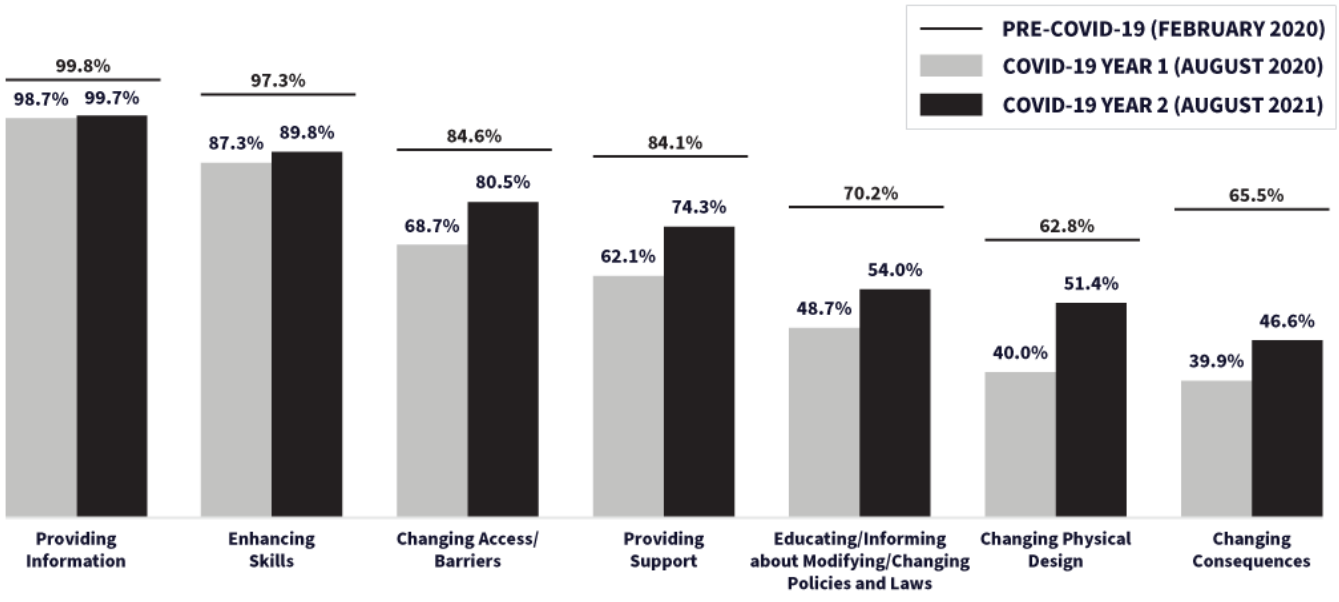


FIGURE 6B. PERCENTAGE OF DFC COALITIONS ENGAGED IN ANY ACTIVITY WITHIN EACH OF THE SEVEN STRATEGIES FOR COMMUNITY CHANGE DURING COVID-19



Source: DFC February 2020, August 2020, and August 2021 Progress Reports

Notes Table 6A: n=693 coalitions reporting in August 2021; n=715 coalitions reporting in August 2020; n=661 coalitions reporting in February 2020.

Notes Table 6B: Totals within each period differ from 100% due to rounding. N=693 coalitions reporting in August 2021; n=715 coalitions reporting in August 2020; n=661 coalitions reporting in February 2020.

Activities Implemented by Strategy and Strategy Type

Table 2 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).[34] In addition to coalitions being generally more likely to have engaged in individual strategies as compared to environmental strategies, activities within each of these strategy types were generally also engaged in by high percentages of coalitions. The exception to this was *Providing Support* activities where the top activity was engaged in by 46% 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 61% of DFC coalitions.

TABLE 2: 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.		
Social Networking: (e.g., Facebook, Twitter, etc.)	91.3%	"We continue to disseminate educational materials at events, through our listserv and our public schools' digital backpack program. Our coalition distributed infographics to realtors informing them about appropriate measures to lock up medications at open houses. We provided brochures to funeral homes to pass on to families regarding safe disposal and securing of prescription medications. We have executed several multi-media campaigns, including billboards and sidewalk clings, which were placed at local playgrounds. Messaging included information about the prescription drug drop box, the Change The Script campaign (both English and Spanish messaging). An anti-vaping logo and design was created by our youth and police collaborative project, which was put on t-shirts and billboards. We planted lawn signs utilizing our data on marijuana use to prevent teens from frequenting a known hot spot after school." (Year 2, Northeast Region)
Informational Materials Disseminated: Brochures, flyers, posters, etc. distributed	84.1%	

[34] 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 2: 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	68.7%	"During this reporting period we continued our new evidence-based prevention program that focused on preventing alcohol and substance use among youth. We delivered 5 lessons in the 5th grade program and 5 lessons in the 6th grade program. These lessons were also offered separately in Spanish. . . We provided weekly training for Peer Leaders members in Middle School and High School who record lessons for this program. . . We worked with Peer Leaders and youth coalition members to enhance skills through Kahoot trivia quizzes and other lessons that focused on specific substances. We trained new youth coalition members to write & record PSAs." (Year 8, Northeast Region).
Community Member Education and Training Programs: Sessions directed to community members (e.g., law enforcement, landlords)	52.1%	
***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	46.0%	"This spring we hosted a Pride Month Rainbow Paint Party with 34 of our middle school and high school youth groups and their peers. We were also able to take 12 of our high school leaders to an outdoor experiential leadership training. These substance-free in-person activities were an opportunity to return to normality for the youth, to decrease isolation, and to re-establish connectedness. These activities offered positive reinforcement at the end of the year. . . We also hosted coffee hours for families of emerging bilingual students. We cross promote and encourage participation in our partner agency community oriented or family events, such as the Rotary summer outdoor concert series." (Year 2, Northeast Region)
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	31.0%	
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)	61.3%	"The coalition distributed 155 locking medicine cabinets and 2,550 [drug deactivation] disposal bags during this reporting period to community organizations and members. We also had translated into Spanish all of our coalition produced materials and distributed them to 5 local Hispanic organizations." (Year 7, Northeast Region)
Improve Access Through Culturally Sensitive Outreach (e.g., multilingual materials)	28.3%	

TABLE 2: 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)	23.1%	"We held an end-of-the-year celebration for all 13 members involved in {youth coalition}. Each member received a certificate of participation and a {Coalition} sweatshirt during the celebration. They were also recognized on our social media. We collaborated with the state Traffic Safety Resource Office, Alcohol Beverage Control, local Police Department, and the local/state university Public Safety Office on their Fake Id program. This will result in increased enforcement efforts related to underage drinking, fake ids, and illegal substance use targeting the university population." (Year 1, Midwest Region)
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	19.6%	
***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)	21.8%	"A speaker presented to all DFC members about the dispensary presence in the community. There is a disparity in the density of dispensaries in the city versus in the suburbs. The DFC learned about lapses in zoning enforcement, in which some retailers are too close to schools or parks or other areas that are not permitted. The DFC plans to use this knowledge in the future to help ensure that zoning and dispensary locations are properly enforced. Additionally, youth coalition members were able to participate in the beginning stages of creating a neighborhood garden. This effort will help with the beautification of the neighborhood while also providing alternative activities for youth." (Year 2, Midwest Region)
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups)	20.2%	
Educating/Informing about Modifying/Changing Policies or Laws: activities to educate and inform with the goal of creating formal change in policies or laws		
Underage Use: Laws/public policies targeting use, possession, or behavior under the influence for minors	13.7%	"Alcohol initiative members and staff wrote a letter to the state senator providing information about two bills aimed at reviving the restaurant industry post-COVID through deregulation of alcohol. The letter communicated the public health informed perspective on alcohol advertising and visibility in the community, as well as density and availability to youth. In conjunction with other educational efforts to bring forward a public health perspective on this issue, bills were altered in committee to remove many of the sections which would increase youth access to alcohol." (Year 10, West Region)
Sales Restrictions: Laws/public policies concerning restrictions on product sales (e.g., methamphetamine precursor access, alcohol at gas stations)	12.1%	

Source: DFC August 2021 Progress Report Data, n=693
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.[35] 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 3 presents the top five community assets put into place after receiving the DFC grant award.[36] 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 3: 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.	68.6%	21.0%	10.4%
Social norms campaigns.	65.4%	16.1%	18.4%
Substance use warning posters.	59.4%	26.5%	14.1%
Town hall meetings on substance use and prevention within the community.	56.1%	25.6%	18.3%
Prescription drug disposal programs.	47.6%	48.7%	3.7%

Source: DFC August 2021 Coalition Classification Tool Data
Note: n=694 coalitions reporting CCT data in August 2021.

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 4 shows the three individual activities coalitions engaged in most. In line with grant expectations, coalitions rated referring to action plans to guide decision making the most highly.

[35] In August 2021, 694 DFC coalitions completed the CCT in time for inclusion in this report (95% of all DFC coalitions).
[36] These were the only assets which were put into place by more than 50% of DFC coalitions after a DFC grant award.

TABLE 4: TOP THREE COALITION ACTIVITIES MOST HIGHLY ENGAGED IN BY DFC COALITIONS

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

Source: DFC August 2021 Coalition Classification Tool Data
Note: n=694 coalitions reporting CCT data in August 2021. 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). Three 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 and implementing 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

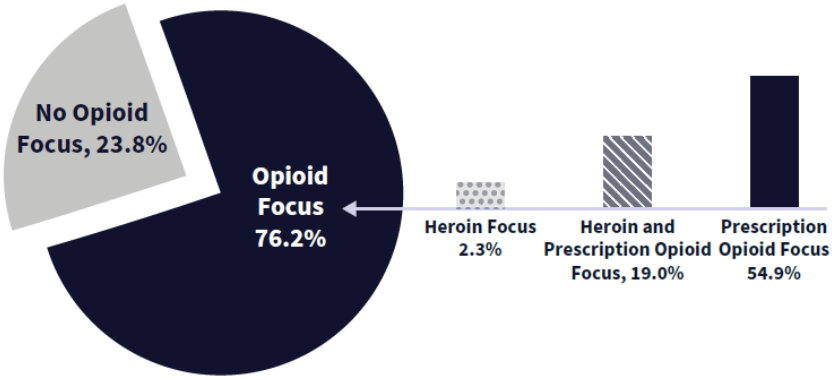
The CDC has identified opioid use and opioid overdose deaths as an epidemic. In 2019, just over two-thirds (70%) of all drug overdose deaths were associated with opioids (e.g., prescription opioids, heroin, fentanyl).[37] While prescription opioids contributed to an early wave of opioid overdose deaths, recent data suggests a current wave that began in 2013 involving synthetic opioids. Most overdose deaths (nearly 85%) involved illicitly manufactured fentanyl, heroin, cocaine, or methamphetamine (alone or in combination) during January–June 2019; most opioid-involved overdose deaths (73%) involved synthetic opioids.[38]

[37] 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

[38] Ibid. see Also O'Donnell J, Gladden RM, Mattson CL, Hunter CT, Davis NL. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants — 24 States and the District of Columbia, January–June 2019. MMWR Morb Mortal Wkly Rep 2020;69:1189–1197. DOI: http://dx.doi.org/10.15585/mmwr.mm6935a1

In August 2021, 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).[39] This was a slight reduction from the percentage of coalitions that selected prescription opioids, heroin, or both as among their top five substances in August 2020 (81%).

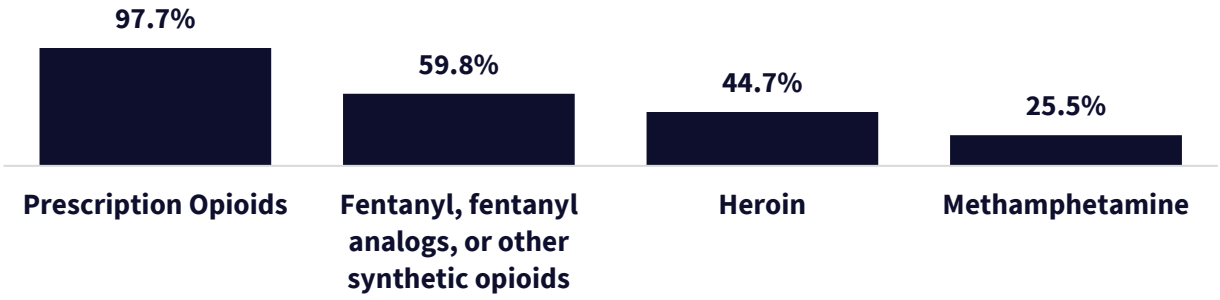
FIGURE 7. PERCENTAGE OF DFC COALITIONS FOCUSED ON OPIOIDS



Source: DFC August 2021 Progress Report

In comparison to selecting opioids as a focal substance, slightly fewer DFC coalitions (70%) 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 two-thirds (60%) indicated their work addressed fentanyl or other synthetic opioids, close to half addressed heroin (45%), and just over a quarter (26%) 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 one coalition indicated a focus solely on methamphetamine.

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

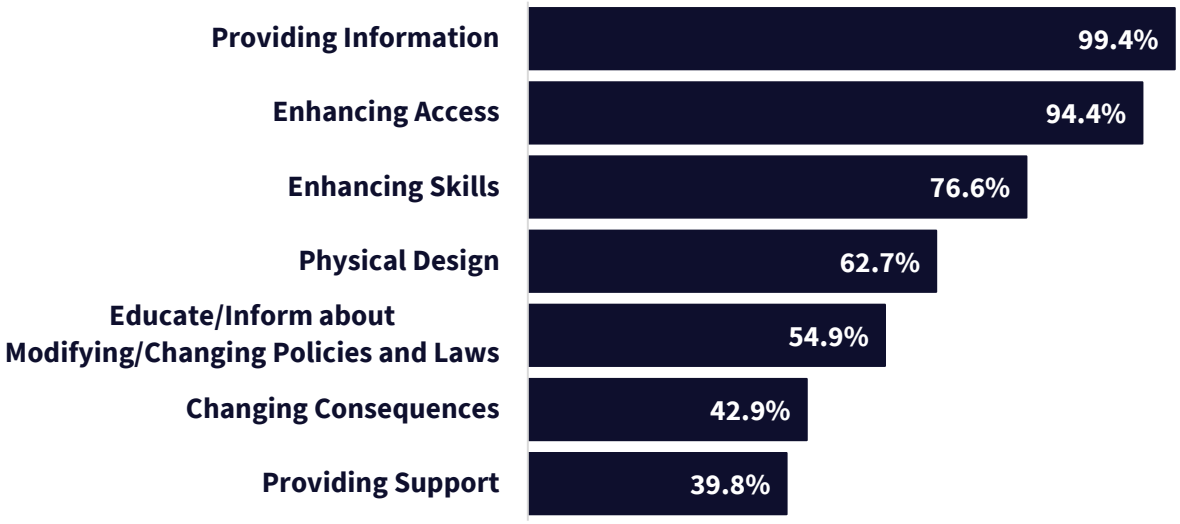


Source: DFC August 2021 Progress Report
Note: Totals do not add to 100% because DFC coalitions could select more than one substance.

[39] Heroin' 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)

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 35% of DFC coalitions reported *Educating and Informing* regarding naloxone policies and Good Samaritan Laws.[40]

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



Source: DFC August 2021 Progress Report Data

Coalitions engaged in a range of activities regarding opioids and/or methamphetamine. In line with the emphasis on prescription opioids, coalitions engaged in a range of activities to educate and communicate about prescription drug misuse and encourage disposal of unused prescription drugs. This included participating in prescription drug take-back day events, working to have prescription drug drop-off boxes available in the community, and providing residents with kits to safely store prescription drugs in the home and to deactivate/dispose no longer needed prescription drugs at home.[41] Another common theme was engaging in or preparing to engage in harm-reduction activities,

[40] 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

[41] The most common take back events are associated with Drug Enforcement Agency (DEA) National Take-Back events (see https://www.dea.gov/takebackday). Distributing drug deactivation kits provides a ware for community members to safely dispose of prescription drugs at home.

particularly around Naloxone, which if available and administered can be used to treat a person who has overdosed. For example, a Year 3 coalition (Midwest Region) conducted a survey to assess current acceptance of harm reduction activities in their community and developed and shared a research paper to increase knowledge and reduce stigma around opioid use disorder as well as the feasibility and cost-effectiveness of implementing harm reduction strategies. In addition, coalitions worked in communities to better connect law enforcement and public health personnel, with the goal of addressing opioid overdoses by offering, and helping to access, treatment.

Vaping

Youth vaping continues to be a national challenge, with past 30-day rates in 2021 of 11.3% among high school students and 2.8% among middle school students.[42] Past-year vaping rates from 2020 were slightly higher, in part due to the longer timeframe: nicotine vaping ranged from 16.6% in 8th grade students to 34.5% in 12th grade students; marijuana vaping ranged from 8.1% in 8th grade students to 22.1% in 12th grade students.[43] Just over two thirds (69%) of DFC coalitions reported that their coalition engaged in activities to address vaping locally (down slightly from 76% in August 2020). Of those coalitions who addressed vaping, 94% reported that their work focused on vaping of nicotine/tobacco, and 85% reported that their work addressed vaping marijuana. Additionally, 41 coalitions (9% of those who addressed vaping) reported addressing another substance. Of all coalitions that reported addressing vaping locally, 80% reported addressing both nicotine and marijuana, 15% of coalitions addressed nicotine/tobacco only, and 5% of coalitions addressed marijuana only. Several coalitions noted that they had added vaping questions to youth surveys in order to better understand the extent of youth vaping locally.

One strategy utilized by coalitions to address vaping was engaging in positive social norms campaigns, emphasizing that most youth choose not to engage in vaping and understand it is a risky behavior. For example, youth in one coalition (Year 4, Northeast Region) designed a billboard campaign sharing data regarding most students not vaping. The coalition noted that an initial negative response to the campaign on social media had the positive impact of starting and engaging in conversations about vaping (on social media and beyond): "The initial post viewed the campaign in a negative light which showed us we may need to rethink the way in which the information was shared. The comment showed lack of trust in the data presented."

Several coalitions also supported the installation of vaping sensors in restrooms in schools (*Changing Physical Design* strategy). Many of these coalitions noted working with school administration to

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[42] The term vaping is used in this report, some reports refer to vaping use as e-cigarette use. Centers for Disease Control and Prevention. (2020, February 24). *About electronic cigarettes (E-cigarettes).* Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html. and Park-Lee E, Ren C, Sawdey M, et al. Notes from the Field: E-Cigarette Use Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. Morbidity and Mortality Weekly Report, 2021; 70:1387–9. and Gentzke AS, Wang TW, Cornelius M, Park-Lee E, Ren C, Sawdey MD, Cullen KA, Loretan C, Jamal A, Homa DM. Tobacco Product Use and Associated Factors Among Middle and High School Students – National Youth Tobacco Survey, United States, 2021. Morbidity and Mortality Weekly Report, 2022; 71(No. SS-5):1–29.

[43] Monitoring the Future 2020 data, see NIDA_2020_TeenMTFInfographic (nih.gov)

connect students who were caught by the sensors to resources and support to quit vaping. For example, a Year 7 (South Region) reported, “After meetings and education the schools have implemented vape detectors in bathroom and have a response system set up to address when they go off. The officers write the student a citation which they are required to go through the court system. Our courthouse representatives have been educated and they educate parents and youth that come in about enforcement, resources, and trainings. They send coalition staff a report on how many citations for vaping have gone through their system.” Similarly, a Year 4 coalition (Midwest Region) noted that, “During this reporting period we were able to provide enough vape detectors to help have every bathroom at the local high and middle school equipped with these. We also are providing programming to the students who are caught, with our Quit Vaping and Smoking Program. If students opt in to taking this class, their suspension is reduced and they are provided with this awesome educational opportunity. It also helps keep the students in school instead of sent home where they will continue to vape or use other substances. Once completing the class, the students are then contacted through a follow up every month for the next few months. We host this program in four of our local schools. One local school has asked for us to provide programming for any students who is caught with a substance in general to reduce suspensions, provide education and keep the students in school.” Some coalitions noted some challenges around adding detection devices in schools, including concerns around responding to detection in a timely manner and the potential for negative interactions between school resource officers and students that would need to be proactively addressed by shifting school culture to center supportive and restorative action in response to substance use (Year 6, Northeast Region).

Core Measures

Key Findings

DFC coalitions (all and most recent cohort) reported significant decreases in past 30-day use across all substances among high school youth. 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 by middle school youth all declined significantly, but misuse of prescription drugs was low (less than 3%) and unchanged from first to most recent report.

This section provides a summary of the core measures data reported by DFC coalitions from first to most recent report.[44] 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 2020) cohort of DFC coalitions.[45] 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 E for full tables).[46]

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 the FY 2020 coalitions. A green 'up' 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 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 non-use; for all four core measures increases (green arrows) reflect findings in line with DFC goals. Notably, in the FY 2020 sample, perception of risk decreased significantly across all substances and both grade levels with a similar trend seen in the all DFC coalitions since inception sample.

[44] DFC coalitions have reported data from 2002 to 2020. 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 2020. 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 $p < .05$.

[45] 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 2020-only sample. For example, to date, 659 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 636, 354 (42%) also were in the FY 2020-only sample. In comparison, 387 of the 1,405 (56%) DFC coalitions that have reported past 30-day prevalence of alcohol use among middle school youth were in the FY 2020-only sample.

[46] . 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 NON-USE	↑	↑	↑	↑
PERCEPTION OF RISK	NC	↓	↓	↓
PARENTAL DISAPPROVAL	↑	↑	↑	NC
PEER DISAPPROVAL	↑	↑	NC	NC

HIGH SCHOOL

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

FY 2020 DFC GRANT RECIPIENTS

MIDDLE SCHOOL

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

HIGH SCHOOL

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

Source: DFC 2002–2021 Progress Reports, core measures data

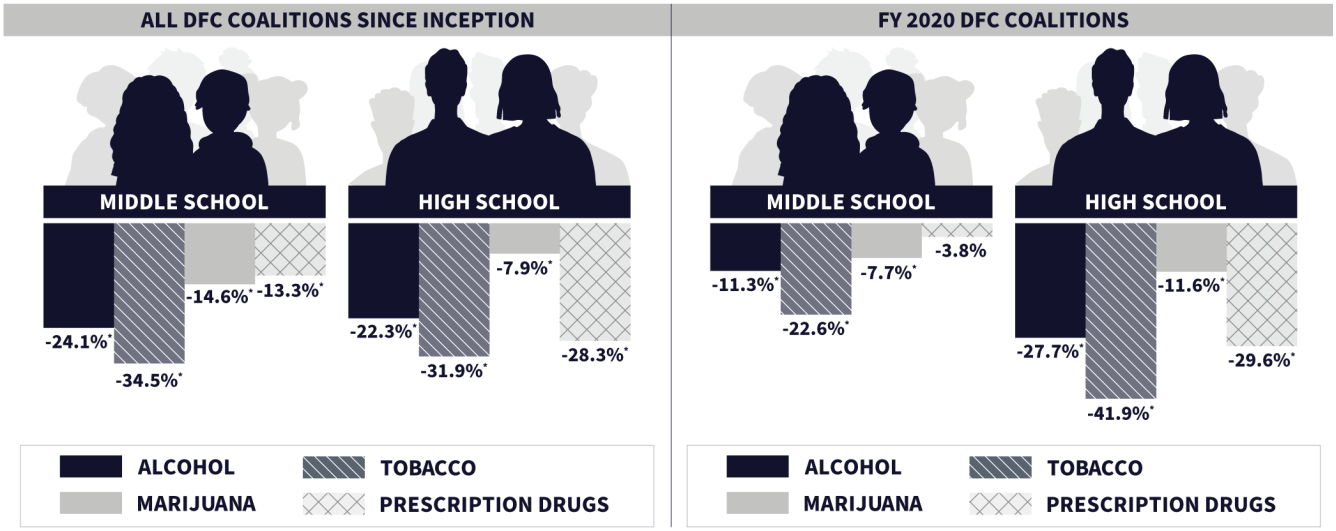
Note: ↑ = significant increase; ↓ = significant decrease; **NC**=No Change

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

In general, past 30-day use increases between middle school and high school (see Tables F.1 and F.2, Appendix F). Alcohol was the most used substance at both grade levels, followed by marijuana. Prescription drug misuse remained relatively low for both grade levels. For all coalitions since inception, past 30-day non-use rates increased 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 (See Figure 10). That is, there were significant decreases in past 30-day use across substances. Similar findings were found for the FY 2020 cohort, although among middle school youth there was no change in prescription drug use. Few middle school youth report misusing prescription drugs (≤ 3%), which may explain why there was no significant change. Figure 11 presents the percentage change in past 30-day prevalence of use.[47] The largest percentage change has been in past 30-day use of tobacco. Extrapolating non-use percentages based on census 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 5).

[47] 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 %).

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



Source: DFC 2002–2021 Progress Reports, core measures data
Note: * indicates $p < .05$

TABLE 5. FY 2020 DFC COALITIONS ESTIMATED INCREASES IN THE NUMBER OF YOUTH REPORTING PAST 30-DAY NON-USE BY SUBSTANCE

SUBSTANCE	MIDDLE SCHOOL	HIGH SCHOOL
Alcohol	22,000	267,000
Tobacco	17,000	155,000
Marijuana	7,000	70,000
Prescription Drug (misuse)	No Change	56,000

Source: DFC 2002–2021 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 and high school levels, across both samples, perceived risk associated with substance use declined significantly from first to most recent report (change regarding alcohol at middle school for all coalitions and at high school for all coalitions for tobacco and prescription drugs were not significant). Across both samples and ages, perceived risk was highest for tobacco and prescription drugs, followed by alcohol and marijuana.
- 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 below 50% at high school. In the current cohort of DFC recipients, the substance with the lowest level of perceived risk of use was marijuana for both age groups but particularly so among high school youth.

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 93% and high school rates of at least 87%.
- The FY2020 middle school rate of parental disapproval for marijuana significantly decreased, though rates were at least 95%. Among high school youth, perceived parental disapproval for marijuana use was unchanged in this sample.
- The FY2020 increase in high school rates of disapproval for alcohol, tobacco and prescription drugs among both samples were statistically significant**.**

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 grade levels and substances. That is, while most youth report not using substances, they also report not perceiving of their peers disapproving should they use substances.
- 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.
- Differences between first and most recent report of perceived peer disapproval at middle school were generally non-significant, with perceived disapproval rates of at least 86%.
- 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):[48] Based on data collected in 2019, past 30-day use of alcohol and marijuana among high school students in DFC communities were significantly lower than rates in the national Youth Risk Behavior Survey (YRBS). Rates of tobacco use (6.1%) were not statistically different.

[48] Comparison between DFC and Youth Risk Behavior Survey data at the high school level w ere possible as the two use the same wording. 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. 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 are collected only in odd years. 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. In addition, YRBS data is mostly collected during the spring of odd-numbered years. 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.

Conclusions

Twice a year, DFC coalitions report a wide range of data through progress reports. The information shared by coalitions is intended to provide understanding on their local community context, how they focus their efforts, what protective and/or risk factors exist in the local community, as well as middle and high school youth core measures data. Collectively, the findings suggest that the DFC support program has been successful at making progress towards grant goals. This includes data from all coalitions funded since 1998 when the grants were first awarded, but also outcomes associated with the most recent cohort awarded in FY 2020. Conclusions based on the progress report data submitted in August 2021 follow.

Collectively, just over 3,200 DFC grants have been awarded in over 2,100 communities with 54% of Americans living in a community with a DFC since first awards were made.

Conclusion 1: DFC coalitions have a broad reach and are working to engage and impact subgroups in their communities who may be underserved.

In FY 2020, there were 732 DFC coalitions and 1 in 5 Americans lived in a community with a DFC-funded coalition.

ONDCP has focused on encouraging DFC coalitions to engage in practices that address advancing racial equity and supporting underserved community equities.[49] Higher percentages of DFC coalitions reported tailoring efforts to specific subgroups of youth/people, particularly Hispanic/Latino, Black/African American, and LGBTQ+ youth/people in August 2021 as compared to August 2020 (59% and 48%, respectively). Around half (51%) of DFC coalitions reported working in frontier and/or rural communities and 30% work in urban/inner city communities.[50]

A key factor in youth not engaging in substance use is feeling connected to one's family, school and/or community[51]. DFC coalitions report focusing on efforts to enhance these types of connections for youth. National trends as well as DFC trends in reported substance use suggest that youth are particularly likely to use alcohol and marijuana. DFC coalitions reported that they are focused on addressing these substances as well as the other two DFC core measure substances (alcohol [98%], marijuana [87%], prescription drug misuse [78%], and/or tobacco [76%]).

98% and 90% of coalitions target youth alcohol and marijuana use, respectively.

Conclusion 2: DFC coalitions succeed at mobilizing the community to prevent and reduce youth substance use across community sectors.

To combat youth substance use, DFC coalitions build capacity by strengthening the involvement of local individuals and groups within their communities, mobilizing approximately 30,000 community members.

[49] This is in line with a Biden-Harris Executive Order found Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government | The White House.

[50] Suburban is the remaining community type. There is some overlap across groups as some working in rural communities may also be working in suburban and urban areas and vice versa.

[51] See footnote 11.

Coalition work is organized through engagement with twelve sectors in the community. Over 75% of coalitions reported having at least one active member in *all* sectors. Sector membership data reported that the Youth and School sectors maintained the highest median number of members. Over two-thirds (67%) of coalitions reported hosting a youth coalition, and these same coalitions reported significantly higher levels of Youth, Law Enforcement, Parent, and School sector involvement.

~30,000 community members mobilized to prevent and/or reduce youth substance use.

Conclusion 3: DFC coalitions are implementing a comprehensive mix of strategies to bring about change in their communities.

Based on their action plans, nearly two-thirds (63%) of DFC coalitions implemented at least one activity in at least five of the seven strategy types. That is, the average coalition was working on solutions by taking a multi-pronged approach designed to potentially impact a range of social determinants of health, from trainings to bring about individual change to activities designed to change the systems with which youth are engaged, such as home access to substances and school substance use policies. DFC coalitions were generally implementing activities at higher levels than during the first year of COVID-19, but still somewhat lower levels in 2021 than prior to the start of the pandemic.

63% Implemented activities across at least 5 strategy types

70% implemented activities to address opioids and/or methamphetamine

69% implemented activities to address youth vaping.

In addition to activities focused on core measure substances, coalitions were implementing activities to address emerging drug threats in their communities, specifically to address opioids (70%) and to address youth vaping (69%). Of those coalitions who addressed vaping, 94% reported that their work focused on vaping of nicotine/tobacco, and 85% reported that their work addressed vaping marijuana.

Conclusion 4: DFC coalitions are meeting the goal of increasing the numbers of youth choosing not to use substances.

Youth past 30-day non-use increased significantly (use decreased significantly) across all core measure substances and school levels (middle and high school) among all DFC grantees since inception. The same was true for FY2020 coalitions, except for non-misuse of prescription drugs at the middle school level. Few middle school youth in this cohort reported misusing prescription drugs ($\leq$ 3%) and this was unchanged from first to most recent report. Given the potential reach of DFC, significant change translates to thousands of youth choosing not to use substances who might have otherwise done so.

Despite these positive trends, remaining core measures suggest there is room for DFC coalitions to make a difference that may contribute to additional increases in non-use. Perception of risk decreased significantly across all substances at the middle and high school levels among FY2020 reporting coalitions, with risk associated with regular marijuana use particularly low. Rates of perceived peer disapproval were lowest for marijuana and then alcohol, the two substances youth were most likely to report having used. While reported use appears to be on the decline, perceptions of risk and disapproval from peers suggest that youth may still need more information and community-level support to fully understand the potential consequences of choosing to use substances particularly during adolescence.

Perception of risk rates associated with marijuana use dipped below 70% and 50% in middle and high school, respectively.

Limitations and Challenges

Based on the 2021 data, many DFC coalitions appear to still be struggling with implementing their initiatives and collecting youth data in their communities because of the COVID-19 pandemic. On average, coalitions implemented fewer strategies than they have in the past, although far more activities were implemented in 2021 than during the initial 2020 phase of COVID-19. In addition, far fewer coalitions were able to submit new core measures data in 2021 than submit this data in a typical year (only ~20% of coalition in 2021 compared to ~50% in an average non-pandemic year). In describing their challenges both in implementation and data collection, coalitions often referenced that schools were facing their own challenges given COVID-19 so participating in something that felt "extra" was challenging. DFC coalitions reported that as schools moved to a virtual learning model followed by many school implementing hybrid models with mixed virtual/in-person learning the schools were focused on meeting educational goals and things like non-required data collection were perceived as an added, unnecessary stress. DFC coalitions, rightly, focused on maintaining and rebuilding positive relationships with the school sector during this time in order to make progress to being able to once again implement activities with youth and to collect data from them. Even as pandemic restrictions appear to be easing, it may be some time before these efforts return to normal/pre-pandemic levels.

COVID-19 may also be a contributing factor in youth substance use, as noted in the Background section of this report. 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. Worldwide, people have likely spent more time isolated from social interaction over the last two years than at any time in recent memory. Though youth are likely spending more time with family members, they are conversely not spending more time away from home with peers. This means that the contextual ingredients often associated with youth substance use patterns may have been on hold, resulting in the decreased use rates reported here. As youth begin to re-engage with peers outside of the school or home, it will be necessary for coalitions to ramp up their community-based efforts while simultaneously keeping an eye on future youth substance use rates.

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.

Another challenge 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 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 grade 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	71.9%
Positive contributions to peer group	68.5%
Family connectedness	64.6%
Positive school climate	62.2%
Opportunities for pro-social family involvement	60.0%
School connectedness	59.7%
Recognition/acknowledgement of efforts	59.2%
Advertising and other promotion of information related to substance use	57.9%
Contributions to the school community	56.9%
Parental monitoring and supervision	52.2%
Laws, regulations, and policies	50.9%
Cultural awareness, sensitivity, and inclusiveness	50.2%
Strong community organization	46.0%
Family economic resources	24.5%
Other protective factor	3.3%
Community Risk Factors	**Percent**
Perceived acceptability (or lack of disapproval) of substance use/Community norms favorable toward substance use	89.0%
Availability of substances that can be misused	84.7%
Individual youth have favorable attitudes towards substance use/misuse	82.4%
Perceived peer acceptability (or lack of disapproval) of substance use	73.2%
Perceived parental acceptability (or lack of disapproval) of substance use	65.9%
Parents lack ability/confidence to speak to their children about substance use	63.2%
Family trauma/stress	57.3%
Early initiation of the problem behavior	55.7%
Parental attitudes favorable to antisocial behavior	38.4%
Low commitment to school	36.2%
Inadequate laws/ordinances related to substance use/access	34.3%
New laws/ordinances allowing substance use/access	27.3%
Inadequate enforcement of laws/ordinances related to substance use	26.6%
Low Levels of active coalition engagement among community members	23.8%
Academic failure	23.7%
Lack of local treatment services for substance use	21.2%
Available treatment services for substance use insufficient to meet needs in timely manner	17.5%
Other challenge	8.7%

Appendix C. Strategies Tables

TABLE C.1: *PROVIDING INFORMATION* ACTIVITIES

ACTIVITY		PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES	NUMBER OF ADULTS SERVED	NUMBER OF YOUTH SERVED
Social Networking: (e.g., Facebook, Twitter, etc.)	633	91.3%	71,735	10,051,030 followers	5,934,169 followers
Informational Materials Disseminated: Brochures, flyers, posters, etc. distributed	583	84.1%	437,719	6,999,093	639,778
Informational Materials Prepared/Produced: Brochures, flyers, posters, etc. prepared	532	76.8%	22,183		
Media Campaigns: Television, radio, print, billboard, bus, or other posters aired/placed	497	71.7%	8,892		
Media Coverage: TV, radio, newspaper stories covering coalition activities	432	62.3%	2,576		
Information on Coalition Website: New materials posted	420	60.6%	5,359	850,015	
Direct Face-to-Face Information Sessions	407	58.7%	3,681	121,521	90,208
Special Events: Fairs, celebrations, etc.	407	58.7%	1,305	216,961	126,754
Other Providing Information activities	111	16.0%	3,468	330,139	87,663
Summary: *Providing Information*	**691**	**99.7%**	**556,918**	**8,517,729**	**944,403**

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	476	68.7%	4,484		167,893
Community Member Education and Training Programs: Sessions directed to community members (e.g., law enforcement, landlords)	361	52.1%	2,258	55,995	
Parent Education and Training Programs: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.	282	40.7%	1,233	68,597	
Teacher/Youth Worker Education and Training Programs: Sessions on drug awareness and prevention strategies directed to teachers or youth workers	178	25.7%	589	15,671	
Business Training (e.g., responsible beverage server/vender training [voluntary or mandatory])	125	18.0%	597	4,431	
Other Enhancing Skills Activities	67	9.7%	319	4,483	2,039
Summary: *Enhancing Skills*	**622**	**89.8%**	**9,480**	**149,177**	**169,932**

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	319	46.0%	1,238	49,166	84,153
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	215	31.0%	1,042	68,371	52,142
Organized Youth Recreation Programs: Recreational events (e.g., athletics, arts, outdoor activities) supported by coalitions	118	17.0%	949	8,335	19,473
Youth/Family Support Groups: Leadership groups, mentoring programs, youth employment programs, etc., supported by coalitions	98	14.1%	767	5,105	5,553
Youth Organizations/Drop-In Centers: Clubs and centers supported by coalitions	78	11.3%	783	3,624	12,054
Other Providing Support Activities	68	9.8%	461	7,503	15,761
Summary: *Providing Support*	**515**	**74.3%**	**5,240**	**142,104**	**189,136**

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)	425	61.3%	682,578	130,638
Improve Access Through Culturally Sensitive Outreach (e.g., multilingual materials)	196	28.3%	124,473	36,974
Increased Access to Substance Use Services (e.g., court mandated services, assessment, and referral, EAPs, SAPs)	193	27.8%	120,257	45,189
Improved Supports for Service Use (e.g., transportation, child care)	63	9.1%	28,977	12,545
Other Changing Access Activities	48	6.9%	74,807	7,948
Summary: *Changing Access/Barriers*	**558**	**80.5%**	**1,031,092**	**233,294**

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)	160	23.1%	
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	136	19.6%	3,411
Strengthening Surveillance (e.g., monitoring "hot spots," party patrols)	111	16.0%	
Other Changing Consequences Activities	54	7.8%	804
Publicizing Non-Compliance (e.g., advertisements highlighting businesses not compliant with local ordinances	38	5.5%	915
Summary: *Changing Consequences*	**323**	**46.6%**	**5,130**

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
Underage Use: Laws/public policies targeting use, possession, or behavior under the influence for minors	95	13.7%	41	139
Sales Restrictions: Laws/public policies concerning restrictions on product sales (e.g., methamphetamine precursor access, alcohol at gas stations)	84	12.1%	44	101
School: Policies promoting drug-free schools	83	12.0%	44	92
Other Educating and Informing about Modifying/Changing Policies Activities	79	11.4%	51	125
Citizen Enabling/Liability: Laws/public policies concerning adult (including parent) social enabling or liability (e.g., social host ordinances)	76	11.0%	18	88
Treatment and Prevention: Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use offenders)	68	9.8%	53	81
Outlet Location/Density: Laws/public policies concerning limitations and restrictions of location and density of alcohol or marijuana outlets	63	9.1%	55	95
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)	57	8.2%	20	88
Cost: Laws/public policies concerning cost (e.g., alcohol, tobacco, or marijuana tax, fees)	54	7.8%	27	74
Workplace: Policies promoting drug-free workplaces	37	5.3%	29	47
Summary: *Educating and Informing about Modifying/Changing Policies or Laws*	**374**	**54.0%**	**382**	**930**

TABLE C.7: *CHANGING PHYSICAL DESIGN* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED	NUMBER OF COMPLETED ACTIVITIES
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups)	140	20.2%	295
Encourage Business/Supplier Designation of "no alcohol" or "no tobacco" zones	71	10.2%	226
Identifying Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	151	21.8%	792
Identify Problem Establishments for Closure (e.g., close drug houses)	20	2.9%	58
Improved Visibility/Ease of Surveillance in Public Places and Substance Use Hotspots (e.g., improved lighting, surveillance cameras, improved line of sight)	38	5.5%	60
Promote Improved Signage/Advertising Practices by Suppliers (e.g., decrease signage or advertising, change product locations)	106	15.3%	2,145
Other Physical Design Activities	44	6.3%	491
Summary: Changing Physical Design	**356**	**51.4%**	**4,067**

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.	68.6%	21.0%	10.4%
Social norms campaigns.	65.4%	16.1%	18.4%
Substance use warning posters.	59.4%	26.5%	14.1%
Town hall meetings on substance use and prevention within the community.	56.1%	25.6%	18.3%
Prescription drug disposal programs.	47.6%	48.7%	3.7%
Recognition programs for businesses that comply with local ordinances.	39.2%	13.3%	47.6%
Billboards warning youth about/against substance use.	37.8%	21.6%	40.6%
Media literacy training.	30.5%	13.0%	56.5%
Vendor/retailer compliance training.	30.0%	35.9%	34.1%
Formalized school substance use policies.	29.3%	60.7%	10.1%
Compliance checks: Alcohol.	28.1%	50.9%	21.0%
Drugged driving prevention initiatives.	27.1%	35.2%	37.8%
Responsible beverage server training.	25.5%	39.0%	35.4%
Compliance checks: Tobacco.	22.6%	51.0%	26.4%
Prescription monitoring program.	19.5%	51.6%	29.0%
Alcohol restrictions at community events.	17.1%	43.4%	39.5%
Secret shopper programs for alcohol outlets.	15.4%	25.1%	59.5%
Social host laws.	15.1%	52.9%	32.0%
Ordinances on teen parties.	13.5%	32.7%	53.7%
Party patrols.	13.1%	19.0%	67.9%
Compliance checks: Marijuana.	10.1%	11.4%	78.5%

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.	2.3	47.5%	39.9%	10.6%	1.2%	0.9%
Identified community organizations or members that provided facilities supporting coalition activities.	2.3	44.6%	36.0%	13.7%	3.0%	2.6%
Developed effective strategies to recruit adult participants for coalition activities and events.	1.8	19.7%	42.5%	33.0%	3.6%	1.2%
Established plans to continue meeting after DFC funding ends.	1.8	25.6%	27.2%	26.8%	10.1%	10.3%
Developed strategies that coalition sectors will continue to support after DFC funding ends.	1.7	23.4%	31.3%	27.8%	10.6%	6.9%
Improved sector members willingness to collaborate on new funding opportunities.	1.6	15.2%	34.2%	31.3%	9.7%	9.7%
Transitioned responsibility for at least one coalition activity to a specific sector.	1.5	18.8%	27.4%	29.7%	18.4%	5.8%
Established procedures for continuing to share information across agencies after DFC funding ends.	1.4	16.5%	26.6%	25.0%	21.4%	10.4%
Secured funding to continue prevention efforts after DFC funding ends.	1.1	10.1%	18.2%	29.1%	28.4%	14.2%
Built Capacity/ Strengthened Collaboration						
Increased member's knowledge of the work (e.g., services or programs offered) of other sector member organizations.	2.3	43.6%	39.2%	15.5%	0.6%	1.2%
Increased community perception of our coalition as the go to resource for addressing youth substance use.	2.2	41.1%	37.2%	18.1%	2.3%	1.3%
Facilitated opportunities for members to collaborate with one another in new ways.	2.1	37.2%	38.6%	20.7%	2.0%	1.4%
Had a strong feeling of cohesiveness across sectors.	2.1	34.3%	42.5%	20.1%	2.5%	0.6%

Made decisions on the allocation of coalition resources in an open and participatory manner.	2.0	32.7%	40.4%	20.7%	3.9%	2.3%
Relied upon multiple sectors to reduce barriers to planning strategies.	2.0	30.5%	39.2%	24.6%	3.2%	2.5%
Recruited new sector members who have the ability to take action in the community.	2.0	30.1%	39.7%	23.4%	4.6%	2.2%
Increased the likelihood of a cross-system/sector approach in strategies to address emerging drug issues in our community.	1.8	24.0%	39.2%	29.5%	5.1%	2.2%
Increased availability of tools, best practices, and/or other information that has informed the work of individual organizations/agencies.	1.8	23.4%	39.1%	31.3%	4.2%	2.0%
Developed shared understanding across sectors that promoted innovative strategy implementation by our coalition.	1.8	21.9%	40.8%	31.1%	4.5%	1.7%
Coalition Cultural Competence						
Considered the cultural makeup of the community when planning and implementing a strategy.	2.2	43.1%	35.2%	18.2%	2.5%	1.0%
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	40.1%	29.8%	19.7%	6.4%	4.1%
Arranged to provide materials (e.g., brochures, billboards) in the home language(s) of English language learners in the community.	1.7	30.2%	19.5%	18.4%	16.9%	14.9%
Created a coalition cultural competence outreach plan to address cultural diversity from demographics to economic class, religion, customs, and beliefs.	1.3	12.7%	22.0%	34.2%	21.4%	9.7%
Arranged to provide services/activities (e.g., training, town halls) in the home language(s) of English language learners in the community.	1.2	13.7%	14.3%	21.4%	26.5%	24.0%
Involved sector members of targeted cultural groups in developing coalition materials for their community.	1.2	12.0%	17.8%	29.7%	27.6%	12.9%
Had a workgroup/subcommittee/task force dedicated to monitoring progress on the coalition cultural competence plan.	0.8	5.5%	10.7%	23.3%	41.1%	19.4%
Coalition Formalization						

Followed our written description of procedures for decision-making.	2.1	33.3%	33.6%	17.1%	3.8%	12.3%
Followed our written description of procedures for leader selection.	1.9	31.1%	23.0%	17.8%	8.7%	19.4%
Followed our written description of procedures for resolving conflicts among members.	1.8	19.0%	11.3%	9.7%	9.0%	51.1%
Maintained a current organizational chart showing coalition structures and relationships.	1.8	32.3%	25.5%	22.3%	14.5%	5.5%
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	26.9%	30.2%	26.2%	13.7%	2.9%
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.	1.6	19.2%	34.7%	31.0%	12.0%	3.0%
Followed our written expectations for member participation (e.g., policy on missed meetings).	1.5	16.1%	25.0%	31.1%	12.6%	15.2%
Community Leadership Engagement						
Had community leaders actively involved in coalition committees.	2.3	47.3%	33.3%	15.6%	2.5%	1.3%
Had community leaders present at coalition events.	2.2	46.6%	30.1%	15.1%	3.9%	4.3%
Data, Evaluation, and Outcomes Utilization						
Increased awareness of harmful consequences associated with substance use by youth.	2.5	56.0%	34.2%	8.7%	0.7%	0.4%
Increased awareness of substance use (e.g., prevalence, types of substances) in the community.	2.4	55.3%	31.3%	12.0%	1.0%	0.4%
Identified data needs to inform future program planning.	2.2	37.5%	41.2%	17.5%	2.5%	1.3%
Collaborated across sectors to share data in a timely manner.	2.0	30.4%	40.1%	21.3%	3.8%	4.5%
Updated its action plans based on evaluation results.	1.8	26.0%	32.6%	23.4%	9.8%	8.1%
Regularly used evaluation results to inform the community about coalition efforts.	1.8	25.2%	32.9%	26.5%	8.4%	7.1%
Increased incidence of at least one specific protective factor against youth substance use in our community.	1.8	21.3%	36.5%	31.4%	6.2%	4.6%
Collected a range of outcomes data to track progress towards coalition goals.	1.7	22.0%	32.9%	31.0%	9.0%	5.2%
Decreased incidence of at least one specific risk factor for youth substance use in our community.	1.6	14.9%	34.2%	33.9%	9.1%	8.0%

Decreased prevalence of substance use in at least one specific target population (e.g., minority youth).	1.5	14.3%	27.6%	32.3%	12.2%	13.6%
Successfully shifted youth social norms related to youth use of at least one substance.	1.4	12.7%	26.0%	37.0%	15.5%	8.7%
Successfully shifted adult social norms related to youth use of at least one substance.	1.2	7.7%	23.4%	43.3%	16.9%	8.7%
Decreased prevalence of specific youth use of at least one substance other than the core measures (e.g., meth, cocaine, inhalants).	1.1	8.2%	16.8%	25.6%	26.3%	23.0%
Strategic Prevention Framework Utilization						
Referred to our action plan to make decisions about activities.	2.6	65.6%	29.7%	4.1%	0.3%	0.4%
Relied on the findings of our ongoing needs assessment to guide our action plan.	2.3	45.9%	35.5%	14.9%	1.3%	2.5%
Emphasized practices supported by research in our action plan.	2.2	40.2%	38.9%	15.3%	3.3%	2.2%
Completed the activities stated in our action plan.	2.1	29.8%	52.5%	16.4%	0.7%	0.6%
Sought feedback on the quality of implementation of activities.	2.1	37.0%	34.9%	21.0%	5.1%	2.0%
Used feedback on the quality of implementation of activities to make improvements.	2.0	28.2%	41.4%	22.9%	4.1%	3.5%
Followed a systematic process for assessing community needs.	1.9	28.5%	36.8%	24.7%	5.4%	4.6%
Followed a plan to address identified gaps in capacity.	1.7	18.7%	38.1%	34.6%	5.9%	2.7%
Engaged in focus groups/interviews with key stakeholders to inform assessment of community needs.	1.6	19.0%	30.1%	27.9%	15.9%	7.1%
Youth Involvement						
Had youth members who shared the coalition's message with the community.	1.9	36.3%	26.9%	23.9%	9.3%	3.6%
Successfully increased youth participation in coalition activities.	1.8	32.9%	22.0%	28.5%	13.0%	3.6%
Had organized youth members who implemented many of the coalition activities.	1.7	28.9%	22.9%	29.7%	12.7%	5.8%
Had organized youth members who planned many of the coalition activities.	1.6	25.2%	24.7%	28.5%	16.5%	5.1%
Had youth members who played a key role in developing our action plan.	1.4	19.5%	22.1%	29.2%	21.3%	7.8%

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	28.1%	56.1%	11.2%
Implementing coalition activities	2.7	38.2%	50.4%	8.8%
Planning coalition activities	2.7	39.3%	49.8%	8.5%
Leading committees and work groups	2.6	50.4%	34.1%	10.8%
Developing the coalition action plan	2.4	53.9%	39.9%	6.1%
Organizing committees and work groups	2.4	58.8%	32.7%	5.8%
Making budget and expenditure decisions	1.9	75.7%	21.0%	1.9%
Developing communications sent to community partners	1.9	76.9%	18.8%	2.7%
Developing communications sent to coalition members	1.8	82.8%	13.3%	2.4%

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	95.0%
	Information about sharing/storage of prescription opioids	87.8%
	Information about opioids (heroin, fentanyl, fentanyl analogs or other synthetic opioids) currently identified as an issue in the community or surrounding community	85.5%
	Distribution of treatment referral cards/brochures/stickers	53.6%
	Promotion of Prescription Monitoring Program	29.8%
	Information about methamphetamine currently identified as an issue in the community or surrounding community	28.2%
	Prescribing guidelines	27.1%
	Information about methamphetamine risks	26.1%
	Information delivered via a town hall forum or conference related to methamphetamine	11.0%
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	61.1%
	Education and training to reduce stigma associated with opioid dependency	53.2%
	Community education and training on signs of opioid/methamphetamine use (e.g., Hidden in Plain Sight trainings)	51.3%
	Prescriber education and training	14.1%
	Education, training, and/or technical assistance on monitoring compliance for the Prescription Monitoring Program	10.6%
Providing Support	Recovery groups/events	33.7%
	Youth/family support groups for individuals affected by opioid/methamphetamine dependency	26.5%
Changing Consequences	Drug task forces to reduce access to opioids/methamphetamine in community	31.9%
	Identify and/or increase monitoring of opioid/methamphetamine use "hot spots"	22.8%
	Recognition programs (e.g., physicians exercising responsible prescribing practices, individuals in recovery from opioid/methamphetamine dependency)	11.6%

STRATEGY TYPE	ACTIVITY	PERCENTAGE OF DFC COALITIONS
Changing Access/ Barriers	Make available or increase availability of local prescription drug take-back events	78.9%
	Make available or increase availability of local prescription drug take-back boxes	73.5%
	Make available or increase availability of Narcan/naloxone	63.6%
	Improving access to opioid methamphetamine prevention, treatment, and recovery services through culturally sensitive outreach (e.g., multilingual materials, culturally responsive messaging)	34.2%
	Make available or increase availability of substance use screening programs (e.g., SBIRT)	23.4%
	Make available or increase availability of judicial alternatives for individuals with an opioid/ methamphetamine dependency who are convicted of a crime (e.g., drug court, teen court)	20.7%
	Make available or increase availability of medication assisted treatment for opioid dependency (e.g., suboxone, Vivitrol, methadone)	17.4%
	Drop-in events/centers to connect people addicted to opioids/methamphetamine and/or their families to treatment/recovery opportunities	14.3%
	Home visit follow-ups after an overdose/overdose reversal (e.g., safety official and healthcare provider visit to share and connect to treatment options)	13.0%
	Make available or increase availability of transportation to support opioid prevention, treatment, or recovery services (e.g., medication assisted treatment, counseling, drug court)	12.0%
Educate/Inform about Modifying/Changing Policies and Laws	Good Samaritan Laws	40.4%
	Policies regarding Narcan/naloxone administration	34.4%
	Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use offenders)	24.2%
	State policies supporting a Prescription Monitoring Program	18.8%
	Crime Free Multi-Housing Ordinances	2.3%
Changing Physical Design	Increase safe storage solutions in homes or schools (e.g., lock boxes)	59.0%
	Clean needles and other waste related to opioid use from parks and neighborhoods)	13.7%
	Identify problem establishments for closure (e.g., close drug houses, "pill mills")	7.0%

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				LONG-TERM CHANGE: FIRST OBSERVATION TO MOST RECENT, FY 2020 DFC GRANT AWARD RECIPIENTS			
	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol	1405	11.6	8.8	-2.8*	387	8.0	7.1	-0.9*
Tobacco	1391	5.8	3.8	-2.0*	378	3.1	2.4	-0.7*
Marijuana	1390	4.8	4.1	-0.7*	383	3.9	3.6	-0.3*
Prescription Drugs	659	3.0	2.6	-0.4*	354	2.6	2.5	-0.1
HIGH SCHOOL								
Alcohol	1493	33.7	26.2	-7.5*	421	27.4	19.8	-7.6*
Tobacco	1478	16.3	11.1	-5.2*	414	10.5	6.1	-4.4*
Marijuana	1478	17.8	16.4	-1.4*	422	17.3	15.3	-2.0*
Prescription Drugs	724	6.0	4.3	-1.7*	389	5.4	3.8	-1.6*

Source: Progress Report, 2002–2021 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 2020 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	1405	88.4	91.2	2.8*	387	92.0	92.9	0.9*
Tobacco	1391	94.2	96.2	2.0*	378	96.9	97.6	0.7*
Marijuana	1390	95.2	95.9	0.7*	383	96.1	96.4	0.3*
Prescription Drugs	659	97.0	97.4	0.4*	354	97.4	97.5	0.1
HIGH SCHOOL								
Alcohol	1493	66.3	73.8	7.5*	421	72.6	80.2	7.6*
Tobacco	1478	83.7	88.9	5.2*	414	89.5	93.9	4.4*
Marijuana	1478	82.2	83.6	1.4*	422	82.7	84.7	2.0*
Prescription Drugs	724	94.0	95.7	1.7*	389	94.6	96.2	1.6*

Source: Progress Report, 2002–2021 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 2020 DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	683	71.5	70.9	-0.6	346	73.8	70.4	-3.4*
Tobacco[c]	1318	81.0	80.2	-0.8*	360	80.3	77.7	-2.6*
Marijuana[d]	654	70.1	67.2	-2.9*	342	70.7	65.9	-4.8*
Prescription Drugs[e]	610	81.0	79.5	-1.5*	343	81.6	79.0	-2.6*
HIGH SCHOOL								
Alcohol[b]	732	72.5	71.5	-1.0*	375	73.8	71.3	-2.5*
Tobacco[c]	1384	81.2	81.6	0.4	382	82.4	79.6	-2.8*
Marijuana[d]	706	53.2	49.5	-3.7*	375	51.3	48.2	-3.1*
Prescription Drugs[e]	667	82.5	82.1	-0.4	371	82.9	82.1	-0.8*

Source: Progress Report, 2002–2021 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 2020 DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	600	94.4	95.1	0.7*	338	95.1	95.9	0.8*
Tobacco[c]	1245	92.7	94.7	2.0*	351	96.7	96.6	-0.1
Marijuana[c]	1271	93.2	94.0	0.8*	358	95.7	95.1	-0.6*
Prescription Drugs[d]	602	95.8	95.7	-0.1	338	96.3	96.3	0.0
HIGH SCHOOL								
Alcohol[b]	650	88.8	90.1	1.3*	368	90.3	90.9	0.6*
Tobacco[c]	1328	86.8	90.2	3.4*	377	92.6	94.6	2.0*
Marijuana[c]	1335	86.9	86.7	-0.2	384	88.1	87.5	-0.6
Prescription Drugs[d]	656	93.9	95	1.1*	368	94.5	95.7	1.2*

Source: Progress Report, 2002–2021 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 2020 DFC GRANT AWARD RECIPIENTS n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	594	86.5	87.4	0.9*	338	88.2	88.1	-0.1
Tobacco[c]	597	89.0	89.9	0.9*	334	90.7	90.9	0.2
Marijuana[c]	603	86.4	86.1	-0.3	334	87.3	86.3	-1.0*
Prescription Drugs[d]	586	91.1	91.3	0.2	333	92.0	92.0	0.0
HIGH SCHOOL								
Alcohol[b]	652	67.9	73.3	5.4*	371	70.9	75.7	4.8*
Tobacco[c]	654	73.1	78.7	5.6*	368	76.2	81.3	5.1*
Marijuana[c]	660	58.3	59.4	1.1*	371	59.9	61.4	1.5*
Prescription Drugs[d]	631	82.0	85.7	3.7*	359	83.4	87.1	3.7*

Source: Progress Report, 2002–2021 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

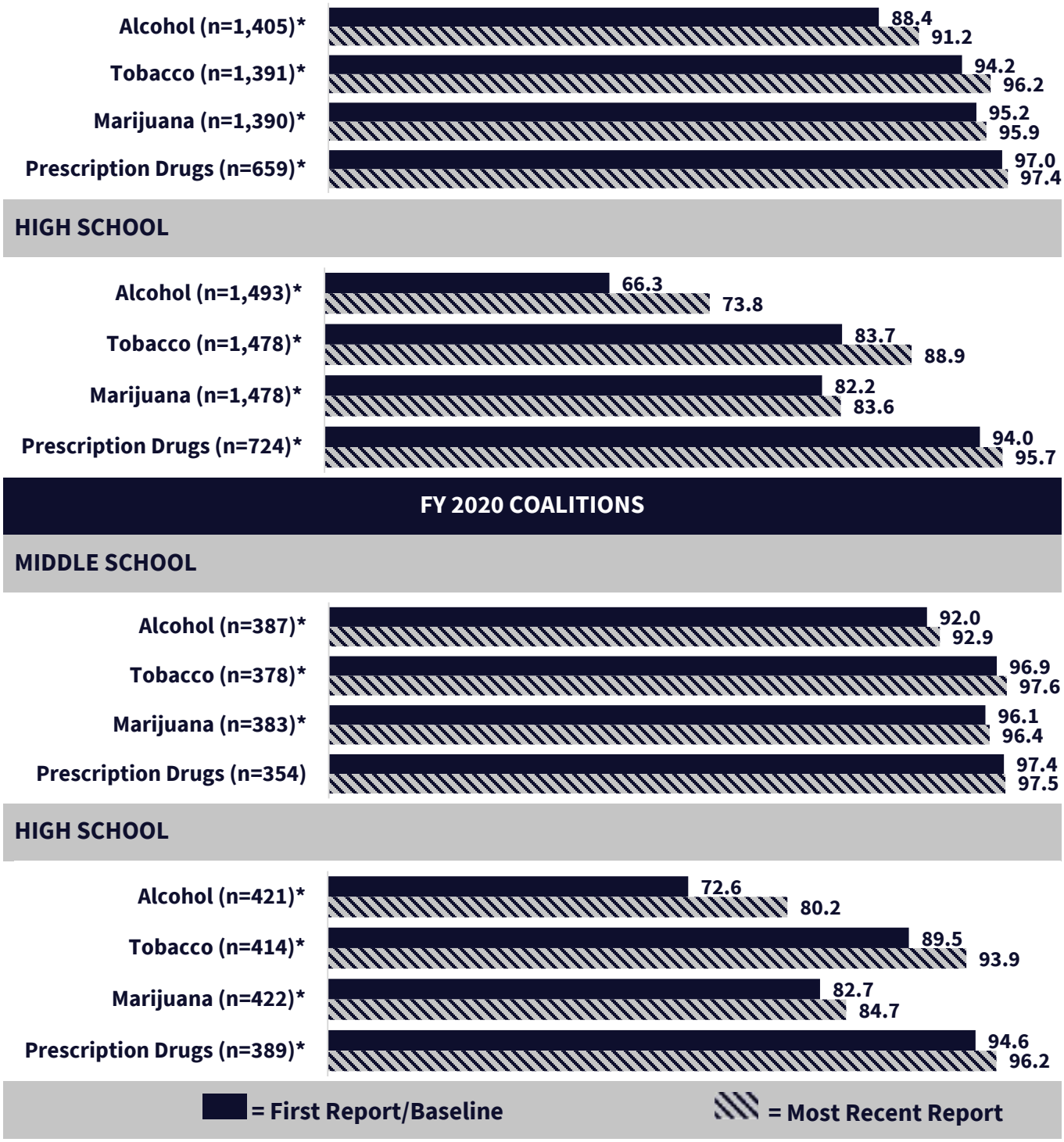
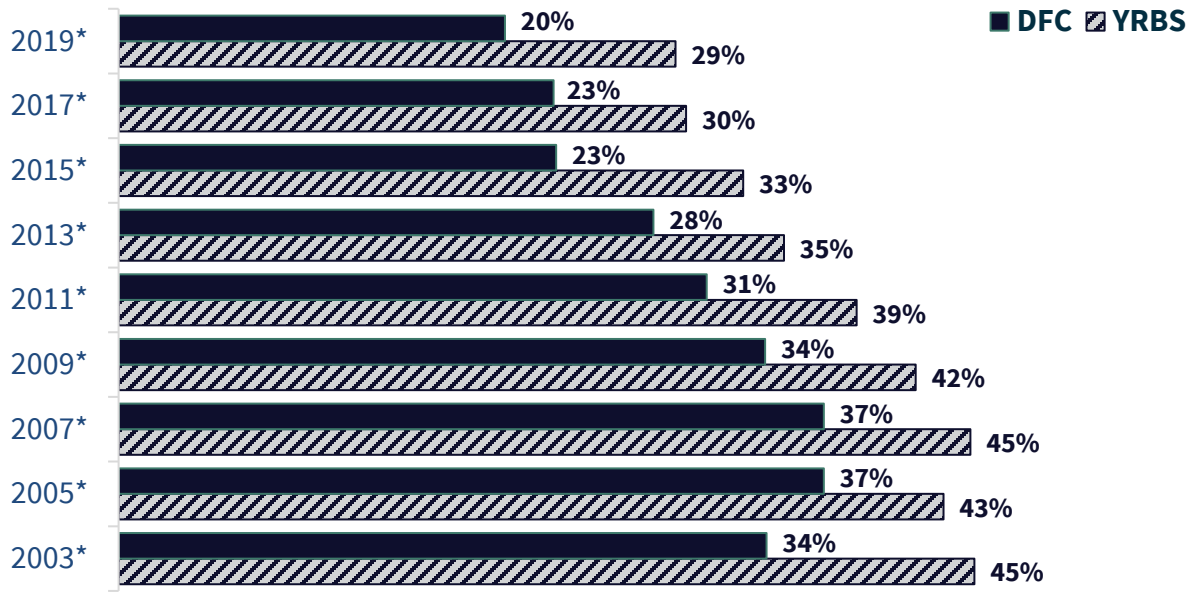


FIGURE F.2. DFC COMPARISON TO NATIONAL YRBS PAST 30-DAY ALCOHOL, TOBACCO & MARIJUANA USE AMONG HIGH SCHOOL STUDENTS

ALCOHOL



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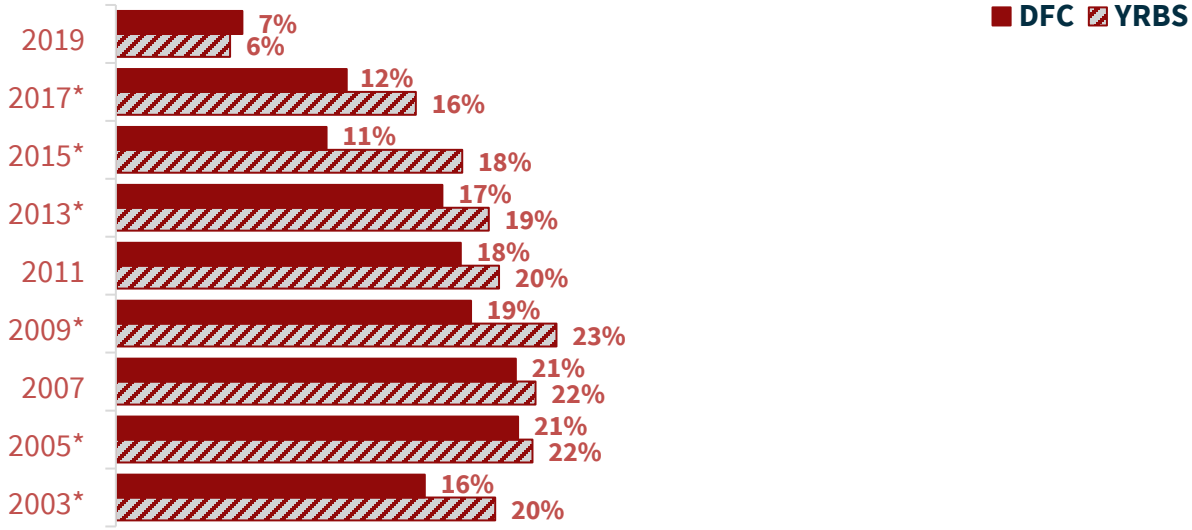
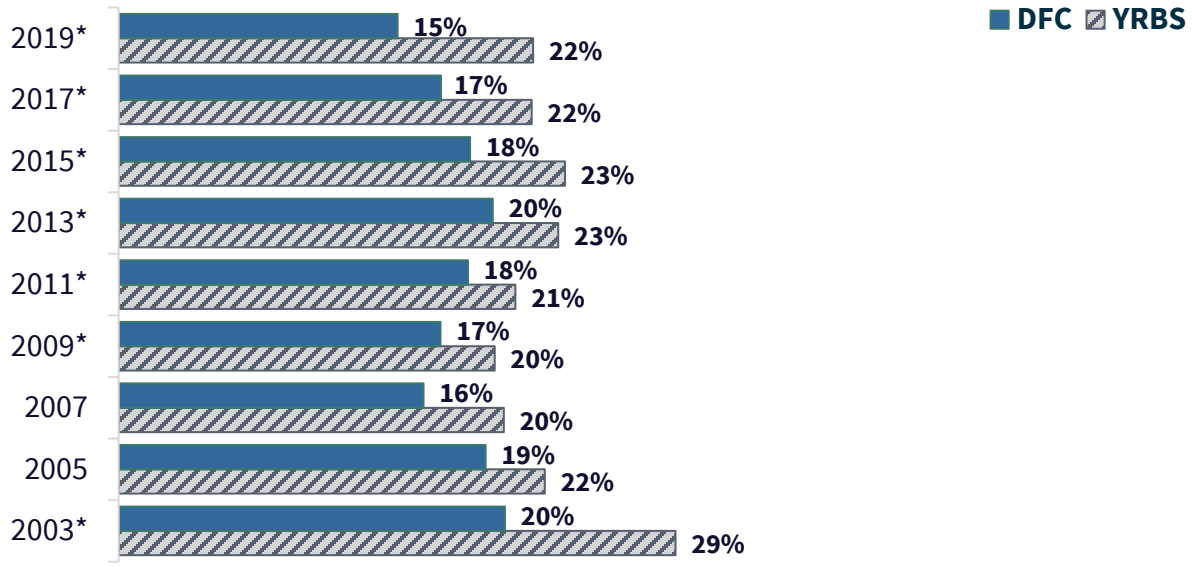


MARIJUANA



Source: DFC Progress Report, 2003–2020 core measures data; CDC 2019 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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Drug-Free Communities (DFC) Support Program National Cross-Site Evaluation Team,

Barbara K. O'Donnel, PhD
Jason Schoeneberger, PhD
Samantha Salvador, MA
Kelly Miloski, MPH
Mattie MacDonald
Jessica Garcia, MPH
Richard A. Van Dorn, PhD
Violette Cloud, Esq., MS
Isolynn A. Massey, BA
Sarah L. Desmarais, PhD

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Comprehensive Addiction and Recovery Act (CARA) Local Drug Crises Program National Cross-Site Evaluation

Cohort 1 Final Report

Published August 2022

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CARA Executive Summary

This summary highlights keys findings from the Comprehensive Addiction and Recovery Act (CARA) Local Drug Crises Program National Cross-Site Evaluation (additional details found in the full report). The CARA grant program is part of the larger CARA Act of 2016, a comprehensive federal response to address the opioid epidemic.[1] CARA Cohort 1 was awarded to current or former Drug-Free Communities (DFC) Support Program community coalitions to implement community-wide strategies that address emerging drug use issues, primarily related to opioids and methamphetamine.

CARA Awards	• 55 grants awarded across 34 states • $50,000/year for three-years (July 2018 to June 2021)
Goals	• Enhance efforts of current or former Drug-Free Communities recipients to prevent or reduce use of opioids, methamphetamine, and/or prescription drugs (misuse) among youth ages 12-18 • Change the culture and context regarding the acceptability of youth use and misuse of these substances
Focused On	• Prescription drugs (98%), fentanyl (78%), heroin (65%), methamphetamine (52%) • 33% focused on all four substances; 1 focused solely on methamphetamine • Demographically diverse communities

BUILDING CAPACITY

CARA coalitions brought together members from the full range of DFC twelve-sectors to meet grant goals, with engagement highest for the Schools, Law Enforcement, Healthcare, and Other Organizations with Substance Use Expertise sectors. Several coalitions noted coming together to better collect and share data to drive coalition decision-making and implementation as well as individual sector's decision-making and work. Building capacity highlights included:

~3,700
people mobilized

84%
maintained their DFC 12-sector model

10
youth members on average

98%
invited new members with opioid/ methamphetamine expertise

Coalitions reported forming relevant new partnerships (beyond DFC sector members) with mental health services, treatment and recovery service providers, funeral homes, assisted living facilities/nursing homes/senior centers, and medical examiners.

Engaging people in recovery in prevention efforts was described as especially helpful in overcoming community stigma around substance use and seeking treatment.

[1] See Pub. L. No. 114-198: https://www.govinfo.gov/content/pkg/PLAW-114publ198/pdf/PLAW-114publ198.pdf and https://www.cdc.gov/opioids/basics/epidemic.html for additional information.

CHANGING CULTURE AND CONTEXT

CARA coalitions implemented a comprehensive range of prevention strategies, including evidence-based practices and innovations. Implementation activity highlights include the following:

MOST COMMONLY IMPLEMENTED STRATEGIES AND IMPLEMENTATION HIGHLIGHTS	
94% of CARA coalitions implemented at least one activity within five or more of the Seven Strategies for Community Change	
Top 3 Activities within **Individual** Strategies (Providing Information, Enhancing Skills, Providing Support)	• Promoting prescription drug drop boxes & take-back events (96%) • Providing information about opioids currently identified as a community issue (94%) • Providing community training on opioid risks (94%)
Top 3 Activities within **Environmental** Strategies (Changing Access/Barriers, Changing Consequences, Changing Physical Design, Modifying/Changing Policies/Laws)	• Making/increasing availability of local prescription drug take-back events (87%) and take-back boxes (85%) • Increasing safe storage solutions in homes or schools (83%)

Harm-Reduction Naloxone Training (West Region)	Methamphetamine Prevention (Midwest Region)	Social Norms Campaign (Northeast Region)
Share data	Train community to recognize distribution and use	Highlight local data
Discuss prevention	Call, text, or google form to law enforcement to report concerns	Parents & teacher discussion guides
Train on & provide naloxone	Partner with state officials/programs to use campaign materials	Social media dissemination
Treatment & recovery partners share resources	Change Tribal policy on methamphetamine sentencing	Posters, banners, and decals placed in high school
	Youth prevention engagement	Youth empowerment team public service announcements
	Decreased youth past 30-day use	

YOUTH SUBSTANCE USE

The impact of CARA Cohort 1 on preventing/reducing youth substance use is unknown, with most coalitions providing only baseline data. Among middle and high school youth, past 30-day misuse of prescription drugs, heroin use, and methamphetamine use were all low (less than 3%) at baseline.

LIMITATIONS AND CHALLENGES

This was the first cohort of CARA recipients; evaluation support was not available to the coalitions during the time of award. The relatively short three-year timeframe for the CARA grant may have contributed to limited core measures data collection, which was required every two years (i.e., some coalitions may have only collected in Year 2). The COVID-19 pandemic further contributed to CARA implementation and data collection challenges beginning in year 2 of award.

CARA Program

The Comprehensive Addiction and Recovery Act (CARA) Local Drug Crises Program was created by the Comprehensive Addiction and Recovery Act of 2016.[2] CARA grants are intended as an enhancement to community coalitions currently or formerly funded by the Drug-Free Communities (DFC) Support Program.[3] In June 2018, the first cohort of CARA recipients were awarded to receive three years of CARA funding (2018–2021) at $50,000 per year. These recipients sought to build on prior DFC work to implement comprehensive, community-wide strategies that address local drug crises and emerging drug use issues, primarily related to opioids and methamphetamine. The CARA National Cross-Site Evaluation Team prepared this report to provide findings based on data from the Cohort 1 recipients.[4] The primary goals for the fiscal year (FY) 2018 to FY 2020 CARA recipients include the following:[5]

- Enhance the ability of established [current or former Drug-Free Communities (DFC) program recipients] community organizations to create community-level change to prevent or reduce use of opioids, methamphetamine, and/or prescription drugs (misuse) among youth ages 12-18.
- Change the culture and context regarding the acceptability of youth use and misuse of these substances through implementation of a comprehensive community-wide action plan.

Key findings presented here include:

- **CARA coalitions, focused primarily on prevention efforts around prescription drugs (98%) and fentanyl (78%), were awarded grants in 55 communities across 34 states. Based on community demographics, these coalitions potentially served a diverse population of youth and people.**
- **CARA coalitions mobilized nearly 3,700 people to engage in youth opioid/methamphetamine substance use prevention efforts and generally (84%) maintained the 12-sector community coalition model, while also engaging with new partners.**
- **CARA coalitions addressed the challenges of emerging drug threats by implementing a comprehensive range of prevention practices, including evidence-based practices and innovations. Restrictions associated with the coronavirus (COVID-19) pandemic contributed to the need to innovate.**
- **CARA coalitions primarily reported baseline data, with too limited an amount of data to assess change. Among middle and high school youth, misuse of prescription drugs, heroin use, and methamphetamine use were all low.**

This report should be read in the context of the ongoing COVID-19 pandemic that impacted work across the United States starting in March 2020. This overlapped significantly with the final year of CARA implementation, which is the focus of this report (July 1st, 2020, to June 30th, 2021), so COVID-19 is

[2] See Pub. L. No. 114-198: https://www.govinfo.gov/content/pkg/PLAW-114publ198/pdf/PLAW-114publ198.pdf

[3] For information about the DFC program see https://www.whitehouse.gov/ondcp/dfc/ and https://www.cdc.gov/drugoverdose/drug-free-communities/index.html; the most recent DFC National Evaluation report can be found here: https://dfcme.ondcp.eop.gov/sites/default/files/resources/FINAL_DFC%20Eval%20Report_2021_march12_508.pdf

[4] The CARA evaluation was awarded to ICF in July 2021, near/after the end of CARA Cohort 1 awards. While Cohort 1 recipients were aware of an evaluation requirement, guidance regarding evaluation-related reporting did not occur until January 2021.

[5] See the funding opportunity announcement for additional information: https://www.samhsa.gov/sites/default/files/grants/pdf/fy18_cara_act_foa_final_11.29.17.pdf; see also the Notice of Award Terms and Conditions https://www.samhsa.gov/sites/default/files/grants/cara_standard_award_terms_2018.pdf

discussed throughout and in a special section. In addition, as discussed in the "Limitations and Challenges" section, during implementation the first cohort of CARA coalitions were not provided with anything more than broad guidance or direction on evaluation.

Background

The Centers for Disease Control and Prevention (CDC) has identified opioid use and opioid overdose deaths as an epidemic. In 2019, more than 70% of all drug overdose deaths were associated with opioids (e.g., prescription opioids, heroin, fentanyl).[6] While prescription opioids still contribute to overdose deaths and were a major factor in the early waves of opioid deaths, beginning in the 1990s, the epidemic has shifted through time. The second wave, beginning in 2010, was characterized by a rapid increase in overdose deaths involving heroin. In the most recent wave, beginning in 2013, overdose deaths are largely related to synthetic opioids (primarily illicitly manufactured fentanyl). Most recently, from January–June 2019, the majority of overdose deaths involved illicitly manufactured fentanyl, heroin, cocaine, or methamphetamine (alone or in combination).[7]

Overdose deaths are only one indicator of opioid use because there are many nonfatal opioid-involved overdoses as well as those who use opioids but do not overdose. Still, what is known about overdoses can provide valuable information for community prevention efforts. An estimated 3 out of 5 overdose deaths involved at least one potential pre-overdose opportunity to link people to care or to implement life-saving actions.[8] Individual circumstances can impact the risk of overdose and highlight the important role of community coalitions in conducting community-wide surveillance and coordination activities. People who have been recently released from an institution, have had a previous overdose, have a mental health diagnosis, and/or have been previously treated for a substance use disorder represent 10–40% of individuals who suffered a fatal drug overdose. In addition, nearly 40% of opioid and stimulant overdose deaths occurred while a bystander was present. This evidence suggests the need for naloxone training and availability, which can reverse the effects of opioid overdose when administered in time, a harm reduction activity.

CDC has identified the following overdose death prevention strategies, all of which are in line with CARA program goals and with the community coalition model, which identifies and engages members from a range of sectors who work together to implement activities within these strategies:[9]

---

[6] See Mattson, C.L., Tanz, L.J., Quinn, K., Kariisa, M., Patel, P., Davis, N.L. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019, MMWR Morb Mortal Wkly Rep 2021;70:202–207, http://dx.doi.org/10.15585/mmwr.mm7006a4; see also https://www.cdc.gov/opioids/basics/epidemic.html and https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates

[7] O'Donnell, J., Gladden, R.M., Mattson, C.L., Hunter, C.T., Davis, N.L. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants — 24 States and the District of Columbia, January–June 2019, MMWR Morb Mortal Wkly Rep 2020;69:1189–1197, http://dx.doi.org/10.15585/mmwr.mm6935a1

[8] See the CDC's Overdose Deaths and Involvement of Illicit Drugs: https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html

[9] See the CDC's Overdose Deaths and Involvement of Illicit Drugs: https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html

- Improving prescribing practices, preventing initiation of drug use, and addressing use of multiple drugs.
- Increasing distribution of and access to naloxone, especially for bystanders who may be able to reverse an opioid overdose.
- Increasing access to risk reduction services and enhancing linkage to care, including to mental health and substance use disorder treatment and support services.

Youth opioid use is associated with a high risk of adverse outcomes including injury, criminal justice involvement, school dropout, and loss of life.[10] Conversely, early prevention may result in positive long-term impacts as most adults who meet the criteria for substance use disorder started substance use during their teen and young adult years.[11] Substance use disorder early in life has been related to higher rates of physical and mental illness, diminished overall health and well-being, and potential progression to substance use disorders across the life course. Monitored by the CDC, the Youth Risk Behavior Surveillance System revealed that in 2019, 7.2% of high school youth reported current prescription opioid misuse, 2.1% reported lifetime use of methamphetamine, and 1.8% reported lifetime use of heroin.[12] Lifetime use of both methamphetamine and heroin decreased significantly among high school youth between 2009 and 2019. Youth who identified as Black and non-Hispanic or as Hispanic were significantly more likely than youth who identified as White and non-Hispanic to report past 30-day prescription opioid misuse and lifetime use of methamphetamine and heroin. The same trends of increased use were seen for youth who identified as lesbian, gay, bisexual, or unsure as compared to youth who identified as heterosexual.

According to the National Survey on Drug Use and Health collected in 2020, 59.3 million (M) people aged 12 or older (21.4%) reported past-year illicit drug use. [13] Additionally, 6.8% of youth ages 12-17 reported living with someone with a substance use disorder in the past year, while 4.9% reported living with someone with an illicit drug use disorder. Co-occurring substance use disorder and major depressive disorder among youth aged 12 to 17 was present in some 644,000 youth. While research is ongoing, one study found that overall rate of drug use by youth (aged 10-14) remained generally stable during the COVID-19 pandemic.[14] Still, youth who expressed "extreme" stress from the uncertainty associated with the pandemic were 2.4 times more likely to report using any substance than youth who reported "very

[10] See the CDC's High-risk Substance Use Among Youth: https://www.cdc.gov/healthyyouth/substance-use/index.htm

[11] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, Washington, DC: HHS, November 2016.

[12] Underwood, J.M., Brener, N., Thornton, J. et al. (2020). Youth Risk Behavior Surveillance System – United States, 2019. *MMWR Suppl*, 2020:69(1). https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2019/su6901-H.pdf

[13] See Results from the 2020 National Survey on Drug Use and Health: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/2020NSDUHFFRSlides090821.pdf and 2020_NSDUH_Highlights.pdf (samhsa.gov). Marijuana was the most commonly used illicit drug (49.6M)) while 9.5M misused opioids (e.g., prescription pain relievers or heroin).

[14] Pelham., W.E., Tapert, S.F., Gonzalez, M.R., et al. (2021). Early Adolescent substance use before and during the COVID-19 pandemic: A longitudinal survey in the ABCED Study Cohort. *Journal of Adolescent Health*, 69, 390-397. Early Adolescent Substance Use Before and During the COVID-19 Pandemic: A Longitudinal Survey in the ABCD Study Cohort (jahonline.org) See also Lundahl, L.H. & Cannoy, C. (2021). COVID-19 and Substance Use in Adolescents. *Pediatr Clin North Am.* 68(5): 977-990. main.pdf (nih.gov)

slight" stress.

Stress in general and living with someone with a substance use disorder are factors that may put youth at risk for substance use, especially if protective factors are not in place in the home and/or community. These risk factors are included in adverse childhood experiences (ACEs), along with a range of other risk factors.[15] 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. CARA and other community 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 community, a positive adult, and/or school.

CARA coalitions develop an action plan to meet CARA goals as part of their grant application (and then update annually), driven in part by understanding of youth substance use patterns and underlying causes in their community. That is, each CARA recipient identifies local solutions to address local problems, such as addressing/enhancing relevant risk and protective factors, and determines how best to implement those solutions. Additionally, each CARA recipient determines how best to operate/function as a coalition in implementing this plan likely informed by the time spent as a current or prior DFC recipient. CARA 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. Coalitions may carry out activity implementation directly or may call upon sectors to implement individually or collaboratively. For example, school sector members may be called on to implement activities with youth in-line with other school activities. This report highlights coalition sector engagement and their implementation of activities.

Data

CARA Cohort 1 recipients provided two primary types of data included in the cross-site evaluation: progress report data and core measures data. CARA recipients were not provided significant technical assistance regarding data submission as the CARA National Evaluation had not yet been awarded. As former DFC recipients, however, CARA recipients were familiar with the general types of information requested in their progress report as all items asked are included in DFC progress reports.

Progress Report Data

In June 2021, the 55 CARA Cohort 1 recipients provided data regarding their final Year 3 efforts (July 1st, 2020, to June 30th, 2021).[16] While the progress reports emphasized Year 3 implementation, coalitions

[15] 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

[16] One of the CARA coalitions responded "No" to the item on whether they had engaged in any activities. CDC reported that the coalition included CARA activities in their DFC Progress Report. These data were not available for the current report. Based on this response, they

could include any overall achievements in their reports. The CARA progress reports included the following information reported on here (the full measure can be found in Appendix A):

- Community context (ZIP codes served [linked to community demographics] and substance focus)
- Building capacity, sector engagement
- Implementation activities by strategy type and qualitative (open text) description of implementation of prevention activities and challenges faced by the coalition[17]

Core Measures Data

CARA coalitions were required to collect and submit new core measures data at least every 2 years related to at least one core measure substance (prescription drug (misuse), heroin, or methamphetamine).[18] These data are collected from middle school and high school youth. The core measures data can be submitted along with the progress report as it becomes available.

Briefly, the core measures are defined as follows (see Appendix A for specific wording):

Past 30-Day Prevelance of Use

Percentage of respondents who reported misusing prescription drugs or using heroin or methamphetamine at least once within the past 30 days.

Perception of Risk

Percentage of respondents who perceived people who misuse prescription drugs or use heroin or methamphetamine 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 use of heroin or methamphetamine is wrong.

Perception of Peer Disapproval

Percentage of respondents who perceived their peers would feel misuse of prescription drugs or use of heroin or methamphetamine is wrong.

Key Finding

Community Context

CARA coalitions, focused on prevention efforts around prescription drugs (98%) and fentanyl (78%), were awarded in 55 communities across 34 states. Based on community demographics, these coalitions potentially served a diverse population of youth & people.

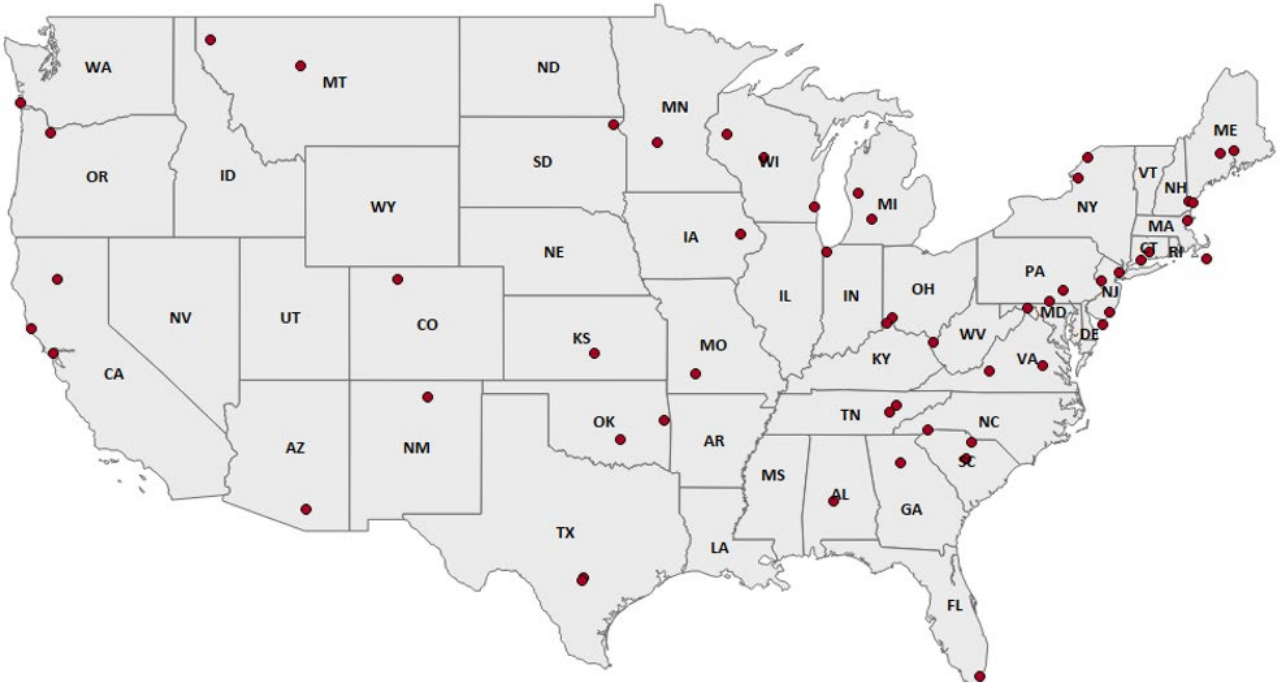
did not report any further data in their final report including the qualitative description of implementation activities. Thus, the number of coalitions included in most analyses in this report was 54 rather than 55.

[17] Throughout this report, when incorporating qualitative anecdotes with findings, CARA coalitions will be identified by U.S. census region where they are located: https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

[18] "Parent" can be parent, guardian, or other relevant adult in the youth's life. Coalitions are encouraged to collect data from youth in at least three grade levels, with at least one in middle school (grades 6 to 8) and at least one in high school (grades 9 to 12).

The 55 CARA Cohort 1 coalitions were in communities across 34 states in the continental United States (see Figure 1). Table 1 provides an overview of the number of CARA coalitions by state. The largest number (4) of CARA coalitions were in New Jersey, followed by 3 coalitions each in California, Maine, and Wisconsin. In their final year of implementation, just under half (40%) of CARA Cohort 1 were current DFC recipients.

FIGURE 1. MAP OF CARA COHORT 1 RECIPIENTS



Source: CARA Cohort 1 FY 2020 mapped based on coalition ZIP code information.
Note: All CARA coalitions were located within the continental United States.

TABLE 1. NUMBER OF CARA COHORT 1 COALITIONS BY STATE

NUMBER OF COALITIONS PER STATE	
4	New Jersey
3	California, Maine, Wisconsin
2	Connecticut, Massachusetts, Michigan, Montana, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia
1	Alabama, Arizona, Colorado, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Minnesota, Missouri, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, South Dakota, Washington

Source: CARA Cohort 1 Award List

Community Demographics

CARA coalitions reported the ZIP codes of the areas they served. To better understand these communities, ZIP codes were matched with census data from the American Community Survey's (ACS) 5-year estimates from 2014-2019.[19] Almost all ZIP codes (99% of 610) could be matched with ACS data. The estimated population served by CARA coalitions was just over nine million about 22% of whom were estimated to be under 18 years old.[20] Of those under 18 in these communities, about 66% identified as White, 17% Black, 4% Asian, 1% American Indian/Alaskan Native, 5% other race, and 6% Multiracial. An estimated 19% of youth in communities with a CARA were Hispanic. The demographics of specific youth served is unknown.

Focus on Specific Subgroups of Youth

In descriptions of their work, race/ethnicity was mentioned by one-fifth (20%) of CARA coalitions. References to race or ethnicity ranged in specificity and description, with most listing the racial breakdown of the community at large. Some references were a description of coalition activities intended to improve or expand services for underserved youth. For example, one (South Region) reported on the importance of partnering with a Tribal-based organization to provide culturally relevant services, since about 10% of the youth served reported affiliations to a nearby Tribe. Translating materials and delivering services in Spanish were mentioned by several coalitions.

One coalition (South Region) noted they were working on forming new partnerships to help overcome barriers to reaching underserved populations in the community (people identifying as African American, Asian, and Latino). Another coalition (West Region) noted they were youth-led and served a mainly Latino population in a high-density urban area. This coalition reported successfully engaging in the following prevention activities:

- Delivered training on opioids to a local Latino organization, covering resources for opioid use disorder (OUD), signs of overdose, how to administer naloxone, the importance of seeking guidance from doctors when taking prescription opioids, and preventative measures.
- Allied with county health and human services, who are integrating the interests of the coalition's Latino members into the county-wide opioid health plans and treatments.
- Developed opioid flyers tailored for the Latino population that were recognized by the county and are now being distributed by it.

Three CARA coalitions mentioned LGBTQ (lesbian, gay, bisexual, transgender, questioning) people in descriptions of their work. One noted a representative from an LGBTQ drug treatment program spoke at a meeting to build coalition member capacity. A second mentioned resources specific to the LGBTQ

[19] See the U.S. Census Bureau's American Community Survey 5-Year Data (2009–2019) https://www.census.gov/data/developers/data-sets/acs-5year.html. Data by ZIP code is not yet available for the 2020 census. Based on 2020 census data, the 9 million people is about 2.7% of the total United States population(https://www.census.gov/quickfacts/fact/table/US/LFE046219).

[20] While DFC work is focused on 12–18 years old, ACS data are not broken into age by race/ethnicity beyond identifying as age under 18.

audience on their website and Facebook page. The third coalition (Northeast Region) reviewed their youth survey data and found that youth who identified as LGBTQ were nearly three times more likely to have reported misusing prescription drugs, using heroin or using methamphetamine (lifetime use) than their peers who did not identify as LGBTQ.[21] The coalition used the information to provide tailored prevention efforts and apply for grants.

Substance Focus

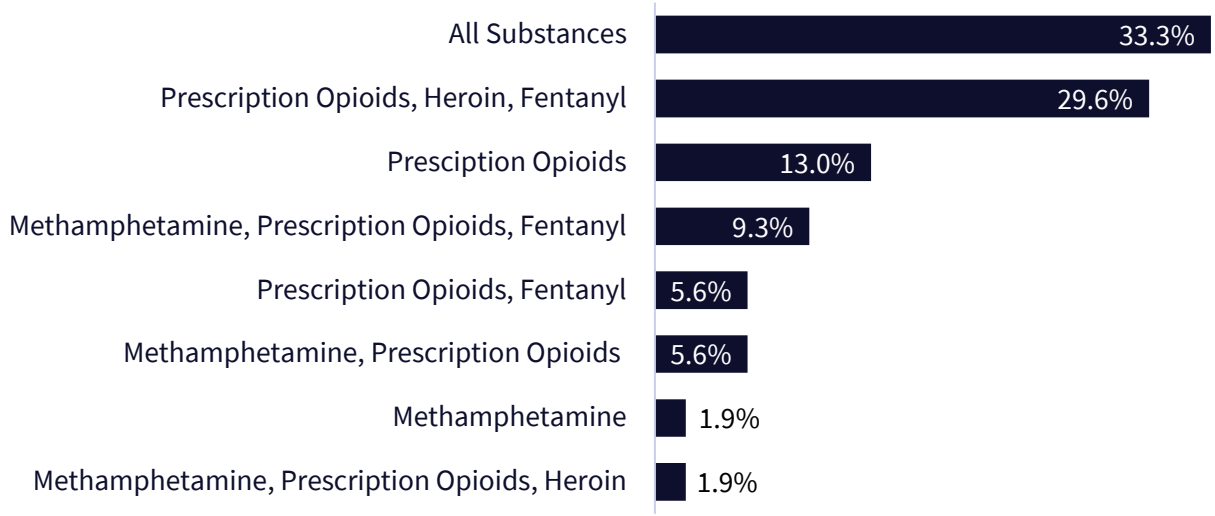
CARA funded coalitions identified from a list of substances (see Table 2) the focus of their prevention efforts.[22] Almost all (98%) coalitions were focused on prescription opioids. The primary focus by CARA coalitions on prescription opioids was also illustrated by the combination of substances the coalitions addressed (Figure 2), which almost always included prescription opioids. Methamphetamine was focused on by the fewest coalitions, only one coalition focused on it solely.

TABLE 2. SUBSTANCES FOCUSED ON BY CARA COALITIONS

SUBSTANCE	NUMBER AND PERCENTAGE OF COALITIONS FOCUSED ON
Prescription opioids	53 (98.1%)
Fentanyl, fentanyl analogs, or other synthetic opioids	42 (77.8%)
Heroin	35 (64.8%
Methamphetamine	28 (51.9%)

Source: CARA June 2021 Progress Report / **Note:** Totals do not equal 100% because coalitions could multiple substances.

FIGURE 2. MIX OF SUBSTANCES ADDRESSED BY COALITIONS



Source: CARA June 2021 Progress Report

Note: Totals do not equal 100% because coalitions could select multiple substances.

[21] The coalition found similar disparities among youth who reported having lived with someone who had a problem with alcohol or other drugs as compared to those who had not lived with someone with these issues.

[22] While the label was prescription opioids, it is clear from coalition descriptions that coalitions were focused on prescription drugs overall. Hereafter, fentanyl will be used to indicate the broader category of fentanyl, fentanyl analogs, or other synthetic opioids.

Key Finding

Building Capacity to Prevent and Reduce Substance Use

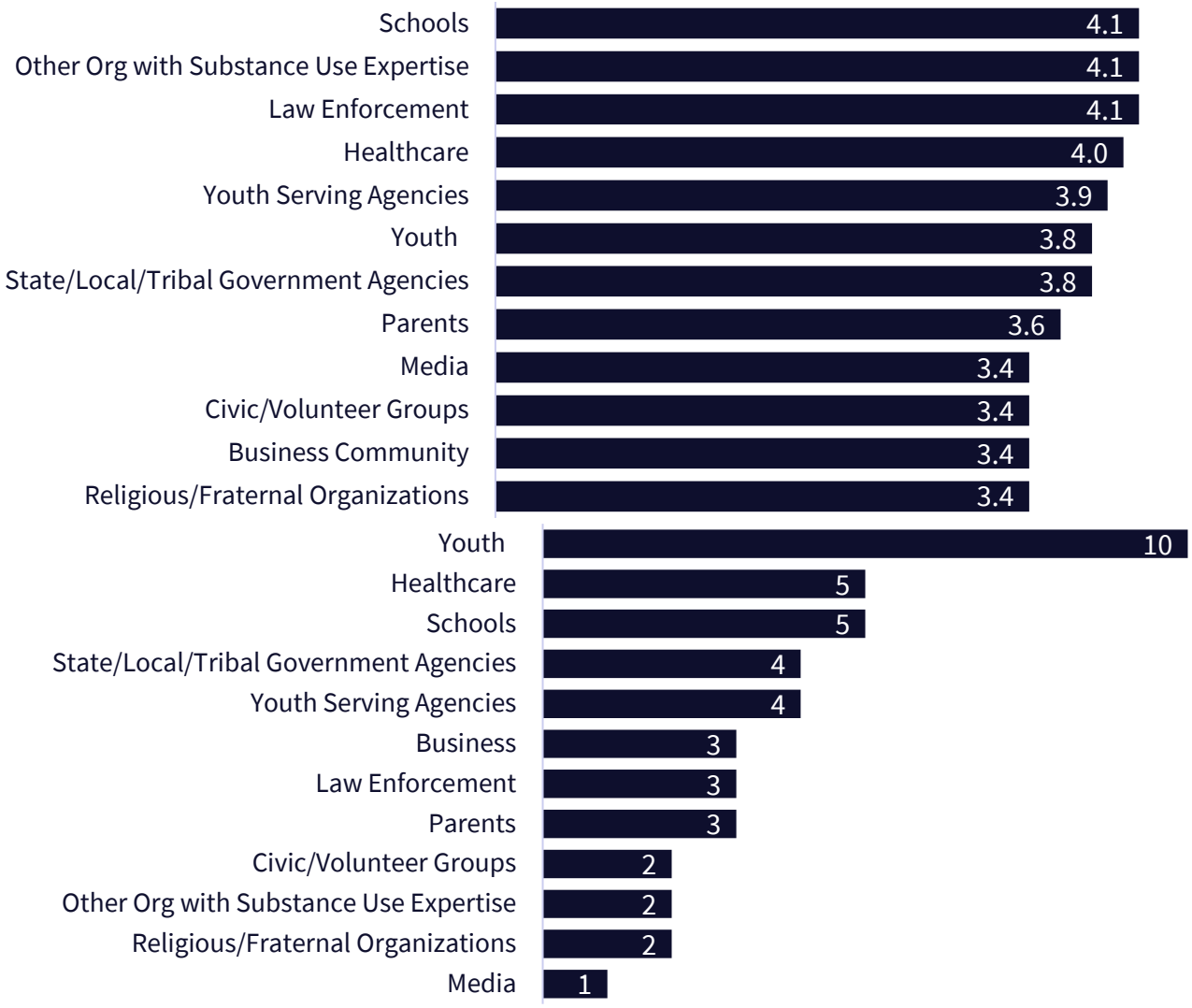
CARA coalitions *mobilized nearly 3,700 people to engage in youth substance use prevention and generally (84%) maintained the DFC Program's 12-sector community coalition model while engaging new partners.*

Comprehensive collaboration is a fundamental premise of effective community prevention. Working alone, efforts can become siloed leaving some needs unmet while others are duplicated. Coalitions create the opportunity to not only communicate more effectively across sectors but to build cross-sector synergy that leads to innovations in prevention efforts that may ultimately be more effective at preventing/reducing substance use. As noted, CARA recipients were required to be prior or current DFC recipients. While DFC recipients are legislatively required to engage the 12 sectors, CARA recipients are only required to be a community coalition. The evaluation examined whether CARA recipients continued to engage with all 12 sectors as well as capacity building activities.

Active Sector Members and Sector Involvement

Overall, 84% of coalitions reported having at least one active member in each of the 12 sectors. All 55 coalitions reported active membership in the Civic/Volunteer, Healthcare, Parent, School, State/Local/Tribal Government agencies, and Youth Serving agencies sectors. Between 95% and 98% of coalitions reported active membership in the Business, Law Enforcement, Media, Other Organizations with Substance Use Expertise, Religious/Fraternal Organizations, and Youth sectors. Based on the median number of sector members, staff, and volunteers (61, 3 and 3, respectively), CARA coalitions mobilized nearly 3,700 community members to engage in meeting grant goals. CARA coalitions reported highest active membership for the Youth sector, with a median of 10 active Youth members (Figure 3).

FIGURE 3. MEDIAN NUMBER OF MEMBERS BY SECTOR



Source: CARA June 2021 Progress Report

The coalitions also were asked to rate the average level of involvement for each sector on a scale of 1 (Very Low) to 5 (Very High). As illustrated in Figure 4, Schools, Other Organizations with Substance Use Expertise, and Law Enforcement were rated as the most highly involved sectors with an average involvement rating of 4.1. The Civic/Volunteer groups, Business, and Religious/Fraternal Organizations were rated lowest on involvement, although still at a Medium rating of 3.4. Notably, many coalitions described challenges in active youth involvement due to COVID-19 restrictions.

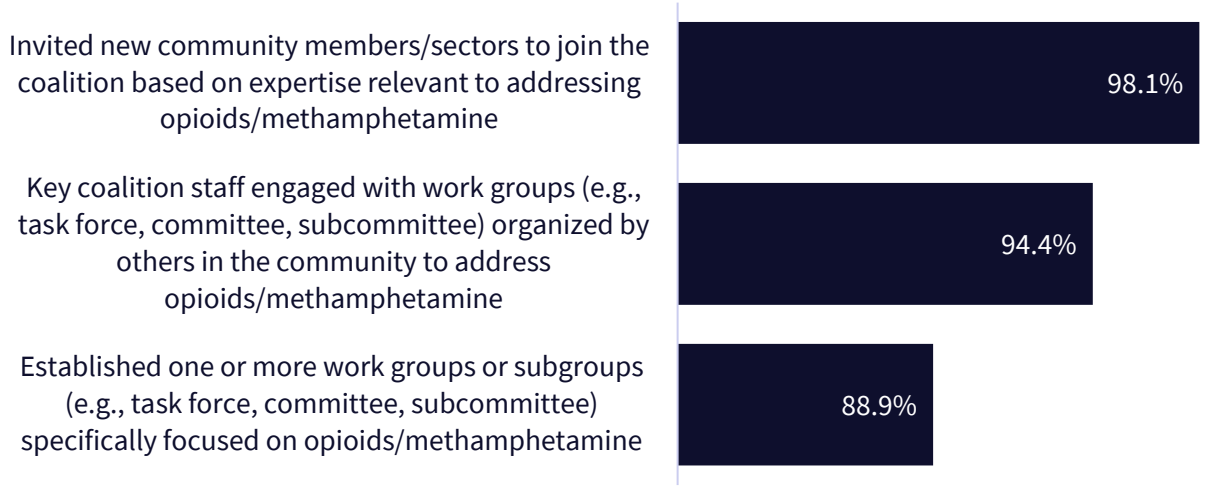
FIGURE 4. AVERAGE RATINGS OF SECTOR INVOLVEMENT

Source: CARA June 2021 Progress Report
Note: 1=Very Low, 2= Low, 3=Medium, 4=High, 5=Very High average level of involvement

Activities to Build Capacity

CARA coalitions were asked to indicate (yes/no) whether they invested resources and effort in three activities to build capacity. A vast majority reported engaging in these specific activities (see Figure 5). Throughout descriptions of implementation activities (see the next section), it was clear coalitions were fully engaged with their sector members. This included building the capacity of the sector members, but also building capacity for the community to implement prevention activities. Sector members participated actively in both planning and delivery of coalition activities. This suggests coalitions will be situated to sustain some programming beyond their CARA grant, with various sectors leading but ideally still working collectively to support the implementation.

FIGURE 5. PERCENT OF CARA COALITIONS ENGAGED IN ACTIVITIES TO BUILD CAPACITY



Source: CARA June 2021 Progress Report

Data Collection and Sharing

Several coalitions noted building capacity through cross-sector engagement around collecting and sharing data to inform planning and implementation of activities.

- "Our prevention priorities are determined by data-driven information and needs assessments collected through . . law enforcement, school, health, and mental health data collection and monitoring." (South Region)
- "The goal of the Listening Sessions was to identify and prioritize Risk and Protective factors, highlight local resources and determine gaps and areas of concern in [communities] . . . to guide the selection of evidence-based strategies and implementation of programs and activities that promote the health and well-being of young people, and to inform targeted media messages that motivate involvement and inspire meaningful action." (West Region)
- "The coalition began a large-scale opioid and meth data collection project by working with partners in healthcare, substance use disorder/Behavioral health, public health, and law enforcement to collect and monitor opioid/methamphetamine related data, including, but not limited to medical examiner data, opioid overdose surveillance, naloxone usage, and related treatment admissions." (Midwest Region)

CARA Innovation in Sector Engagement

CARA coalitions' descriptions highlighted some of the ways they were working to engage with new sector members. This included 18% of CARA coalitions who described forging new partnerships, in some cases as part of their response to COVID-19, which shifted community needs and resources. Examples of innovation and new partnerships included:

- Building relationships with funeral homes and with assisted living facilities/nursing homes/senior centers. These coalition efforts focused on the importance of proper prescription drug disposal particularly for those working with the elderly. In several cases, at-home drug disposal kits were provided by coalitions to these partners.
- A Midwest Region coalition partnered with a medical examiner, which proved helpful: "Through a partnership with the County's medical examiner . . . the coalition has been able to gain access to comprehensive quarterly reports for deaths related to opioids and other drugs, specific to our County and the region of our state. These reports have allowed for better understanding of . . . deaths related to drugs and have led to the development of harm reduction practices and their promotion through flyers, cards, educating local organizations, and social media."
- Coalitions noted their work with mental health services, not only around substance use but also in understanding how some community members were experiencing COVID-19. In some cases, people may have faced challenges in accessing mental health services without community supports, while in other cases mental health challenges may have initiated or been exacerbated by COVID-19 concerns and restrictions. Coalitions work to help those facing mental health challenges not resort to substance use as a coping mechanism.[23] For example, a West Region coalition noted, "Our coalition engaged with a local Air Force Base to provide services and training around the increased concerns affecting young airmen and airwomen [due to COVID-19]."

[23] See Czeisler, M.E., Lane, R.I., Petrosky, E., et al. (2020) Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – Untied States, June 24-30, 2020, MMWR Morb Mortal Wkly Rep2020; 69(32):1049-1057, http://dx.doi.org/10.15585/mmwr.mm6932a1

Treatment and Recovery Sector Engagement

Multiple coalitions cited efforts to engage with treatment and recovery partners. In addition to linking community members to resources, these efforts supported trainings. Several coalitions noting that hearing from people in recovery was especially helpful in overcoming stigma around substance use and willingness to seek treatment.

- "We spent significant effort on addressing stigma. We created a publicity campaign called 'Treatment Works' and a media brainstorming session with people in recovery. We created bus benches with six quotes from the brainstorming session including: Recovery is possible, this is who I was meant to be, Medication Assisted Therapy kept me off drugs, I can keep promises to my kids again, I am more than my addiction, and I rediscovered my purpose in life. . . . We asked several of the participating members to write down their stories, which were then turned into recorded radio PSAs public service announcements utilizing their own voices. We recorded two PSAs in Spanish. . . . There is a website associated with the PSAs and bus benches that has resources for treatment and behavioral health resources." (West Region)

Key Finding

- Speakers included people in recovery, doctors, and treatment coordinators. Parents and youth heard about the recovery process and what someone with opioid use disorder (OUD) experiences. As a result, OUD-associated stigma and its negative effects were understood as well. For example, how stigma reduces the odds of someone with OUD seeking treatment. (West Region)
- "We worked with a local recovery center to distribute Harm Reduction Kits (containing a safe at-home prescription drug destruction bag, lip balm, chewing gum, 911 Good Samaritan Law information and a fentanyl test strip." (Northeast Region)
- "We worked on trainings to teach people in recovery the skills they need to create community-level change around recovery, recovery supports, and stigma reduction. The group decided to move forward with this project digitally, holding the two trainings online via Microsoft Teams." (West Region)

Strategy Implementation

CARA coalitions implemented a comprehensive range of approaches, including evidence-based practices and innovations COVID-19 pandemic restrictions contributed to the need to innovate in implementing prevention.

Coalitions were asked to indicate (yes/no) whether they invested resources and effort in each of 36 activities to address opioids/methamphetamine in their community. These activities were identified by the DFC National Evaluation Team during site visits focused on addressing opioids. These activities were grouped into the Seven Strategies for Community Change, with any given activity linked to a single

strategy.[24] More generally, coalitions described implementing activities, many of which were included on the list. The strategies can be are divided into individual-focused strategies (*Providing Information, Enhancing Skills,* and *Providing Support*) and environmental-focused strategies (*Changing Access/Barriers, Changing Consequences, Changing Physical Design,* and *Educating/ Informing about Modifying/Changing Policies or Laws*). CARA recipients are encouraged to prioritize implementing environmental strategies as most effective for long-term community-level change.

Overview: Implementation of Strategies

Most CARA coalitions implemented a comprehensive mix of strategies to create community change, with most (94%) implementing at least one activity across at least five of the seven strategy types (see Figure 6). All CARA coalitions reported implementing at least one *Providing Information* activity while 98% reported implementing at least one *Changing Access/Barriers* and at least one *Enhancing Skills* activity (see Figure 7). *Providing Support* activities were implemented by the smallest percentage of CARA coalitions, with only 44% indicating at least one activity of this type.

FIGURE 6. PERCENT OF COALITIONS ENGAGED IN AT LEAST 1 ACTIVITY BY NUMBER OF STRATEGIES

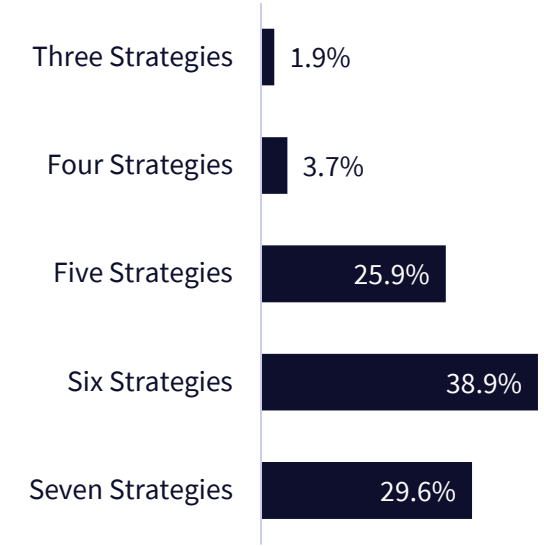
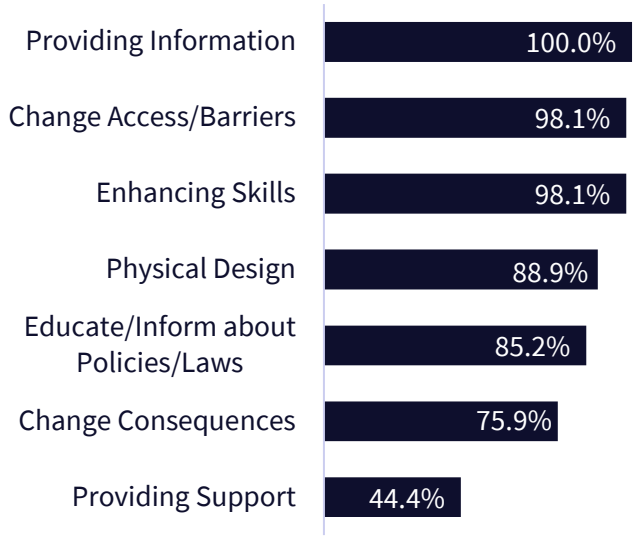


FIGURE 7. PERCENT OF COALITIONS ENGAGED IN AT LEAST 1 ACTIVITY BY STRATEGY TYPE



Source: CARA June 2021 Progress Report

In general, a higher percentage of CARA coalitions reported implementing more activities aligned with individual strategies than environmental strategies. Coalitions were also more likely to mention individual strategies in their descriptions of activities. In part, some individual activities may be easier for coalitions to quickly implement, helping them to occur more regularly (e.g., distributing resources and trainings, once developed). Still, coalitions were also implementing a comprehensive range of

[24] 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. CARA 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 CARA grant funding limitations, see https://www.grants.gov/web/grants/view-opportunity.html?oppId=329980

environmental strategies (if to a lesser extent for any given strategy). Table 3 provides an overview of the seven most implemented activities within each strategy type.

The top seven activities within individual strategies were implemented by at least 85% of coalitions while the top seven activities within environmental strategies were implemented by at least 63%. Within environmental strategies, four of the seven most implemented activities were related to *Changing Access/Barriers*, led by making available or increasing availability of prescription drug take-back events and take-back boxes (87% and 85%, respectively). Strategies to *Educate/Inform about Modifying/Changing Policies* regarding naloxone administration (63%) was also a top seven environmental strategy.

TABLE 3. TOP SEVEN ACTIVITIES *MOST* IMPLEMENTED BY STRATEGY TYPE

INDIVIDUAL STRATEGIES		ENVIRONMENTAL STRATEGIES	
ACTIVITY	**%**	**ACTIVITY**	**%**
Providing Information: Promotion of prescription drug drop boxes/take-back events	96.3	*Changing Access/Barriers*: Make available or increase availability of local prescription drug take-back events	87.0
Providing Information: Information about opioids currently identified as an issue in the community or surrounding community	94.4	*Changing Access/Barriers*: Make available or increase availability of local prescription drug take-back boxes	85.2
Enhancing Skills: Community education and training on opioid risks for various community members	94.4	*Changing Physical Design* Increase safe storage solutions in homes or schools	83.3
Enhancing Skills: Education and training to reduce stigma associated with opioid use disorder	90.7	*Changing Access/Barriers*: Make available or increase availability of Narcan/naloxone	79.6
Providing Information: Information about sharing/storage of prescription opioids	88.9	*Changing Access/Barriers*: Improving access to opioid/methamphetamine prevention, treatment, and recovery services through culturally sensitive outreach	75.9
Providing Information: Distribution of treatment referral cards/brochures/stickers	88.9	*Changing Consequences*: Drug task forces to reduce access to opioids/ methamphetamine in community	63.0

Enhancing Skills: Community education and training on signs of opioid/ methamphetamine use	85.2	*Educating/Informing about Modifying/Changing Policies or Laws*: Policies regarding Narcan/ naloxone administration	63.0

Source: CARA June 2021 Progress Report

In comparison, Table 4 shows the five least implemented activities in by strategy type. *Providing Information* on methamphetamine was the least implemented individual strategy, although almost one-third (32%) implemented it. Fewer than 25% of coalitions implemented the five least implemented environmental strategies. Several coalitions (24%) described efforts to link people with substance use disorders and/or their families to treatment and/or recovery opportunities, activities highlighted further based on descriptions of these activities.

TABLE 4. TOP FIVE ACTIVITIES LEAST IMPLEMENTED BY STRATEGY TYPE

INDIVIDUAL STRATEGIES		ENVIRONMENTAL STRATEGIES	
ACTIVITY	**%**	**ACTIVITY**	**%**
Enhancing Skills: Prescriber education and training	51.9	*Changing Access/Barriers*: Drop-in events/centers to connect individuals with opioids/ methamphetamine use disorders and/or their families to treatment/recovery opportunities	24.1
Enhancing Skills: Education, training, and/or technical assistance on monitoring compliance for the Prescription Monitoring Program	40.7	*Changing Physical Design*: Clean needles and other waste related to opioid use from parks and neighborhoods	20.4
Providing Support: Youth/family support groups for those who have relationships with individuals who use/misuse opioids/ methamphetamine	37.0	*Changing Physical Design*: Identify problem establishments for closure	20.4
Providing Support: Recovery groups/events	35.2	*Changing Access/ Barriers*: Home visit follow-ups after an overdose/overdose reversal (e.g., safety official and healthcare provider visit to share and connect to treatment options)	11.1

Providing Information: Information delivered via a town hall forum or conference related to methamphetamine	31.5	*Educating/Informing about Modifying/Changing Policies or Laws*: Crime free multi-housing ordinances	5.6

Source: CARA June 2021 Progress Report

Implementation Highlights and Innovation

Following are highlights of prevention activities engaged in by CARA coalitions in Year 3, their final grant year. In a few cases, we highlight a given coalition because of unique practices or innovation. Collectively, these activities are aligned with changing community culture in line with the grant goals.

Evidence-Based Practices

CARA coalitions are strongly encouraged to engage in evidence-based practices. Just over one-third (37%), specifically noted they were using such practices in describing their prevention activities.[25] In some cases, CARA coalitions may be implementing evidence-based practices but not using that wording. For example, references to evidence-based practices included the following:

- A coalition reported a key priority was to "expand evidence-based prevention around school-based interventions."
- A coalition stated, "since the inception of our coalition in 2001, our focus has been on partnership, utilizing evidence-based programs and initiatives, and strong evaluation."
- A coalition reported supporting the county's participation in Communities That Care (CTC),[26] which focuses on evidence-based strategies for adolescent substance use prevention and outcome goals.
- A coalition described efforts around using the Screening, Brief Intervention and Referral to Treatment (SBIRT) tool, an evidence-based comprehensive approach for early identification and intervention with youth/people whose current substance use puts their health at risk.[27]

Social Norms Campaign

One CARA coalition (Northeast Region) highlighted efforts to successfully implement a social norms campaign, virtually and in person. Social norms campaigns are an evidence-based practice that provide youth with current, accurate information on youth substance use, emphasizing that most youth make good choices and countering the belief that "everyone is doing it."[28] Activities within the campaign included the following:

[25] Many additional practices are also considered evidence-based, but the coalition may not have identified them as such. For example, an activity improving access and use of naloxone is an evidence-based harm reduction practice but was rarely referenced as such.

[26] See https://www.communitiesthatcare.net/ and https://www.blueprintsprograms.org/communities-that-care-ctc/ for additional information and research on Communities That Care (CTC).

[27] See https://www.samhsa.gov/sbirt and for https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4741.pdf for additional information about Screening, Brief Intervention, and Referral to Treatment (SBIRT).

[28] For more information about social norms campaigns and evidence, see https://socialnorms.org/social-norms-approach/. Research suggests that when properly implemented, these campaigns are effective. See also Dempsey, R.C., McAlaney, J., & Bewick, B.M. (2018), A Critical Appraisal of the Social Norms Approach as an Interventional Strategy for Health-Related Behavior and Attitude Change, Frontiers in Psychology (6), https://www.frontiersin.org/articles/10.3389/fpsyg.2018.02180/full (which highlights key opportunities and challenges to this approach).

- A locally collected youth survey data, which found most students in the high school do not use substances, including misusing prescription drugs.
- Distributed information and pens with campaign messages when students picked up books during virtual schooling period.
- Distributed discussion guides to parents and teachers encouraging conversations.
- Social media dissemination, including a virtual trivia game event attended by 700 students who competed for restaurant gift cards. This was so successful, a local mental health agency partnered with the coalition to host a game focused on mental health and substance use.
- Hung posters and banners at the school and put campaign messages on over 800 decals placed in the high school to encourage social distancing.
- Youth empowerment team created radio and video PSAs and the video version was shared at a youth film festival.

Focus on Methamphetamine Prevention

Methamphetamine was less often mentioned by coalitions in describing their work. One Midwest Region coalition stood out for its comprehensive emphasis on addressing methamphetamine, reporting that past 30-day use of methamphetamine went from 1.5% in 2016 to 1.3% in 2018 and to 0.9% in 2020. They noted bringing a youth/family focus to work that was missing in their community as well as actively engaging with Tribal and non-Tribal entities to work on common goals. Activities included the following:

- Trainings to recognize the signs of methamphetamine use and distribution.
- Introduced an anonymous tip line to call or text police to report concerns. In response to feedback about texting, worked with city and county law enforcement to create a Google form for anonymous reporting. Worked with media, school, behavioral health, and law enforcement partners to share information about the form with the community.
- In partnership with law enforcement, created and disseminated information specifically for farmers and others who own large amounts of land so they would know the signs of methamphetamine labs and people seeking rural areas to engage in drug transactions.
- Partnered with state officials and programs to use methamphetamine campaign materials.
- Worked on Tribal policy dictating that methamphetamine manufacturing sentencing move to the federal level.
- Worked with youth to prevent future methamphetamine use as the community sees higher use rates in ages 18–24.

Harm Reduction: Comprehensive Naloxone Training

Harm reduction practices are aimed at reducing negative consequences associated with drug use and respecting people who use drugs by meeting them where they are.[29] Providing information, training, and access around naloxone was a commonly mentioned harm-reduction strategy both in person and virtually. Coalitions often paired training with working to make naloxone more available, an additional harm-reduction practice. Understanding how to use naloxone and having it available are shown to

[29] See https://www.hhs.gov/overdose-prevention/harm-reduction for additional information.

reduce overdose deaths in communities. This kind of outreach also provides an opportunity to link substance users with treatment and recovery, potentially preventing future use. One coalition (West Region) exemplified a comprehensive approach, planning and implementing a "Not Just Naloxone Training" focused on the recovery continuum:

- Trainings start with data on local challenges related to opioids.
- Discuss prevention and the key role it plays in helping to avert opioid use.
- Train on naloxone administration and provide participants with free naloxone kits.
- Partner from a treatment program discusses options for treatment and provides local examples and resources.
- Partner in recovery presents on the importance of maintenance for long-term recovery and local recovery organizations and resources.

Implementation During COVID-19

COVID-19 presented significant challenges and unexpected successes while CARA coalitions implemented their plans to prevent and reduce youth substance use. Nearly all coalitions (97%) were specific about how they navigated one or more barriers as their communities responded to the pandemic during their final year of CARA implementation. Although COVID-19 cases, closures, and social distancing guidelines impacted the economic, health, and food systems for millions of Americans, CARA coalitions maintained their focus on prevention. Coalitions also identified new skills and resources in the planning and implementation of prevention strategies in the COVID-19 context.

Challenges Experienced by Coalitions

- **Data collection Issues.** Just over one-third (36%) of coalitions described how difficult it was to collect and evaluate survey data from target populations. As a result, their capacity for self-evaluation and strategic planning was limited.
- **Need to address mental health:** Around one in six (16%) coalitions noted increases in drug use and mental health needs in their communities. Coalitions perceived that economic and health stressors along with social isolation requirements resulted in an increased need to link community members to mental health services as a prevention strategy.

"Evaluation during COVID 19 was a challenge. We did get . . . our school districts to take the KS Communities That Care Survey in Jan 2021, even though the students were remote. We had a total 53% participation rate. That was a success for a year like this." (Midwest Region)

"[Our coalition] recognized the need to share out as much information as possible, pair up with our social workers and Life Counselors to ... assist parents with issues surrounding risk behaviors in... families and in the community. Because of isolation during the early part of this reporting period our community experienced increased overdoses, mental health issues and suicides." (South Region)

- **COVID impact on access and activity delivery format:** While 9% of CARA recipients specifically mentioned event cancellations limited access to intended populations, it was clear that many coalitions shifted to social media because of this challenge. In accordance with CDC guidelines for in-person gatherings, coalition networking events and efforts to provide information and support in communities had to be re-imagined and social media was central to this shift.

> "The biggest challenge as of late has been the COVID-19 pandemic. This has resulted in the cancellation of in-person trainings, two medicine collection events scheduled for spring of 2020, and a large regional conference with 400 registrants." (Midwest Region)

- **Budget impacts:** While less common (4%), coalitions reflected on changes to staffing and budgets related to the COVID-19 pandemic putting strains on state, local, and private economic funding streams.

> "Staffing: In May of 2020 we were informed that our local hospital would not be renewing our grant. This was a significant cut to our overall budget (about 30% cut) and resulted in us not being able to fill a staff position when someone retired last spring." (Northeast Region)

Successes in Overcoming Challenges Experienced by Coalitions

Despite the challenges, 65% of CARA recipients conveyed their organizational resilience by finding new paths to data collection, resources, and access to key populations to implement prevention activities in line with their local goals. As noted in the "Building Capacity" section, 18% of coalitions described forging new partnerships, some of which were in line with new COVID-19 needs. The following are examples of coalitions adapting to COVID-19 challenges (see also the social norms example presented earlier in this report).

- **Social media/Virtual:** One in five coalitions leveraged social media to implement the seven strategies in new ways. Social media and virtual platforms allowed them to engage with sector members in coalition meetings and with key audiences throughout the pandemic.

> "Remote work, however, has allowed [staff] to continue to provide education, trainings, and programs virtually and increase social media presence." (Midwest Region)

- **Adaptation/Redesign**: Along with shifting to virtual delivery, 16% of CARA recipients described how they redesigned activity implementation. In response to the pandemic, coalitions created new ways and innovative methods to implement their original prevention strategies with fidelity.

  In addition, 9% of coalitions specifically described implementing contactless events: Contactless event planning allowed coalitions to avoid cancellations due to

> "The biggest challenge with this program was COVID and the lack of ability to be in person . . . We adapted and recorded all [drug use] material ahead of time so that the presentations [in schools] were consistent and streamlined with simple instructions for the [high school Health] teachers to follow." (South Region)
>
> "The coalition adapted the event to include a drive-thru pharmacy destruction pouch pick up instead of medication drop off. For Fall 2020/Spring 2021, a take back event was held as

COVID-19 restrictions and in some cases helped coalitions reach wider audiences.

usual but with contactless drop off options." (Midwest Region)

- **Shifted focus from implementing activities to planning:** A few coalitions (2%) described how their staff shifted from implementing activities to focus on planning and revising their action plan as needed. Limitations on in-person events increased efficiency and gave at least one coalition additional time for strategic reflection and planning.

"Due to the pandemic, staff had additional time to analyze our [survey] data." (Northeast Region)

Core Measures

CARA coalitions reported baseline data only. Among middle and high school youth, misuse of prescription drugs, heroin use, and methamphetamine use were all low.

Ideally, the CARA Cohort 1 coalitions would have provided two core measures data points associated with their grant. However, only four coalitions provided more than one data point. In addition, the data provided was baseline data collected prior to or in the first year of the grant. In addition, most CARA coalitions collected data regarding prescription drug misuse, with far fewer collecting data on heroin or methamphetamine. Only 80% of coalitions reported collecting any core measure data from middle school youth, while slightly more (89%) reported collecting any core measures data from high school youth. For example, most CARA recipients (100% and 98% at middle and high school, respectively) provided baseline data on past 30-day prescription drug misuse, but substantially fewer reported data for methamphetamine use (34% and 41% at middle and high school, respectively) and heroin use (34% and 37% at middle and high school, respectively). No coalitions reported more than baseline data for methamphetamine or heroin use, and only four coalitions reported post-grant award data on prescription drug misuse.[30] Given the limited data available, it is unknown if CARA recipients collectively made significant progress on reducing youth use of these substances.

Table 5 presents the baseline data for core measures. While CARA recipients were selected based on challenges in the community, the youth data are promising. Very few middle school or high school youth reported misusing any of the substances. Past 30-day prescription drug misuse was most common, but still low in both middle school and high school youth (2% and 2.7%, respectively). In addition, only past 30-day prescription drug misuse showed a small uptick between middle school and high school youth (from 2% to 2.7%). The data suggests coalitions can focus on long-term prevention, while still working to address the use of substances that is occurring.

Key Finding

TABLE 5. CORE OUTCOME HIGHLIGHTS BY SCHOOL LEVEL

[30] CARA coalitions were first asked to report on progress in 2021. As a result, most coalitions were only able to report a single baseline value, preventing the evaluation team's ability to change over time for Cohort 1.

OUTCOME		MIDDLE SCHOOL	HIGH SCHOOL
Past 30-Day Prevalence of Use	Heroin (n=15; n=18)	0.2% (99.8% non-use)	0.3% (99.7% non-use)
	Methamphetamine (n=15; n=20)	0.4% (99.6% non-use)	0.5% (99.5% non-use)
	Prescription drug (misuse; n=47; n=52)	2.0% (98% non-misuse)	2.7% (97.3% non-misuse)
Perception of Risk	Heroin	74%	89%
	Methamphetamine	85%	87%
	Prescription drug	79%	78%
Perception of Parent Disapproval	Heroin	No data	99%
	Methamphetamine	95%	99%
	Prescription drug	95%	94%
Perception of Peer Disapproval	Heroin	98%	88%
	Methamphetamine	99%	89%
	Prescription drug	92%	88%

Source: CARA June 2021 Progress Report
Note: n indicates number of coalitions collecting data, with each coalition collecting data from multiple youth. The first n is for number of coalitions collecting middle school data while the second is for the number of coalitions collecting high school data.

Baseline data related to the perception of risk, parent disapproval, and peer disapproval are also summarized in Table 5. Relative to perceived parent and peer disapproval, perception of risk was lower on average though all values were greater than 78%. Rates across the two disapproval core measures were generally consistent from middle to high school, though peer disapproval for prescription drug misuse was four percentage points lower at the high school level compared to the middle school level. Finally, perceived risk associated with heroin use was lower in middle school than high school youth (by 15 percentage points).

Limitations and Challenges

There are several limitations to keep in mind regarding the findings in this report. As discussed throughout this report, COVID-19 represented challenges to coalitions with regard to both implementation and core measure data collection. Another challenge was that the CARA National Cross-Site Evaluation Team was contracted in July 2021. This was after CARA Cohort 1 awards had ended. The DFC National Evaluation Team anticipated the upcoming CARA program evaluation and included relevant items for the progress report in the 2020 Office of Management and Budget (OMB) package. CARA recipients were added to the DFC *Me* system in late 2020 and were asked to complete a Year 2 progress report in January 2021 (Year 2 ended June 2020). This was followed by a Year 3 progress report that was completed in June 2021. No data were collected on Year 1 progress. Because no evaluation contract was in place, CARA recipients received minimal support in completing the progress report, although many were familiar with reporting based on similarities to DFC reporting. Still, during the timeframe when CARA coalitions were implementing the grant, direction was not available to them

about participating in an evaluation. While prior DFC work likely contributed to many coalitions successfully tracking their efforts, some coalitions may have needed additional supports in this area.

A significant portion of the CARA progress report includes qualitative data (detailed descriptions of implementation and outcomes other than core measures). Data analysis for this includes coding the responses for key themes, a time intensive process. In some cases, coalitions provide only limited details about their prevention activities, while other coalitions can provide significant detail. For example, in some cases naloxone trainings are simply identified as an activity engaged in, while in other cases details about the content of the training, who participated in delivery of the training (cross-sector), number of participants, and information on perceived effectiveness are provided. It is possible some innovative strategies were not described in sufficient detail to be included here.

CARA coalitions were required to collect new core measure data at least every two years. Ideally, baseline core measures data would have been collected at the start of the grant, and subsequently two years later. However, CARA coalitions could also collect data in Year 2 and still be in compliance with the grant requirement. In this case, there would not be any evidence of change over the three-year time frame of the grant. Core measure data provided by CARA recipients with their progress reports was limited and primarily represented a single baseline time point. Within Cohort 1 there was insufficient core measures data provided to analyze for change over the course of the grant award. In some cases, related to lack of a national evaluation contractor from whom to receive guidance, the recipients felt unsure what core measures data they would be expected to collect. More specifically, coalitions reported that the COVID-19 pandemic impacted CARA core measures data collection beginning in spring of 2020. As many students moved to various forms of remote instruction, schools were focused on addressing their own challenges and this may have limited their ability to support work with the coalitions, even when school engagement with the coalition remained high. Many coalitions reported struggles in working with schools to collect data from youth during the pandemic. The incoming cohort of CARA recipients has the potential to receive the award for up to five years, instead of three. This increased timeframe, along with ongoing support from an evaluation team, will likely contribute to better understanding change over time in these communities.

While additional data points are needed, available core measures data from CARA Cohort 1 suggest an additional challenge. Collectively, baseline data suggest prevention efforts of CARA coalitions to reduce youth substance use may be difficult to observe in core measures, as efforts are focused on maintaining near zero use across substances. That is, CARA efforts regarding youth will be focused primarily on maintaining prevention of use rather than reductions in current levels of use. Ideally, early prevention efforts will result in longer-term outcomes beyond high school although these data are unlikely to be available from CARA recipients. The low prevalence of use rates reported by CARA recipients are similar to other national data for this age range.

APPENDIX A. CARA Annual Progress Report

OMB Control Number: 3201-0012; Expiration Date: 1/31/2023

The public reporting burden for each progress report is estimated to be 6 hours. To help ensure minimum reporting burden on grant award recipients, ongoing technical assistance is available from DFC_Evaluators@icf.com to address problems or issues in real time. Mail comments regarding the accuracy of this burden estimate and any suggestions for reducing the burden to: U.S. Office of Personnel Management, Federal Investigative Services, Attn: OMB Number (3201-0012), 1900 E Street NW, Washington, DC 20415-7900. You are not required to respond to this collection of information unless a valid OMB control number is displayed.

Data Protection & Security. All data collection processes used for the National Evaluation were reviewed and approved by an Institutional Review Board (IRB) to ensure appropriate human subjects protections. Each CARA recipient is responsible for having a data management plan in place per grant requirements. In addition, they can receive guidance on data protection and security from both the National Evaluation team and from local evaluators if retained. Each coalition must decide how to best collect core measures data from youth. Many coalitions utilize state surveys either as is or with an approved addition of grant core measures. An agreement is established between the coalition and the school(s) and/or the state to share the data. Other coalitions may utilize local surveys and must get approval through any school processes to collect the data, which may include local IRB approval. For the purposes of the National Evaluation, core measure data is aggregated by grade level; individual student level data are not shared by the coalition for this purpose.

COALITION STRUCTURE AND PROCESSES SECTION

Subsection: Coalition Information

Business Official: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Award Number: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Coalition Name: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Year of CARA Award *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*

Project Coordinator Contact Information:

Name: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Title: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Address: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Phone: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*
Email: *(Note: this field will be auto populated and cannot be changed without approval from your Government Project Officer)*

Month and year the CARA coalition was first established: ___/___ Format: 04/2021

Does your coalition actively work with a local High Intensity Drug Trafficking Area (HIDTA) Program?

- **Yes (If Yes, select from drop-down list to indicate which HIDTA working with. You can also look up your HIDTA here: https://www.nhac.org/news/HIDTA_Counties.htm)**
- **No**

Please provide your coalition's social media contact information for the following, if applicable:

Twitter handle: _____

Facebook page/URL: _____

Instagram handle: _____

Number of paid staff (*Number of staff with salaries funded partially or fully through the CARA grant.*): _____

(Note: Number of staff with salaries funded partially or fully through the CARA grant.)

Number of unpaid staff (*Number of staff who are not paid but who contribute significantly to coalition work.*): _____

(Note: Number of unpaid staff that contribute significantly to coalition work.)

Please provide a brief summary of your coalition. This is your "Elevator Speech". Consider including a brief sentence on: (a) your community and population(s) of focus, (b) your primary goals, (c) the activities you are focusing on, (d) accomplishments to date, (e) successes concerning goal achievement, f) challenges in goal achievement, and g) things that make your coalition unique. (Maximum of 2,000 character with spaces):

Subsection: ZIP Codes Served (CARA Only) and Congressional Districts

Please review the ZIP code(s) served by your CARA coalition: *(information will be pre-populated by system)*

Is/are the ZIP code(s) listed above correct?

- ❍ Yes
- ❍ No *(please list the correct zip codes served by your coalition):* _____

Note: please look up congressional district by entering your information here: https://www.house.gov/representatives/find-your-representative

What is the congressional district associated with your CARA coalition address?

- ❍ Enter congressional district number for your coalition address here. Identify by state and two-digit number (e.g., OH01 for Ohio Congressional District 1): _____

What is/are the congressional district associated with the zip code(s) served by your CARA coalition?

- ❍ Enter congressional district(s) served by your coalition here. Identify by state and two-digit number (e.g., OH01 for Ohio Congressional District 1): _____

BUILDING CAPACITY SECTION

Capacity refers to the types (such as skills or technology) and levels (such as individual or organizational) of resources a coalition has at its disposal to meet its aims.

Subsection: Sectors

Sectors ***(If an individual can be categorized as part of two or more sectors (e.g., a police officer who is also a parent), please only include them in the count for the sector in which they serve (e.g., count only as a police officer because primary reason for engagement is this role). Do not double count individual across sectors.)***	***How many coalition members represent this sector?*** *A person can be counted as representing the sector if they provide any support to the coalition. They do not need to have been active in the past six months, but they do need to be available to the coalition if needed. Do **not** count everyone working for a partner organization if they are not directly involved in coalition activities. If an individual member represents more than one sector (e.g., police officer who is also a parent), choose the sector they represent in an official capacity)*	**How many of these coalition members are "active"?** *(Members should **only** be counted as active if they have attended a meeting, participated in planning/ implementing a coalition event, or provided some type of support to the coalition **in the past six months**.)*	**What is the average level of involvement for this sector?**				
			Very High	**High**	**Medium**	**Low**	**Very Low**
Parents			m	m	m	m	m
Youth	***(Members of your coalition's hosted youth coalition should be included in this count, if applicable)***		m	m	m	m	m
Business Community			m	m	m	m	m
Civic/Volunteer Groups			m	m	m	m	m
Healthcare Professionals			m	m	m	m	m
Law Enforcement Agency			m	m	m	m	m
Media			m	m	m	m	m
Religious/Fraternal Organizations			m	m	m	m	m
Schools			m	m	m	m	m
State, Local, and/or Tribal Government Agencies with Expertise in Substance Use			m	m	m	m	m
Youth-Serving organizations			m	m	m	m	m
Other Organization with Expertise in Substance Use Please specify the organization. *(Indicate the name of the organization that represents this sector in your coalition.)* _____			m	m	m	m	m

LOCAL DRUG CRISES SECTION

Subsection: Addressing Opioids/Methamphetamine

1. Has your coalition engaged in any activities to address opioids (e.g., prescription opioids, heroin, fentanyl, fentanyl analogs or other synthetic opioids)/methamphetamine (Local Drug Crises) in the community? Yes/no (If yes, the following items will be made available).

2. Indicate (yes/no) if your work focuses on each of the following substances specifically:

	Yes	No
• Methamphetamine		
• Prescription opioids		
• Heroin		
• Fentanyl, fentanyl analogs or other synthetic opioids		

3. What strategies or activities has your coalition engaged in specifically around the issue of addressing opioids/methamphetamine (Local Drug Crises) in your community? Indicate Yes/No for each option to indicate in which strategies/activities the coalition has invested resources and effort explicitly to address opioids/methamphetamine (Local Drug Crises). If you are engaged in the activity, but not with the intention to address opioids/methamphetamine, please select "No".

Strategy/Activity	Yes	No
Building Capacity		
Established one or more work groups or subgroups (e.g., task force, committee, subcommittee) specifically focused on opioids/methamphetamine		
Invited new community members/sectors to join the coalition based on expertise relevant to addressing opioids/methamphetamine		
Key coalition staff engaged with work groups (e.g., task force, committee, subcommittee) organized by others in the community to address opioids/methamphetamine		
Providing Information (e.g., community education, increasing knowledge, raising awareness		
Prescribing guidelines		
Promotion of Prescription Monitoring Program		
Promotion of prescription drug drop boxes/take back events		
Information about opioids (heroin, fentanyl, fentanyl analogs or other synthetic opioids) currently identified as an issue in the community or surrounding community		
Information about methamphetamine currently identified as an issue in the community or surrounding community		
Information about methamphetamine risks		
Information about sharing/storage of prescription opioids		
Information delivered via a town hall forum or conference related to methamphetamine		
Distribution of treatment referral cards/brochures/stickers		
Enhancing Skills (e.g., building skills and competencies)		
Community education and training on opioid risks for various community members (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 to showing homes		
Community education and training on signs of opioid/methamphetamine use (e.g., Hidden in Plain Sight trainings)		
Prescriber education and training		
Education, training, and/or technical assistance on monitoring compliance for the Prescription Monitoring Program		
Education and training to reduce stigma associated with opioid use disorder		
Providing Support (e.g., increasing involvement in drug-free/healthy alternative activities)		
Youth/family support groups for those who have relationships with individuals who use/misuse opioid/methamphetamine		
Recovery groups/events		
Enhancing Access/Reducing Barriers (e.g., improving access, availability, and use of systems and services)		
Make available or increase availability of local prescription drug take-back boxes		
Make available or increase availability of local prescription drug take-back events		
Make available or increase availability of judicial alternatives for individuals with an opioid/ methamphetamine use disorder who are convicted of a crime (e.g., drug court, teen court)		
Drop-in events/centers to connect individuals with opioids/methamphetamine use disorders and/or their families to treatment/recovery opportunities		
Make available or increase availability of transportation to support opioid prevention, treatment, or recovery services (e.g., medication assisted treatment, counseling, drug court)		
Home visit follow-ups after an overdose/overdose reversal (e.g., safety official and healthcare provider visit to share and connect to treatment options)		
Improving access to opioid/methamphetamine prevention, treatment, and recovery services through culturally sensitive outreach (e.g., multilingual materials, culturally responsive messaging)		
Make available or increase availability of Narcan/naloxone		
Make available or increase availability of medications for opioid use disorder (e.g., suboxone, Vivitrol, methadone)		
Make available or increase availability of substance use screening programs (e.g., SBIRT)		

Strategy/Activity	Yes	No
Changing Consequences (e.g., incentives/disincentives, increasing attention to enforcement and compliance)		
Drug task forces to reduce access to opioids/methamphetamine in community		
Identify and/or increase monitoring of opioid/methamphetamine use "hot spots"		
Recognition programs (e.g., physicians exercising responsible prescribing practices, individuals in recovery from opioid/methamphetamine use disorder)		
Physical Design (e.g., improving environmental and structural signs and areas to support the initiative)		
Increase safe storage solutions in homes or schools (e.g., lock boxes)		
Clean needles and other waste related to opioid use from parks and neighborhoods		
Identify problem establishments for closure (e.g., close drug houses, "pill mills")		
Educate/Inform about Modifying/Changing Policies (e.g., changing institutional or government policies)		
State policies supporting a Prescription Monitoring Program		
Policies regarding Narcan/naloxone administration		
Good Samaritan Laws		
Crime Free Multi-Housing Ordinances		
Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use)		

4. Please describe any key activities your coalition has engaged in around the issue of addressing opioids/ methamphetamine in your area. Activities may be key at any step in the process from capacity building and building community awareness to reducing opioid/methamphetamine use and overdoses/deaths. Provide as much detail as possible about the activity:
    - What was the activity (clear description, including context if part of other activities)?
    - Who (staff/community members/sectors) was involved in planning and carrying out the activity?
    - Who was the audience(s) for the activity?
    - When did activity occur (including how often if more than once)?
    - How the activity impacted the community (e.g., any opioid/methamphetamine outcomes associated with the activity)?

Be clear on how effective the activities were based on coalition goals for the activity. Identify any challenges that had/would need to be addressed in order for similar activities to be effective in other communities.

COMMUNITY AND POPULATION-LEVEL OUTCOMES SECTION

Evaluation measures the quality and outcomes of coalition work.
Evaluation enables the improvement of interventions and coalition practices.

Subsection: Core Measures

Core measures will be reported in a separate section of the DFC *Me* system. To create a new core measures report, select the Core Measures tab under Reporting. Once you've completed entering your core measures data into a report, click Mark as Ready for Submission. Then, in the Progress Report Community & Population Level Outcomes Section, click the box next to the name of your core measures report to attach the measures to the progress report.

Once the system is updated, you must submit the survey used to collect the data that you are submitting in order to be able to submit core measures data. You will receive a survey review guide from the DFC & CARA National Evaluation teams once their review of your survey is complete. Be sure to leave adequate time prior to core measures data submission to complete this step in the process. Surveys can be submitted at any time. Your survey review guide provides you with information on what data the grant award recipient is expected to submit (which core measures have been approved for which substances) as well as guidance on how to calculate percentage use. For substances labeled as Optional, data may be submitted if available but are not required.

Survey *(dropdown of coalition's approved surveys. Note may be preapproved in February 2021)) -*

For which grade levels are you reporting data? *Select all grade levels that you will report data for. Please note that if you are unable to separate your data by grade level, please select "All Middle School (aggregate data)" and/or "All High School (aggregate data)" to report combined core measures data for middle and high school students.*

Month and Year Data Were Collected: __/__

Core Measure: Past 30-Day Use

Please report the percentage of students who reported any use in the past 30 days, including only reporting use on one day

Grade	Measure	Prescription Drugs	(Optional) Heroin	(Optional) Methamphetamine
6	30-day Use %			
	Sample Size			
7	30-day Use %			
	Sample Size			
8	30-day Use %			
	Sample Size			
9	30-day Use %			
	Sample Size			
10	30-day Use %			
	Sample Size			
11	30-Day Use %			
	Sample Size			
12	30-Day Use %			
	Sample Size			
Middle School	30-Day Use %			
	Sample Size			
High School	30-Day Use %			
	Sample Size			

Core Measure: Perception of Risk

Please report the percentage of students who reported moderate and great risk responses for each substance

Grade	Measure	Prescription Drugs	(Optional) Heroin	(Optional) Methamphetamine
6	30-day Use %			
	Sample Size			
7	30-day Use %			
	Sample Size			
8	30-day Use %			
	Sample Size			
9	30-day Use %			
	Sample Size			
10	30-day Use %			
	Sample Size			
11	30-Day Use %			
	Sample Size			
12	30-Day Use %			
	Sample Size			
Middle School	30-Day Use %			
	Sample Size			
High School	30-Day Use %			
	Sample Size			

Core Measure: Perception of Peer Disapproval

Please report the percentage of students who reported wrong and very wrong responses for each substance

Grade	Measure	Prescription Drugs	(Optional) Heroin	(Optional) Methamphetamine
6	30-day Use %			
	Sample Size			
7	30-day Use %			
	Sample Size			
8	30-day Use %			
	Sample Size			
9	30-day Use %			
	Sample Size			
10	30-day Use %			
	Sample Size			
11	30-Day Use %			
	Sample Size			
12	30-Day Use %			
	Sample Size			
Middle School	30-Day Use %			
	Sample Size			
High School	30-Day Use %			
	Sample Size			

Core Measure: Perception of Parent Disapproval

Please report the percentage of students who reported wrong and very wrong responses for each substance

Grade	Measure	Prescription Drugs	(Optional) Heroin	(Optional) Methamphetamine
6	30-day Use %			
	Sample Size			
7	30-day Use %			
	Sample Size			
8	30-day Use %			
	Sample Size			
9	30-day Use %			
	Sample Size			
10	30-day Use %			
	Sample Size			
11	30-Day Use %			
	Sample Size			
12	30-Day Use %			
	Sample Size			
Middle School	30-Day Use %			
	Sample Size			
High School	30-Day Use %			
	Sample Size			

Subsection: Outcomes Summary

Note: You are only required to complete these four fields if you will be submitting Core Measures with this progress report. The exception to this is to submit your Data Management Plan in the noted field.

Compared to your coalition's area of focus (zip codes served), the geographical area covered by these data is:

- ❍ Larger
- ❍ Smaller
- ❍ The Same
- ❍ Don't Know

Does your data represent your population of focus?

- ❍ Yes
- ❍ No

If no, please explain: _____

Does your data represent the same grades and same schools that were surveyed in your last report?

- ❍ Yes
- ❍ No If no, please explain: _____

Do you have any concerns about the quality of your data? Please explain.

- ❍ Yes. If yes, please explain: _____
- ❍ No

Please report any notable accomplishments related to evaluation achieved during this reporting period *(Maximum of 2,000 character with spaces)**:***

Please report any additional details, including barriers or challenges, about your evaluation activities that were not captured above *(no character limit)**: describe geographic area***

(ENTER Data Management Plan in this field)

Recommended Core Measures Wording

30-Day Use		
During the past 30 days have you used prescription drugs not prescribed to you?	Yes	No
During the past 30 days have you used heroin?	Yes	No
During the past 30 days have you used methamphetamine?	Yes	No

Perception of Risk				
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?	No Risk	Slight Risk	Moderate Risk	Great Risk
How much do you think people risk harming themselves physically or in other ways if they use heroin?	No Risk	Slight Risk	Moderate Risk	Great Risk
How much do you think people risk harming themselves physically or in other ways if they use methamphetamine?	No Risk	Slight Risk	Moderate Risk	Great Risk

Perception of Peer Disapproval				
How wrong do your friends feel it would be for you to use prescription drugs not prescribed to you?	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your friends feel it would be for you to use heroin?	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your friends feel it would be for you to use methamphetamine?	Not at all wrong	A little bit wrong	Wrong	Very wrong

Perception of Parent Disapproval				
How wrong do your parents feel it would be for you to use prescription drugs not prescribed to you?	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your parents feel it would be for you to use heroin?	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your parents feel it would be for you to use methamphetamine?	Not at all wrong	A little bit wrong	Wrong	Very wrong

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Comprehensive Addiction and Recovery Act (CARA) National Cross-Site Evaluation Team,

Barbara K. O'Donnel, PhD
Jason Schoeneberger, PhD
Samantha Salvador, MA
Richard A. Van Dorn, PhD
Violette Cloud, Esq., MS
Isolynn A. Massey, BA
Sarah L. Desmarais, PhD

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