DRUG-FREE COMMUNITIES (DFC) SUPPORT PROGRAM

END-OF-YEAR 2023 REPORT NATIONAL CROSS-SITE EVALUATION

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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 August 2022 to July 2023 and core measures data from 2002 to 2023. Additional details about the program and findings are presented in full in the report.

- **DFC coalitions met the goal of preventing and reducing youth substance use in their community(ies).[1] This was true for the DFC program collectively (all coalitions ever funded) and for the most recent DFC cohort (awarded in Fiscal Year [FY] 2022) highlighted in this report.**
  - Figure ES1 provides an overview of core outcome findings for the current DFC cohort as of August 2023, with changes reflecting change from first report to most recent report of the given core measure.[2] Significant decreases in past 30-day prevalence of substance use from first report to most recent report are also presented as percentage change in Figure ES2.
  - Among high school youth in each of the samples, there were significant decreases from first report to most recent report in past 30-day use. Among high school youth, prescription drug misuse had the largest decrease (-43%), followed by the decrease in tobacco use (-40%).
  - The same was true for middle school youth. In both samples, past 30-day alcohol, marijuana and tobacco use, and prescription misuse reported by middle school youth all declined significantly from first report to most recent report. Among middle school youth, decreases were relatively consistent across substances (27% to 29%).

FIGURE ES1. OVERVIEW OF CORE OUTCOMES FINDINGS FY 2022 GRANT RECIPIENTS

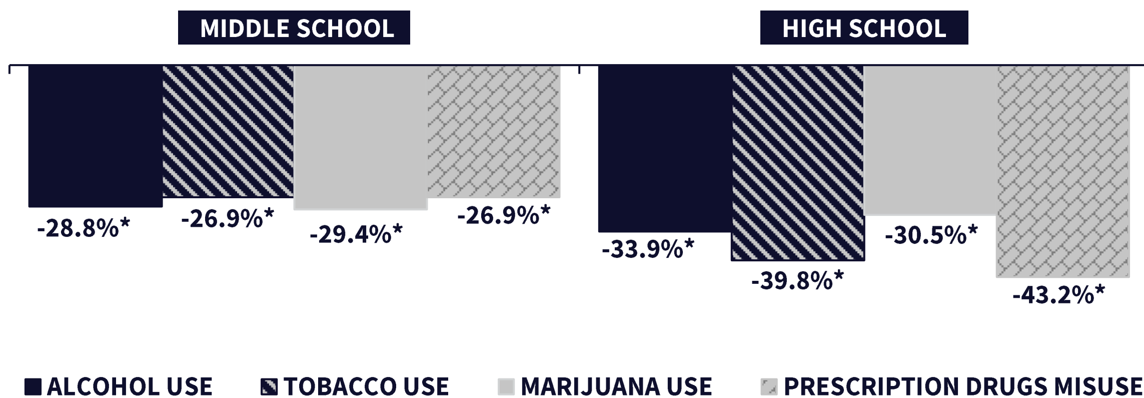
MIDDLE SCHOOL					HIGH SCHOOL				
OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS	OUTCOME	ALCOHOL	TOBACCO	MARIJUANA	PRESCRIPTION DRUGS
PAST 30-DAY USE	↓	↓	↓	↓	PAST 30-DAY USE	↓	↓	↓	↓
PERCEPTION OF RISK	↓	NC	↓	NC	PERCEPTION OF RISK	NC	↓	NC	NC
PARENTAL DISAPPROVAL	↓	↓	↓	↓	PARENTAL DISAPPROVAL	NC	↑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

Source: DFC 2002–2022 Progress Reports, core measures data
Note: Up arrows indicate significant increases ($p < .05$); down arrows indicate significant decreases ($p < .05$); NC=No Change

[1] 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.

[2] DFC coalitions have reported data from 2002 to 2023. 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 2023. 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 at least $p < .05$.

FIGURE ES2. PERCENTAGE CHANGE IN PAST 30-DAY SUBSTANCE USE/MISUSE: FY 2022 DFC COALITIONS



Source: DFC 2002–2023 Core Measures Data
Note: All decreases significant; **p* < .05

- Prescription drug misuse remained relatively low for youth in both middle and high school (less than 3% at most recent report).
- Based on data collected in 2021, past 30-day use of alcohol and marijuana among high school youth in DFC communities were significantly lower than rates in a national sample from the Youth Risk Behavior Survey (YRBS).[3] There were no differences in the DFC versus national YRBS samples in high school youth use of tobacco. YRBS does not collect comparable data on prescription drug misuse.
- While decreases were seen in substance use, middle school youth perceptions of risk associated with marijuana significantly decreased for all DFC coalitions since inception, and for both marijuana and alcohol for the most recent DFC cohort. Among high school youth, there were significant decreases in perceptions of risk associated with substance use. There was no change in high school perception of risk for alcohol, tobacco, and prescription drug use; however, perceived risk associated with marijuana use among all DFC since inception, and for tobacco use in the most recent cohort.
- High school youth reported significantly increased perception of peer disapproval across all substances and increased perception of parent disapproval for tobacco use. Additionally, high school youth in DFC communities reported significantly lower past 30-day use of alcohol and marijuana in 2021 as compared to a national sample from the Youth Risk Behavior Survey; however, past 30-day tobacco use did not differ between these two samples.
- In line with youth substance use, coalitions focused prevention efforts on core measure substances (alcohol [97%], marijuana [92%], tobacco [81%], and/or prescription drug misuse [73%]).[4]

- **Nearly 1 in 4 Americans (23%; ~75 million people) lived in a community with a DFC coalition in 2023, including approximately 3 million middle school aged youth and approximately 4 million high school aged youth.**
  - In 2023, nearly a quarter of Americans (23%) lived in a community served by a DFC-funded coalition.[5]
  - Over half of Americans (55%) have lived in a community with a DFC coalition since 2005.

[3] YRBS data for 2023 are not yet available.
[4] Coalitions selected up to five substances focused on from a list of substances.
[5] In FY 2022, the DFC program awarded 744 coalitions.

- **DFC coalitions served a diverse range of communities across the United States and its territories to address local problems with local solutions, with nearly three fourths (72%) working to address health equity issues in their communities.**
  - More than half of DFC coalitions (54%) were working in rural and/or frontier communities.[6] Slightly fewer (45%) were working in suburban communities and just over one-fourth (28%) were working in urban and/or inner-city communities.
  - Coalitions reported tailoring prevention efforts to serve a diverse range of demographics. This includes over three-fourths of coalitions tailoring efforts for White, Non-Hispanic and Hispanics youth/people (75% and 72%, respectively) and over half (59%) tailoring prevention efforts for Black/African American youth/people. Coalitions also reported tailoring efforts to best support Asian/Asian-American, American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander youth/people (23%, 12% and 8%, respectively).
  - Two-thirds (66%) of coalitions reported tailoring prevention efforts to support LGBTQ+ youth/people.[7]
  - Among the three-fourths of DFC coalitions working to address health equity issues in their communities, coalitions were most likely to be working to address equity issues around socioeconomic status (94%) and race/ethnicity (91%); around three-fourths were addressing equity issues around sexual orientation/gender identity and geographic setting (80% and 79%, respectively).[8]
  - On average, coalitions felt they were most effective at planning with a focus on equity, addressing adverse childhood experiences, and diversity in participants in coalition activities that were representative of the community.
- **DFC coalitions were meeting the program goal of building community capacity to prevent and reduce youth substance use, successfully mobilizing approximately 43,000 community members to engage in evidence-based youth substance use prevention/reduction efforts.**
  - In total, DFC coalitions reported mobilizing approximately 10,000 youth to engage in substance use prevention efforts.
  - Most coalitions (92%) reported having at least one member from each of twelve sectors, although fewer reported active members from all sectors (76%). The Youth and School sectors contributed the highest median number of sector members to coalitions (7 and 4, respectively). The School sector was selected most often as the sector leading the coalition (18%).
  - Almost all coalitions (99%) reported working with at least one school, with most (85%) working with multiple schools either in a single or multiple districts. Just under 1 in 5 (18%) DFC coalitions were being led by the school sector. Almost all coalitions (99%) reported conducting work directly in schools, with schools serving a crucial role in connecting the coalition to youth and families and vice versa. Some coalitions noted effectively working with the school sector to address mental health challenges that may contribute to youth substance use.

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[6] Coalitions selected all that apply from the list of the five geographic settings.

[7] LGBTQ+ stands for lesbian, gay, bisexual, transgender, questioning youth/people, with the plus representing other sexual orientations such as asexual, non-binary, and two spirt.

[8] Coalitions were asked to select from a list of all that apply the areas of health equity they were working to identify and/or address.

- **Over two-thirds of DFC coalitions (70%) 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.
  - Just over half (55%) of DFC coalitions who hosted a youth coalition included youth members at coalition/leadership meetings, with 45% reporting youth coalition representatives being involved in coalition decision making.
  - Hosting a youth coalition appears to be one way coalitions support youth in being better connected to their families, schools, and communities—connections that are correlated with lower likelihood of substance use engagement.[9] This is in line with coalition overall efforts focused on strengthening protective factors including the connections of youth to their community (94%), family (82%), and school (78%).
- **Addressing risk factors and enhancing protective factors present in their communities was a guiding focus for the work of DFC coalitions.**
  - DFC coalitions perceived community norms favorable toward substance use as the strongest risk factor in their communities while access to safe, high-quality schools was the strongest protective factor.
  - DFC coalitions were highly focused on addressing favorable attitudes toward substance use and on enhancing perceptions that peers would disapprove of such use. As reported in the core measures, these efforts in DFC communities appear to have been effective among high school youth demonstrated by an increase in perceived peer disapproval across substances.
  - DFC coalitions also engaged in efforts to enhance positive youth connections to their community (94%), family (82%), and school (78%).
- **DFC coalitions worked to bring about change by implementing a comprehensive mix of strategies, with more than three-fourths (80%) implementing at least one activity in at least five of the seven strategy types.**
  - *Providing Information* remains the most common strategy with virtually all coalitions (99%) conducting at least one activity of this strategy type. *Changing Access/Barriers* was the most engaged in environmental strategy, with 87% of coalitions implementing at least one activity of this type(e.g., reducing home and social access; improved access to overdose prevention materials).
  - Coalitions were able to put in place a range of community assets following DFC awards including culturally competent substance use prevention materials (72%) and social norm campaigns (72%).

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

- **DFC coalitions reported that they implemented activities to address opioid and/or methamphetamine use (78%) and vaping (82%), while fewer (9%) identified xylazine as an emerging issue.**
    - Just over three-fourths (78%) of DFC coalitions implemented activities to address opioids and/or methamphetamine, with most implementing activities to address prescription drug misuse and/or fentanyl use (93% and 84%, respectively).[10]
    - Most DFC coalitions (82%) implemented activities to address youth vaping. Of these coalitions, 96% reported that their work focused on vaping nicotine/tobacco, and 89% reported that their work addressed vaping marijuana.
    - The primary focus of coalition's opioid-related work was to address issues around prescription drug misuse (93%) followed by use of fentanyl, fentanyl analogs, or other synthetic opioids (85%).[11]
    - Among coalitions who implemented activities to address vaping, 96% were focused on vaping nicotine/tobacco and 89% focused on vaping marijuana.
    - DFC coalitions noted identifying xylazine as either emerging in their community or that they were tracking data to be ready should it emerge in their communities. Coalitions were also engaged in educating their communities about risks associated with xylazine by providing both information and trainings.

[10] Fentanyl use here references the use of fentanyl, fentanyl analogs or other synthetic opioids.
[11] Coalitions selected all substances that applied including prescription drugs, heroin, fentanyl, and methamphetamine.

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:[12]

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

DFC Program Partners and Funding

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

- **Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC)** provides grant management services and government project officer support and monitoring.
- **CADCA**, a nonprofit organization, provides training and technical assistance to strengthen the capacity of DFC coalitions. This is accomplished through the National Coalition Academy, which is a grant funded by ONDCP.[13]
- **DFC National Cross-Site Evaluation Team** conducts the national evaluation and provides related technical assistance (e.g., data collection and reporting) to DFC coalitions. In addition to high level annual reports such as this, additional evaluation information is shared in issue briefs on specific topics.

DFC grant award recipients receive up to $125,000 annually for up to 5 years per award, with a maximum of 10 years of grant award funding per grant recipient.[14] 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 744 community coalitions awarded DFC grants in Fiscal Year (FY) 2022. Of these, 400 (54%) were funded through an initial 5-year grant; the

[12] ICF, an independent third-party evaluator, was awarded this contract from ONDCP.
[13] CADCA is the name of the organization, not an acronym. Please see https://nationalcoalitioninstitute.org/ for additional information about the National Coalition Institute and resources offered by CADCA.
[14] 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/overdose-prevention/php/drug-free-communities/nofo-faq.html. For information on the FY 2022 awards please see CDC-RFA-CE22-2205 and CDC-RFA-CE20-2004-CC22 at https://www.grants.gov/.

remaining 344 (46%) were in Years 6 to 10 of funding. As of 2023, over 3,500 DFC grants have been awarded in over 2,200 communities.[15]

Background

National data consistently suggests that middle school and high school youth (ages 12-18), the focus of DFC prevention efforts, are at risk for both initiating substance use, engaging in regular substance use and, in some cases, developing substance use disorders. For example, findings from the 2021 Youth Risk Behavior Survey (YRBS) suggest that among high school youth, 22.7% reported current (past 30-day) alcohol use, 15.8% current marijuana use, 6% current prescription opioid misuse, and 13% reported ever using illicit drugs.[16] The 2022 National Survey on Drug Use and Health (NSDUH) reported that among youth aged 12-17, 7.3% reported any past month (30-day) illicit drug use, including 6.4% who reported past-month marijuana use.[17] 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.[18] Alcohol is the most commonly used substance among youth although youth use of alcohol is generally trending downward and remains a leading cause of preventable death in the United States.[19] Research suggests from 2015-2019, an estimated 1 in 5 deaths among adults aged 20 to 49 years in the United States were attributed to excessive alcohol use.[20] Excessive drinking contributes to about 4,000 deaths among people below the age of 21 in the U.S. each year. Youth alcohol use is linked to alcohol dependence later in life, death from alcohol poisoning, unintentional injuries, such as car crashes, falls, burns, and drownings. Prevention may reduce premature death and other consequences related to alcohol use.[21]

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[15] Based on available data through FY 2023, 2,284 communities have received DFC grant awards, with 1,026 communities receiving a Year 1 to Year 5 award and 1,258 communities receiving an additional Year 6 to Year 10 award. Combined, these total 3,542 DFC grant awards. This is a conservative estimate of awards through FY 2021 as much award data pre-2009 were not available.

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

[17] See Table 1.25B and Table 1.2B Section 1 PE Tables – Results from the 2022 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. .

[18] 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.

[19] Centers for Disease Control and Prevention. 2021 Youth Risk Behavior Survey Data. Accessed September 13, 2023. http://yrbs-explorer.services.cdc.gov/

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

[21] CDC - Fact Sheets-Minimum Legal Drinking Age - Alcohol. (2020, September 3). Centers for Disease Control and Prevention. Why A Minimum Legal Drinking Age of 21 Works | Alcohol Use | CDC

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 substance use 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 substance use prevention efforts, community coalitions can bring about synergistic change, rather than change occurring only in siloed activities engaged in by each sector. DFC coalitions may also bring about change in how each sector engages in their own efforts as well as their engagement in the collective efforts. That is, there is a sum effect of collaborative change occurring based on coalition efforts as well as enhanced individual sector efforts.

DFC coalitions develop an action plan as part of their grant application and then are expected to update these plans at least annually, driven in part by ongoing understanding of youth substance use 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, the 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 risk and protective factors (or social determinants), which are conditions in each of the places where youth/people live, learn, work and play.[22] Coalitions may be able to implement activities by addressing risk factors or enhancing protective factors, which contributes to the increased likelihood of youth making positive choices (in this case not to engage in substance use). Risk factors include adverse childhood experiences (ACEs).[23] Experiencing ACEs, particularly two or more, has been associated with a range of negative outcomes including an increased risk of substance use problems, both during adolescence and into adulthood. Conversely, exposure to a range of protective factors (positive childhood experiences) 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 to the

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

[23] See the CDC's Preventing Adverse Childhood Experiences for more information on this topic: Program: Essentials for Childhood: Preventing Adverse Childhood Experiences through Data to Action | Adverse Childhood Experiences (ACEs) | CDC

families, schools and communities are far less likely to engage in substance use than those who are not.[24]

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 the coalition classification tool (CCT). Beginning in 2023, DFC coalitions moved to a single annual progress report (as compared to every six months previously), making ongoing support and guidance to track implementation regularly even more critical.[25] This report includes all core measures data submitted through August 2023, as well as detailed analysis of coalition efforts reflected in the coalitions' submission of their August 2023 progress report and the CCT.[26] In addition to the shift to a single annual progress report in 2023, the progress report was revised to include a broader section on diversity and health equity, revised and more extensive risk and protective factor measures, and several new activities were added to strategy types.

Progress Report

DFC coalitions collect and submit a broad range of data through annual progress reports including information about the community context, building capacity, and implementation of substance use 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.[27]

- *Coalition Structure & Process* includes information regarding the potential reach of the program (associated with ZIP codes served), community context (e.g., geographic setting, school setting, HIDTA collaboration), focus of coalition efforts (e.g., substances focused on), and diversity and health equity (e.g., demographic group tailored prevention efforts, working to address health equity). Beginning in 2023, coalitions were able to indicate that they are not tailoring efforts to specific groups of youth/people because the given group is not present in the community(ies) the coalition serves. In

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[24] 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.

[25] Given this shift, comparison to six-month implementation data were not appropriate. Throughout this report, we call out revised or added measures. Additional information about the progress report can be requested from ICF at dfc_evaluators@icf.com.

[26] All 744 FY 2022 coalitions submitted reports in time to be included in this report.

[27] Throughout this report, when incorporating qualitative anecdotes with findings, DFC coalitions will be identified by their FY 2022 funding year (1–10) and by the U.S. census region where they are located (see Census Regions and Divisions of the United States).

addition, new items regarding health equity were added in 2023. Coalitions were first asked to indicate if they were working to address health equity in their community(ies). If they responded yes, they then selected what types of health equity issues they were working on (i.e., socioeconomic status, race/ethnicity, geographic setting, sexual orientation/gender identity, other). Finally, they are asked to report on how effective they perceived their coalition's efforts had been at addressing diversity and health equity across a range of issues and to describe their efforts.

- *Building Capacity* includes data on the number of members (total and active), level of member involvement by sectors, and changes in sector involvement. Coalitions also report on hosting (or not) a youth coalition and their capacity building activities. The 12 required community sectors[28] 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.
- A revised *Risk & Protective Factors* measure was introduced in 2023 to better capture the potential range of factors coalitions identify as issues in their communities. The new measure includes 35 risk factors and 34 protective factors across four broad categories: community factors, school, faith, and peer factors, family/parent/caregiver factors, and individual factors (see Appendix A). Generally, each risk factor is matched to a corresponding protective factor (e.g., low school connectedness risk and high school connectedness protective).[29] For each factor, coalitions were asked to indicate the extent to which the factor is an issue in their community and to indicate yes/no if they are working to address/enhance the factor.
- *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.[30] DFC recipients are encouraged to prioritize implementing environmental strategies as they are most effective for long-term, community-level

Individual Strategies

Providing Information
Enhancing Skills
Providing Support

Environmental Strategies

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

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[28] As per the notice of funding opportunity. For further information see the most current notice of funding opportunity here: Apply for DFC Funding | Overdose Prevention | CDC.

[29] The only risk factor without a matching protective factor is the individual factor, "Youth experience death of peer/classmate/close friend.'

[30] 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 Apply for DFC Funding | Overdose Prevention | CDC.

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

Core Measures Data

DFC coalitions are required to collect and submit new youth core measures data at least every two years from at least three grades.[31] Briefly, the core measures are defined as follows (see Appendix B for specific wording for each of the core measure items):

Past 30-Day Prevelance of Use

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

Perception of Risk

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

Perception of Parent Disapproval

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

Perception of Peer Disapproval

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

Data associated with each core measure are summarized by substance and time of report (first versus most recent report), allowing for the calculation of change in response patterns over time. Coalitions are encouraged to provide first report data that were collected within three years prior of grant receipt as a baseline, but are not required to submit data until Year 2 of their award. In addition, these data are reported by school level (i.e., middle school grades 6 through 8; high school grades 9 through 12). Finally, given that core measures are a key outcome of the program, analyses are conducted for two samples: all DFC coalitions since inception and the FY 2022 cohort only.

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

Community Context

Key Findings

In 2023, one-fourth (25%) of Americans lived in a community with a DFC-funded coalition, with prevention efforts tailored to a diverse range of geographic settings and demographics.

Around half of coalitions work in rural/frontier communities or suburban communities (54% and 45% respectively) while just over one-fourth (28%) work in urban and/or inner-city communities.

Most coalitions (>90%) indicated that their communities included youth/people who were White, Non-Hispanic, Hispanic, and Black/African American and were tailoring prevention to effectively serve youth/people in these groups (75%, 72% and 59%, respectively). Fewer communities reported serving and/or tailoring efforts to American Indian/Alaska Native, Native Hawaiian or Other Pacific Islander, or Asian/Asian American youth/people. Two-thirds of DFC coalitions (66%) were tailoring prevention efforts to best serve youth/people identifying as LGBTQ+.

Nearly three-fourths (72%) reported working to some extent to identify and address health equity issues. Of these, focus was on a range of equity issues including socioeconomic status (94%), race/ethnicity (91%), sexual orientation/gender identity (80%), and geographic (79%).

DFC coalitions perceive large numbers of risk and protective factors as being present in their communities. Coalitions are engaging to address a broad range of factors, including enhancing perceptions that peers will disapprove of substance use.

The following sections summarize DFC coalitions' responses to questions pertaining to the communities with whom they work on prevention including working to identify and address healthy equity issues in these communities.

DFC Reach

In 2023, there were DFC coalitions in each of the 50 states, as well as in the District of Columbia and three United States territories (Guam, Puerto Rico, and Virgin Islands). Given the number and broad geographic distribution of DFC coalitions, many Americans potentially benefit from the program as they live in communities served by grant recipients. An estimated 75 million people (23% of the U.S.

population) lived in communities served by DFC coalitions receiving funding in 2023.[32] This included approximately 3 million middle school youth ages 12 to 14 (23% of all middle school youth) and about 4 million high school youth ages 15 to 18 (23% of all high school youth). Since 2005, approximately 186 million, or 56% of the U.S. population, has lived in a community with a DFC coalition.

Geographic Setting

Based on selecting all that apply, DFC coalitions reported serving on average one or two of the five geographic settings (frontier, rural, suburban, urban, and inner city). Just over half (54%) were working in rural and/or frontier communities. Slightly fewer (45%) were working in suburban communities and just over one-fourth (28%) were working in urban and/or inner-city communities.[33]

Diversity and Health Equity

To understand the diversity of communities served by DFC coalitions, recipients were asked to indicate if given race/ethnicity subgroups were present in the community, and if they were present, if the coalition was making efforts to tailor prevention efforts to that group (see Figure 1). Almost all coalitions indicated that their communities included youth/people who were White, Non-Hispanic, Hispanic, and Black/African American. Nearly three-fourths were tailoring efforts to White, non-Hispanic and Hispanic youth/people (75% and 72%, respectively) while over half (59%) tailored prevention efforts to Black/African American youth/people. Over a third of coalitions (37%) reported that American Indian/Alaska Native and/or Native Hawaiian or Other Pacific Islander youth/people were not present in their community while just under one-fifth (18%) reported Asian/Asian-American youth/people were not present in the community and coalitions were less likely to tailor prevention efforts to these subgroups when present in the community.

Two-thirds of coalitions (66%) indicated they were tailoring prevention efforts to LGBTQ+ youth/people.[34] Coalitions could also indicate that other subgroups of youth were present in their community. Most common identified other groups were immigrant and/or refuge, low socioeconomic/poverty, Middle Eastern/Arabic, and youth with disabilities.

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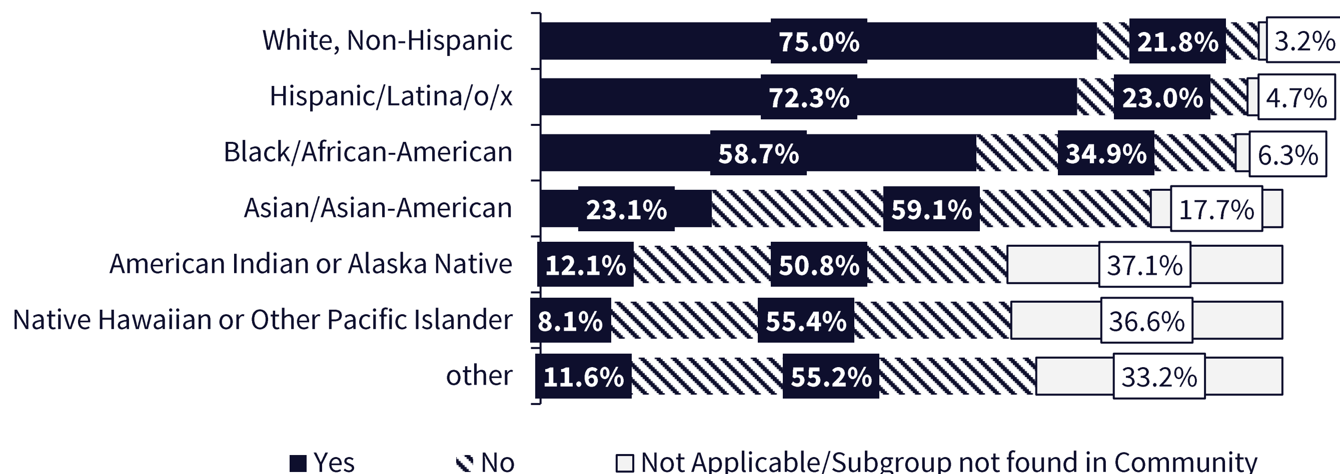
[32] DFC coalitions identify catchment areas by ZIP codes, indicating all ZIP codes in which grant activities are conducted. These ZIP codes were merged with 2023 United States (U.S.) Census data to provide an estimate of DFC coalitions potential reach and impact. DFC coalitions provide ZIP codes while the U.S. Census 2023 Age Groups and Sex table uses ZIP Code Tabulation Area (ZCTA). These are similar but not identical (see https://www.census.gov/topics/population/age-and-sex/data/tables.html. and https://www.census.gov/programs-surveys/geography/guidance/geo-areas/zctas.html). Some ZIP codes (less than 5%) reported by DFC coalitions were not found in the U.S. Census ZCTA, typically because they represent smaller communities. Census estimates reported here are likely a conservative estimate of potential reach of the DFC grant. Estimates excluded a coalition that serves the entire state of New Jersey. Including this coalition increases the percentage to about 25%.

[33] 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

[34] A small number of coalitions (4%) indicated that LGBTQ+ youth/people were not present in their communities. Given that this is unlikely, the response was treated as not tailoring efforts. Going forward, not applicable will not be an option for this subgroup.

FIGURE 1. PERCENTAGE OF DFC FOCUSED ON TAILORING PREVENTION EFFORTS BY RACE/ETHNICITY

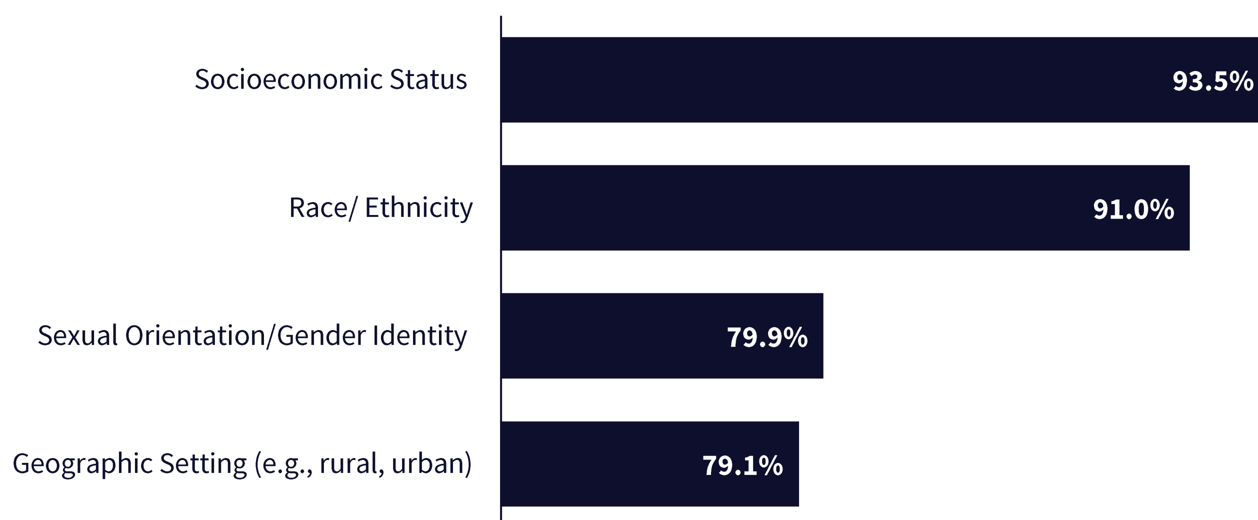


Source: DFC August 2023 Progress Report

Note: Not applicable indicates that a given race/ethnicity subgroup is not present in the community. No indicates they are present, but the coalition is not making efforts to tailor prevention efforts to the group while yes indicates they are tailoring efforts to the subgroup.

Beyond tailoring prevention efforts, DFC coalition were asked if they were working to identify and/or address health equity issues in their communities (see Figure 2). Nearly three-fourths (72%) reported working to some extent to address health equity. Among those who responded yes, almost all were working to address health equity related to socioeconomic status (94%) and to race/ethnicity (91%). While not quite as high, just over three-fourths reported working to address health equity related to sexual orientation/gender identity (80%) and to geographic setting (79%).

FIGURE 2. PERCENTAGES OF DFC COALITIONS WORKING TO ADDRESS HEALTH EQUITY BY TYPE

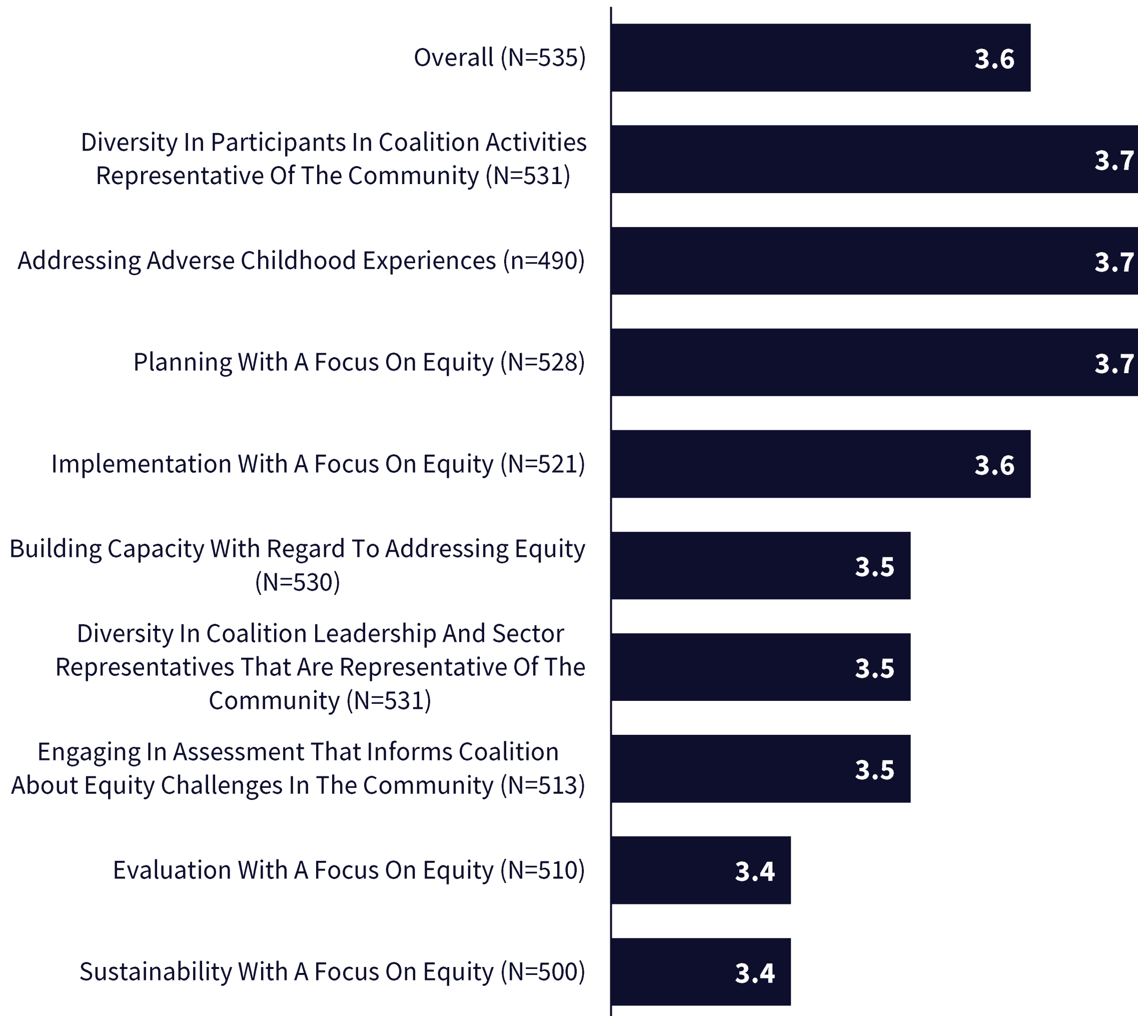


Source: DFC August 2023 Progress Report

Note: Percent is within the 536 DFC coalitions (72%) who reported working to identify and/or address health equity. Just over one-fourth of DFC coalitions (28%) were not working to identify and/or address any health equity issues in their community.

Finally, DFC coalitions indicated how effective they perceived their coalition's efforts had been at addressing diversity and health equity across a range of issues (see Figure 3; see also Figure C.1, Appendix C). On average, coalitions felt they were most effective at planning with a focus on equity, addressing adverse childhood experiences, and diversity in participants in coalition activities that were representative of the community (M=3.7, score of 4 indicates moderately effective).

FIGURE 3. AVERAGE EFFECTIVENESS IN WORKING TO ADDRESS HEALTH EQUITY BY TYPE



Source: DFC August 2023 Progress Report

Note: Percent is within the 535 DFC coalitions who reported working to identify and/or address health equity and who indicated they were working on the specified issue. Effectiveness was rated ass 1=Very Ineffective, 2=Somewhat Ineffective, 3=Somewhat Effective, 4=Moderately Effective, 5=Very Effective

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 Table 1). On average, DFC coalitions reported focusing on 4.3 substances. Nearly all coalitions reported addressing alcohol (97%) and marijuana (92%). Coalitions also reported addressing tobacco/nicotine (81%) and nearly three-fourths

focused on any prescription drugs (73%).[35] The next most common substance focused on was heroin, fentanyl, fentanyl analogs or other synthetic opioids (35%).

TABLE 1: PERCENTAGE OF DFC COALITIONS FOCUSED ON A GIVEN SUBSTANCE

SUBSTANCE	PERCENT
Alcohol	97%
Marijuana	92%
Tobacco/Nicotine	81%
Any Prescription Drugs	73%
Prescription Drugs (Opioids)	70%
Heroin, Fentanyl, Fentanyl analogs or other Synthetic Opioids	35%
Prescription Drugs (Non-Opioids)	29%
Synthetic Drugs/Emerging Drugs	8%
Over-the-Counter (OTC) drugs	8%
Methamphetamine	7%
Stimulants (uppers)	2%
Cocaine/Crack	1%
Inhalants	1%

Source: DFC August 2023 Progress Report
Note: Coalitions could select up to five substances from the list. Only substances with ≥ 1% of DFC coalitions selecting are displayed.

Community Protective and Risk Factors

In August 2023, DFC coalitions completed a newly revised risk and protective factors measure. 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. The new measure was designed to include a broader range of these factors (see Appendix A) and to better understand both the extent to which factors are present in a community and to identify those factors coalitions are focused on engaging in addressing/enhancing. The responses provide valuable insights into areas DFC coalitions identify as requiring more focused intervention and highlight the strengths that can be used to facilitate a healthier and more supportive environment for all community members.

The questions are divided into four main categories: 1. Community Factors, 2. School, Faith, and Peer Factors, 3. Family/Parent/Caregiver Factors, and 4. Individual Factors. For each category, we present the prevalence of specific risk and protective factors, along with the extent coalitions' engagement in addressing or strengthening these factors. Responses to the survey questions were coded based on the extent to which each factor is perceived as a risk or protective element in the community, categorized as No/Low (0), Moderate (1), or High (2). Additionally, DFC coalitions indicated whether they engaged in efforts to address each risk factor or strengthen each protective factor, coded as Yes (1) or No (0).

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

On average, DFC coalitions indicated that 25 of the 35 risk factors were a risk to any extent (71%; range from 1 to all 35) and that 26 of the 34 protective factors were present to any extent in their community (76%; range from 1 to all 34). Table 2 identifies those risk and protective factors that were identified as being an issue in DFC communities to the greatest and least extent (see Table A.1, Appendix A for data for all factors). Note that for risk factors being present to a low extent indicates the factor is less likely to need to be addressed. Conversely, when protective factors are present to a low extent, coalitions are less able to build on the factor as already present in the community.

TABLE 2. RISK AND PROTECTIVE FACTORS IDENTIFIED AS PRESENT TO THE GREATEST AND LEAST EXTENT IN DFC COMMUNITIES

Highest Rated Risk Factors (≥1.2)	Mean	Highest Rated Protective Factors (≥1.1)	Mean
Perceived community norms favorable toward substance use (Community)	1.50	High/Broad access to safe, high-quality schools across the lifespan (School)	1.27
High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use (Peer)	1.31	High commitment to staying in school and attending school (School)	1.22
Easy availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing (Community)	1.26	Broad access to a range of faith-based services in the community (Faith)	1.18
Families/parents/caregivers lack ability/confidence to speak to their children about substance use (Family)	1.22	High rates of youth academic success (School)	1.17
Lack of local treatment services for substance use and/or poor access to mental health services generally in the community (Community)	1.21	Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors (Peers)	1.10
Individual youth have favorable attitudes towards substance use/misuse (Individual)	1.21		
Risk Factors Present to Lowest Extent (≤0.6)	**Mean**	**Protective Factors Present to Lowest Extent (≤0.7)**	**Mean**
Youth as little/no interest in education and work and has poor school and work habits that may contribute to failure (Individual)	0.55	Few youth who have experienced two or more risk factors/stressors (Individual)	0.69
Youth experience death of peer/classmate/close friend (Individual)	0.54	Perceived community norms promote non-use/misuse of substances (Community)	0.69
Low access to safe, high-quality schools across the lifespan (School)	0.36	Sufficient access to mental health and treatment/recovery services in the community (Community)	0.64
Poor access to a range of faith-based services in the community (Faith)	0.33	Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing (Community)	0.61
		Treatment/recovery services for substance use are sufficient to meet demand in a timely manner (Community)	0.58

Source: DFC August 2023 Progress Report

Note: Extent present coded as No/Low = 0, Moderate - 1, or High = 2.

DFC coalitions perceived community norms favorable toward substance use as being a risk to the greatest extent in their communities while high/broad access to safe, high-quality schools was the strongest protective factor. On average, schools were perceived as a protective factor in DFC communities to a great extent. Faith factors were less likely to be identified as risk factors while broad access to faith-based services in the community was among the highest protective factors. Factors related to youth feeling connected to their communities, schools, and families were generally rated as being both risk and protective factors in the middle range (see Table A.1, Appendix A).

On average, DFC coalitions were engaged in efforts to address 23 risk factors (range from 5 to 35) and efforts to enhance 25 protective factors (range from 3 to 34). Table 3 provides an overview of the risk and protective factors coalitions were engaged in addressing/enhancing to the greatest extent (see all Table A.2, Appendix A). DFC coalitions were highly focused on addressing favorable attitudes toward substance use and enhancing perceptions that peers would disapprove of such use. A sign that these efforts were working was significant increases among high school youth over time in perceiving peer disapproval of substance use (see Core Measures section and Table F.5).

TABLE 3. RISK AND PROTECTIVE FACTORS THAT NINETY PERCENT OR MORE (≥90%) OF DFC COALITIONS WERE ENGAGED IN ADDRESSING/ENHANCING

Highest Rated Risk Factors	%	Highest Rated Protective Factors	%
Individual youth have favorable attitudes towards substance use/misuse (Individual)	97.9%	Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use (Peer)	96.5%
High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use (Peer)	96.5%	Perceived community norms promote non-use/misuse of substances (Community)	95.2%
Perceived community norms favorable toward substance use (Community)	96.4%	Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use (Family)	95.2%
Families/parents/caregivers lack ability/confidence to speak to their children about substance use (Family)	95.7%	High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations (Community)	94.6%
Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use (Family)	94.0%	Families/parents/caregivers encourage youth to engage in healthy behaviors including avoiding substance use (Family)	94.0%
Early initiation of negative or unhealthy behavior, including substance use (Individual)	91.0%	Prevention, advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community (Community)	91.5%
		Delayed or no initiation of negative or unhealthy behavior, including substance use (Individual)	91.0%
		Youth have good life skills such as good decision-making and problem-solving skills (Individual)	90.6%

Source: DFC August 2023 Progress Report

DFC coalitions also provided qualitative data describing their work around risk and protective factors. In many cases, coalitions described their efforts to identify local factors, with fewer describing actions taken to address/enhance factors. Four specific risk factors showed up as key themes in this data: *Rising Youth Mental Health Concerns, Local Legalization of Marijuana, Bordering Communities with Different Laws, and Divestment from School Administrators.*

Addressing Concerns about Youth Mental Health Contributing to Substance Use

Coalitions identified increasing and sustained mental health concerns among youth in their communities as a risk factor. This included increased and rising rates of depression, anxiety, and suicidality. The coalitions noted that substance use, and mental health are intricately intertwined for young people. They describe how unaddressed mental health needs present a unique and pervasive risk for substance use. Several coalitions highlighted data that informed their thinking and action in this area.

- "Though our data show clear and consistent decreases in youth use of all substances during the past several years, risk factors remain generally steady, and youth expressing significantly higher rates of anxiety, depression, and suicidality… Additional concerning data included 43% students identifying as female reporting significant challenges with anxiety and sadness. This population also reports higher rates of both alcohol and tobacco use." (Year 6, Midwest Region)
- "The YRBS data showed that a high-risk factor in our community is high rates of suicide attempts and high rates of students feeling lonely, depressed, suicidal, or helpless. We have focused a lot of our efforts on connecting our substance use work with mental health as well. For example, when hosting a yoga workshop at the end of the school year to teach students healthy coping skills we explained how yoga could be used as a coping skill both for substance use and mental health issues. Whenever we provide information to students or parents about substance use or prevention resources, we also include mental health resources." (Year 3, Northeast Region)
- "Youth also experience mental health challenges, particularly those misusing drugs and alcohol. For example, based on our most recent data collection between 2020 and 2021: a. students who smoked marijuana during the past 30-days were 1.3 times more likely to be depressed and consider suicide; b. students who drank alcohol during the past 30-days were 2x more likely to be depressed and consider suicide; c. students who misused prescription drugs were 2x more likely to be depressed and consider suicide." (Year 10, Northeast Region)

Local Legalization of Marijuana

Coalitions also identified local legalization of marijuana as a specific risk factor for youth substance use. This included legislation supporting recreational marijuana, misinformation regarding the risks of recreational marijuana for children and adolescence, and favorable attitudes towards marijuana use among youth and adults.

- "New Jersey's first 13 dispensaries for adult-use marijuana opened in April 2022 to great fanfare, with a total of 24 open to date. The messaging around this newly legal substance (adults age 21 and up only) continues to be an area of concern across all risk factors. Youth perceive it as a safe and suitable treatment for anxiety, parents think it's "no big deal" and the rules and regulations for the adult use market, including enforcement, continue to evolve and are being written by a state commission that has not been charged with taking sound public health measures into consideration. Additionally, non-licensed retailers continue to sell Delta 8, Delta 10, and tetrahydrocannabinol (THC) products in convenience stores, gas stations, vape shops, etc. These products are legal but unregulated and can be

as intoxicating as marijuana. They should not be sold to anyone under age 21, but enforcement is lacking and efforts to regulate the products further have stalled." (Year 8, Northeast Region)[36]

- "With the passing of recreational marijuana in the State of Arizona for adults over the age of 21 we are seeing more advertisements, dispensaries, shops selling marijuana, and marijuana grows in our area. This continues to increase the norms around marijuana use. Many still think that it is natural and safe. We are seeing an increase in youth using vape/electronic devices with THC which is a high concentrate as well as edibles and wax and oils with high concentrates of THC. Further adult family members/friends are not safeguarding their recreational THC products and the number of poisonings continues to grow. In fact, the Dispensaries Association and the Poison and Drug Information Center are teaming up to bring awareness to this problem. In 2022 there were 739 cases of cannabis-related incidents in Arizona with more than half involving children. Of the 394 pediatric cases 60% of them required hospitalization." (Year 5, West Region)
- "With the new law allowing medicinal use marijuana in our state, youth have a favorable attitude towards use of marijuana products. There is also a lack of disapproval from some parents and guardians. We have focused our efforts on providing information about the risks of youth use of marijuana and the current restrictions on marijuana use." (Year 3, Midwest Region)
- "This year, [coalition] was also faced with an all-time low in perception of risk, particularly with marijuana, with the state legalizing the substance for recreational adult use and the opening of retail establishments. Due to the mixed political and family messaging (local conditions) and social media advertising of marijuana that our youth report experiencing daily, the perception of risk towards marijuana is at an all-time low." (Year 5, Northeast Region)
- "In the area we are focusing on, students have developed more positive attitudes towards cannabis following the legalization of recreational marijuana in Illinois. A significant portion, about one-third, believe that there is little to no risk in consuming marijuana at a young age. However, many of these students lack a clear understanding of the potential addictive properties and long-term effects on developing brains." (Year 8, Midwest Region)

Bordering Communities with Different Laws

Coalitions described the risks associated with bordering communities with different substance use laws, policies, and cultures. This included county-lines, state-lines, and even international borders.

- "Ours is a "dry" county, so there are no billboards or storefront advertisements for alcohol. However, the county line and state line are both close geographically, so we know youth can access those and/or purchase from bootleggers locally or acquire from adult friends and family." (Year 1, South Region)
- "On the other side of the bridge, it is completely illegal to possess or consume marijuana medically and recreationally, but one can consume alcohol underage as long as their parent or spouse is present and gives permission. Two cities, with different laws, just minutes apart from one another that also look completely opposite from one another physically and legally." (Year 3, Midwest Region)
- "Another risk factor in our communities is around marijuana legalization. The context of surrounding states' marijuana legalization has influenced attitudes towards substance use, making it more accessible and acceptable, especially since all of our neighboring states permit its recreational use." (Year 4, Midwest Region)

[36] For additional information see Delta 8 vs. Delta 9 vs. Delta 10: Uses, Effects, More (healthline.com); see also Delta 8 see 5 Things to Know about Delta-8 Tetrahydrocannabinol – Delta-8 THC | FDA

Divestment from School Administration

DFC coalitions also described divestment from school administration as a risk factor. Coalitions reported that schools were concerned about providing substance use prevention programming in schools and sharing data about the extent of substance use in their schools.

- “We have ongoing issues attaining buy-in from school administrators and staff, who we need on board in order to best reach the youth in our community. More concerning, perhaps, were the worries about negative school climates and waning feelings of school connectedness (for both youth and parents). We tried really hard to collaborate with the school district on bringing resources to them that would help address the climate concerns, but it hasn't been a priority for the school.” (Year 5, West Region)
- “One additional risk factor we seem to be experiencing is the fact that some of our teachers and faculty do not want to share information on the amount of substance use their school is experiencing. This causes a domino effect for the work our coalition is trying to do. It does not give us an accurate depiction of the problem in those schools, so when we are there, we aren't sure what the most pertinent information to share with them is, like what is the most popular drug at their school.” (Year 5, South Region)
- “In 2023, we experienced strong "risk factors" from two sources. One was from our now past High School administration, who no longer desired to support activities and presentations that **could** be deemed a trigger even if the activities and presentations were geared towards teaching the youth to make good life (saving) decisions given by persons with lived experience who were close to the students ages; combined with the administration's "reaching their limit" hearing parent complaints.” (Year 5, Northeast Region)

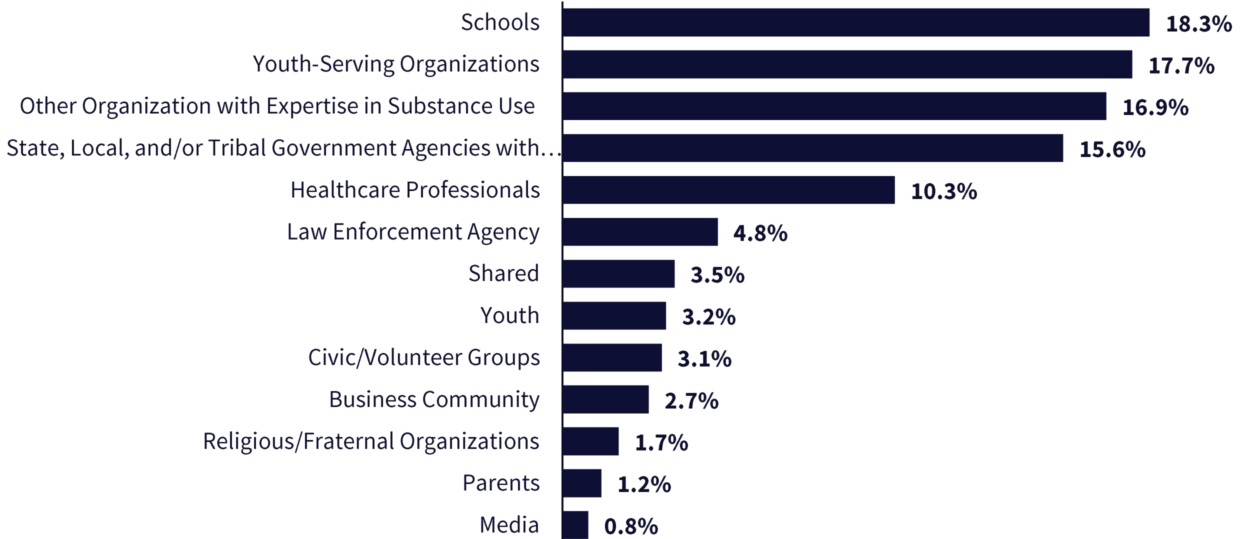
Building Capacity to Prevent and Reduce Substance Use

Key Findings

In 2023, DFC coalitions successfully mobilized approximately 43,000 community members to engage in youth substance use prevention/reduction efforts. Most (92%) coalitions report having at least one member from each of twelve sectors, although fewer (76%) reported active members from all sectors. **Over two-thirds (70%) 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.[37] Building capacity in the community to address substance use prevention work is an ongoing process aligned with the DFC goals. The average coalition in 2023 had 46 active members, with two paid and two unpaid staff. Across the 744 DFC coalitions a total of just under 43,000 active members were mobilized to engage in prevention efforts. Paid staff add just under 1,500 community members (a total of approximately 44,500 active members).[38] When asked to identify which sector leads the coalition, DFC coalitions were most likely to identify the Schools (18.3%) and Youth-Serving Organizations (17.7%) sectors (see Figure 4). A few coalitions (3.5%) reported that leadership was shared across a combination of sectors.

FIGURE 4. SECTOR IDENTIFIED AS LEADING THE DFC COALITION



Source: DFC August 2023 Progress Report, n=744

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[37] See CADCA (2019). Community Coalitions Handbook handbookcompressed.pdf (cadca.org) 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

[38] Extreme outliers (above 3 standard deviations from the mean) were excluded from these analyses prior to identifying the total.

DFC coalitions selected the six most common activities they had engaged in during the reporting period to build capacity from a list of twelve activities (see Table 4). Over half of DFC coalitions selected outreach (73% of coalitions), recruitment (71%), engaging the general community in substance use prevention initiatives (61%), strengthening strategies (59%), and training for coalition members (54%). Three newly added items related to building capacity around opioid/ methamphetamine use prevention work were selected in the top six by smaller percentages of DFC coalitions. The most engaged building capacity activity of this type was having key coalition staff engaged with work groups organized by others in the community to address opioid/methamphetamine use (19.1%).

TABLE 4. ENGAGEMENT IN ACTIVITIES TO BUILD CAPACITY

BUILDING CAPACITY ACTIVITY	PERCENTAGE
Outreach (e.g., engaging key partners in substance use prevention initiatives)	73.4%
Recruitment (e.g., increasing coalition membership and participation)	70.8%
Engaging the general community in substance use prevention initiatives	61.3%
Strengthening strategies (e.g., planning/executing substance use/misuse prevention initiatives)	59.1%
Training for coalition members (e.g., building leadership capacity among coalition members)	54.2%
Building shared vision/consensus (e.g., attaining an agreement among coalition members regarding goals, planned initiatives, etc.)	39.4%
Working with other coalitions	33.3%
Increasing fiscal resources (e.g., attaining funding for substance use prevention initiatives)	28.5%
Improving information resources (e.g., engaging in research or evaluation activities)	28.1%
Gathering community input (e.g., holding hearings on drug problems)	23.0%
Key coalition staff engaged with work groups (e.g., task force, committee, subcommittee) organized by others in the community to address opioids/methamphetamine	19.1%
Invited new community members/sectors to join the coalition based on expertise relevant to addressing opioids/methamphetamine	17.6%
Strengthening data connections across coalition sectors	12.4%
Established one or more work groups or subgroups (e.g., task force, committee, subcommittee) specifically focused on opioids/methamphetamine	11.0%

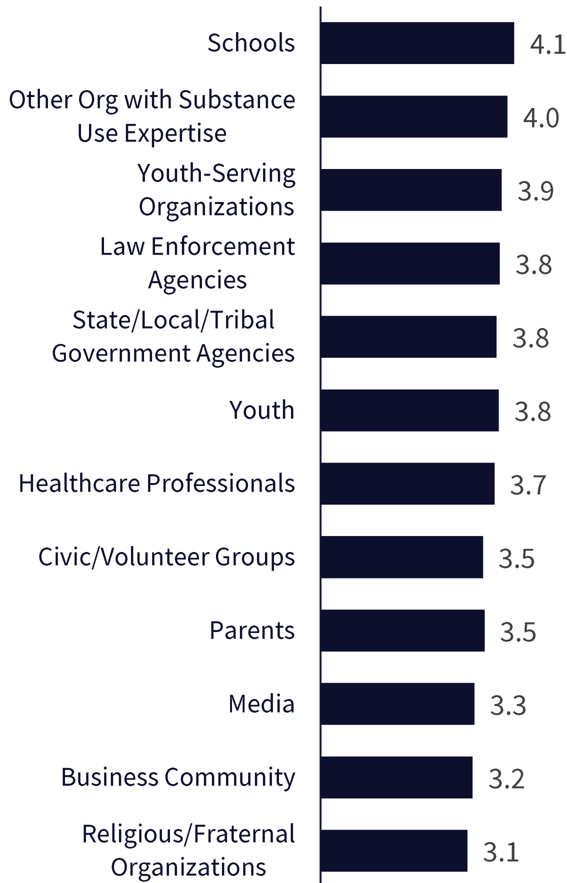
Source: DFC August 2023 Progress Report Data, n=744
Note: Coalitions selected their top six building capacity activities from this list.

Sector Level of Involvement and Active Sector Members

While almost all (92%) 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, Other Organizations with Substance Use Expertise, and Youth-Serving Organizations were on average rated as the most highly involved sectors, although all sectors averaged ratings of medium or higher involvement (see Figure

5). On average, coalitions reported 2 to 14 active members per sector, with the median number of active members highest for the Youth and Schools sectors (see Figure 6).

FIGURE 5. AVERAGE RATINGS OF ACTIVE MEMBER SECTOR INVOLVEMENT



Source: DFC August 2023 Progress Report; n= 744
Note: 1 = Very Low, 2 = Low, 3 = Medium, 4=High, 5 = Very High

FIGURE 6. MEDIAN NUMBER OF ACTIVE MEMBERS BY SECTOR

Source: DFC August 2023 Progress Report; n=744

Engagement with the School Sector

Individual schools and school districts are important partners for DFC coalitions and almost all coalitions (99%) report working with at least one school with most (85%) working with multiple schools either in a single or multiple districts (see Table 5).[39] The few DFC coalitions not working with schools (1%) may still be working on building a relationship or may be working at broader regional/state levels. Just under one-fifth of coalitions (18%) reported that schools were the coalition's lead sector. Through schools, coalitions can reach students/youth, as well as their parents

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

and families. The coalitions implemented each of the Seven Strategies for Community Change with/within the school sector. Much of this work focused on the nexus of substance use and mental health in youth.

TABLE 5: ENGAGEMENT WITH SCHOOLS

DESCRIPTION OF SCHOOLS AND DISTRICTS THAT COALITIONS WORKED WITH	PERCENTAGE OF DFC COALITIONS ENGAGING WITH SCHOOLS IN THIS WAY
Multiple schools in a single district	43%
Multiple schools in multiple districts	42%
Single school in a single district	14%
Not applicable/Not working directly with schools	1%

Source: DFC August 2023 Progress Report Data, n=744

Schools and Mental Health

Since 2011, increasing numbers of youth have reported experiencing mental health challenges with 42% of high school youth in 2021 reporting feeling persistently sad or hopeless, 29% reporting poor mental health and 1 in 4 youth having seriously considered suicide.[40] Mental health challenges can contribute to youth engagement in risky behaviors such as substance use/misuse, which is linked to poor school performance and other negative outcomes for youth. Many DFC coalitions described working to build capacity and to implement activities in schools around addressing mental health alongside substance use prevention. Coalitions found that while students are expressing the need for mental health services more than ever, schools often lack the resources to meet the demand. For example, a year 5 coalition (Northeast Region) described, "Access/availability [of resources] has been a risk factor of our coalition since inception. [Now] there is community buy-in and readiness to target this risk factor, with support, both in-kind and financial, to implement strategies. School social workers and counselors have reported a staggering increase in students' school mental health issues."

Coalitions described six different ways they engaged with schools at the nexus of substance use and mental health (for examples of coalitions describing each type, see Table 6). Notably, many of these efforts were led and/or implemented by/with the youth coalition hosted by the DFC coalition. Recognizing that students may need a place to go in school when they are experiencing a mental health need, some DFC coalitions **created safe spaces.** Safe spaces are rooms where students can go when stressed or needing support. Often, the youth coalitions would come up with welcoming and fun names for these rooms to encourage other students to utilize them. Safe spaces give students a chance to talk through their problems with school counselors or partake in calming activities like

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

journaling and games. Students are also provided with information on mental health services in the community. Coalitions **worked to implement or strengthen counseling services in schools.** This included advocating for and facilitating creation of mental health services in schools that did not already have them, incorporating screening and referral procedures into existing school mental health services, and building relationships with counseling and mental health staff to provide more comprehensive and cohesive resources and supports to students. Coalitions were engaged in **educating the school community about mental health and providing resources.** Coalitions provided information and education through school decorations, sporting events, and public services announcements. Coalitions **worked with students to facilitate peer support and peer mentoring programs.** Coalition youth were eager to support each other and worked with coalitions to create engaging ways to connect with their peers who may need help and provide them with support and guidance. Coalitions **worked with schools to provide mental health programming in the classrooms.** Some coalitions created their own instructional materials, and others used pre-existing programming. The programming may have been an entire course, or a few one-off presentations. Finally, many coalitions found that LGBTQ+ youth face mental health risks at a greater rate than their peers. Coalitions provided **support and resources, specifically for LGBTQ+ youth.**

TABLE 6: COALITION VOICES ON ENGAGING WITH SCHOOLS

SCHOOL ENGAGEMENT STRATEGY	COALITION VOICES
Providing Safe Spaces	"The coalition saw a need to establish Calming Rooms throughout [the county] to support youth in having a safe, calm alternative place to destress and engage in calming behaviors. Located in the guidance counselor offices, this space is a designated safe space for students to reflect, calm down, and take care of their mental health. This resource is available for all students as needed with activities such as books, games, journals, and more. School counselors have noted that this has provided a great resource and oftentimes, students are more willing to speak with counselors after having some time in the coping room. The ultimate goal is to provide a safe space for mental health and overall well-being while offering an alternative to substance use such as vaping to manage stress and emotions." (Year 6, South Region)
Implementing and Strengthening Counseling Services	"We have a screening and referral program set up with the school. We are in a very rural community and we have been working hard to get more agencies to serve our community. We were able to identify a rehab center, a counseling center, a shelter, and several other agencies that our county was part of our service area, but they were not serving our community. We have been able to meet, establish relationship and get them to engage in our coalition and to provide services in our community. We have had one on one meetings and help make a more streamline referral process." (Year 7, South Region)

SCHOOL ENGAGEMENT STRATEGY	COALITION VOICES
Mental Health Awareness	“One high school completed a fundraiser for mental health through collaboration with their wrestling team. Their event was called Stronger as One: Take down the Stigma! A middle school created and shared a weekly podcast for the What Helps Me Sources of Strength campaign. Another high school created a substance misinformation leads to misuse bulletin board (game style - they'll have to lift up pieces of paper to see if the statement is true/false).” (Year 3, Midwest region)
Peer Support	“The middle school implemented the “Start with Hello” Program. Eighth grade Hello Leaders went through training on “Start with Hello” and then they ran trainings with our entire student body (570 students). The Hello Leaders then went through additional trainings on Mental Wellness as well as JEDI (justice, equity, diversity, and inclusion). Out of those trainings, the team decided to host a Mental Wellness week with each day representing a positive coping skill (i.e., listening to music, doing artwork, exercise, talking with someone).” (Year 5, Midwest Region)
Mental Health in the Classroom	“A Signs of Suicide class was required for all Juniors. The goals of this program are to decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes about depression, encourage personal help-seeking and/or help-seeking on behalf of a friend, reduce the stigma of mental illness and acknowledge the importance of seeking help or treatment, engage parents and school staff as partners in prevention through “gatekeeper” education, and encourage schools to develop community-based partnerships to support student mental health.” (Year 3, Northeast Region)
LGBTQ+ Support	“Our efforts to promote LGBTQ+ mental health have been proactive, as we have disseminated our LGBTQ+ resources during all of our lunch pop events across middle and high schools. By making these resources readily available in school settings, we are fostering a more supportive and accepting environment for LGBTQ+ youth, reducing barriers to accessing vital information and support. These notable accomplishments reflect the coalition's unwavering commitment to creating a community where everyone has equal access to resources and support, contributing to a safer, healthier, and more inclusive environment for all.” (Year 5, Northeast Region)

Hosting a Youth Coalition

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

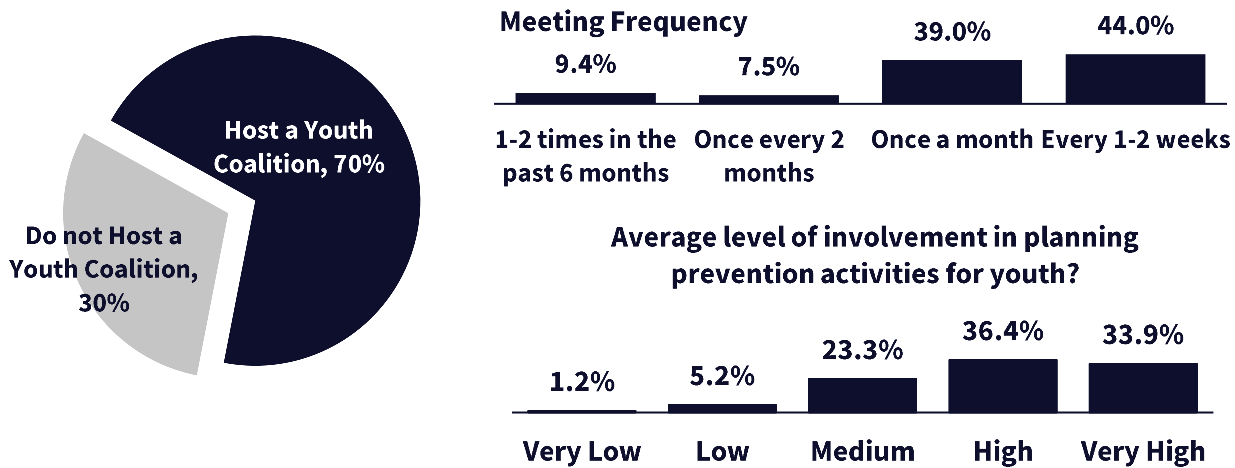
> A group of youth who work together to plan and implement activities related to the mission of the full coalition. An adult coalition member serves as a mentor or leader, but the youth have key leadership roles. The youth coalition is integral to the full coalition, but generally meets independently.

In August 2023, over two-thirds (70%) of DFC coalitions reported hosting a youth coalition (see Figure 7). Most (83%) reported the youth coalition met at least once a month and rated youth coalition involvement in planning prevention activities as high or very high (70%).[41] Of the coalitions not

[41] Of these coalitions, 44% met once every 1- or 2 weeks while 39% met once a month, for a total of 83%.

hosting a youth coalition (30%), more than two-thirds (70%) were working to host a youth coalition within the next twelve months, while the remaining had no plans to host a youth coalition.

FIGURE 7. DFC COALITIONS REPORTING HOSTING A YOUTH COALITION, MEETING FREQUENCY, AND LEVEL OF INVOLVEMENT OF THE YOUTH COALITION



Source: DFC August 2023 Progress Report

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 (2.9, medium involvement).[42] That is, for those coalitions hosting a youth coalition, their average youth sector level of involvement was higher than the other most highly rated sectors. This level of engagement was similar to that of schools (4.1) who overall were rated highest on engagement (see Figure 5).

Making it clear that youth coalitions are central to the work of DFC coalitions who host them, just under half (45%) 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. In addition, within those coalitions that hosted a youth coalition, 8% identified Youth sector as their lead sector as compared to 3% for all DFC coalitions. Just over one-third (37%) 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 in youth coalitions.

Youth Coalition Activities

Youth coalitions led many activities in and alongside their DFC coalition. Youth coalitions were essential in providing information to other young people, parents and caregivers, and the community at-large. For example,

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[42] Mann-Whitney-Wilcoxon $X^2(4) = 188.08$, $p < .0001$

> "Our high school youth coalition educated 7th & 8th graders in the SPORTS Prevention Plus Wellness Program (PPW). They educated the community during October Medicine Abuse Safety Awareness Month. The youth coalition educated parents and caregivers about medicine safety and Rx Drop Box locations during the Town Safety Spooktacular Event. The youth coalition also assisted in distributing packets of information that included an informational brochure, Rx Fact Card with year-round Rx drop-off locations, and SAMHSA's "Talk They Hear You" App. They passed out Medicine Safety Tips to parents, candy to trick-or-treaters, face painted children, and gave them coloring sheets that said, "Say Boo to Drugs" and "Owl Never Do Drugs". They also assisted the Sheriff's Office at National DEA Take Back Day and distributed our year-long Rx Drop Box location fact cards to individuals who dropped off medication. Overall, 155 informational materials were distributed during this event."
> (Year 6, South Region)

As another example, youth coalitions provided information in both English and Spanish. In this Year 6 (Northeast Region) coalition,

> "The Youth Coalition created an anti- vaping campaign in Spanish and English. The messaging consisted of data and information on quitting vaping. The posters were displayed downtown on Main Street in the large window of a Community Health clinic. The anti-vaping campaign was produced on yard signs and displayed at drop-off/pick up locations two middle schools, three high schools, and four medical facilities including two local hospitals and large health complexes."

Youth coalitions were also involved in disseminating surveys and analyzing survey results to provide information. In one Year 4 coalition (Northeast Region), "The teens were involved in planning for the youth survey and analyzing / sharing its results. They created a video about our youth survey, which explained the purpose and confidentiality to their peers and showed how the results of the prior survey had led to improvements in the schools; the video was shown in each class before the students took the survey. Later, they created posters about the findings which were used for Drug & Alcohol Facts Week." Similarly, in a Year 8 coalition (South Region), "Youth coalition members worked to design our multi-media prevention campaigns, including creating the billboards and writing and recording the radio public service announcements (PSAs). They wrote social media prevention messages and shared them across platforms. Members helped to plan for the annual Teen Leadership Summit and serve as "youth staff" and mentors during the event. Members participated in a Photovoice project, documenting risk and protective factors, and shared these pictures in a public setting."

Youth Coalition Recruitment and Retention

DFC coalitions use deliberate and specific strategies to create a youth coalition and sustain engagement with the youth coalition. For instance, a Year 3 coalition (South Region) hosts an annual youth leadership summit to recruit new youth coalition members and to increase engagement among current youth coalition members. This coalition describes,

> "Our coalition has been working diligently to build a youth coalition, and we are in still the early stages of this effort. In 2022, we produced the first Youth Leadership Summit. In 2023, we hosted the second

annual Youth Leadership Summit. The programming activities and promotional media were determined with youth participation and sector member input. Youth expressed looking forward to engaging in a leadership capacity even more so in the future. Their parents have also expressed interest in their children becoming more involved."

Summits, conferences, and community events can also help coalitions reach a diverse set of youth, so that the youth coalitions are representative of the communities they serve. For instance, a Year 10 coalition (South Region), partners with the youth-arms of two local organizations to host a Community Rally.

> "To ensure membership is representative of the community, the Youth Council, in partnership with two other youth groups, host a Community Rally for all local schools and youth serving organizations at the beginning of the school year. Special attention is paid to ensure that all youth and youth groups are invited regardless of race, gender, and sexual orientation. The Community Rally is planned and presented by students of the Youth Council. Youth Council leadership serves as ambassadors and are most effective recruiters for the coalition."

Coalitions also stressed the importance of branding of the youth coalition to engage more youth. For example, a Year 5 coalition (Midwest Region) completely rebranded their youth coalition to revitalize interest and improve retention.

> "Collectively, they found it has been harder over the past year to engage peers into just substance abuse prevention programming. The youth decided that they wanted to completely rebrand the youth leadership council. In our county, about 60% of youth are part of sports and all of the youth leadership council students were involved in at least one. They felt reaching this group would be a great way to include more health topics that would engage more students and give them more inspiration to want to be drug-free, especially if being healthy and competing is part of their lifestyle. The group created their own chapter called PALS (Prevention, Advocacy, Leadership, Strategies) to add more leadership components that include more specialized training on advocacy work and leadership."

Leadership Development in Youth Coalitions

To sustain thriving youth coalitions and to build leadership skills among youth participants, DFC coalitions provided leadership and training opportunities for their youth coalition members. In one Year 6 coalition (South Region), "The youth coalition recruited new members via school events like Open House and Back to School night and established their leaders, for example, President, Vice President, Secretary, and Public Relations Chair. In September 2022, all youth coalition members were trained in Prevention Plus Wellness, an evidence-based program that addresses total health and wellness with prevention through goal-setting tools." Another Year 4 (South Region) coalition described, "The youth gained valuable training in the areas of leadership, wellness, decision making, and substance use education to help them better understand not only themselves, but the needs of their peers and community around them. This in-house training was a one-day youth retreat." Similarly, a Year 6 coalition (Northeast Region) reported, "There is nothing stronger than peer-to-peer education. 6 youth leaders developed a recruitment strategy of an all-day youth training where over

50 youth attended, the week prior to school start. This training included public speaking, advocacy, and policy skills."

Youth Coalitions and Policy Impacts

Youth coalitions have positive impacts on policy development and implementation. For some coalitions, their youth coalition was instrumental in engaging legislators and school administrators on important coalition objectives. Engaging in policy change empowers the youth in the coalition and build positive relationships in the community. For example, youth leaders in a Year 5 (Midwest Region) coalition helped create policy and implement a compliance check program in their community.

> "Our youth also assist with compliance checks for alcohol and tobacco. Our county has never done alcohol compliance checks until the very end of 2022. One of our youth leaders worked with law enforcement and the health department to completely build that program, created a policy, and implemented the program from start to finish. We are now gearing up to complete our first set of on-premise checks in the next week and continuing to do county and city regulatory compliance checks of off premise operations."

In a Year 4 coalition (South Region), the youth coalition members advocated for substance-free public space policies.

> "The youth coalition members have been advocating for smoke and tobacco free parks and public spaces for the past 4 years. They have met with civic organizations, business leaders, Town Commissioners, two different mayors, other town officials. They have also shared their concerns at community tabling events. This year, the Town adopted a smoke and vape free parks and public spaces policy. Afterwards, the youth wrote thank you notes to town officials."

Youth Coalitions and Mental Health Beyond the School Walls

Youth mental health remained a priority for youth coalitions. A Year 6 (Northeast Region) described, "The Youth Coalition designed and executed a "Mental Health is Health" campaign, which included roundtable discussions, posters that are displayed throughout the schools, town hall, library, senior center and local businesses, social media posts, and a PSA that will be shown on our local cable access channel as well as the high school's morning announcements." A Year 4 coalition with a similar focus (South Region) described, "The youth coalition planned and implemented a Youth Mental Health Awareness Campaign. The campaign included a youth led panel discussion at the Youth Summit for both parents and youth. This Youth Summit was a huge success with over 300 youth and parent attendees. This reflects the need that youth, parents, and families are feeling regarding mental health challenges."

Engaging Youth without a Youth Coalition

Coalitions without a youth coalition reported several strategies for engaging youth: partnering with existing organizations, working with schools, hosting youth events, and creating opportunities for youth input and involvement. Table 7 provides examples of these.

TABLE 7: COALITION VOICES ON ENGAGING WITH YOUTH

ENGAGEMENT STRATEGY	COALITION VOICES
Partnering with Existing Community Organizations	“We currently work very closely with a local group, which is mainly comprised of youth coalition members. We felt it was important to work together, and not compete, for youth involvement in our coalition. We attend their youth meetings and help assist one another in action plan strategies as they align. This year, we have done a great job of working with the staff, school advisors, and youth to work on many of our strategies together.” (Year 3, Midwest Region) "The coalition has seen increase engagement with youth when partnering with groups that are already established within the 3 schools where the coalition can show where the goals or mission align and where the coalition can partner and or support the youths’ activities. The coalition is starting to work with small youth groups to engage and advocate the larger student body, education on healthy choices, substance use prevention presentations, mentoring, leadership trainings, healthy coping skills, and providing healthy alternative activities. This set-up is working well for the coalition, schools, and youth.” (Year 7, Midwest Region)
Working with Schools to Begin a Youth Coalition	“We work with more than 100 youth in the schools to meet various activities in the Action Plan. We have not formalized the school-based activities into a Youth Council or Prevention Clubs. At present youth attend our activities but we do not have a plan for intentional follow-up, or meetings aligned with the Action Plan. This year's focus was on the implementation of school-based activities. Now that we are in the schools, we can begin organizing a Youth Council.” (Year 2, Northeast Region) “With the addition of a school representative from our district, we have had much more interest from local schools (middle and high schools) to start youth coalitions. We have had initial meetings at one school with the assistant principal and 2 parents from their PTO, and we are working to start something in this new 2023-24 school year. Two other high schools have expressed interest in opportunities for guest speakers in this new school year, as well as more parent workshops going forward.” (Year 8, Midwest Region)
Hosting Youth Events	"Our Pathways to Prevention event is held at the local fairgrounds, at night, on the weekend of Red Ribbon Week (RRW). This project is geared towards middle and high school-aged youth and creates an ideal platform for information dissemination directly to youth and their families. Our county is rural, so this is something fun teens can go to locally and not drive too far away from home. Typically, there have been 300 plus visitors to this attraction and the first event was hosted back in 2011." (Year 3, South Region) "We actively involve youth in leadership training initiatives, particularly through the Elementary-to-High School Transition Program. High school students, typically in their Junior or Senior years, play a pivotal role as sponsors and mentors for their younger counterparts entering high school.” (Year 10, Midwest Region)

ENGAGEMENT STRATEGY	COALITION VOICES
Creating Opportunities for Youth Input & Involvement	"In order to engage youth, they are invited to the coalition meetings when ever possible, Teen Nights, and any volunteering opportunities in the community such as health related events, tabling events, and to do community service such as cleaning the alley ways or volunteering at the local food pantry." (Year 1, West Region) "We hired a student intern. She is also serving as our Youth Sector Representative. She has been a great addition to the Coalition and has engaged students in Coalition efforts. For example, our intern started a student-run podcast called "Dear Someone" which can be streamed on Spotify, hosted by three high school students. The podcast aims to provide guidance, comfort, and bits of comedic relief to students navigating through the highs and lows of adolescence." (Year 9, Northeast Region)

Strategy Implementation

Key Findings

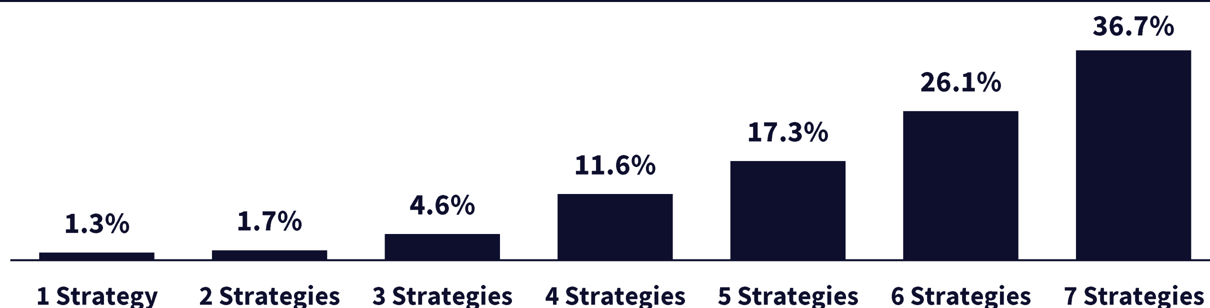
DFC coalitions implemented a comprehensive mix of strategies, with most (80%) implementing at least one activity in at least five of the strategy types. Over 75% of DFC coalitions implemented activities to address the emerging drug issues of opioid/methamphetamine use and youth vaping (78% and 82%, respectively).

Each DFC coalition is expected to develop and implement an annual action plan to meet grant goals. DFC coalitions focus on selecting and implementing activities from the range of the Seven Strategies for Community Change that best address local needs and challenges.[43] A primary purpose of collaboration across sectors is to leverage skills and resources in the innovative planning and implementation of prevention. DFC coalitions vary in the extent to which the range of sectors is involved in the development and implementation of the action plan. This section of the report provides an overview of the activities and strategies implemented by DFC coalitions as reported in their August 2023 Progress Report.[44] This is followed by information on community assets put into place in the community as a result of DFC funding. Next, strategies implemented to address emerging drug issues are described.

Comprehensive Strategy Implementation

To assess how DFC coalitions are implementing their action plans, 41 unique prevention activities were linked to one of the Seven Strategies for Community Change. Most (80%) DFC coalitions implemented at least one activity in at least five of the seven strategies (see Figure 8).

FIGURE 8. PERCENTAGE OF DFC COALITIONS IMPLEMENTING THE SEVEN STRATEGIES FOR COMMUNITY CHANGE BY NUMBER OF STREATGIES ENGAGED



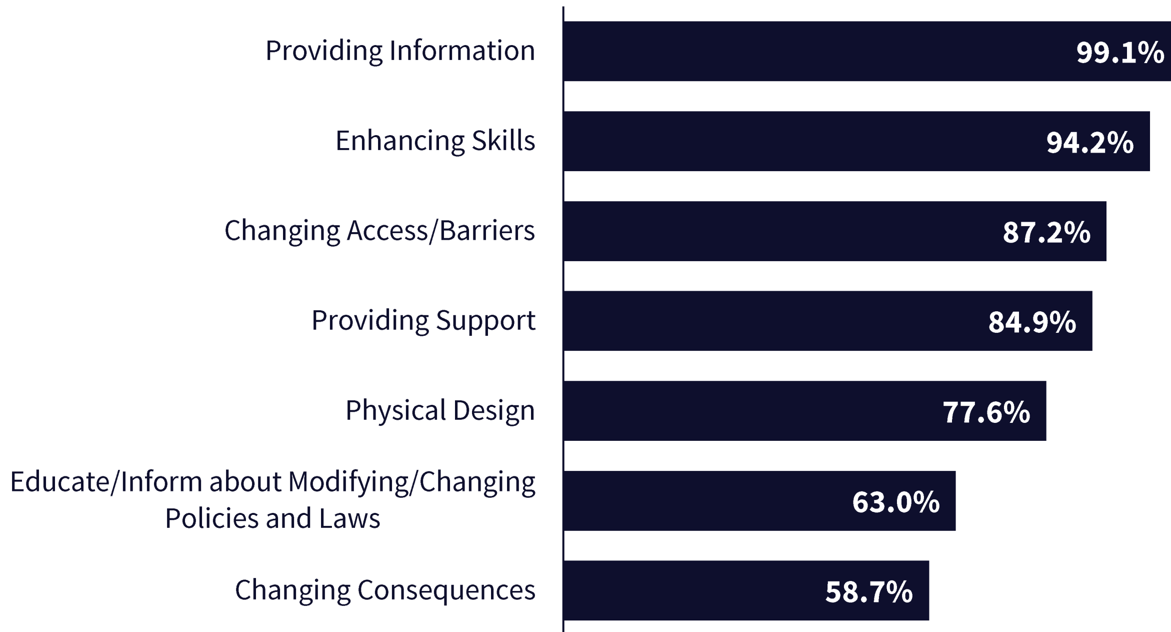
Source: DFC August 2023 Progress Report; n=744

[43] The activities were identified based on coding of coalition descriptions of activities during an earlier phase of the DFC National Evaluation. DFC coalitions also have the option to add 'Other' activities for each of the seven strategies, bringing the total to 48 activities. Community Anti-Drug Coalitions of America (CADCA) derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see Implementation Primer: Putting Your Plan into Action | CADCA

[44] Coalitions were asked to report on activities that were implemented from August 1st, 2022 through August 1st, 2023.

Implementation of each of the seven strategies ranged from over half to almost all coalitions (see Figure 9). Two of the three individual strategies (*Providing Information* and *Enhancing Skills)* were implemented by almost all coalitions while a third, *Providing Support*, was implemented by four-fifths of coalitions (85%). The most implemented environmental strategy was *Changing Access/Barriers* (87%). Coalitions were least likely to have implemented at least one activity in *Changing Consequences*, although over half of coalitions did so (59%).

FIGURE 9. PERCENTAGE OF DFC COALITIONS IMPLEMENTING THE SEVEN STRATEGIES FOR COMMUNITY CHANGE BY NUMBER OF STRATEGIES ENGAGED



Source: DFC August 2023 Progress Report, n=744

Activities Implemented by Strategy and Strategy Type

Table 8 provides an overview of the most common activities engaged in by DFC coalitions by strategy (see also Tables D.1 to D.7, Appendix D).[45] In addition to coalitions being generally more likely to have implemented individual strategies as compared to environmental strategies, activities within each of these strategy types were generally also implemented by high percentages of coalitions. Working in the community to *Change Access/Barriers* was the most common environmental strategy, and the most common activity in this strategy included efforts to reduce home and/or social access of substances, implemented by 69% of DFC coalitions.

[45] 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 Apply for DFC Funding | Overdose Prevention | CDC.

TABLE 8: TOP TWO ACTIVITIES BY STRATEGY TYPE

INDIVIDUAL STRATEGIES		
ACTIVITY	PERCENT	COALITION VOICES
***Providing Information*: activities provide community members with information related to youth substance use, including prevention strategies and the consequences of use.**		
Informational Materials Disseminated:	91.3%	"In terms of innovative outreach, we have implemented guerrilla-style programs, such as the "Popcorn QR" initiative, which attaches QR codes to popcorn bags distributed at school events. This initiative has driven student and parent engagement, contributing to our goal of promoting interactive methods of information dissemination. By empowering individuals with engaging and convenient methods of accessing resources, we are helping build an informed community capable of making healthy decisions." (Year 2, South Region)
Social Networking: (e.g., Facebook, Twitter, etc.)	87.5%	"Tik Tok is a great way to create fun, youth-focused content. Our administrative assistant has done a great job creating unique content that is prevention focused. Our most-watched TikTok video is one that speaks to fentanyl using the song "You Spin Me Round (Like a Record)" by artist Dead Or Alive. We are at 1,233 total views. Our YouTube was launched in June of 2023. We have our 'Did You Know' commercials hosted on the platform. The analytics show we are leading in views from new viewers." (Year 5, West Region)
***Enhancing Skills*: activities designed to increase the skills of participants.**		
Youth Education and Training Programs: Sessions focused on providing information and skills to youth	70.4%	"The Big Picture provides important skills-training for youth, youth-serving professionals, and community members. Written and performed by teens. The Big Picture is composed of vignettes illustrating different adolescent health concerns. Students learn about health topics through a field trip to Teen Health Connection and write vignettes in response to statistics from the CDC's Youth Risk Behavior survey (YRBS), the CDC's Adolescent Behaviors and Experiences survey (ABES), the local Youth Drug Survey (YDS), and other sources of public data. Students also learn important prevention principles. Students work with a contracted playwright and stage director to create a new script and health education production. Live performances by student actors held in a community theater are open to the public, parents, adolescent-serving professionals, and invited guests. This activity enhanced skills for the 56 teens involved in the production and provided information to over 800 9th grade students who attended a performance with their health education class." (Year 8, South Region)

TABLE 8: CONTINUED

INDIVIDUAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***Enhancing Skills*: activities designed to increase the skills of participants.**		
Community Member Education and Training Programs: Sessions directed to community members (e.g., law enforcement, landlords)	53.4%	"Our coalition presented at a county level training for school nurses on the impacts of trauma and correlation with SUD trends. It also incorporated skills nurses can use with students to combat stigma and help students get the support they need. Two coalition staff and two County Board of Health staff provided the presentation to the group with about 100 attendees." (Year 3, South Region)
***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	63.8%	"Sober parties were a result of the Youth Summit that was held this fall. These sober parties unexpectedly took off quickly and needed extra chaperones and support from our coalition, as well as help planning. We were so pleased to see the coalition youth taking leadership roles in the planning, recruiting, advertisement/PR of the event, as well as taking on jobs the night of the sober parties. They actively participated as a lead role in the success of the parties and alternative events. The post-surveys all showed appreciation for these events for the youth, acknowledging that they were not aware of so much to do in their community and how much fun they could have without alcohol and other drugs." (Year 3, Midwest Region)
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	34.7%	"The creation of a support group for parents/guardians of LGBTQ+ youth was a direct response to needs that our community expressed. This activity contributes to substance use reduction by promoting positive mental health, a root cause of substance use that disproportionately affects LGBTQ+ youth in our community. The support of multiple initiatives throughout Suicide Prevention Month (e.g., "Purple Washout Day", where members of the community wear purple to raise awareness of suicide and decrease associated stigma, and "Yoga on the Turf", where members of the community practice mindfulness/yoga and discuss suicide/stigma) also contributes to substance use reduction by addressing root causes of substance use (i.e., losing someone to suicide)." (Year 4, Northeast Region)

TABLE 8: CONTINUED

ENVIRONMENTAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***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 (e.g., prescription drug disposal/storage; alcohol storage; make available or increase availability of local prescription drug take-back events and/or prescription drug take-back boxes)	69.2%	“The Coalition hosted two National Prescription Drug Take-Back Day events and has 5 drop box locations throughout thee County for residents to dispose of their unused and expired medications. We collect an average of at least 275 lbs. of prescription medications every 6 months. We have also distributed 125 Rx Drug lockboxes at 2 Rx Drug Take-Back Day events and distributed 125 Pill locking bottles.” (Year 4, South Region)
Improve access to overdose prevention materials (e.g., distribution of naloxone and/or fentanyl test strips)	50.9%	“We organized a Latinx health fair with over 40 services providers and distributed 200 medicine safe lock boxes and 60 packages of Naloxone to the community. We also provided 3 workshops about opiate prevention in person and 2 online in Spanish reaching 75 people.” (Year 1, West Region)
***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.**		
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	33.7%	“The city hasn’t participated in alcohol compliance checks for over 15 years. The captain of the police department sits on our coalition and it was a goal of his to get them started back up again. This past year, they conducted their first round of checks. The department used youth coalition members to participate in the alcohol checks.” (Year 3, Midwest Region)
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap, open container laws)	25.5%	“[Police department] now contacts us on a monthly basis to check our availability for their bimonthly DUI checkpoints. This engagement has become a highlight activity for our coalition.” (Year 9, West Region)
***Changing Physical Design*: activities to change the physical design or structure of the environment to reduce risk or enhance protection.**		
Increase safe storage solutions in homes or schools (e.g., lock boxes, drug deactivation kits)	48.0%	“[Coalition] is able to provide refrigerator/cabinet locks to promote the safe storage of alcohol through the state’s Department of Health Services, Small Talks campaign. In addition, although opioids are not a substance of focus, … [coalition] is able to distribute medication lock boxes and bags, and medication deactivation units. These items are a huge draw, pulling in individuals at community events and initiating prevention conversations.” In total [coalition] attended 4 community events in which safe storage solutions were offered, to interact with an estimated 124 family units, distributing 58 lock boxes, 55 medication travel lock bags, 55 fridge locks and 176 medication deactivation packets.” (Year 5 Midwest Region)

TABLE 8: CONTINUED

ENVIRONMENTAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***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)	33.3%	"During this reporting period the Outreach Specialist conducted environmental scans in several neighborhoods and hosted neighborhood meetings to listen to community members concerns. Some communities are having problems with beer establishments not maintaining their property and allowing loitering and littering. During Beer and Wrecker Board meetings community members voiced concerns on establishments that violate the noise ordinance and block the streets during their business hours making it difficult for them to get in their own driveway. The Coalition provided members with an informational one pager that included non-emergency numbers to be called during these incidents and how to report violations. (Year 5, South Region)
Educating/Informing about Modifying/Changing Policies or Laws: activities to educate and inform with the goal of creating formal change in policies or laws.		
School: Policies promoting drug-free schools	27.4%	"A major policy achievement this reporting period is that [city] Public Schools implemented a new substance use diversion program called iDECIDE at both the middle and high school levels. Several staff at each school were trained in October 2022, and the program was implemented within the schools last winter. [City] Public Schools were excited to offer this new diversion program to students because the program can be applied to any substance and is the first diversion program Natick has been able to offer at the middle school level where youth vaping and alcohol use are already identified as areas of concern. The model of the diversion program is not punitive and also encourages youth to identify their own personal reasons for using substances and goals to decrease their substance use in the future. (Year 10, Northeast Region)
Citizen enabling/Liability	20.2%	"While our Social Host Law has been in effect since 2015, repeated annual data collection shows that the general public is unaware of the Social Host Law in [county]. The 2 major accomplishments were working with the [county] Sheriff's Office and District Attorney to make it mandatory as a condition of sentencing to receive Social Host Law awareness training and compliance check procedures training following compliance check failures and social host law violations." (Year 9, Northeast Region)

Source: DFC August 2023 Progress Report Data, n=744
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.

Newly Added Activities

For the 2023 progress report, a small number of new activities (5) were added: three in *Enhancing Skills*, one in *Changing Access/Barriers* and one in *Changing Physical Design*. Two of the five were in the top two activities presented in Table 8. Specifically, improving access to overdose prevention

materials (51%, *Changing Access/Barriers)* and increasing safe storage solutions in homes or schools (48%, *Changing Physical Design).* While the new *Enhancing Skills* activities were not in the top two activities for this strategy, coalitions were engaged in these activities as well including:

- Trainings specifically on identifying signs of potential drug use and/or risks associated with drug use (51%; e.g., risks of adolescent marijuana use; opioid risks/signs of use for various community members; signs of methamphetamine use/sales)
- Implementation/Supported Implementation of an Evidence-Based Curriculum in School Setting (50%)
- Education and training specifically to reduce stigma associated with substance use/substance use disorder (43%)

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.[46] 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 9 presents the top five community assets put into place after receiving the DFC grant award funding (see also Table E.1, Appendix E), including culturally competent materials (73%) and social norms campaigns (72%). Culturally competent materials are in line with coalitions working to address health equity in their community while social norms campaigns are in line with increasing youth understanding and perceptions of substance use as not acceptable. Table 10 highlights examples of coalition work around these assets.

TABLE 9: TOP FIVE COMMUNITY ASSETS 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	72.7%	18.1%	9.2%
Social norms campaigns	72.0%	13.1%	14.9%
Substance use warning posters	63.3%	23.3%	13.4%
Town hall meetings on substance use and prevention within the community	63.1%	18.2%	18.7%
Prescription drug disposal programs	51.1%	44.2%	4.7%

Source: DFC 2023 Coalition Classification Tool Data; n=744

[46] In August 2023, 744 DFC coalitions completed the CCT in time for inclusion in this report (100% of all DFC coalitions).

TABLE 10: EXAMPLES FROM COALITIONS OF TOP FIVE IMPLEMENTED COMMUNITY ASSETS

COMMUNITY ASSET	COALITION VOICESON ACTIVITY
Culturally competent materials that educate the public about issues related to substance use	"During this past reporting period, our coalition has made significant strides to increase our services to Spanish speaking and immigrant populations. The coalition created and translated all Too Good For Drugs and Violence Middle School and High School materials into Spanish for Spanish speaking students. The coalition also translated Social Host Law Palm Cards into Spanish for police officers to distribute during SHL calls. For a community wide summer event, we provided all 5 vendors with free signage (Wristband Required, We ID, etc.) in both English and Spanish. Notably, the coalition held its first Cannabis Presentation and Panel for parents and caregivers. The coalition partnered with the NY National Guard Counter Drug Task Force to provide free Spanish Translations." (Year 10, Northeast Region)
Social norms campaigns	"Our coalition partnered with the County Health Department for presentations to be given on Vaping and Marijuana. This presentation was provided to our coalition and to our youth advisory board. Our Youth Advisory Board created social norm campaigns on the dangers of Vaping. They passed out these campaigns since they were made postcard size and also placed them in the bathroom stalls at the high school since that is where majority of the vaping takes place. Our Youth Advisory Board is currently in the process of planning their first "Vape Take Back Day". "(Year 3, Midwest Region)
Substance use warning posters	"We developed and distributed of marijuana prevention posters. In addition, our coalition produced a meth prevention poster, a non-medical use of cough syrup fact sheet, and a recruitment and informational flier about our Youth Summit. These fliers were disseminated to many youth and adults in the community by way of local places (e.g., Boys and Girls Clubs, Recreation Centers, Supermarkets, Churches, and door to door via their homes), and the marijuana prevention posters were disseminated to the High School with plans to disseminate to many other community gathering spots." (Year 3, South Region)
Town hall meetings on substance use and prevention within the community	"A key accomplishment of the Coalition is the planning and implementation of culturally responsive Town Hall meetings that provided neighborhoods with data-driven programs, policies and practices that assist communities in understanding how improving environmental conditions in neighborhoods supports a reduction in drug use. Importantly, evaluation surveys have highlighted how these neighborhood gatherings provide parents, caregivers, and community leaders with strategies effective in preventing the onset of substance use in the home and school environment. During the past year, the Coalition has reached 5,300 attendees at Town Hall meetings." (Year 9, South Region)
Prescription drug disposal programs	"Our coalition, in collaboration with the Police Armory, launched two National Prescription Drug Take Back Days. The prescription drug disposal location was the Police Armory. We distributed prevention pamphlets (in both English and Spanish), Safe Storage items (i.e., Boxes, Bags, and Pill Bottles), and other tangibles. We posted advertisement flyers in both English & Spanish on social media. This has contributed to making our initiatives accessible to community members." (Year 3, Northeast Region)

Source: DFC 2023 Progress Report data.

The CCT also asked coalitions to describe the extent to which they engaged in specific coalition activities in the past year to grow as a coalition and to bring about change in their community. Activities were grouped into 7 categories (see Appendix E, Table E.2 for all activities). Table 11 shows the coalition activities they reported engaging in to the greatest extent. In line with grant expectations, coalitions rated referring to action plans to guide decision making to the highest extent, as well as increasing awareness of harmful consequences associated with substance use by youth.

TABLE 11: TOP FOUR COALITION ACTIVITIES MOST HIGHLY ENGAGED IN BY DFC COALITIONS TO GROW AS A COALITION

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

Source: DFC August 2023 Coalition Classification Tool Data, n=744
Note: 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 reported to be primarily carried out by staff were developing communications sent to coalition members and community partners (46.3%), making budget and expenditure decisions (43.1%), and developing communications sent to community partners (38.7%) (See Table E.3, Appendix E for full listing). Two tasks were identified by at least half of DFC coalitions as being the responsibility of coalition staff and members equally: planning coalition activities (53.9%), and both identifying and recruiting new coalition members (58.1%).

Addressing Emerging Drug Issues

DFC coalitions had the opportunity to answer items focused specifically on addressing emergent drug issues including address opioids and/or methamphetamine, vaping, and other emerging threats. In each case, coalitions addressing the issue were asked to provide additional information.

Opioids and Methamphetamine

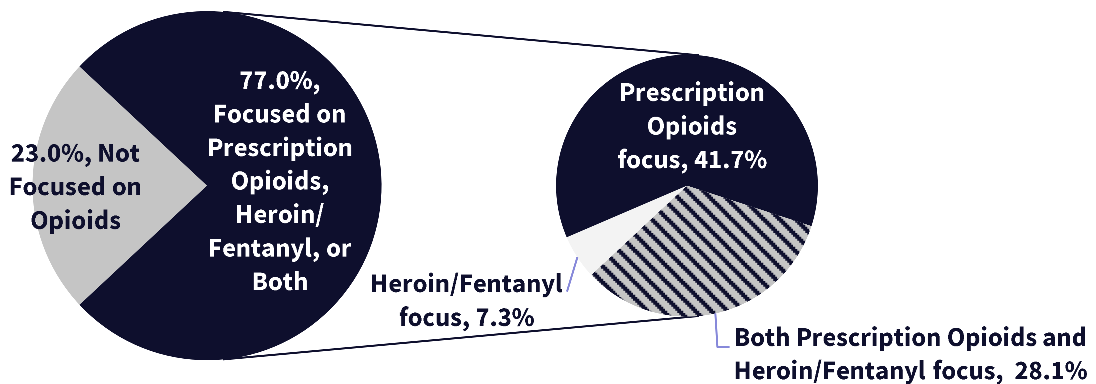
The CDC has identified opioid use and opioid overdose deaths as an epidemic.[47] Provisional data from CDC's National Center for Health Statistics show that drug overdose deaths decreased by 3% from 111,029 overdose deaths in 2022 to 107,543 overdose deaths in 2023; this is the first annual reduction in drug overdose deaths in the United States since 2018. The provisional data shows overdose deaths involving opioids decreased from 84,181 opioid overdose deaths in 2022 to 81,083 opioid overdose deaths in 2023. While provisional counts of overdose deaths from synthetic opioids (fentanyl) decreased from 76,226 deaths in 2022 to 74,702 deaths in 2023; psychostimulants (including methamphetamine) increased from 35,550 deaths in 2022 to 36,251 deaths in 2023. Although several

[47] 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. NVSS - Drug Overdose Deaths (cdc.gov)

states across the nation saw decreases, there were some states that experienced increases during this time and overdose deaths remains a concern across the nation.[48]

According to August 2023 data, just over three-fourths of DFC coalitions (77%) selected prescription opioids, heroin, or both as among their top five substances focused on (see Figure 10).[49] There was a decrease in the percentage of coalitions who selected only prescription opioids as their focus substance (47% in 2022 to 42% in 2023), while there was an increase in the percentage of coalitions selecting heroin and prescription opioids as their focus (25% in 2022 to 28% in 2023) and of coalitions selecting heroin as their focus substance (4% in 2022 to 7% in 2023). Collectively this suggests that coalitions are shifting their focus slightly to opioid issues beyond prescription drugs. In addition, of the 84 coalitions (11%) that reported working with other emerging issues, 69 were focused on xylazine which is often mixed with fentanyl.

FIGURE 10. PERCENTAGE OF DFC COALITIONS FOCUSED ON OPIOIDS



Source: DFC August 2023 Progress Report

In comparison to selecting opioids as a focal substance, slightly more DFC coalitions (78% as compared to 77%) indicated they engaged in activities to address opioids and/or methamphetamine, with almost all indicating they had addressed prescription opioids (93%; see Figure 11). It is likely this small difference is due to some coalitions addressing opioids but not as a top five substance. Of these coalitions, 85% indicated their work addressed fentanyl or other synthetic opioids, 39% addressed heroin, and just under a quarter (23%) 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 7% of coalitions focused on substances that did not include prescription drugs and only three coalitions indicated a focus solely on methamphetamine.

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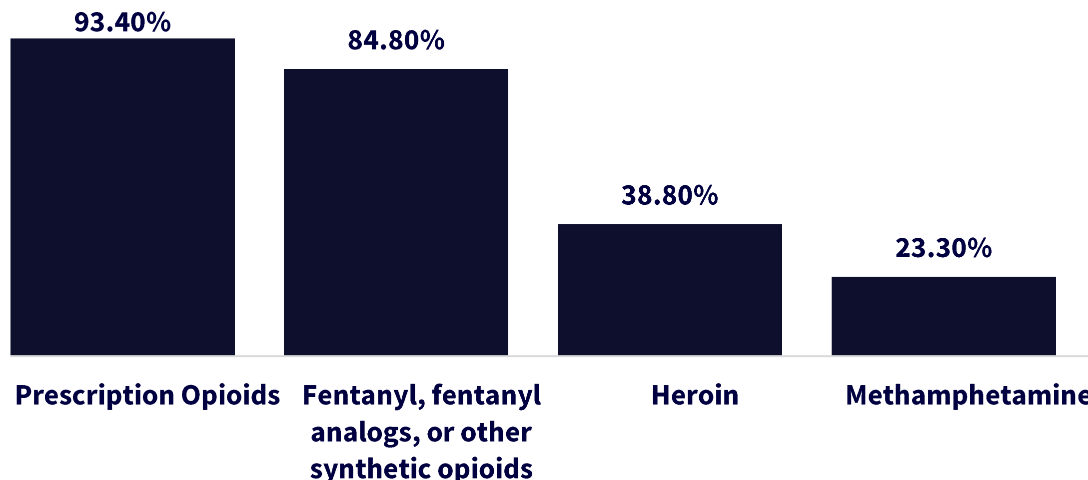
[48] Tsai, Brian (2024, May 15). U.S overdose deaths decrease in 2023, first time since 2018. *CDC's National Center for Health Statistics.* https://blogs.cdc.gov/nchs/2024/05/15/7623/

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

FIGURE 11. SUBSTANCES SELECTED BY COALITIONS WHO IMPLEMENTED ACTIVITIES SPECIFICALLY TO ADDRESS OPIOIDS/METHAMPHETAMINE



Source: DFC August 2023 Progress Report
Note: Totals do not add to 100% because DFC coalitions could select more than one substance.

Vaping

From 2022 to 2023, national trends showed that the use of e-cigarettes or vaping had declined from 14.1% to 10%, although vaping remained the most common strategy for consuming tobacco among youth.[50] Among middle school youth, the trend over time was non-significant from 2022 to 2023 (3.3% to 4.6%). Among high school youth who reported vaping, approximately 4 in 10 (40%) reported frequent use and nearly one in three (30%) reported daily use. Among middle and high school students who currently use e-cigarette products, most (87%) reported using flavored e-cigarettes.

Over three-fourths (82%) of DFC coalitions reported their coalition engaged in activities to address vaping locally. Of those coalitions who addressed vaping, 96% reported their work focused on vaping of nicotine/tobacco, and 89% reported their work addressed vaping marijuana. Additionally, 73 coalitions (12% of those who addressed vaping) reported addressing another substance. Of all coalitions that reported addressing vaping locally, 86% reported addressing both nicotine and marijuana, 10% of coalitions addressed nicotine/tobacco only, and 3% of coalitions addressed marijuana only. Youth who use vapes for nicotine have almost five-time-higher odds of using vapes for cannabis use. Cannabis and nicotine vaping has been associated with a higher frequency of engaging in other substance use, including cigarettes, alcohol, and illicit or prescription drug misuse.[51]

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[50] Birsdey, J., Cornelius, M., Jamal, A., et al. (2023). Tobacco Product Use among US Middle and High School Students – National Youth Tobacco Survey, 2023. MMWR Morb Mortal Wkly Rep 2023;72:1173–1182. DOI: http://dx.doi.org/10.15585/mmwr.mm7244a1

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

Newly Emerging Drugs

As noted, coalitions were able to enter information about any other newly emerging drugs they faced in their communities with just over one-tenth responding yes (11%). The vast majority of responses identified xylazine as an emerging issue. Other dugs mentioned included psychedelics, Kratom, and Delta 8 and similar hemp products with THC. Below we highlight efforts around xylazine and psychedelics.

Xylazine: An Emerging Issue

Just under one-tenth (9%) of coalitions recognize xylazine (street names tranq, zombie) as an emerging issue in their community, by far the most common emerging drug issue. Primarily coalitions noted building awareness, providing information and training around xylazine. A Year 10 coalition (Northeast Region) described, “Xylazine, nicknamed tranq, has hit our area. It first came on our radar approximately 9 months ago from a national drug watch organization. While numbers are still small, nowhere near the amount of opioids or even the smaller demographic of meth users, it is showing it's devastation.” The impact of Xylazine on community health and safety was also noted, with an emphasis on the challenges communities face managing its presence and use within the community. For example, a Year 7 coalition (West Region) described, “Xylazine is increasingly being found in the U.S. illegal drug supply and is linked to overdose deaths. Xylazine can be life-threatening and is especially dangerous when combined with opioids like fentanyl.”

Coalitions also described collaborative efforts with local law enforcement and health agencies to address challenges specific to Xylazine. A Year 1 coalition (West Region) shared, “Fentanyl has plagued our community terribly, as has its concomitant use with xylazine, also known as “tranq” which is why the coalition works with the police department to have the most up-to-date information and keep the community at the forefront of official information, protection, and prevention of new threats.”

A primary strategy for addressing Xylazine in the community was providing information through education and awareness programs aimed to increase public understanding of the risks associated with Xylazine. Some coalitions provided information to the broader community. For instance, a Year 7 coalition (West Region) “shared the link to the Centers for Disease Control and Prevention's document, "What You Should Know About Xylazine," via email, our newsletter and social.” Other coalitions provided information to frontline workers in their communities. A Year 2 coalition (West Region) focused on healthcare professionals, “Our hospital staff has been educated on the signs of this substance such as open wounds that won't heal, and they have been directed to test the patient for xylazine if these symptoms exist.” In a Year 7 coalition (Northeast Region), the coalition coordinator, “put together a comprehensive one-page document to highlight the most important bits of information about Xylazine that she had collected to be distributed to community partners, most specifically police departments throughout the region as well as other regional coalitions.”

Psychedelics: An Emerging Issue

A few coalitions also identified psychedelics, primarily psilocybin (mushrooms) as an emerging threat. One Year 6 coalition (West Region) shared, “Mushrooms are increasing in popularity among high school students and there have been 3 young people in our service area who have died as a result of accidents while using this drug.” Another Year 4 coalition described (Northeast Region) “The coalition is addressing the emerging threats of Psilocybin (Psychedelic fungi) that is available over the counter in several local convenience stores.” Other coalitions described barriers in the community given the decriminalization and retail availability of psilocybin. A Year 9 coalition (Northeast Region) noted, “Our jurisdiction passed a law decriminalizing the possession of psychedelic mushrooms for personal use.” To respond to this threat, coalitions are focused on providing information and educating and informing policies or laws. A Year 6 coalition (West Region) described, “Our coalition added more information about psychedelics in our annual "Let's Talk" booklet. We have written blogs and educated the community at education events. Additionally, coalition volunteers have met with state and local lawmakers to share the latest information and discuss the importance of community education as this drug becomes more normalized and there is increased access and chance for misuse.”

Core Measures

Key Findings

DFC coalitions (all and most recent cohort) reported significant decreases in past 30-day use across all substances among middle and high school youth. In the most recent DFC cohort, middle school youths' perception of risk for alcohol and marijuana both declined significantly; high school youth perception of risk associated with tobacco use also decreased significantly. Middle school youths' perception of peer disapproval for substance use was unchanged. Among high school youth, perceived peer disapproval significantly increased across the four substances.

This section summarizes the core measures data reported by DFC coalitions.[52] The core measures data were analyzed in two ways: 1) using all available data from DFC coalitions since the grant's inception, and 2) using data from the most recent (FY 2022) cohort of DFC coalitions. The first analysis provides information on changes in community outcomes since DFC was first funded, whereas the second analysis focuses on outcomes associated with the current context of DFC coalitions. Key data are presented in the body of this report, with full tables available in Appendix F.

Core Measures Findings Summary

Figure 12 provides a high-level summary of the core outcomes results for the sample of all coalitions since inception and for the FY 2022 cohort of coalitions. Arrows indicate statistically significant increases (up arrows) or decreases (down arrows). A value of 'NC' or No Change indicates there was no statistically significant difference between the first and most recent report for that outcome. For past 30-day use, significant decreases reflect findings in line with DFC goals. For perceptions of risk, parental disapproval, and peer disapproval, significant increases reflect findings in line with DFC goals. Notably, in both samples (all DFC coalitions since inception and the FY 2022 sample), past 30-day use decreased significantly across all substances and for both middle and high school youth.

[52] DFC coalitions have reported data from 2002 to 2023. 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 2023. 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 at least $p < .05$.

FIGURE 12. OVERVIEW OF CORE OUTCOMES FINDINGS

ALL DFC GRANT RECIPIENTS SINCE INCEPTION

MIDDLE SCHOOL

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

HIGH SCHOOL

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

FY 2022 DFC GRANT RECIPIENTS

MIDDLE SCHOOL

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

HIGH SCHOOL

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

Source: DFC 2002–2023 Progress Reports, core measures data

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

Past 30-Day Prevalence of Use and Percentage Change

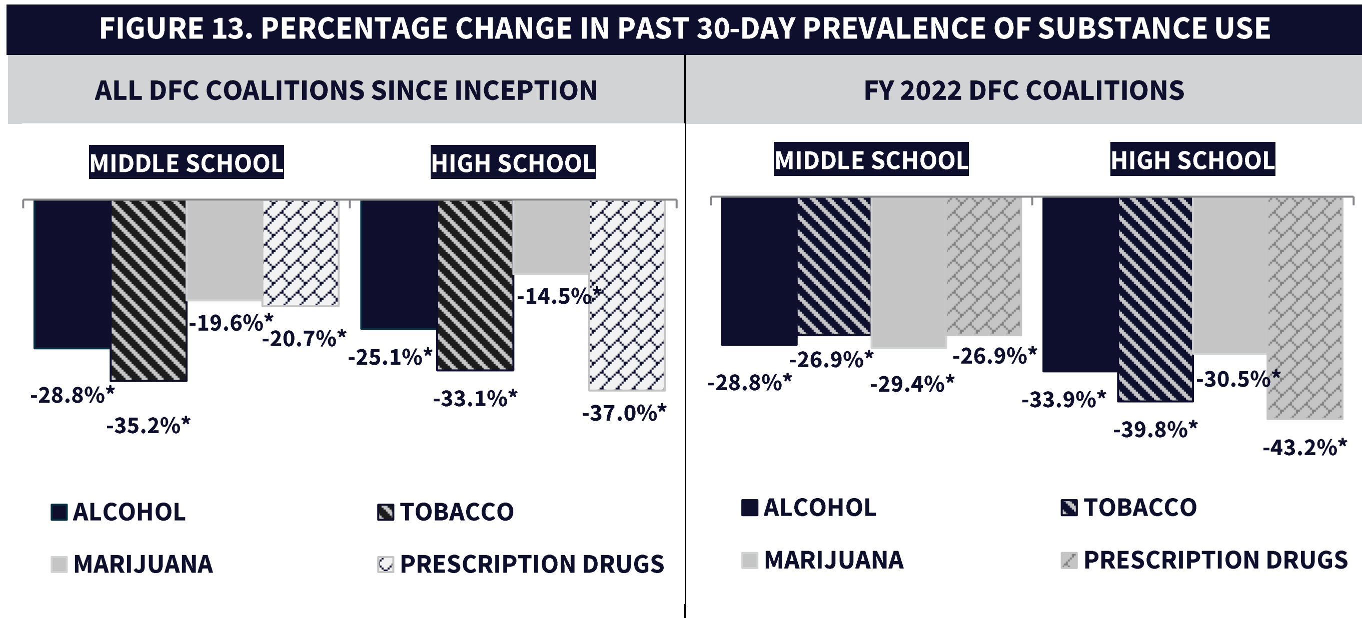
For all coalitions since inception, past 30-day use rates significantly decreased across all substances at both the middle and high school levels, indicating that that DFC coalitions are successfully meeting their goal of preventing youth substance use. In other words, there were significant decreases in past 30-day use across substances, meaning that more youth in DFC communities were choosing positive behaviors and were avoiding substance use. This same pattern was also observed in the FY 2022 cohort. Past 30-day use decreased at both middle school and high school levels (see Tables F.1, Appendix F). Alcohol remained the most commonly used substance at both school levels, followed by marijuana. Prescription drug misuse was relatively low for both school levels, with less than 3% reported in the most recent data.

Figure 13 presents the percentage change in past 30-day prevalence of substance use among middle and high school students.[53] The data are shown for both samples: all DFC coalitions since the program's inception and the FY 2022 DFC coalitions.

[53] 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 %).

For all DFC since inception, the largest percentage decrease in past 30-day substance use among high school youth was for prescription drugs (37%) followed by tobacco use (33%). In the FY 2022 sample, among middle school youth the percentage change decreases were similar across substances (ranging from 27% to 29%), while for high school youth percentage change declines were again greatest for past 30-day prescription drug misuse followed by tobacco use. Extrapolating non-substance 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 12).

FIGURE 13. PERCENTAGE CHANGE IN PAST 30-DAY PREVALENCE OF SUBSTANCE USE



Source: DFC 2002–2023 Progress Reports, core measures data
Note: * indicates p < .05

TABLE 12. FY 2022 DFC COALITIONS ESTIMATED INCREASES IN THE NUMBER OF YOUTH REPORTING PAST 30-DAY NON-USE BY SUBSTANCE

SUBSTANCE	MIDDLE SCHOOL	HIGH SCHOOL
Alcohol	63,000	316,000
Tobacco	21,000	131,000
Marijuana	30,000	186,000
Prescription Drug (misuse)	21,000	76,000

Source: DFC 2002–2023 Progress Reports, core measures data
Notes: Number of estimated youth based on extrapolating percentage change to potential reach based on census estimate (see DFC Reach section for details).

Perception of Risk

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

- At the middle school level, most changes over time were nonsignificant. Across both samples, perceived risk associated with marijuana use declined significantly from inception to the most

recent report. For the FY 2022 cohort, perceived risk associated with alcohol use also significantly decreased.

- At the high school level, most changes over time were also nonsignificant. For all DFC coalitions since inception, there was a significant decrease in perceived risk associated with marijuana use. In the FY 2022 cohort, there was a significant decrease in perceived risk associated with tobacco use.
- At most recent report, across both samples and school levels, perception of risk associated with marijuana use was lower than for any other substance. This trend was particularly pronounced among high school youth. For example, in the most recent cohort of DFC coalitions, there was nearly a 20-percentage point difference between perceived risk associated with marijuana use and that associated with alcohol use (51.4% and 70.9%, respectively).

Perception of Parental Disapproval

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

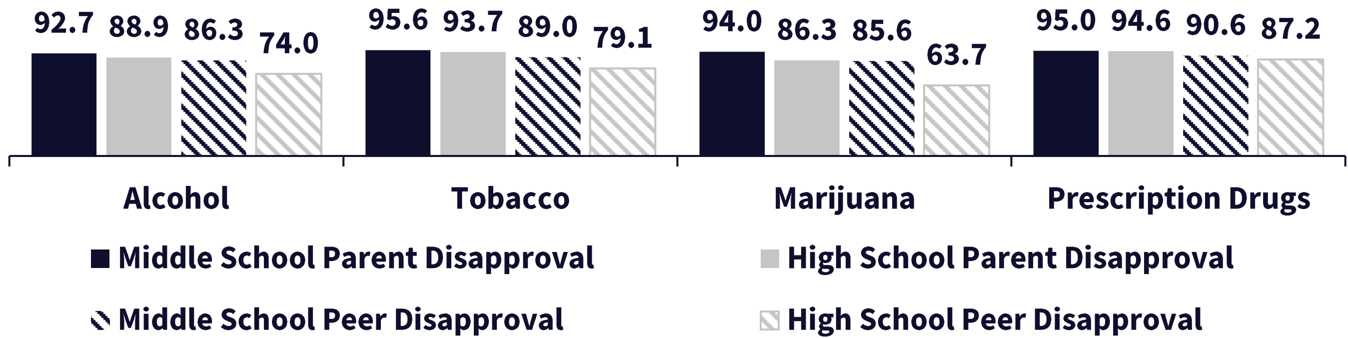
- Generally, the reported rates of perceived parental disapproval were high across samples and substances, with middle school rates of at least 93% and high school rates of at least 86%.
- Among middle school youth, perceptions of parental disapproval generally decreased significantly. Across all DFC coalitions since inception, perceptions of parental disapproval increased significantly for tobacco and marijuana.
- Among high school youth, perceptions of parental disapproval were unchanged for marijuana use in both samples, and for alcohol use and prescription drug misuse within the most recent DFC cohort. Across all DFC coalitions since inception, perceptions of parental disapproval increased among high school youth for alcohol, tobacco, and prescriptions drugs. The same was true for perceived parental disapproval of tobacco use in the FY 2022 cohort.

Perception of Peer Disapproval

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

- Perceptions of peer disapproval were generally lower than perceptions of parental disapproval across substances, particularly for high school youth (see Figure 14 for an example and Tables F.4 and F.5, Appendix F). For example, while most high school youth reported not using substances and believed their parents would disapprove of such use, they were less likely to perceive of their peers disapprove if they used substances.
- In the sample of all DFC coalitions since inception, there were significant increases in peer disapproval perceptions of peer disapproval across substance and grade levels. The only exception to this was for middle school youth perceptions of peer disapproval of prescription drug use, which was unchanged (and was very high at 91%).
- In the most recent cohort, among high school youth, there were significant increases in perceptions of peer disapproval across all substances. For middle school youth in this sample, there was no change over time across substances.

FIGURE 14. PERCEPTION OF PARENT AND PEER DISAPPROVAL AT MOST RECENT REPORT BY SUBSTANCE (FY 2022 DFC COHORT)



Source: DFC 2002–2023 Progress Reports, core measures data

Comparison with National Data

Past 30-day substance use data from DFC coalitions were compared to national data where appropriate (see Table F.6, Appendix F):[54] Based on data collected in 2021, past 30-day use of alcohol and marijuana among high school students in DFC communities were significantly lower than rates in the national sample from the Youth Risk Behavior Survey (YRBS). Rates of tobacco use were not statistically different between the DFC and YRBS samples.

[54] . For more information on YRBS data see https://www.cdc.gov/healthyYouth/data/yrbs/index.htm and https://www.cdc.gov/healthyyouth/data/yrbs/data.htm. Comparison between DFC and Youth Risk Behavior Survey data at the high school level were possible as the two use the same wording. Comparisons examine confidence intervals (95%) for overlap between the two samples. CDC YRBS data corresponding to DFC data are available only for high school students on the past 30-day use measures and only for alcohol, tobacco, and marijuana. YRBS data from 2023 are not yet available. Some DFC coalitions report using YRBS data to track local trends and thus may be included in the national YRBS data. That is, some change in YRBS data may occur in part due to efforts from DFC coalitions. Comparisons with the national sample also may also be influenced by the range of survey instruments that DFC coalitions use to collect core measures data. Although surveys must use appropriate DFC core measures wording to be included in the DFC National Evaluation data, the order of core measure items and the length of the surveys can vary widely across DFC coalitions. While DFC coalitions are required to report core measures data every 2 years, each coalition may determine their own data collection schedule, further limiting the comparison between the two national samples. Because there is likely some overlap between samples, these comparisons are conservative estimates of the difference that DFC is making in communities.

Limitations and Challenges

In 2023, DFC coalitions shifted to submitting one progress report annually rather than two progress reports. Significant training and supports were provided to coalition in this transition. This has included regular reminders to track implementation as well as suggesting available, free to use tools to support such tracking. Similarities in trends found here relative to earlier years suggest that coalitions were able to track successfully.

DFC coalitions have made progress in overcoming challenges related to collecting core measures data. For example, over half of DFC coalitions (59%) submitted at lease some new past 30-day use core measure data in 2023.[55] In describing their challenges in core measures data collection, coalitions often referenced that schools were still facing capacity challenges first seen during the COVID-19 pandemic. Many schools remain primarily focused on education recovery efforts and education goals, as opposed to initiatives that they may perceive as ancillary to the primary purpose of educating students.[56] DFC coalitions have focused on maintaining and/or rebuilding positive relationships with the school sector to support both implementing activities with youth in this setting and collecting data from youth.

In addition to the challenges associated with working with schools, DFC coalitions also report changes in state engagement in conducting public health surveys, with some eliminating them and others making them optional rather than required for schools to have youth complete. Several states have also introduced legislation requiring active parent consent, rather than opting out of surveys. It can be difficult to identify strategies that ensure that schools or youth, particularly high school youth, will provide consent forms to parents and then return them. This also can add burden on the schools to track responses, although DFC coalitions are able to support such tracking. This has resulted in some DFC coalitions struggling to collect representative data, even if they are able to collect data in the schools.

More generally, although grant activities of DFC coalitions were designed and implemented to prevent and/or reduce youth substance use, it is not possible to establish a causal relationship in core measure changes over time because there is not an appropriate comparison or control group of communities from which the same data are available. Overall, multiple years of findings from the DFC National Evaluation support the conclusion that DFC coalitions are associated with decreased youth substance use across a range of substances providing evidence for this community-based approach to prevention. In addition, while DFC coalitions' core measures data has typically been significantly lower than national data, where comparisons are possible, the data are similar enough to suggest DFC coalitions are providing reliable, valid data.

Another challenge related to core measures is that each DFC coalition makes local decisions regarding how to collect core measures data, such as where to administer the survey, what grades to

[55] Data submitted in any given year includes baseline data for new DFC coalitions (collected within past three years) as well as any new data that were not available at the time of the August 2022 data collection. This generally includes data collected primarily in both the current and prior year.

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

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, the DFC National Evaluation Team reviewed all surveys for core measures, and core measures data may only be entered if the item was 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 school level, emphasizing that data collection is predicated on school attendance. Finally, DFC coalitions are encouraged and receive training to collect representative data from their area of focus; however, each coalition is ultimately responsible for their own sampling strategies.

Appendix A. Risk and Protective Factors Focused on by Coalitions

Table A.1 presents the extent to which each risk and protective factor was identified as issues in DFC communities. The difference between being perceived as a risk versus protective factor is also presented. Extent was scored as No/Low (0), Moderate (1), or High (2). Positive significant differences in the tables are bolded and represent factors that DFC coalitions were significantly more likely to perceive the protective as being present to a greater extent than the risk factor. Table C.2 provides information regarding the percentage of DFC coalitions who engaged in efforts to address/enhance the given risk/protective factors (No=0; Yes=1). Positive significant differences in the tables are bolded and represent factors that DFC coalitions were significantly more likely to being engaged in addressing as a protective factor. Note that generally, DFC coalitions reported being engaged with factor as both a risk and protective factor.

TABLE A.1: AVERAGE EXTENT OF PROTECTIVE AND RISK FACTORS IN DFC COMMUNITIES

Community Risk (R) and Protective (P) Factors	Average Extent of Protective Factor in Community	Average Extent of Risk Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
Community			
R: Low rates of youth connection to the community; little sense that youth have a voice in the community/active in community organizations P: High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations	0.94	0.97	-0.03
R: Few community activities for young people P: Plentiful community activities for young people	0.81	1.09	-0.28*
R: Inadequate laws/ordinances related to substance use/access P: Laws, regulations, and policies in place related to substance use/access	1.07	0.82	**0.25***
R: Inadequate enforcement of laws/ordinances related to substance use P: Adequate law enforcement presence sufficient to enforce laws/ordinances related to substance use	0.97	0.86	**0.11***
R: Perceived community norms favorable toward substance use P: Perceived community norms promote non-use/misuse of substances	0.69	1.50	-0.81*
R: Advertising promoting substance use highly visible in the community P: Prevention, advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community	0.86	1.07	-0.21*

Community Risk (R) and Protective (P) Factors	Average Extent of Protective Factor in Community	Average Extent of Risk Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
R: Weak community organization (e.g., High rates of violence/crime, little access to safe, stable housing) P: Strong community organization (e.g., low rates of crime/violence, high access to safe, stable housing)	1.00	0.66	**0.34***
R: Easy Availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing P: Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing	0.61	1.26	-0.65*
R: High rates of poverty and limited access to educational/economic opportunities; High unemployment and/or underemployment P: High rates of economic stability and access to educational/economic opportunities	0.88	0.94	-0.06
R: Community organizations have limited emphasis on cultural awareness, sensitivity, and inclusiveness and promoting equity P: Community organizations have a strong emphasis on cultural awareness, sensitivity, and inclusiveness and promoting equity	0.99	0.77	**0.22***
R: Community supports are generally unavailable or are inequitably available (e.g., only available in certain neighborhoods or to those with economic resources) P: Community supports are generally available and are equitably available (e.g., available to range of families in the community)	0.98	0.78	**0.20***
R: Lack of local treatment services for substance use and/or poor access to mental health services generally in the community P: Sufficient access to mental health and treatment/recovery services in the community	0.64	1.21	-0.57*
R: Available treatment/recovery services for substance use insufficient to meet needs in timely manner P: Treatment/recovery services for substance use are sufficient to meet demand in a timely manner	0.58	1.18	-0.60*

Community Risk (R) and Protective (P) Factors	Average Extent of Protective Factor in Community	Average Extent of Risk Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
School, Faith, Peer			
R: Low school connectedness: Youth do not feel a sense of connectedness to schools/teachers; Youth unlikely to have adults who are mentors/someone to confide in at school P: High school connectedness: Youth feel a sense of connection to schools/teachers; Youth have adults who are mentors/someone they can confide in at school	1.03	0.89	**0.14***
R: Low commitment to attend/stay in school; High rates of truancy and/or extended time missing school or dropping out of school P: High commitment to staying in school and attending school	1.22	0.69	**0.53***
R: High rates of youth struggling in school; Academic failure P: High rates of youth academic success	1.17	0.73	**0.44***
R: Low access to safe, high-quality schools across the lifespan P: High/Broad access to safe, high-quality schools across the lifespan	1.27	0.36	**0.91***
R: Few youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult P: Most youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult	0.87	0.67	**0.20***
R: Poor access to a range of faith-based services in the community P: Broad access to a range of faith-based services in the community	1.18	0.33	**0.85***
R: High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use P: Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	0.75	1.31	-0.56*
R: Poor access to adult or peer-to-peer mentoring for youth in need of a mentor; youth have poor access to someone to turn to when help is needed in schools or peer group P: High/easy access to adult or peer-to-peer mentoring for youth in need of a mentor or someone to provide help/advise	0.79	0.95	-0.16*

Community Risk (R) and Protective (P) Factors	Average Extent of Protective Factor in Community	Average Extent of Risk Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
R: Youth have easy access to peers who engage in negative, unhealthy, or delinquent behavior P: Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors	1.10	1.16	-0.06*
R: High rates of bullying schools/peer group P: Low rates of bullying schools/peer group	0.80	1.02	-0.22*
Family			
R: Low family connectedness: youth do not feel connected to their families/parents/caregivers do not perceive family as a source of support P: Family connectedness (youth feel connected to families/caregivers – feel can talk to them about range of feelings/issues)	1.01	0.76	**0.25***
R: Family trauma/stress (e.g., parental/sibling substance use, domestic violence, death of family member) P: Families/parents/caregivers engage in prosocial behaviors and maintain healthy stable relationships	0.98	1.17	-0.19*
R: Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use P: Families/parents/caregivers encourage youth to engage in healthy behaviors including avoiding substance use	0.96	1.19	-0.23*
R: Family/parental/guardian attitudes favorable to antisocial behavior P: High engagement by families/parents/caregivers in monitoring and supervision of youth	0.82	0.74	**0.08***
R: Families/parents/caregivers lack ability/confidence to speak to their children about substance use P: Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use	0.72	1.22	-0.50
Individual			
R: High rates of youth who have experienced two or more risk factors/stressors (e.g., abuse, homelessness, school failure) P: Few youth who have experienced two or more risk factors/stressors	0.69	1.03	-0.34*
R: Early initiation of negative or unhealthy behavior, including substance use P: Delayed or no initiation of negative or unhealthy behavior, including substance use	0.76	1.08	-0.32*

Community Risk (R) and Protective (P) Factors	Average Extent of Protective Factor in Community	Average Extent of Risk Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
R: Individual youth have favorable attitudes towards substance use/misuse P: Youth have good life skills such as good decision-making and problem-solving skills	0.91	1.21	-0.30*
R: Youth only follow rules around substance use when appropriately supervised; Breaks rules related to substance use across settings (school, home, other settings) P: Youth generally follow and appreciate rules related to substance use at home, in school and other settings even without supervision	0.86	0.97	-0.11*
R: Youth have few if any appropriate, prosocial, healthy activities or interest P: Youth seek out and engages in available positive, healthy, or prosocial behaviors	1.04	0.75	**0.29***
R: Youth as little/no interest in education and work and has poor school and work habits that may contribute to failure P: Youth value education and work and engages in habits to succeed in these settings	1.08	0.55	**0.53***
R: Youth experience death of peer/classmate/close friend	NA	0.54	NA

Source: DFC 2023 Progress Report)
Notes: Extent scored as No/Low (0), Moderate (1), or High (2);
[a]Mean difference calculated by subtracting the average risk score from the average protective score. Therefore, a positive difference indicates the average protective score was higher than the risk score. Conversely, a negative score signifies the risk score exceeded the protective score.; significance based on paired test with all differences significant at least at $^{*}p < .05$

TABLE A.2: PERCENTAGE OF DFC COALITIONS ENGAGED IN EFFORTS TO ENHANCE PROTECTIVE AND ADDRESS RISK FACTORS

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
Community			
R: Low rates of youth connection to the community; little sense that youth have a voice in the community/active in community organizations P: High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations	94.62	89.52	**5.1***
R: Few community activities for young people P: Plentiful community activities for young people	86.29	85.89	0.40
R: Inadequate laws/ordinances related to substance use/access P: Laws, regulations, and policies in place related to substance use/access	78.36	70.56	**7.80***
R: Inadequate enforcement of laws/ordinances related to substance use P: Adequate law enforcement presence sufficient to enforce laws/ordinances related to substance use	66.67	67.34	-0.67
R: Perceived community norms favorable toward substance use P: Perceived community norms promote non-use/misuse of substances	95.16	96.37	-1.21
R: Advertising promoting substance use highly visible in the community P: Prevention, advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community	91.53	65.19	**26.34***
R: Weak community organization (e.g., High rates of violence/crime, little access to safe, stable housing) P: Strong community organization (e.g., low rates of crime/violence, high access to safe, stable housing)	46.51	34.14	**12.37***
R: Easy availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing P: Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing	82.12	85.75	-3.63*
R: High rates of poverty and limited access to educational/economic opportunities; High unemployment and/or underemployment P: High rates of economic stability and access to educational/economic opportunities	36.96	34.95	2.01

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
R: Community organizations have limited emphasis on cultural awareness, sensitivity, and inclusiveness and promoting equity P: Community organizations have a strong emphasis on cultural awareness, sensitivity, and inclusiveness and promoting equity	76.21	68.68	**7.53***
R: Community supports are generally unavailable or are inequitably available (e.g., only available in certain neighborhoods or to those with economic resources) P: Community supports are generally available and are equitably available (e.g., available to range of families in the community)	70.30	55.38	**14.92***
R: Lack of local treatment services for substance use and/or poor access to mental health services generally in the community P: Sufficient access to mental health and treatment/recovery services in the community	70.16	66.80	**3.36***
R: Available treatment/recovery services for substance use insufficient to meet needs in timely manner P: Treatment/recovery services for substance use are sufficient to meet demand in a timely manner	59.14	52.82	**6.32***
School, Faith, Peer			
R: Low school connectedness: Youth do not feel a sense of connectedness to schools/teachers; Youth unlikely to have adults who are mentors/someone to confide in at school P: High school connectedness: Youth feel a sense of connection to schools/teachers; Youth have adults who are mentors/someone they can confide in at school	77.82	76.08	1.74
R: Low commitment to attend/stay in school; High rates of truancy and/or extended time missing school or dropping out of school P: High commitment to staying in school and attending school	51.75	43.68	**8.07***
R: High rates of youth struggling in school; Academic failure P: High rates of youth academic success	45.70	37.90	**7.80***
R: Low access to safe, high-quality schools across the lifespan P: High/Broad access to safe, high-quality schools across the lifespan	34.14	18.28	**15.86***

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
R: Few youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult P: Most youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult	38.44	32.26	**6.18***
R: Poor access to a range of faith-based services in the community P: Broad access to a range of faith-based services in the community	29.97	21.64	**8.33***
R: High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use P: Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	96.51	96.51	0.00
R: Poor access to adult or peer-to-peer mentoring for youth in need of a mentor; youth have poor access to someone to turn to when help is needed in schools or peer group P: High/easy access to adult or peer-to-peer mentoring for youth in need of a mentor or someone to provide help/advise	73.92	71.24	2.68
R: Youth have easy access to peers who engage in negative, unhealthy, or delinquent behavior P: Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors	83.74	77.42	**6.32***
R: High rates of bullying schools/peer group P: Low rates of bullying schools/peer group	64.25	62.77	1.48
Family			
R: Low family connectedness: youth do not feel connected to their families/parents/caregivers do not perceive family as a source of support P: Family connectedness (youth feel connected to families/caregivers – feel can talk to them about range of feelings/issues)	81.72	69.49	**12.23***
R: Family trauma/stress (e.g., parental/sibling substance use, domestic violence, death of family member) P: Families/parents/caregivers engage in prosocial behaviors and maintain healthy stable relationships	76.48	69.76	**6.72***
R: Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use P: Families/parents/caregivers encourage youth to engage in healthy behaviors including avoiding substance use	93.95	93.95	0.00

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
R: Family/parental/guardian attitudes favorable to antisocial behavior P: High engagement by families/parents/caregivers in monitoring and supervision of youth	75.13	56.45	**18.68***
R: Families/parents/caregivers lack ability/confidence to speak to their children about substance use P: Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use	95.16	95.70	-0.54
Individual			
R: High rates of youth who have experienced two or more risk factors/stressors (e.g., abuse, homelessness, school failure) P: Few youth who have experienced two or more risk factors/stressors	73.25	62.77	**10.48***
R: Early initiation of negative or unhealthy behavior, including substance use P: Delayed or no initiation of negative or unhealthy behavior, including substance use	90.99	90.99	0.00
R: Individual youth have favorable attitudes towards substance use/misuse P: Youth have good life skills such as good decision-making and problem-solving skills	90.59	97.85	-7.26*
R: Youth only follow rules around substance use when appropriately supervised; Breaks rules related to substance use across settings (school, home, other settings) P: Youth generally follow and appreciate rules related to substance use at home, in school and other settings even without supervision	81.45	76.34	**5.11***
R: Youth have few if any appropriate, prosocial, healthy activities or interest P: Youth seek out and engages in available positive, healthy, or prosocial behaviors	89.65	77.28	**12.37***
R: Youth as little/no interest in education and work and has poor school and work habits that may contribute to failure P: Youth value education and work and engages in habits to succeed in these settings	65.19	43.01	**22.18***
R: Youth experience death of peer/classmate/close friend	NA	40.86	NA

Source: DFC 2023 Progress Report

Notes: *p < .05; Percentage point difference calculated by subtracting the percent risk score from the percent protective score. Therefore, a positive difference indicates the protective score percentage was higher than the risk score. Conversely, a negative score signifies the risk score percentage exceeded the protective score percentage.

Appendix B. 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 B.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/GUARDIAN/CAREGIVER DISAPPROVAL				
	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your parents or guardians feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?				
How wrong do your parents or guardians feel it would be for you to smoke tobacco?				
How wrong do your parents or guardians feel it would be for you to smoke marijuana?				
How wrong do your parents or guardians feel it would be for you to use prescription drugs not prescribed to you?				

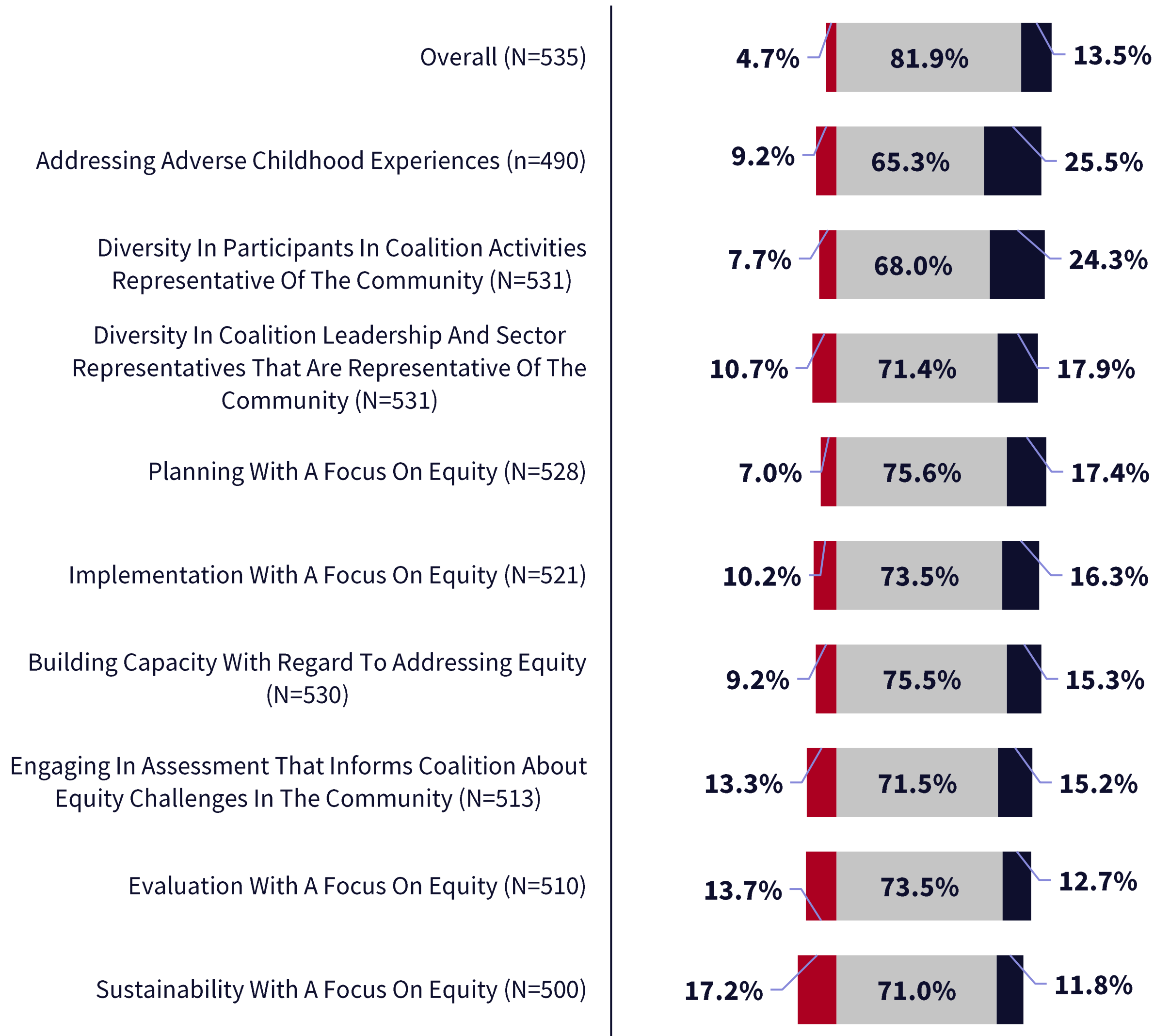
PERCEPTION OF PEER DISAPPROVAL	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?				
How wrong do your friends feel it would be for you to smoke tobacco?				
How wrong do your friends 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 C. Health Equity

Figure C.1 provides an overview of how effective DFC coalitions perceived their work to be across a range of activities. For simplicity, responses of very ineffective and somewhat ineffective were combined as were responding somewhat or moderately effective.

FIGURE C.1. EFFECTIVENESS IN WORKING TO ADDRESS HEALTH EQUITY BY TYPE



Source: DFC August 2023 Progress Report

Note: Percent is within the 535 DFC coalitions who reported working to identify and/or address health equity and who indicated they were working on the specified issue. Effectiveness was rated as 1=Very Ineffective, 2=Somewhat Ineffective, 3=Somewhat Effective, 4=Moderately Effective, 5=Very Effective

Appendix D. Strategies Tables

TABLE D.1: *PROVIDING INFORMATION* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Informational materials disseminated	679	91.3%
Social networking (Facebook, Twitter, etc.)	651	87.5%
Direct, face-to-face information sessions	616	82.8%
Conduct or promote special programs and/or special events (e.g., prescribing guidelines, PDMP, drop boxes/take back events, fairs, town halls, community celebrations)	612	82.3%
Informational materials prepared/produced (e.g., information about marijuana; information about opioids, fentanyl, and methamphetamine; information on sharing/ storage of prescription drugs; treatment referrals)	606	81.5%
Media campaigns: Television/radio/print/billboards/bus or other posters	592	79.6%
Media coverage: TV/radio/newspaper stories	492	66.1%
New Information on Coalition website	395	53.1%
Other Providing Information activities	101	13.6%
Summary: Providing Information	*737*	*99.1%*

Source: DFC 2023 Progress Report

TABLE D.2: *ENHANCING SKILLS* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Youth Education and Training Programs	524	70.4%
Community Member Education and Training Programs	397	53.4%
Trainings specifically on identifying signs of potential drug use and/or risks associated with drug use (e.g., risks of adolescent marijuana use; opioid risks/signs of use for various community members; signs of methamphetamine use/sales)	379	50.9%
Implementation/ Supported Implementation of an Evidence-Based Curriculum in School Setting	373	50.1%
Parent Education and Training Programs	373	50.1%
Education and training specifically to reduce stigma associated with substance use/substance use disorder	316	42.5%
Sector-based Training (e.g., responsible beverage service/vendor training, prescription drug monitoring trainings, prescriber education & training; training on use and how/where to access naloxone and/or fentanyl test strips)	308	41.4%
Teacher/Youth Worker Education and Training Programs	275	37.0%
Other Enhancing Skills Activities	73	9.8%
Summary: Enhancing Skills	*701*	*94.2%*

Source: DFC 2023 Progress Report

TABLE D.3: *PROVIDING SUPPORT* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Alternative/drug-free social events	475	63.8%
Youth/family community involvement (e.g., school or neighborhood cleanup)	258	34.7%
Organized youth recreation programs (e.g., athletics, arts, outdoor activities)	188	25.3%
Youth/family support groups (e.g., for those who have relationships with individuals who use/misuse substances and recovery groups/events)	156	21.0%
Youth organizations/drop-in centers	141	19.0%
Other Providing Support Activities	99	13.3%
Summary: Providing Support	*632*	*84.9%*

Source: DFC 2023 Progress Report

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

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Reducing Home and Social Access (e.g., prescription drug disposal/storage; alcohol storage; make available or increase availability of local prescription drug take-back events; make available or increase availability of local prescription drug take-back boxes)	515	69.2%
Improve access to overdose prevention materials (e.g., distribution of naloxone and/or fentanyl test strips)	379	50.9%
Improve access to prevention, treatment, and recovery services through culturally sensitive outreach (e.g., multilingual materials/ speakers; culturally responsive messaging)	248	33.3%
Increased Access to Substance Use Services (e.g., court mandated services, assessment and referral, recovery services; make available or increase availability of substance use screening programs (e.g., SBIRT); judicial alternatives for individuals with a substance use disorder who are convicted of a crime (e.g., drug court, teen court)	222	29.8%
Improve supports for service use (e.g., childcare, transportation; make available or increase availability of transportation to support prevention, treatment, or recovery services [e.g., medication assisted treatment, counseling, drug court])	85	11.4%
Other Changing Access Activities	56	7.5%
Summary: Changing Access/Barriers	*649*	*87.2%*

Source: DFC 2023 Progress Report

TABLE D.5: *CHANGING CONSEQUENCES* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Recognition programs (e.g., programs for merchants who pass compliance checks, recognizing drug-free youth; physicians exercising responsible prescribing practices; individuals in recovery)	251	33.7%
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap programs, open container laws; drug task forces to reduce access to opioids/methamphetamine in community)	190	25.5%
Strengthening Surveillance (e.g., monitoring "hot spots," party patrols; identify and/or increase monitoring of opioid/methamphetamine use "hot spots")	147	19.8%
Publicize Non-Compliance (e.g., highlighting businesses not compliant with local ordinances)	50	6.7%
Other Changing Consequences Activities	77	10.3%
Summary: Changing Consequences	*437*	*58.7%*

Source: DFC 2023 Progress Report

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

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
School: Policies promoting drug-free schools	204	27.4%
Citizen enabling/Liability: Laws/public policies concerning adult (including parent) social enabling or liability such as social host ordinances; policies regarding Narcan/naloxone administration; Good Samaritan Laws)	150	20.2%
Underage Use: Laws/public policies focusing on use, possession, or behavior under the influence for minors	117	15.7%
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; Prescription Drug Monitoring Programs)	82	11.0%
Outlet Location/Density: Laws/public policies concerning limitation and restrictions of location and density of alcohol or marijuana outlets	82	11.0%
Treatment/Prevention: Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use)	80	10.8%
Sales Restrictions: Laws/public policies concerning restrictions on product sales (e.g., alcohol at gas stations)	75	10.1%
Cost: Laws/public policies concerning cost (e.g., alcohol, tobacco, or marijuana tax, fees)	62	8.3%
Workplace: Policies promoting drug-free workplaces	43	5.8%
Other Educating and Informing about Modifying/Changing Policies Activities	73	9.8%
Summary: Educating and Informing about Modifying/Changing Policies or Laws	*469*	*63.0%*

Source: DFC 2023 Progress Report

TABLE D.7: *CHANGING PHYSICAL DESIGN* ACTIVITIES

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Increase safe storage solutions in homes or schools (e.g., lock boxes, drug deactivation kits)	357	48.0%
Identify Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	248	33.3%
Promote improved signage/advertising/practices by suppliers (e.g., Decrease signage or advertising, change product locations; post no smoking/no vaping signage)	209	28.1%
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups; clean needles and other waste related to substance use from parks and neighborhoods)	154	20.7%
Encourage business/supplier designation of "no alcohol," "no tobacco," or "no marijuana" zones	57	7.7%
Improve visibility/ease of surveillance in public places and substance use hotspots (e.g., improved lighting, surveillance cameras, improved lines of sight)	56	7.5%
Identify problem establishments for closure (e.g., close drug houses)	28	3.8%
Other Physical Design Activities	74	9.9%
Summary: Physical Design	*577*	*77.6%*

Source: DFC 2023 Progress Report

TABLE D.8: PERCENTAGE OF COALITIONS ENGAGING IN STRATEGIES AND IN INNOVATION BY STRATEGY TYPE

ACTIVITY	NUMBER OF COALITIONS ENGAGED IN AT LEAST ONE ACTIVITY	PERCENT OF COALITIONS ENGAGED IN ACTIVITY	NUMBER OF COALITIONS REPORTING ENGAGED IN INNOVATION	PERCENTAGE OF COALITIONS ENGAGED IN INNOVATION
Providing Information	*737*	*99.1%*	380	51.6%
Enhancing Skills	*701*	*94.2%*	287	40.9%
Changing Access/Barriers	*649*	*87.2%*	219	33.7%
Providing Support	*632*	*84.9%*	308	48.7%
Physical Design	*577*	*77.6%*	168	29.1%
Educating and Informing about Modifying/Changing Policies or Laws	*469*	*63.0%*	155	33.0%
Changing Consequences	*437*	*58.7%*	172	39.4%

Source: DFC 2023 Progress Report

Note: Some coalitions who reported engaging in activities within a given strategy type responded in the innovation section that they had not engaged in any activities of the given type. The decision was made to use the count from the detailed strategy section as the number of coalitions that engaged in the given activity type.

Appendix E. Coalition Classification Tool

TABLE E.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	72.7%	18.1%	9.2%
Social norms campaigns	72.0%	13.1%	14.9%
Substance use warning posters.	63.3%	23.3%	13.4%
Town hall meetings on substance use and prevention within the community	63.1%	18.2%	18.7%
Prescription drug disposal programs	51.1%	44.2%	4.7%
Recognition programs for drug-free youth	50.6%	14.2%	35.2%
Recognition programs for businesses that comply with local ordinances	41.2%	13.0%	45.8%
Billboards warning youth about/against substance use	40.7%	18.6%	40.7%
Media literacy training	33.1%	11.9%	55.0%
Vendor/retailer compliance training	32.8%	35.9%	31.3%
Drugged driving prevention initiatives	32.5%	35.3%	32.1%
Formalized school substance use policies	32.1%	57.3%	10.6%
Compliance checks: Alcohol	28.0%	51.4%	20.6%
Responsible beverage server training	26.5%	39.1%	34.4%
Compliance checks: Tobacco	25.2%	51.4%	23.4%
Alcohol restrictions at community events	20.5%	44.4%	35.1%
Prescription monitoring program	18.9%	53.4%	27.7%
Secret shopper programs for alcohol outlets	16.6%	24.4%	59.0%
Compliance checks: Marijuana	15.9%	14.5%	69.6%
Social host laws	15.1%	53.7%	31.2%
Ordinances on teen parties	12.4%	34.8%	52.7%
Party patrols.	11.4%	19.7%	68.9%

Source: CCT 2023 Data

TABLE E.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						
Developed strategies that coalition sectors will continue to support after DFC funding ends	1.9	29.6%	36.4%	26.0%	5.6%	0.0%
Established plans to continue meeting after DFC funding ends	1.9	30.9%	31.1%	25.7%	7.6%	0.3%
Improved sector members willingness to collaborate on new funding opportunities	1.7	17.3%	35.2%	31.7%	8.6%	2.4%
Established procedures for continuing to share information across agencies after DFC funding ends	1.5	20.3%	28.4%	27.4%	18.3%	0.5%
Transitioned responsibility for at least one coalition activity to a specific sector	1.5	20.2%	28.0%	32.4%	16.5%	0.0%
Secured funding to continue prevention efforts after DFC funding ends	1.3	13.4%	21.3%	34.1%	23.3%	0.8%
Built Capacity/ Strengthened Collaboration						
Increased members' knowledge of the work (e.g., services or programs offered) of other sector member organizations	2.4	48.1%	39.6%	11.6%	0.5%	0.1%
Increased community perception of our coalition as the go to resource for addressing youth substance use	2.2	42.8%	39.5%	15.4%	1.5%	0.8%
Had a strong feeling of cohesiveness across sectors	2.2	37.1%	41.6%	19.3%	1.3%	0.7%
Facilitated opportunities for members to collaborate with one another in new ways	2.1	35.7%	40.0%	21.4%	2.0%	0.8%
Made decisions on the allocation of coalition resources in an open and participatory manner	2.1	37.1%	36.3%	21.7%	3.6%	1.3%
Relied upon multiple sectors to reduce barriers to planning strategies	2.0	32.3%	40.8%	22.4%	3.2%	1.3%
Recruited new sector members who have the ability to take action in the community	2.0	29.7%	42.0%	24.6%	2.8%	0.8%

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
Increased the likelihood of a cross-system/sector approach in strategies to address emerging drug issues in our community	1.9	27.4%	44.6%	23.6%	2.9%	1.5%
Increased availability of tools, best practices, and/or other information that has informed the work of individual organizations/agencies	1.9	26.5%	43.0%	26.8%	2.7%	1.1%
Developed shared understanding across sectors that promoted innovative strategy implementation by our coalition	1.8	19.8%	46.2%	29.6%	3.1%	1.3%
Coalition Cultural Competence						
Considered the cultural makeup of the community when planning and implementing a strategy	2.3	45.0%	37.9%	15.3%	0.8%	2.0%
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	2.2	43.9%	33.9%	16.6%	3.6%	4.7%
Arranged to provide materials (e.g., brochures, billboards) in the home language(s) of English language learners in the community	1.8	33.1%	21.6%	19.5%	13.8%	7.2%
Arranged to provide services/activities (e.g., training, town halls) in the home language(s) of English language learners in the community	1.4	20.2%	17.8%	21.0%	22.8%	0.0%
Created a coalition cultural competence outreach plan to address cultural diversity from demographics to economic class, religion, customs, and beliefs	1.2	10.3%	23.2%	35.6%	21.7%	5.5%
Involved sector members of targeted cultural groups in developing coalition materials for their community.	1.2	9.9%	23.4%	31.3%	25.3%	2.9%
Had a workgroup/subcommittee/task force dedicated to monitoring progress on the coalition cultural competence plan	0.8	5.6%	11.5%	24.5%	41.6%	7.9%
Coalition Formalization						

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
Followed our written description of procedures for decision-making	2.1	34.7%	28.0%	18.1%	3.7%	23.0%
Followed our written description of procedures for leader selection	2.0	28.8%	25.0%	15.3%	7.9%	6.2%
Followed our written description of procedures for resolving conflicts among members	2.0	20.3%	13.0%	9.8%	6.0%	15.4%
Maintained a current organizational chart showing coalition structures and relationships	1.8	31.7%	25.0%	24.1%	13.0%	0.0%
Utilized a structure that primarily relied on the coalition as a whole (as compared to subcommittees/work groups reporting to the coalition) to complete the work of the coalition	1.7	24.8%	29.6%	33.6%	10.4%	2.7%
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	1.6	23.0%	29.6%	30.5%	14.2%	50.9%
Followed our written expectations for member participation (e.g., policy on missed meetings)	1.6%	16.6%	26.0%	29.9%	12.2%	15.5%
Community Leadership Engagement						
Had community leaders present at coalition events	2.3	47.3%	33.3%	16.1%	2.5%	16.7%
Had community leaders actively involved in coalition committees	2.3	44.6%	36.3%	15.8%	2.0%	9.2%
Data, Evaluation, and Outcomes Utilization						
Increased awareness of harmful consequences associated with substance use by youth	2.6	61.4%	33.6%	4.8%	0.0%	0.7%
Increased awareness of substance use (e.g., prevalence, types of substances) in the community	2.5	59.7%	32.8%	6.8%	0.1%	5.1%
Identified data needs to inform future program planning	2.2	37.6%	43.6%	16.5%	1.6%	2.4%
Collaborated across sectors to share data in a timely manner	2.1	34.3%	41.6%	19.8%	2.8%	3.3%
Increased incidence of at least one specific protective factor against youth substance use in our community	2.0	27.8%	42.0%	23.4%	3.3%	20.3%

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
Regularly used evaluation results to inform the community about coalition efforts	1.9	26.1%	36.7%	27.4%	6.4%	1.7%
Collected a range of outcomes data to track progress towards coalition goals	1.8	22.8%	39.2%	30.0%	5.6%	0.8%
Updated its action plans based on evaluation results.	1.8	23.4%	35.5%	25.6%	10.4%	0.0%
Decreased incidence of at least one specific risk factor for youth substance use in our community	1.7	18.1%	38.6%	33.6%	4.8%	0.1%
Decreased prevalence of substance use in at least one specific target population (e.g., minority youth)	1.6	15.3%	32.7%	33.2%	7.4%	0.5%
Successfully shifted youth social norms related to youth use of at least one substance	1.6	14.2%	33.3%	41.0%	6.3%	11.5%
Successfully shifted adult social norms related to youth use of at least one substance	1.4	9.4%	26.6%	48.1%	10.7%	5.0%
Decreased prevalence of specific youth use of at least one substance other than the core measures (e.g., meth, cocaine, inhalants)	1.3	9.6%	20.3%	30.1%	19.5%	1.5%
Member Empowerment						
Placed the responsibility for what activities to implement on members	1.8	16.6%	45.8%	33.7%	3.3%	1.2%
Placed the responsibility for implementing coalition activities on members	1.7	14.1%	42.2%	38.8%	4.4%	0.0%
Placed the responsibility for setting the agenda for coalition meetings on members	1.1	8.8%	21.3%	39.6%	28.0%	0.8%
Strategic Prevention Framework Utilization						
Referred to our action plan to make decisions about activities	2.6	60.5%	34.1%	5.1%	0.0%	3.2%
Completed the activities stated in our action plan.	2.3	40.4%	49.5%	9.6%	0.1%	1.5%
Emphasized practices supported by research in our action plan	2.2	40.6%	40.8%	14.7%	2.4%	1.3%
Relied on the findings of our ongoing needs assessment to guide our action plan	2.2	41.6%	37.8%	17.3%	2.0%	2.8%
Used feedback on the quality of implementation of activities to make improvements	2.1	34.8%	43.4%	18.3%	1.7%	0.3%

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
Sought feedback on the quality of implementation of activities	2.1	36.9%	39.4%	19.5%	3.3%	0.3%
Followed a systematic process for assessing community needs	1.9	28.1%	36.4%	27.3%	5.4%	1.6%
Followed a plan to address identified gaps in capacity	1.7	17.5%	40.3%	33.5%	5.5%	4.7%
Engaged in focus groups/interviews with key stakeholders to inform assessment of community needs	1.6	21.4%	28.5%	31.7%	13.7%	0.0%
Youth Involvement						
Had youth members who shared the coalition's message with the community	2.0	41.5%	27.0%	21.3%	7.9%	0.0%
Successfully increased youth participation in coalition activities	2.0	39.9%	30.8%	20.7%	7.4%	10.3%
Had organized youth members who implemented many of the coalition activities	1.8	29.9%	27.6%	26.9%	12.3%	18.2%
Had organized youth members who planned many of the coalition activities	1.7	28.5%	24.9%	28.4%	13.7%	12.0%
Had youth members who played a key role in developing our action plan	1.5	20.2%	24.0%	31.3%	20.3%	1.1%

Source: CCT 2023 Data

TABLE E.3: RESPONSIBILITY FOR IMPLEMENTING COALITION TASKS

COALITION TASK	AVERAGE CCT SCORE	PERCENTAGE IMPLEMENTED PRIMARILY AND OFTEN BY STAFF MEMBERS	PERCENTAGE IMPLEMENTED BY STAFF AN COALITION MEMBERS EQUALLY	PERCENTAGE IMPLEMENTED PRIMARILY AND OFTEN BY COALITION MEMBERS
Identifying and recruiting new coalition members	2.9	25.4%	58.0%	16.6%
Implementing coalition activities	2.7	39.4%	47.1%	13.5%
Planning coalition activities	2.7	34.5%	53.9%	11.5%
Leading committees and work groups	2.6	49.5%	33.5%	17.0%
Developing the coalition action plan	2.3	56.0%	38.6%	5.5%
Organizing committees and work groups	2.4	54.4%	35.3%	10.3%
Developing communications sent to community partners	2.0	75.4%	17.0%	7.6%
Making budget and expenditure decisions	1.9	75.0%	20.6%	4.4%
Developing communications sent to coalition members	1.8	82.1%	11.6%	6.3%

Source: CCT 2023 Data

Appendix F. Core Measure Data Tables

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

SCHOOL LEVEL AND SUBSTANCE	CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2022 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	1551	11.1	7.9	-3.2*	408	7.3	5.2	-2.1*
Tobacco	1529	5.4	3.5	-1.9*	386	2.6	1.9	-0.7*
Marijuana	1533	4.6	3.7	-0.9*	397	3.4	2.4	-1.0*
Prescription Drugs	805	2.9	2.3	-0.6*	377	2.6	1.9	-0.7*
Methamphetamine	9	0.7	0.6	-0.1	9	0.7	0.6	-0.1
Heroin	15	0.4	0.3	-0.1	15	0.4	0.3	-0.1
HIGH SCHOOL								
Alcohol	1650	32.3	24.2	-8.1*	446	23.6	15.6	-8.0*
Tobacco	1628	15.1	10.1	-5.0*	432	8.3	5	-3.3*
Marijuana	1632	17.3	14.8	-2.5*	441	15.4	10.7	-4.7*
Prescription Drugs	887	5.4	3.4	-2.0*	422	4.4	2.5	-1.9*
Methamphetamine	21	0.9	0.8	-0.1	21	0.9	0.8	-0.1
Heroin	21	0.6	0.6	0.0	21	0.6	0.6	0.0

Source: Progress Report, 2002–2023 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-SUBSTANCE USE[a]

SCHOOL LEVEL AND SUBSTANCE	CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2022 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	1551	88.9	92.1	3.2*	408	92.7	94.8	2.1*
Tobacco	1529	94.6	96.5	1.9*	386	97.4	98.1	0.7*
Marijuana	1533	95.4	96.3	0.9*	397	96.6	97.6	1.0*
Prescription Drugs	805	97.1	97.7	0.6*	377	97.4	98.1	0.7*
Methamphetamine	9	99.3	99.4	0.1	9	99.3	99.4	0.1
Heroin	15	99.6	99.7	0.1	15	99.6	99.7	0.1
HIGH SCHOOL								
Alcohol	1650	67.7	75.8	8.1*	446	76.4	84.4	8.0*
Tobacco	1628	84.9	89.9	5.0*	432	91.7	95.0	3.3*
Marijuana	1632	82.7	85.2	2.5*	441	84.6	89.3	4.7*
Prescription Drugs	887	94.6	96.6	2.0*	422	95.6	97.5	1.9*
Methamphetamine	21	99.1	99.2	0.1	21	99.1	99.2	0.1
Heroin	21	99.4	99.4	0.0	21	99.4	99.4	0.0

Source: Progress Report, 2002–2023 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 SUBSTANCE USE[a]

SCHOOL LEVEL AND SUBSTANCE	CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2022 DFC GRANT AWARD RECIPIENTS			
	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	849	70.5	70.9	0.4	397	71.3	69.9	-1.4*
Tobacco[c]	1480	80.6	80.5	-0.1	399	79.3	79.2	-0.1
Marijuana[d]	819	70.1	67.6	-2.5*	390	70.1	67.3	-2.8*
Prescription Drugs[e]	773	81.0	81.1	0.1	388	81.3	81.2	-0.1
HIGH SCHOOL								
Alcohol[b]	908	70.9	71.3	0.4	428	70.0	70.9	0.9
Tobacco[c]	1553	80.9	81.2	0.3	423	80.5	79.0	-1.5*
Marijuana[d]	879	52.6	50.7	-1.9*	423	51.0	51.4	0.4
Prescription Drugs[e]	844	82.5	82.6	0.1	419	82.9	82.8	-0.1

Source: Progress Report, 2002–2023 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 OF SUBSTANCE USE[a]

SCHOOL LEVEL AND SUBSTANCE	CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2022 DFC GRANT AWARD RECIPIENTS			
	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	761	94.1	93.4	-0.7*	380	94.3	92.7	-1.6*
Tobacco[c]	1391	93.1	94.6	1.5*	378	96.2	95.6	-0.6*
Marijuana[c]	1419	93.2	93.8	0.6*	389	94.7	94.0	-0.7*
Prescription Drugs[d]	760	95.6	95.1	-0.5*	379	95.7	95.0	-0.7*
HIGH SCHOOL								
Alcohol[b]	829	88.6	89.1	0.5*	415	89.3	88.9	-0.4
Tobacco[c]	1489	87.5	90.4	2.9*	408	92.9	93.7	0.8*
Marijuana[c]	1503	86.2	86.2	0.0	422	86.0	86.3	0.3
Prescription Drugs[d]	827	93.8	94.5	0.7*	409	94.2	94.6	0.4

Source: Progress Report, 2002–2023 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 OF SUBSTANCE USE[a]

SCHOOL LEVEL AND SUBSTANCE	CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2022 DFC GRANT AWARD RECIPIENTS			
	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL								
Alcohol[b]	763	85.7	86.4	0.7*	389	86.2	86.3	0.1
Tobacco[c]	768	88.4	88.9	0.5*	387	89.1	89.0	-0.1
Marijuana[c]	774	85.1	85.7	0.6*	390	85	85.6	0.6
Prescription Drugs[d]	754	90.5	90.7	0.2	383	91	90.6	-0.4
HIGH SCHOOL								
Alcohol[b]	831	66.5	72.5	6.0*	422	68.1	74.0	5.9*
Tobacco[c]	830	72.8	77.6	4.8*	414	75.2	79.1	3.9*
Marijuana[c]	834	56.6	60.7	4.1*	419	57	63.7	6.7*
Prescription Drugs[d]	815	81.7	85.9	4.2*	418	82.9	87.2	4.3*

Source: 2002–2023 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.

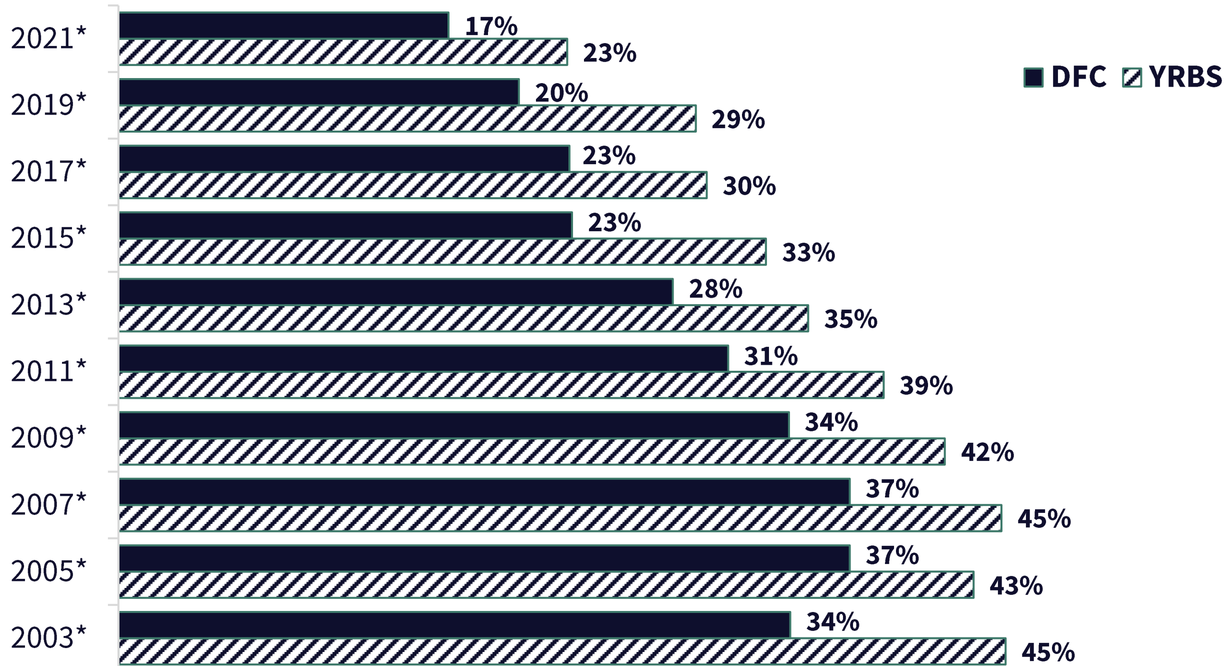
[b] Perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

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

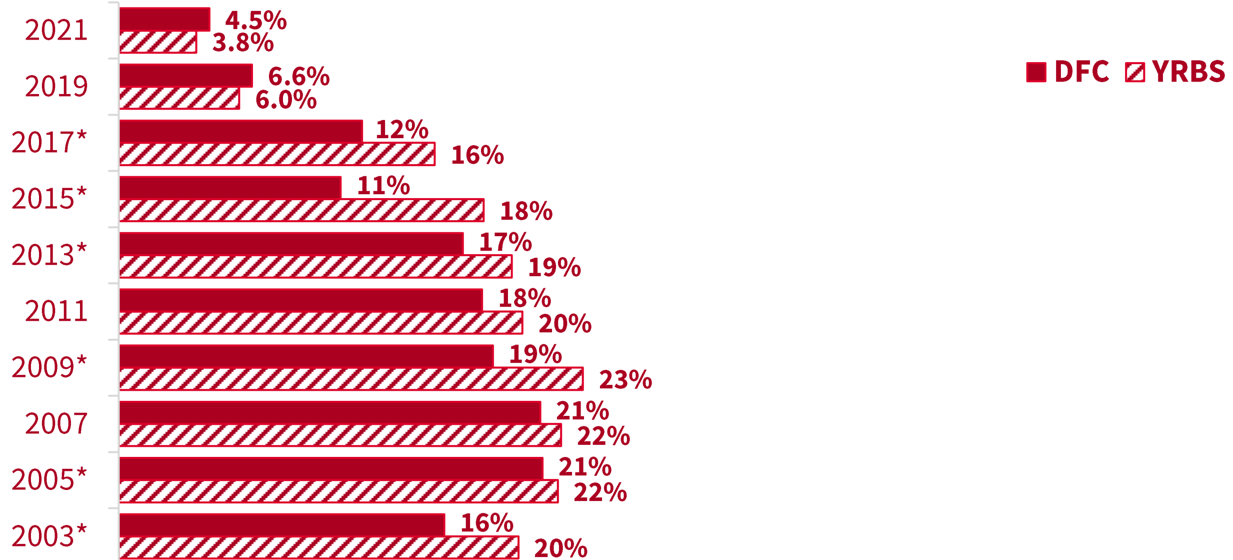
[d] Perception of disapproval of any use of prescription drugs not prescribed to user

FIGURE F.1. DFC COMPARISON TO NATIONAL YRBS PAST 30-DAY ALCOHOL, TOBACCO & MARIJUANA USE AMONG HIGH SCHOOL STUDENTS

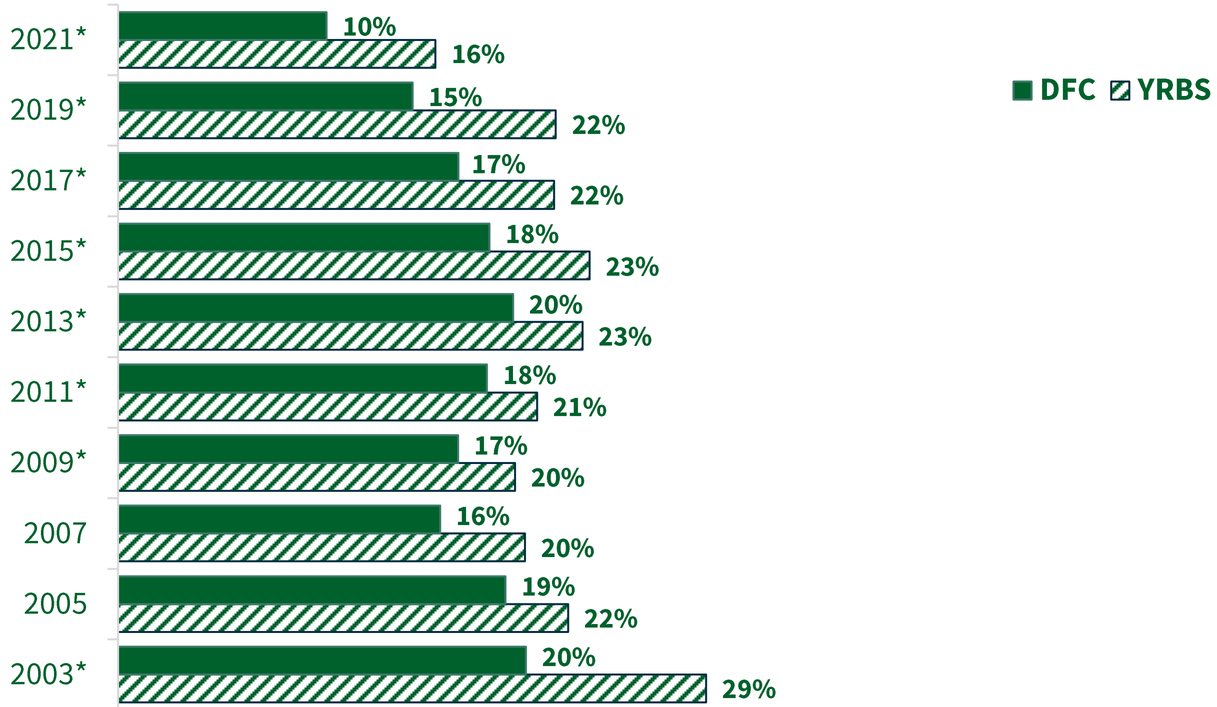
ALCOHOL



TOBACCO



MARIJUANA



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

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

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