Attachment 4:

Sample Evaluation Report and Executive Summary

Drug-Free Communities (DFC) Support Program: Executive Summary of 2017 End-of-Year Report Findings

Funded and directed by the Office of National Drug Control Policy (ONDCP), with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Drug-Free Communities (DFC) Support Program funds community coalitions to build community capacity to prevent and reduce youth substance use. The contributions of community coalitions constitute a critical part of the Nation's drug prevention infrastructure. They are a catalyst for creating local change where drug problems manifest and affect the citizens of this country. A summary of findings based on national evaluation data through August 2017 reported by DFC grant award recipients through fiscal year (FY) 2016, presented in full in the 2017 National Evaluation End-of-Year Report, follows.[1]

Preventing/Reducing Youth Substance Use: Long-Term Change in DFC Core Measures

DFC coalitions report on four core measures linked to four core substances in order to understand change in DFC coalitions' communities over time. The four core measures are:

- past 30-day use;
- perception of risk;
- perception of parental disapproval; and
- perception of peer disapproval.

The four core substances are alcohol, tobacco, marijuana, and misuse of prescription drugs (use of prescription drugs not prescribed to you). Analyses of changes in core measures over time were conducted separately for middle school and high school youth and were conducted both for the sample of all DFC coalitions funded to date and for the sample of fiscal year (FY) 2016 DFC coalitions.

Within communities with a DFC coalition, most middle school and high school youth reported not using each of the four core measure substances (alcohol, tobacco, marijuana, [non-misuse] prescription drugs) and over time prevalence of past 30-day use decreased significantly for all substances.

DFC coalitions made significant progress toward achieving the goal of preventing and reducing youth substance use. While most youth report not using substances, some youth do report use and prevalence of past 30-day use declined significantly between the first and the most recent data reported across all core measure substances, across both school levels, and in both samples (see Figures 1 and 2). The only exception to this was middle school youth past 30-day misuse of prescription drugs, which was unchanged in the FY 2016 sample.

Prevalence of tobacco use has seen the largest declines in both age groups, followed by decreases in prevalence of alcohol use. DFC coalitions reported targeting prevention efforts toward addressing alcohol (97%), marijuana (90%), misuse of prescription drugs (86%), and tobacco use (60%).

[1] See https://www.whitehouse.gov/ondcp/grants-programs/for additional details about the DFC program and the findings summarized here. FY 2016 DFC grants were awarded in September 2016, with required reporting occurring in February and August 2017.

Figure 1: Percentage Change In Past 30 Day Use: First Report To Most Recent Report (All DFC Coalitions Ever Funded)

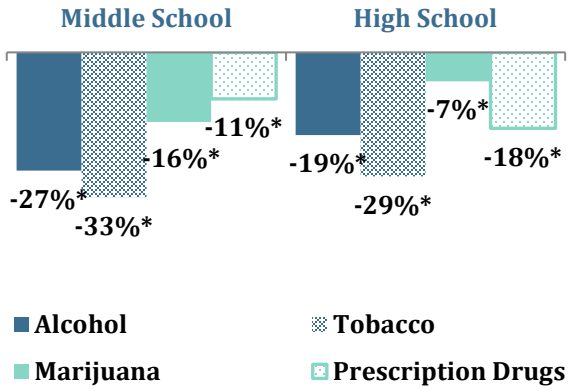
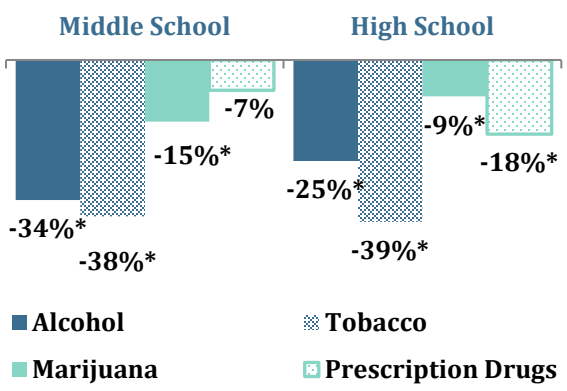


Figure 2: Percentage Change In Past 30 Day Use: First Report To Most Recent Report (FY 2016 DFC Coalitions Only)



Source: Progress Report, 2002–2016 core measures data
Note: * p<.05; Percentage change outcomes represent weighted averages for each DFC grantee based on the total number of students used in the percentage point change calculation (i.e., adding number of students surveyed at first).

Across school levels, youth were least likely to report past 30-day misuse of prescription drugs (94-98% reporting not misusing). While most middle school youth and high school youth also reported not using alcohol in the past 30-days (88-93% and 64-76%, respectively), past 30-day prevalence of non-use was lowest for this substance. Most youth also report choosing not to use marijuana or tobacco. At most recent report, fewer high school youth reported not using tobacco than reported not using marijuana (91% and 84%, respectively in the FY 2016 sample). That is, more high school youth report having used marijuana than tobacco in the past 30-days, although marijuana use remained lower than alcohol use.

In FY 2016, approximately 1 in 5 Americans, including 1 in 5 youth, lived in a community with a DFC coalition. Given that DFC coalitions work at the community level, the significant decreases in prevalence of past 30-day use translate to thousands of additional youth making the choice not to use a given substance.

In FY 2016, 677 DFC coalitions received a grant award. These DFC coalitions worked in a broad range of community settings (e.g., 53% rural, 42% suburban, 25% urban) putting forward local solutions to address locally identified problems. Each DFC coalition indicates all ZIP codes in which their grant activities are targeted; these ZIP codes were merged with 2010 U.S. Census data to provide an estimate of the number of people that DFC grant award recipients may reach. Approximately 1 in 5 Americans (19%) was living in a DFC coalition's target area in 2017. Since 2005, nearly 1 in 2 Americans has lived in a community with a DFC coalition (48%).

1 in 5 Americans (19%) lived in a community with a DFC funded coalition in 2017. Since 2005, 48% of the U.S. population has lived in a community with a DFC coalition.

To better understand at the national level the significant decreases in youth substance use that is occurring in communities with a DFC coalition, percentage change in the FY 2016 sample was multiplied by the capture area population estimates (see Table 1). The estimates for reduced use/increased non-use are in the thousands.

For example, the significant decreases in alcohol use resulted in an estimated 83,000 middle school and 274,000 high school youth choosing not to use this substance. While the significant declines in prevalence of past 30-day use are promising, youth substance use still requires prevention efforts as prevalence of use remains a concern, particularly for alcohol. Targeting efforts to begin in middle school, or earlier, is also crucial as youth use of substances generally increases between middle school and high school.

Table 1. FY 2016 DFC Coalitions: Estimated Increases in Youth Choosing Not to Use….

Substance	Middle School Youth	High School Youth
Alcohol	83,000	274,000
Tobacco	43,000	188,000
Marijuana	15,000	49,000
Prescription Drugs	No Change	40,000

Youth in DFC communities generally reported high and/or increased perceptions of parental and peer disapproval. One concern was that high school youth reported relatively lower perception of peer disapproval than middle school youth, especially for marijuana and alcohol use.

Most (91% or more) middle school youth in communities served by DFC coalitions perceived parental disapproval of substance use across substances (alcohol, tobacco, marijuana, and misuse of prescription drugs) at both first report and most recent report. Perceived parental disapproval for tobacco use increased significantly among middle school youth in both samples (e.g., from 94% to 96% in the FY 2016 sample). Middle school youth's perceived parental disapproval for alcohol use and for marijuana use increased significantly for all DFC coalitions funded (but not for the FY 2016 only sample). Perception of parental disapproval for misuse of prescription drugs was unchanged in both samples. Middle school youth also were high on perceived peer disapproval across substances, with 85-91% perceiving that their peers would disapprove of substance use. For middle school youth in both samples, there were significant increases in perceived peer disapproval for alcohol use; perceived peer disapproval of tobacco use also increased significantly in the *All DFC Coalitions Ever Funded* sample, but not in the FY 2016 sample. Middle school youth in both samples had no change in perceptions of peer disapproval of marijuana use and misuse of prescription drugs.

Similar to middle school youth, most (85-94%) high school youth reported perceiving that their parents would disapprove of use across substances. For high school youth in both samples, there were significant increases in perceived parental disapproval for both alcohol use and tobacco use; there was no change in perceived parental disapproval for misuse of prescription drugs (93-94% perceived parental disapproval at each time point). Perceived parental disapproval for marijuana use was unchanged in the *All DFC Coalitions Ever Funded* sample, but *decreased* significantly in the FY 2016 sample (-0.8 percentage points). For high school youth in both samples, there were significant increases in perceived peer disapproval for all substances, with the exception of perception of peer disapproval of marijuana use in the FY 2016 sample which was unchanged.

While high school youth in communities with a DFC coalition did report increased perceptions of peer disapproval, it is worth noting that perceived peer disapproval among high school youth was lower than perceived peer disapproval among middle school youth. For example, 85-87% of middle school youth perceived that peers would disapprove of alcohol use while only 63-68% of high school youth shared this perception, some 20 percentage points lower. The gap between the age groups was even greater for marijuana between middle school (86-87%) and high school youth (55-57%), some 30 percentage points lower. High school youth also had lower perceptions of peer disapproval than middle school youth for tobacco and prescription drugs although the gap here was slightly smaller, especially at most recent report (15 percentage points for tobacco and 9 percentage points for prescription drug misuse).

While youth generally had high perceptions of risk across substances, perception of risk data suggest that DFC coalitions may need to engage in additional activities to help youth understand the risks associated with use, especially risks associated with marijuana use.

Across grade levels, perception of risk was highest for both tobacco (79-82%) and for illicit use of prescription drugs (80-83%) as compared to perceived risk for alcohol (69-72%). The lowest perceived risk was for marijuana use in both middle school (71-72%) and especially high school (51-55%) youth. While perceived risk was generally unchanged or increased for alcohol, tobacco, and prescription drugs, an unexpected finding was that perceived risk of marijuana use actually *decreased* significantly from first to most recent report. This was true for high school youth in both samples and for middle school youth in the FY 2016 sample. In addition, middle school youth in the FY 2016 sample also *decreased* significantly in their perception of risk associated with tobacco use. These findings suggest that DFC coalitions may need to renew or increase efforts to ensure that youth, beginning in middle school, understand risks associated with substance use.

DFC Coalitions: Building Capacity to Prevent Youth Substance Use

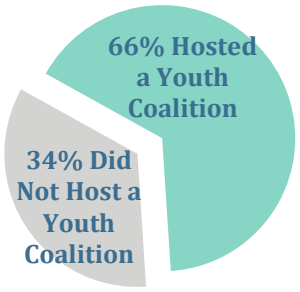
Including DFC staff and the coalitions' active sector members, DFC coalitions mobilized an estimated 30,500 community members to engage on youth substance use prevention work.

On average, DFC coalitions reported that they have 5 staff (2 paid, 3 volunteer) and 40 active members from across the 12 required DFC sectors. Collectively, the 677 FY 2016 DFC coalitions engaged an estimated 30,500 community members in youth substance use prevention work in 2017. The Law Enforcement and School sectors were rated highest on involvement with the DFC coalition, with these members engaged in collaborating on a range of activities including youth and parent education programs, providing alternative drug-free social activities for youth, and prevention summits/town halls.

Law Enforcement sector members, which can include a range of local, regional and state law enforcement as well as representative from High Intensity Drug Trafficking Areas (HIDTA) Program, were also identified by DFC coalitions as playing a key role in addressing opioids in the community.

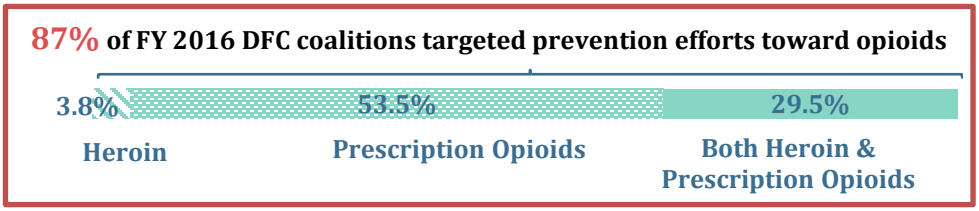
Evaluation findings suggest that hosting a youth coalition is a promising DFC practice.

Youth are both one of the sectors with whom DFC coalitions must engage and the focus of the DFC goal: youth substance use prevention. One strategy that DFC coalitions use to engage youth in both ways is hosting a youth coalition. Approximately two-thirds (66%) of DFC coalitions reported hosting a youth coalition, with the majority (76%) of these providing participating youth with the opportunity to lead on planning and implementing activities with support from the broader coalition. Collectively, analyses comparing DFC coalitions with a hosted youth coalition, versus those without one, suggest that hosting a youth coalition is a promising practice.



For example, DFC coalitions with a hosted youth coalition, versus those without one, were significantly more likely to perceive youth as very highly involved with the coalition and less likely to perceive youth as having only some or low involvement. Both School and Law Enforcement sector members also were rated as significantly more involved when the DFC coalition hosted a youth coalition. DFC coalitions having a hosted youth coalition, versus not having one, were significantly more likely to have at least one member representing every sector (95% versus 88%), at least one active member in every sector (78% versus 69%), and at least one active member in the youth sector (97% versus 89%). Finally, hosting a youth coalition was related to engaging in significantly more prevention activities including implementing at least one alternative/drug-free social event, at least one youth training, at least one parent training, and at least one social networking activity.

Capacity building was also evident in DFC coalitions' efforts to address opioids, with most (87%) DFC coalitions reporting they were targeting heroin, prescription opioids, or both. In addition, almost all (95%) report having a prescription drug take-back event in the community and nearly two-thirds (64%) of DFC coalitions note that these events were put into place as a result of coalition efforts following DFC grant award.



The DFC grant award supports communities in finding local solutions to local problems and many DFC communities have identified opioids as a substance they focus at least some attention on addressing. Specifically, 87% of DFC coalitions targeted heroin, prescription drugs (including prescription opioids) or both. A key strategy for addressing prescription opioids is bringing prescription take-back events into the community. While almost all (95%) DFC coalitions reported holding such an event in 2017, nearly two-thirds (64%) reported that the DFC grant award preceded implementation of these events. That is, the work of the DFC coalition following grant award contributed to introducing this activity to the community.

In 82% of FY 2016 States/Territories with a DFC coalition, at least one DFC coalition mentioned opioids specifically.

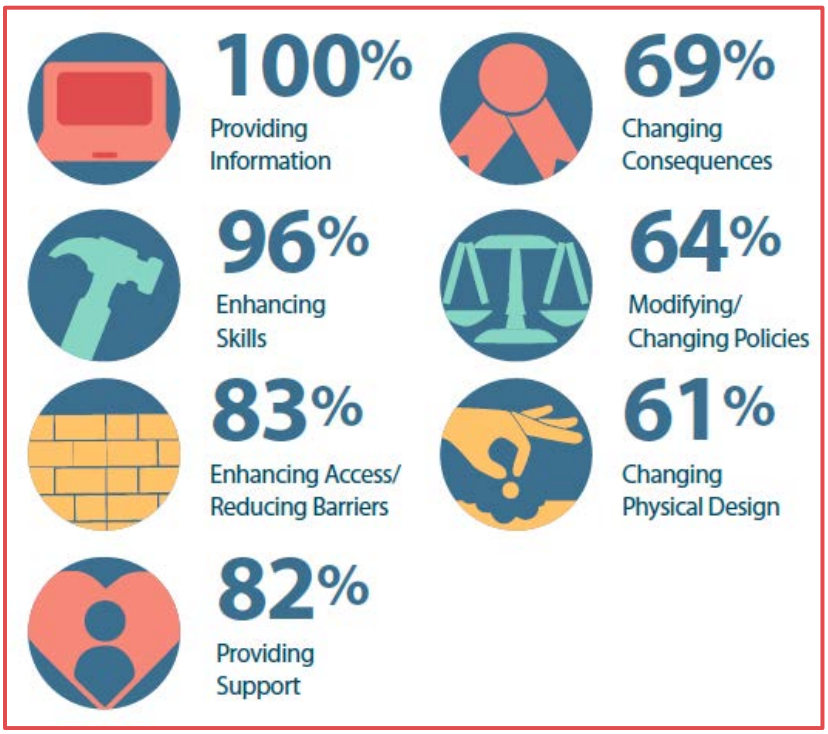
In addition to selecting heroin, prescription opioids, or both as a target substance, DFC coalitions described their efforts in the August 2017 Progress Report. In 44 of 54 (82%) States or Territories with a DFC coalition, at least one of these coalitions was talking about this work. DFC coalitions reported disseminating information through various media to large numbers of community members. A number of DFC coalitions reported that they planned, participated in, and/or presented at summits, forums, and town halls specifically on heroin and other opioids. Some of these provided an opportunity for community members, local substance abuse treatment providers, and others to discuss how to reduce access to prescription drugs, while others focused more broadly on educating attendees about the dangers of heroin and prescription opioid drug misuse. DFC coalitions also implemented trainings about the harmful effects of opioids and naloxone training. Several DFC coalitions noted that collaboration with Law Enforcement sector, in particular, was central to addressing opioids and perceived that activities to address opioids were successful, in part, because of the relationship that already existed between the coalition and this sector, while also improving on that relationship. Several DFC coalitions also noted that they were helpful to local and State policymakers who were trying to better understand what communities can do to address opioids.

Implementing Prevention Activities

DFC grant award recipients engaged in a comprehensive range of strategies in order to prevent and reduce youth substance use.

DFC coalitions engaged in a broad range of practices that moves from community mobilization and awareness to community action (and ultimately community outcomes). DFC coalitions are encouraged to engage in a range of prevention strategy activities, categorized by seven (7) strategy types, and clearly do so, with just under two-thirds (60%) of DFC coalitions implementing at least one activity within each of the seven strategies. Most (79%) DFC coalitions implemented at least one activity within at least five of the seven strategy types. The comprehensiveness of these strategies is important because substance use has no one, single cause and, therefore, no one, single solution.

All (100%) of the 660 DFC coalitions that submitted an August 2017 Progress Report indicated they had engaged in *Providing Information* dissemination activities. Nearly all (96%) provided services related to *Enhancing Skills*. Activities within these two strategies tend to build credibility in the community, identify the coalition as a reliable source of information, and serve to build capacity both by informing people about the coalition and training community members to engage in prevention work directly. Lower percentages of DFC coalitions engaged in *Enhancing Access/Reducing Barriers* to prevention and treatment services (83%), *Providing Suppo*rt (82%), and *Changing Consequences* (69%) activities. DFC coalitions were least likely to report engaging in activities to educate and inform on *Modifying/Changing Policies* to decrease substance use and associated negative behaviors (64%) and *Changing Physical Design* to decrease opportunities for and encouragement of substance use (61%).



Across the Seven Strategies for Community Change, more DFC coalitions engaged in activities targeting youth than those targeting any other community group: alternative drug-free activities for youth were the most implemented *Enhancing Support* activity; reducing home and social access to substances was the most implemented *Enhancing Access/Reducing Barriers* activity; and more DFC coalitions focused on educating about school policies (where youth are centrally located) than on any other category of *Modifying/Changing Policies*. In summary, DFC coalitions engage youth directly in building stronger and more positive community connections that are associated with substance use prevention.

Note*:* Given the evaluation design, a causal relationship cannot be claimed with certainty between DFC coalition activities and the outcomes reported here. However, the results are consistent with expectations that DFC is effective when the program has been implemented as intended. Please see the full report for additional information.

Drug-Free Communities Support Program National Evaluation

June 2018

2017 National Evaluation End-of-Year Report

Solving Local Problems with Local Solutions

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ICF

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Drug-Free Communities Support Program

The Drug-Free Communities (DFC) Support Program 2017 National Evaluation End-of-Year Report provides an annual update on DFC national evaluation findings. Together, the findings inform regarding DFC coalitions' progress on achieving the following primary goals of DFC:

- 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 abuse among youth.
- Reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse. [1]

First, this report provides an overview of the history and background of the program. Next, evaluation findings are presented in three sections: building capacity data (e.g., DFC coalition membership data), strategy implementation data, and core measure outcome data. The building capacity data identify ***who*** DFC coalitions have engaged with in the community to prevent and reduce youth substance use. Process data on strategies implemented by DFC coalitions provides information regarding ***how*** DFC coalitions work to bring about community change. Finally, changes in the DFC core outcomes data are presented reflecting ***community-level change*** in youth past 30-day non-use, perception of risk of use, and perception of parental and peer disapproval of use associated with four key substances (alcohol, tobacco, marijuana, and misuse of prescription drugs).

History and Background

Created through the DFC Act of 1997, the DFC Support Program funds community coalitions to prevent and reduce youth substance use by emphasizing finding local solutions for local problems. DFC coalitions are comprised of representatives from 12 sectors (defined in the Building Capacity section) that organize as community-based coalitions to meet the local prevention needs of the youth and families of their community.

The DFC Support Program is funded and directed by the Office of National Drug Control Policy (ONDCP). ONDCP has engaged several partners to collaborate in supporting DFC coalitions to help them succeed (see Figure 1). The Substance Abuse and Mental Health Services Administration (SAMHSA) provides grant award management and government project officer monitoring support. Training and technical assistance intended to strengthen the capacity of the DFC coalitions, including the required National Coalition Academy, are provided by the Community Anti-Drug Coalitions of America (CADCA). In

[1] For DFC, youth are defined as individuals 18 years of age and younger. For the fiscal year 2016 funding opportunity announcement for Drug-Free Communities Support Program grants, see https://www.samhsa.gov/grants/grant-announcements/sp-16-001

addition to conducting the national evaluation, the DFC National Evaluation Team provides technical assistance support to DFC coalitions regarding data collection and reporting.

DFC grant award recipients receive up to $125,000 per year for up to 5 years per award, with a maximum of 10 years of grant award funding.[2] Since 1998, the DFC Support Program has awarded DFC grants to community-based coalitions that represent all 50 States, several Territories, and rural, urban, suburban, and Tribal communities. In fiscal year (FY) 2016, 677 community coalitions were awarded DFC grants.[3] Of these, 389 (57%) were in Year 1 to Year 5 of receiving a DFC grant while the remaining 288 (43%) were in Year 6 to 10. As of FY 2016, more than 2,500 DFC grants had been awarded in more than 1,700 communities.[4]

Figure 1. Drug-Free Communities Support Program: Partners for Change

Notes: DFC Grant Award Recipients are supported in achieving DFC goals by ONDCP, SAMHSA, CADCA, and the DFC National Evaluation Team. DFC Coalitions engage 12 sectors to achieve change in the community, represented here by the 12 icons in the outer circle.

Data in 2017 End-of-Year Evaluation Report

In several sections of this report, FY 2016 DFC grant award recipients who submitted a progress report through the DFC Management and Evaluation (DFC *Me)* system in August

[2] DFC coalitions must demonstrate that they have matching funds from non-Federal sources relative to the amount of Federal dollars requested. In Years 1-6, a 100 percent match is required. In Years 7 and 8, this increases to a 125 percent match, and finally in Years 9 and 10 to a 150 percent match. See the FY 2016 funding opportunity announcement for further information on matching https://www.samhsa.gov/grants/grant-announcements/sp-16-001.

[3] In FY 2016, ONDCP awarded 92 new DFC grants and 585 continuation grants for coalitions already in a five-year cycle. In addition, three new DFC Mentoring grants, and 18 continuation DFC Mentoring grants were awarded in FY 2016.

[4] Based on data available to the DFC National Evaluation for awards through FY 2016, 1,735 communities have received DFC grant awards, with 941 communities receiving a Year 1 to Year 5 award and the remaining 794 communities receiving an additional Year 6 to Year 10 award. Combined, this totals 2,529 DFC grant awards. This is a conservative estimate of awards through FY 2016 because data from the early years of DFC (pre-2009) were not consistently available.

2017 are the primary focus.[5] DFC coalitions reported on membership and activities from February 1, 2017 through July 31, 2017.[6] Table 1 outlines the number of FY 2016 grant award recipients who submitted the August 2017 progress report by year of award. In total, 660 of the FY 2016 DFC coalitions submitted a report in August 2017.[7] In addition, all core measure data submitted through 2017 were included in this report. For the core measures analyses, in addition to examining all core measures data submitted through August 2017, analyses were conducted looking at data submitted by FY 2016 coalitions specifically.

Table 1. Number of FY 2016 DFC Grant Award Recipients Submitting August 2017 Progress Report by Year of Award

FY 2016 Grant Award Recipients		
Year of Award	Number of Grant Award Recipients Submitting Report	Percent of Grant Award Recipients Submitting Report
Year 1	60	9.1%
Year 2	106	16.1%
Year 3	95	14.4%
Year 4	83	12.6%
Year 5	34	5.1%
Year 6	30	4.5%
Year 7	77	11.7%
Year 8	94	14.2%
Year 9	58	8.8%
Year 10	23	3.5%
Total	660	100.0%

Source: DFC August 2017 Progress Report

Progress Report Data

DFC coalitions collect and submit a broad range of data biannually in required progress reports. Sector membership data (presented in the Building Capacity section of this report) includes information about DFC coalitions' number of members, number of active members, and level of involvement by each of the 12 sectors.

[5] DFC grant awards are made in September of each fiscal year with the award going from October 1 to September 30 of the following year. This means that FY 2016 awards were made in September 2016, with the grant award recipients submitting progress reports in February and August 2017.

[6] DFC *Me* was developed under the leadership of ONDCP in 2015, with DFC coalitions first using this system in February 2016.

[7] This represents nearly all (97%) FY 2016 DFC grant award recipients. Additional DFC coalitions may have completed the progress report after the point at which data were received by the DFC National Evaluation Team for this report. The DFC National Evaluation Team received progress report data after providing SAMHSA project officers with six weeks to approve the progress reports. SAMHSA project officers were likely engaged in ongoing interaction with the few (3%) DFC coalitions who did not meet the reporting requirement in this timeframe.

The 12 required sectors include:[8]

1. Youth (age 18 or younger)
2. Parent
3. School
4. Law Enforcement
5. Healthcare Professional or Organization (e.g., primary care, hospitals)
6. Business
7. Media
8. Youth-Serving Organization
9. Religious/Fraternal Organization
10. Civic/Volunteer Group (i.e., a member from a local organization committed to volunteering)
11. State, Local, or Tribal Governmental Agency with expertise in the field of substance abuse
12. Other Organization involved in reducing substance abuse

DFC coalitions also report on the activities they have implemented over the previous six months (presented in the Strategy Implementation section of this report). Activities are grouped into the Seven Strategies for Community Change, with any given activity linked to a single strategy.[9] The seven strategies are *Providing Information*, *Enhancing Skills*, *Providing Support*, *Enhancing Access/Reducing Barriers*, *Changing Consequences*, *Changing Physical Design*, and educating or informing the community about *Modifying/Changing Policies.* For each completed activity, DFC coalitions are asked to provide additional information (e.g., number of completed activities, number of youth participating, number of adults participating).

Progress report data includes information regarding the community context (e.g., geographic setting), focus of coalition efforts (e.g., target substances), budget, key risks and protective factors found in the local community (e.g., availability of substances, positive school climate), information on planning activities, and general challenges. DFC coalitions provide in their grant applications the ZIP codes that define the catchment area for the community in which they target activities. Throughout the progress report, DFC coalitions are able to report anecdotally about their work, successes, and challenges from the previous six months.

[8] As per the FY 2016 funding opportunity announcement. See https://www.samhsa.gov/grants/grant-announcements/sp-16-001.

[9] See CADCA publication on the seven strategies: http://www.cadca.org/resources/coalition-impact-environmental-prevention-strategies. CADCA derived the strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre, see http://www.udmo.com/powerup/faq/7%20strategies.pdf

Core Measures Data

DFC coalitions are required to collect and submit new core measures data every two years.[10] DFC coalitions attach new core measures data to either their February or August report once data collection is complete. This report focuses on findings regarding the current DFC core measures, which were revised in January 2012.[11] Briefly, the core measures are defined as follows (see Appendix A for specific wording for each of the core measure items):

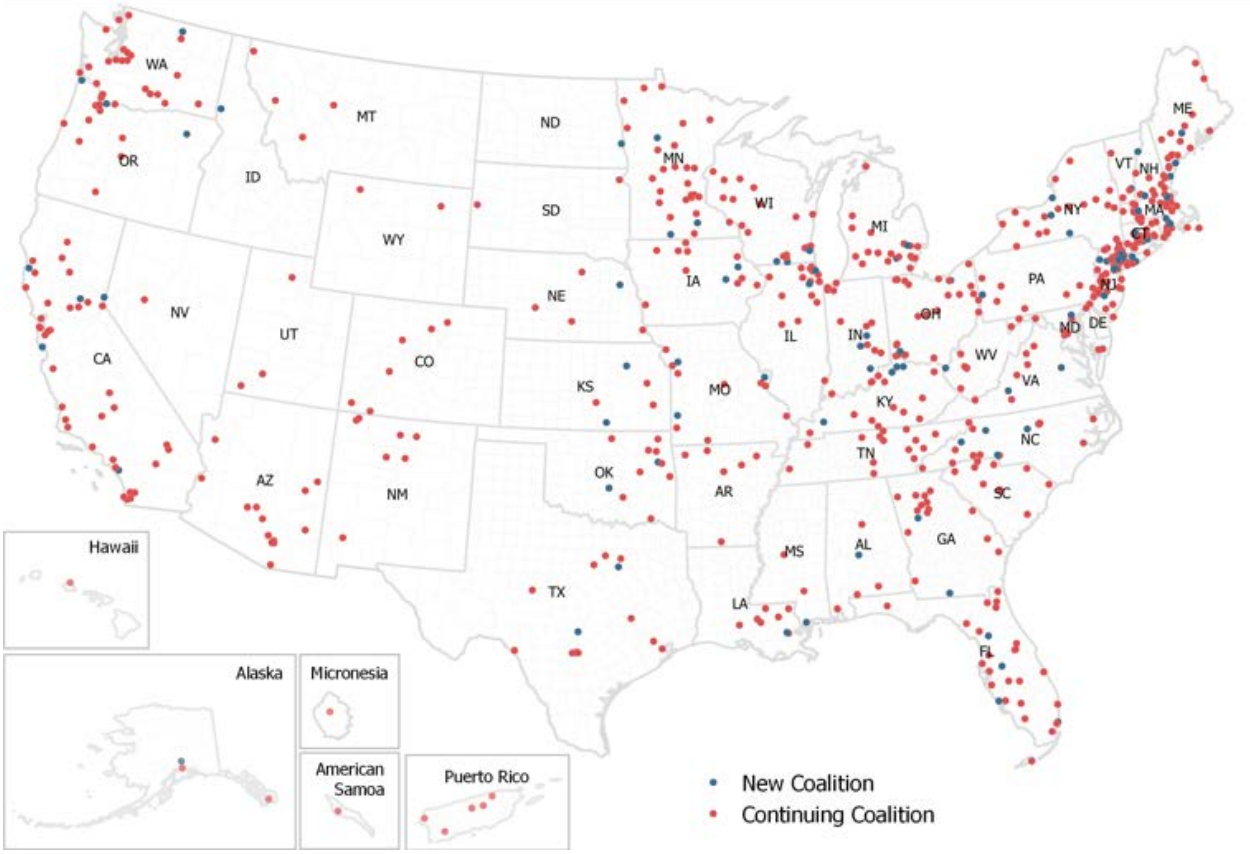
- **Past 30-Day Prevalence of Use/Non-Use:** The percentage of survey respondents who reported using alcohol, tobacco, or marijuana (prevalence of use) or reported misuse of prescription drugs at least once within the past 30 days (prevalence of misuse). Given that the focus of DFC is on prevention, past 30-day prevalence data are reported here as prevalence of non-use (non-misuse). That is, the data reflect the percentage of youth who did not report use (misuse) of the substance in the prior 30 days.[12]
- **Perception of Risk:** The percentage of survey respondents who perceived that use of a given substance has moderate risk or great risk. Perceived risk of alcohol use is associated with five or more drinks of an alcoholic beverage (i.e., beer, wine, or liquor) once or twice a week (binge drinking of alcohol). Perceived risk of tobacco use is associated with smoking one or more packs of cigarettes a day. Perceived risk of marijuana use is associated with using marijuana once or twice a week. The perception of risk of prescription drug use core measure is associated with any use of prescription drugs not prescribed to the user (misuse).
- **Perception of Parental Disapproval:** The percentage of survey respondents who perceived that their parents would feel that regular use of alcohol (1-2 drinks nearly every day) or engaging in *any* use of tobacco, marijuana, or misuse of prescription drugs is wrong or very wrong.
- **Perception of Peer Disapproval:** The percentage of survey respondents who perceived that their friends would feel it would be wrong or very wrong for them to drink alcohol regularly (1-2 drinks nearly every day), or engage in *any* use of tobacco, marijuana, or misuse of prescription drugs.

DFC Reach

In FY 2016, ONDCP awarded 92 new DFC grants (i.e., 62 Year 1 and 30 Year 6) and 585 DFC continuation grants, bringing the total number of FY 2016 DFC grant award recipients included in the evaluation to 677 (see Figure 2 for geographic location).[13] DFC coalitions identify their catchment areas by ZIP code. Each DFC coalition indicates all ZIP codes in which their grant activities are targeted; these ZIP codes were merged with 2010 U.S.

[10] DFC coalitions are encouraged to collect data from youth in at least three grade levels, with at least one grade level in middle school (Grades 6 through 8) and at least one in high school (Grades 9 through 12).
[11] A few core measures were revised in 2012, while 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.
[12] These prevalence of non-use data are simply calculated by subtracting the prevalence of use percentage from 100 percent.
[13] DFC coalitions provide target ZIP code information in their grant application; this data is available for all 677 coalitions.

Figure 2. FY 2016 DFC Grant Award Recipients were Located in Most States and in Three US Territories



Source: DFC FY 2016 Grant Application coalition ZIP code information

Census data to provide an estimate of the number of people that DFC grantees may reach and impact.[14] The total estimated population of all catchment areas of DFC grantees funded in FY 2016 was approximately 58.6 million, or 19 percent of the population of the United States. These catchment areas include approximately 2.4 million middle school students ages 12–14 (nearly one-fifth [19%] of all middle school youth) and

***DFC Potential Reach*:**

1 in 5 Americans lived in a community with a DFC funded coalition in 2017.

Since 2005, 48% of the U.S. population has lived in a community with a DFC

[14] See United States Census 2010 data Age and Sex Table by ZIP code tabulation area (ZCTA) https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table. DFC coalitions provide ZIP codes while the US Census uses ZCTAs. These are similar but not identical (see https://www.census.gov/geo/reference/zctas.html). Note that some ZIP codes reported by DFC coalitions are not found in the Census ZCTA, typically because they represent smaller communities. That is, Census estimates reported here are likely a conservative estimate of potential reach of the DFC grant.

3.3 million high school students ages 15–18 (nearly one-fifth [19%] of all high school youth).[15]

Since DFC grant award recipient data on catchment areas have been collected (i.e., 2005), DFC community coalitions have targeted areas with a combined population of approximately 150.9 million (48%) of the U.S. population. That is, nearly 1 in 2 persons in the United States has lived in a community with a DFC coalition since 2005.

Community Context

DFC coalitions answer a range of questions regarding geographic setting, focus of prevention on specific subgroups of youth, identification of the top five substances targeted by the coalition, and key local risk and protective factors.[16] This information helps to better understand the types of communities DFC coalitions are working in and the problems they are addressing locally. The following sections summarize their responses to these questions.

Geographic Setting

On average, DFC coalitions reported serving 1.3 geographic settings.[17] Of the 660 coalitions, self-identifying as working in rural (53%) or suburban (42%) communities was most common, followed by urban (25%) areas. Smaller percentages of DFC coalitions indicated working in inner city (9%) or frontier (2%) communities.[18]

Focus on Specific Subgroups of Youth

Just over one fourth (27%) of FY 2016 DFC coalitions reported that they targeted information/interventions to one or more specific groups demographically. Specifically, DFC coalitions were most likely to report that they focused on working with Hispanic/Latino (19%) and/or Black/African-American (9%) youth. Some DFC coalitions focused on American Indians/Alaskan Natives (6%), lesbian/gay/bisexual/transgender (LGBT) youth (4%), Asian (3%), and/or Native Hawaiian/Pacific Islander (<1%) youth.

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

[16] DFC coalitions could select multiple responses for each of these questions. Therefore, total responses exceed 100 percent.

[17] DFC coalitions selected all geographic settings that applied. The median number of geographic settings served was 1, with a minimum of 1 and a maximum of 4.

[18] DFC communities self-identify on each of these. Frontier communities are generally communities with sparse population located some distance (at least 60 miles) from larger population centers and services. See https://www.federalregister.gov/documents/2014/05/05/2014-10193/methodology-for-designation-of-frontier-and-remote-areas and https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/NRHAFrontierDefPolicyPaperFeb2016.pdf.aspx?lang=en-US for additional information.

Substances Targeted by DFC Coalitions

DFC coalitions were asked to select up to five substances that their coalition was focused on targeting in their communities. On average, coalitions reported targeting 4.3 substances. Most DFC coalitions reported targeting efforts to address alcohol (97%), marijuana (90%) and misuse of prescription drugs (86%; see Table 2).[19] For DFC coalitions focused on prescription drugs, most were focused on the misuse of prescription opioids (83%) in comparison with the misuse of prescription non-opioids (29%), although just over one-fourth (26%) indicated that they were focused on the misuse of both types of prescription drugs. Just under two-thirds (60%) of the FY 2016 DFC coalitions were focused on addressing tobacco use.

Table 2. Alcohol, Marijuana, Prescription Drugs, and Tobacco Were Targeted by Most DFC Coalitions

Substance	Number of DFC Coalitions Targeting Substance	Percent of DFC Coalitions Targeting Substance
Alcohol	642	97.3%
Marijuana	596	90.3%
Prescription Drug (Any)	565	85.6%
Prescription Drugs (Opioids)	548	83.0%
Tobacco	398	60.3%
Heroin	220	33.3%
Prescription Drugs (Non-Opioids)	191	28.9%
Synthetic Drugs/Emerging Drugs	92	13.9%
Over-the-counter (OTC) drugs	79	12.0%
Methamphetamine	25	3.8%
Cocaine/Crack	7	1.1%
Inhalants	4	0.6%
Stimulants (uppers)	3	0.5%
Tranquilizers	1	0.2%
Steroids	1	0.2%
Hallucinogens	0	0.0%

Source: DFC August 2017 Progress Report

Community Risk and Protective Factors

DFC coalitions are encouraged to identify local risk and protective factors. Risk factors are the characteristics of the community, individuals, families, schools or other circumstances that may *increase* the likelihood or difficulty of mitigating substance use and its associated harms. DFC coalitions may focus prevention activities on reducing or addressing risk

[19] Beginning in August 2017, DFC coalitions could specify prescription drugs (opioids) versus prescription drugs (non-opioids) as a target substance. Prior to that time, the category was broadly labeled as prescription drugs.

factors that are perceived to be particularly important in a community. Conversely, protective factors are the characteristics of a community, individuals, families, schools or other circumstances that *decrease* the likelihood of substance use and its associated harms. DFC coalitions may focus prevention activities on building upon or strengthening protective factors that are perceived to be particularly important in a community.

On average, DFC coalitions selected 6 of 13 risk factors as the focus of what they needed to address in their community. The most commonly reported risk factors in August 2017 were availability of substances (87%), perceived acceptability of substance abuse (86%) and favorable attitudes toward the problem behavior (82%; see Table 3). Approximately half of the DFC coalitions identified family-related risk factors that needed to be addressed including parents lacking the ability or confidence to speak with their children about substance use (59%), parental attitudes that are favorable toward antisocial behavior (53%), and family trauma/stress (50%). One-fourth (25%) of DFC coalitions identified the lack of local treatment services for substance use as a risk factor while one-fifth (19%) indicated that available treatment services for substance use were insufficient to meet needs in a timely manner.

While DFC coalitions were able to identify local risk factors that need to be addressed, they also identified a range of local protective factors. On average, DFC coalitions selected 7 of 13 protective factors as the focus of activities to build upon current community strengths. Key protective factors that DFC coalitions reported working to strengthen included pro-social community involvement (70%), positive peer groups (64%), laws, regulations, and policies (61%), opportunities for pro-social family involvement (60%), and advertising and other promotion of information related to ATOD use (60%; see Table 3). Slightly more than half of the DFC coalitions also were working to build upon perceived school community (56%) and school connectedness (53%) strengths.

Table 3. Risk and Protective Factors Identified by DFC Coalitions

% of DFC Coalitions Identifying Given Risk Factor That Needs to Be Addressed		% of DFC Coalitions Identifying Given Protective Factor to Strengthen	
Availability of substances that can be abused	87.0%	Pro-social community involvement	69.8%
Perceived acceptability of substance abuse	86.4%	Positive contributions to peer group	63.9%
Favorable attitudes toward the problem behavior	82.1%	Positive school climate	63.3%
Parents lack ability/ confidence to speak to their children about ATOD use	58.5%	Laws, regulations, and policies	61.4%
Parental attitudes favorable to antisocial behavior	53.0%	Opportunities for pro-social family involvement	60.6%
Early initiation of the problem behavior	51.4%	Advertising and other promotion of information related to ATOD use	59.7%
Family trauma/stress	50.2%	Contributions to the school community	55.9%
Low commitment to school	40.8%	Recognition/ acknowledgement of efforts	55.2%
Inadequate enforcement of laws/ordinances related to substance use	30.3%	Strong community organization (e.g., less crime, less visible drug dealing)	54.1%
Inadequate laws/ordinances related to substance use/access	30.0%	School connectedness	53.3%
Lack of local treatment services for substance use	24.5%	Family connectedness	52.1%
Academic failure	24.2%	Parental monitoring and supervision	51.1%
Available treatment services for substance use insufficient to meet needs in timely manner	19.2%	Cultural awareness, sensitivity, and inclusiveness	41.1%
		Family economic resources	17.1%

Note: ATOD refers to Alcohol, Tobacco, and Other Drugs
Source: DFC August 2017 Progress Report

Building Capacity to Prevent and Reduce Substance Use

DFC coalitions are required to engage community members from the 12 sectors to conduct their work (see Figure 3 for the 12 sectors). Comprehensive community collaboration to reduce and prevent substance use among youth is a fundamental premise of effective community prevention, and the DFC program. This section examines DFC coalitions' efforts at building community capacity to reduce and prevent substance use among youth as measured by sector membership. This includes the number of active members by sector and the average level of involvement of each sector's members. Next, an analysis of DFC coalitions' engagement with youth coalitions is presented. Finally, DFC's work to build community capacity is highlighted with respect to addressing opioids.

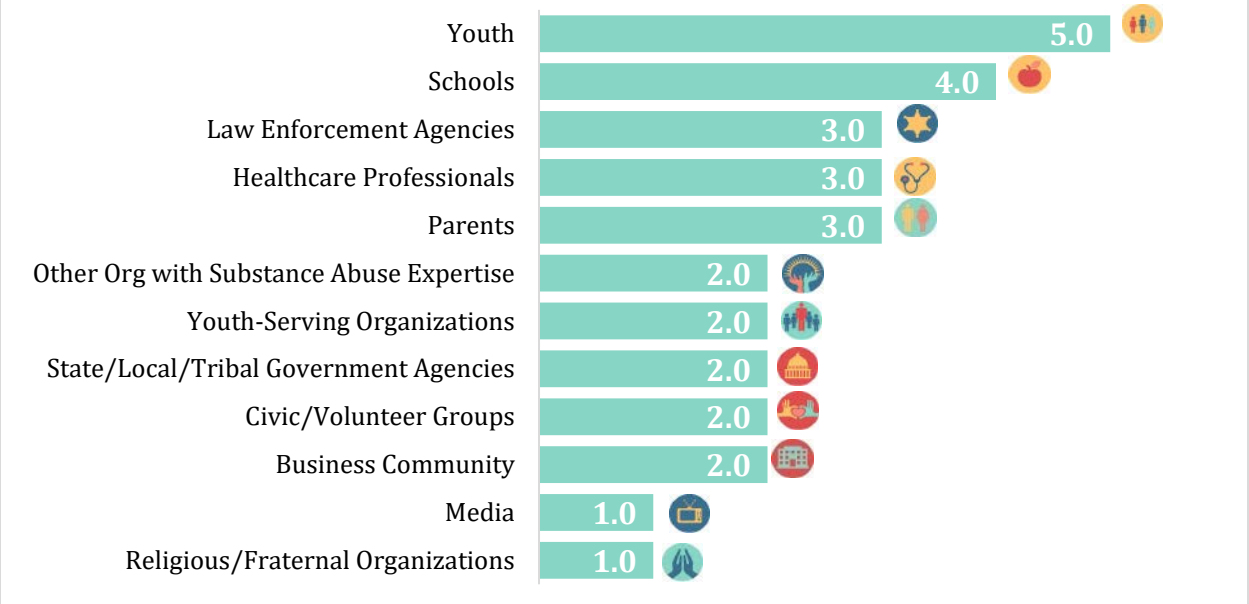
Number of Active Members

In the August 2017 Progress Report data, almost all DFC coalitions (92%) reported meeting the grant requirement of having at least one current member from each of the 12 sectors.[20] While most DFC coalitions identified at least one member for each sector, fewer (75%) reported having at least one active member from each sector; this was an increase from reporting at least one active member in August 2016 (70%). Active members were defined as those who had attended at least one meeting during which coalition work was conducted within the past 6 months.[21] That is, active members are likely to be contributing to planning and carrying out the coalitions' action plan, including implementation of activities. Generally, the average number of sector members and active members within a DFC coalition fluctuates as members move into and out of the community or experience work/family changes that impact the member's ability to work with the coalition. Youth sector members are expected to change, as each year some youth graduate from high school.

Figure 3 provides an overview of the median number of active members from each of the 12 sectors based on the August 2017 data.[22] The median number of active members ranged from 1 to 5 per sector. On average, the Youth sector had the highest median number of active members across DFC coalitions (5 active members), followed by Schools (4 active members), and Law Enforcement Agencies, Healthcare Professionals, and Parents (3 active members each). The median number of active members was lowest for the Media and Religious/Fraternal Organizations sectors (1 active member each).

[20] SAMHSA Project Officers work with DFC coalitions that have challenges in meeting this grant requirement.
[21] The DFC National Evaluation Team provided technical assistance to DFC coalitions regarding defining active members.
[22] The median is used here rather than the mean because a small percentage of DFC coalitions report very large numbers of active members, particularly for youth and parents, skewing the mean.

Figure 3. DFC Coalitions Median Number of Actively Engaged Members by Sector: Youth and Schools Sectors Contributed the Highest Average Number of Members



Notes: Numbers represent the median number of active members from each sector. The number of DFC coalitions reporting on the number of active members by sector was 660.
Source: DFC August 2017 Progress Report

Summed across the 12 sectors, DFC coalitions reported involving a median of 40 total active members.[23] Extrapolating from the median across all 677 FY 2016 DFC coalitions, DFC coalitions engaged approximately 27,000 active sector members. DFC coalitions, who also rely on the work of paid and volunteer staff, reported involving a median of 2 paid and 3 volunteer staff in August 2017. The addition of staff brings the total potential number of community members mobilized by the 677 FY 2016 DFC coalitions to work on youth substance use prevention to just under 30,500. Overall, the median number of active members reported by sector was slightly higher during this reporting period compared with August 2016.[24]

DFC Coalitions: Building Community Capacity

The 677 FY 2016 DFC coalitions mobilized an estimated **30,500** individuals to engage in youth substance use prevention work.

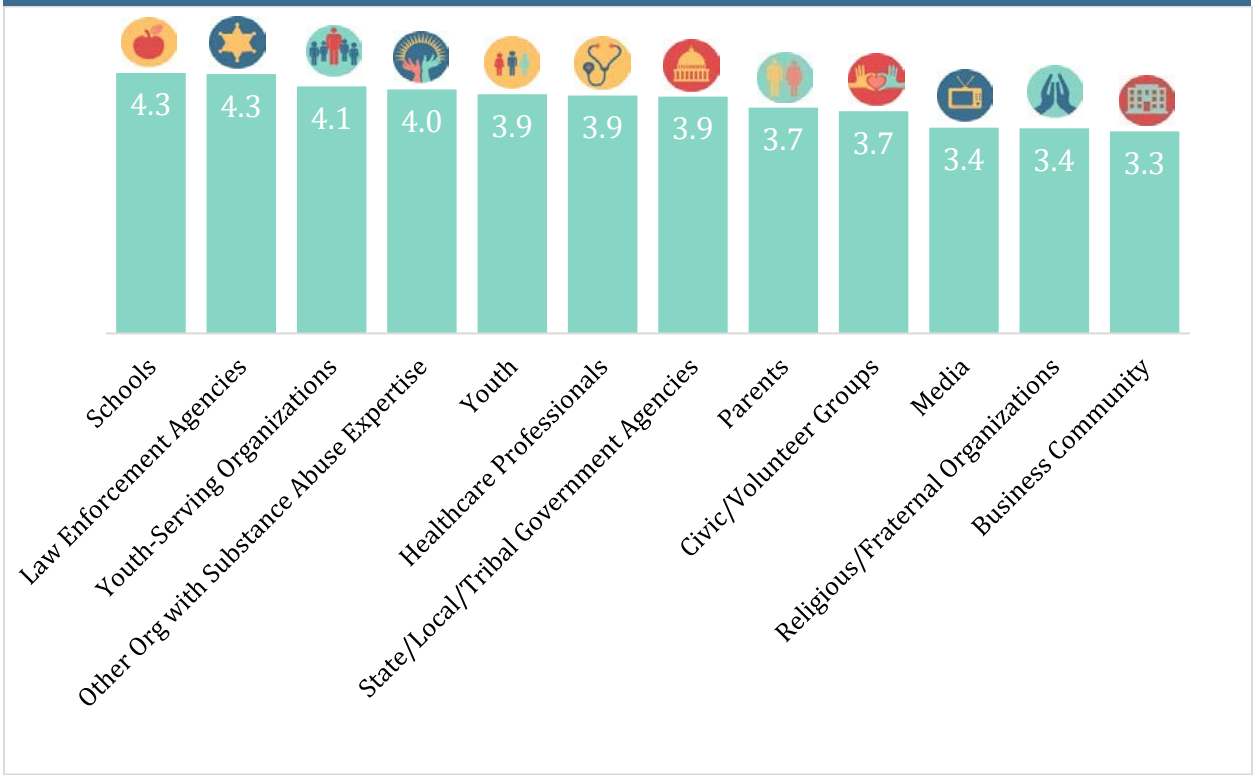
Involvement of Active Members

DFC grant award recipients were asked to indicate how involved, on average, active members from each sector were in coalition activities (see Figure 4). Involvement was

[23] The median number is the midpoint in a frequency distribution. Note that when the number of active members is first summed, the median is larger (40) than if the median number of active members by sector, as presented in Figure 3, is summed (30).
[24] In August 2016, the median number of active members was 36 (compared with 40 in August 2017). The median number of staff was the same across the 2 years (five staff). The median of summed total members was 41 in August 2016 compared with 45 in August 2017.

rated on a five point scale, with 5 indicating very high involvement, 4 indicating high involvement, 3 indicating medium involvement, 2 indicating some involvement, and 1 indicating low involvement. On average, no sector was rated as being below medium involvement (none was below 3). Four sectors were rated as being between high and very high on involvement (4 to 5). The School and Law Enforcement sectors had the highest average level of involvement (4.3 each), followed by Youth-Serving Organizations and Other Organizations with Substance Abuse Expertise (4.1 and 4.0, respectively).

Figure 4. DFC Coalitions' Reported a Range of Involvement Across Sectors, with Schools and Law Enforcement Sectors Having the Highest Average Involvement Rating



Notes: Level of involvement by sector was rated on a five point scale: 5 (very high involvement), 4 (high involvement), 3 (medium involvement), 2 (some involvement), 1 (low involvement).
Source: DFC August 2017 Progress Report

Given the relatively higher involvement of Law Enforcement and School sectors, progress report data were examined for descriptions of these sectors' types of involvement. DFC coalitions reported engaging Law Enforcement sector members through speaking at youth and parent education programs, providing trainings on topics such as naloxone and fake IDs, and collaboration on national night out events and prevention activities (e.g., underage drinking projects).

Several coalitions mentioned specifically working with their Law Enforcement sector on opioid issues:

- "We held a 2 hour logic model/strategic planning meeting with heads of the local law enforcement agencies to combat opioid and heroin abuse."
- "[Our coalition] is working to stay on top of the opioid epidemic, partnering with our police department and [our State] HIDTA [High Intensity Drug Trafficking Areas] on a door hanger campaign to educate the community on the dangers of meth and opioid abuse."
- "We have been working very closely with our local police department to help them provide education and training on opioid use as well as the reversal drug Narcan."

DFC coalitions reported strong collaboration with School sector members, in part as a primary location for reaching out to and engaging youth. One coalition noted that, "We have been able to work with our School sector coalition members to have access to youth to conduct prevention activities (such as sticker shocks), gather/provide information (health fairs), and inform them about the coalition."[25] DFC coalitions provide schools with information through presentations on the coalition mission and activities, invitations to prevention summits, meetings with school staff to discuss survey results and trends, and even subgroups (committees) designed specifically to work with and in schools. As one DFC coalition explained, "During this period, three sector members met with school leadership teams to drill into their core measure survey responses for their students as a result of the youth survey…This created an opportunity to engage superintendents, principals, counselors, coaches, and teachers and discuss opportunities for student success while addressing substance use issues, healthy eating, physical activity, depression, and suicide issues."

DFC Youth Coalitions

Given the DFC program's focus on preventing youth substance use, youth engagement was examined closely in the DFC National Evaluation. Site visits conducted from 2012 to 2015 suggested that hosting a separate youth coalition was a promising strategy to successfully engage youth in substance use prevention. To better understand how youth coalitions within a broader DFC coalition structure can enhance DFC work, three questions were added to the progress report beginning in February 2016. Specifically, DFC coalitions were asked to indicate (yes/no) if they had a youth coalition, and if yes, how often the youth coalition met and how involved the youth coalition was in planning prevention activities for youth. A *youth coalition* is defined as:

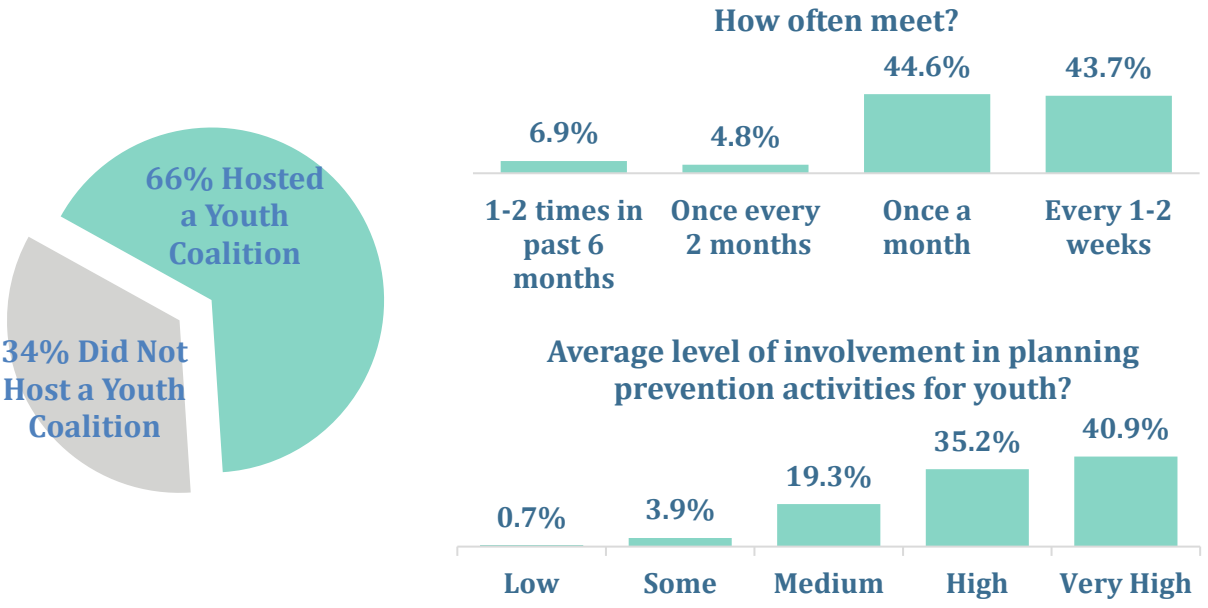
> A group of youth who work together to plan and implement activities related to the mission of the full coalition. An adult coalition member serves as a mentor or leader,

[25] Sticker shock campaigns typically involve collaboration between Youth and Business sector members at a minimum. A message regarding youth use of the substance (e.g., alcohol or tobacco) is developed and printed on stickers. For example, the sticker might explain the penalty for adults if they purchase alcohol for a minor. Stickers are then placed on the substance at the point of purchase in order to raise awareness of the issue.

but the youth have key leadership roles. The youth coalition is integral to the full coalition, but generally meets independently.

These new data were analyzed and are reported here. Together, the findings provide further support for DFC coalitions hosting a youth coalition as a promising practice. Of the 660 DFC coalitions who responded to the youth coalition questions in the August 2017 Progress Report, 435 coalitions (66%) reported hosting a youth coalition in their work (see Figure 5). This is 5 percentage points greater than what was reported in August 2016 (61%). Of these 435 coalitions, most (88%) reported that their hosted youth coalition meets at least once a month.[26] DFC coalitions also reported on the level of involvement of their hosted youth coalition in planning prevention activities for youth, using the same scale as sector member involvement. Average involvement for youth coalitions in these planning activities received a rating of 4.1 on the 1 (low) to 5 (very high) scale, which falls within the high category (4). The majority of DFC coalitions (76%) reported that these youth coalitions are highly or very highly involved in coalition planning and activities; one-fifth (19%) reported medium involvement while few (less than 5%) reported low or only some involvement in planning activities.

Figure 5. Two-Thirds (66%) of DFC Coalitions Hosted a Youth Coalition, With Most Youth Coalitions Meeting at Least Monthly (88%) and Highly or Very Highly (76%) Involved in Planning and Implementing Prevention Activities



Source: DFC August 2017 Progress Report

[26] Of these coalitions, 43.7% met once every 1-2 weeks while 44.6% met once a month, for a total of 88.3%. Another 4.8% met once every two months while 6.9% of those with youth coalitions reported that they met only 1-2 times in the past six months.

Comparison of DFC Coalitions Hosting Versus Not Hosting a Youth Coalition

To better understand how DFC coalitions hosting a youth coalition might differ from those coalitions not hosting a youth coalition, additional analyses were conducted for both membership and strategy engagement. Given that most DFCs hosting a youth coalition reported that youth were highly involved in planning and implementing activities, these analyses sought to better understand the overall relationship between youth coalitions and youth engagement.

Membership Involvement and Youth Coalitions

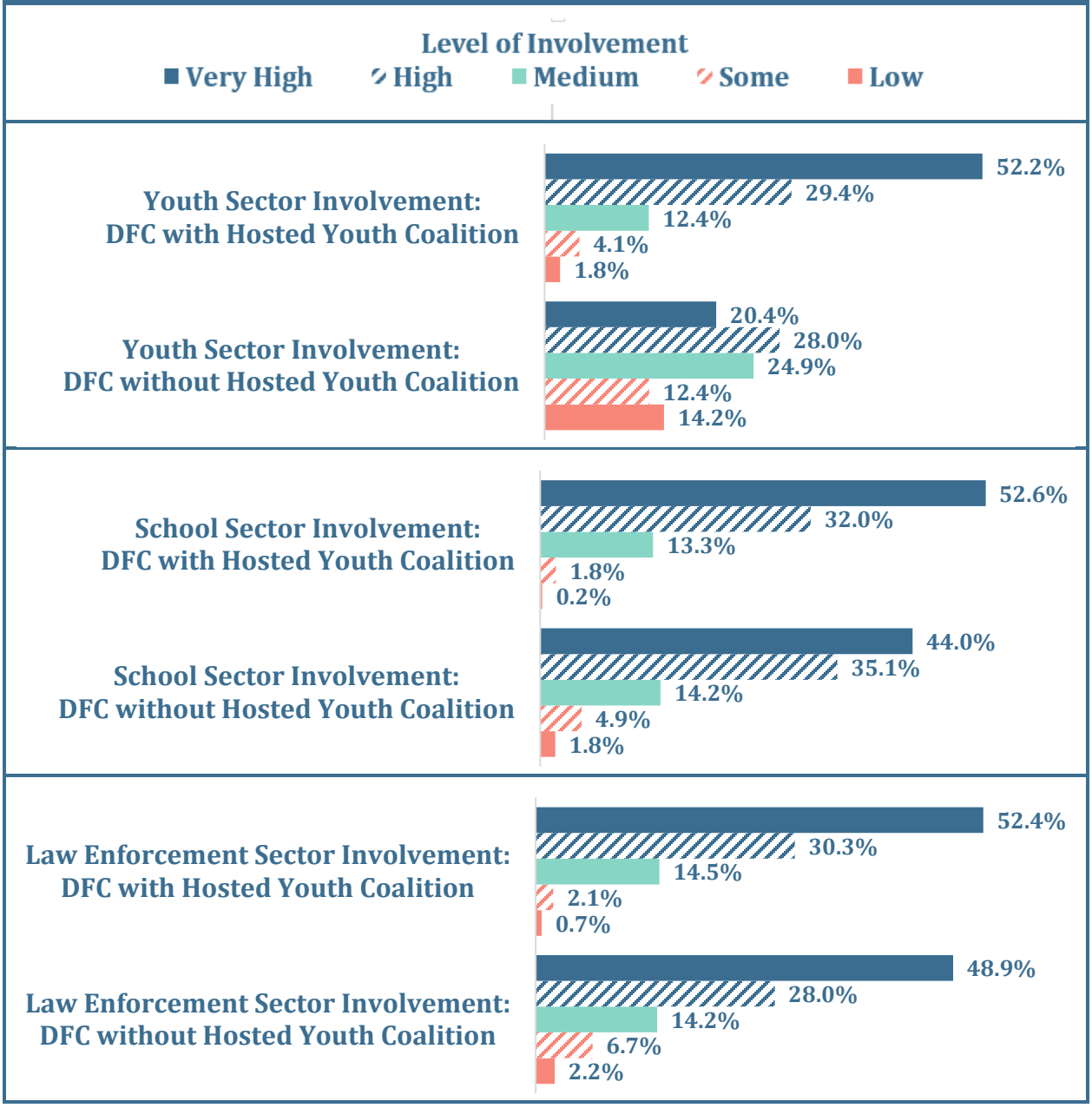
Perceptions of Youth, Law Enforcement, and School sector involvement with the DFC coalition all differed significantly between those DFC coalitions hosting versus not hosting a youth coalition (see Figure 6).[27] The largest difference was for youth sector involvement. While half (52%) of DFC coalitions with a hosted youth coalition perceived Youth sector members to be very highly involved, only one-fifth (20%) of DFC coalitions without a hosted youth coalition did so. Conversely, far fewer DFC coalitions with versus without a hosted youth coalition perceived their Youth sector members as having only some or low involvement (6% versus 37%, respectively). Looking at this as an average level of Youth sector involvement by assigning numbers to the involvement scale (5 indicating very high involvement, 4 indicating high involvement, 3 indicating medium involvement, 2 indicating some involvement, and 1 indicating low involvement), the difference between the two groups was a full point on the five point scale. Those DFC coalitions that reported hosting a youth coalition had a higher average level of Youth sector involvement (4.3 [high involvement]) than those that reported not hosting a youth coalition (3.3 [medium involvement]). This finding supports what was observed during site visits with regard to higher youth engagement associated with youth coalitions. Comparing this to Figure 4, this would place the Youth sector at the highest level of involvement with the School and Law Enforcement sectors for those DFC coalitions with a hosted youth coalition. Those DFC coalitions without a hosted youth coalition had average youth involvement similar to that of the lowest sector (Business).

The significant findings for perceived School and Law Enforcement sectors' involvement were similar to those for the Youth sector, although the difference was less extreme (see Figure 6). More DFC coalitions with a hosted youth coalition, versus those without one, perceived their School (53% versus 44%, respectively) and Law Enforcement (52% versus 49%, respectively) sectors as having very high involvement. Conversely, fewer DFC coalitions with a hosted youth coalition, versus those without, perceived their School (2% versus 7%, respectively) and Law Enforcement (3% versus 9%, respectively) sectors to have only some or low involvement. Looking at the average scores, this difference was

[27] Based on chi-square analyses: Youth sector $\chi^2(4) = 102.3$, $p < .0001$; School sector $\chi^2(4) = 12.2$, $p < .02$; Law Enforcement sector $\chi^2(4) = 12.1$, $p < .02$

again less extreme. DFC coalitions hosting a youth coalition, versus those not hosting a youth coalition, had higher levels of average involvement for the School (4.35 versus 4.15) and Law Enforcement (4.32 versus 4.15) sectors.

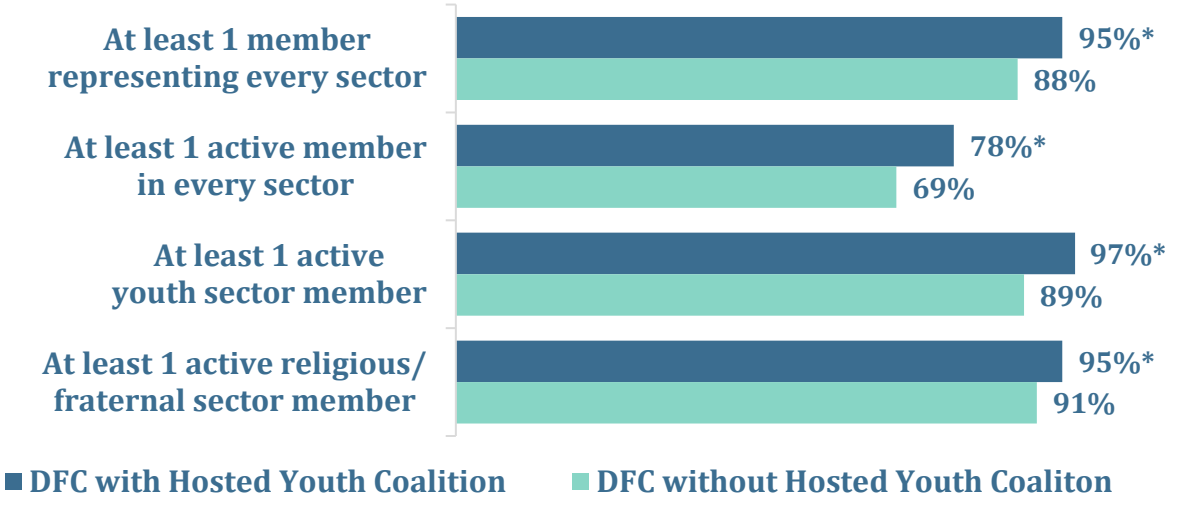
Figure 6. Average Level of Involvement by Youth, School, and Law Enforcement Sector Members was *Significantly* Higher in DFC Coalitions With a Hosted Youth Coalition Versus Those Without One



Note: Within each sector there was a significant difference ($p < .05$) between those DFC coalitions with a hosted youth coalition, versus those without a hosted youth coalition.
Source: DFC August 2017 Progress Report

In addition (see Figure 7), DFC coalitions with a hosted youth coalition were more likely than those DFC coalitions without a hosted youth coalition to have at least one member representing each of the 12 sectors (95% versus 88%, respectively)[28] and to have at least one *active* member in all 12 sectors (78% versus 69%, respectively).[29] DFC coalitions with a hosted youth coalition, versus those without, were significantly more likely to have at least one *active* member in the youth sector (97% versus 89%, respectively)[30]. DFC coalitions with a hosted youth coalition, versus those without, were significantly more likely to have at least one *active* member in the religious/fraternal organizations sector (95% versus 91%, respectively), although almost all coalitions reported having an active member for this sector.[31]

Figure 7. DFC Coalitions With as Compared to Without a Hosted Youth Coalition were *Significantly* More Likely to Have at Least 1 Member and at Least 1 *Active* Member Representing Each of the 12 Sectors. These DFC Coalitions Also Were Significantly More Likely to Have at Least 1 *Active* Youth Sector Member and 1 *Active* Religious/Fraternal Organization Sector Member.



Note: * indicates $p < .05$ (significant difference)
Source: DFC August 2017 Progress Report

Strategy Engagement and Youth Coalitions

DFC coalitions with a hosted youth coalition were further compared with those without one to gain a better understanding of the differences in implementation activities undertaken by each during the August 2017 reporting period (see the Strategy Implementation section for descriptions of the Seven Strategies for Community Change and

[28] $\chi^2(1) = 11.56$, $p < .01$
[29] $\chi^2(1) = 5.85$, $p < .02$
[30] $\chi^2(1) = 4.45$, $p < .04$
[31] $\chi^2(1) = 17.98$, $p < .01$

for overall analyses of implementation activities).[32] The results of these chi-square analyses suggest that DFC coalitions with a hosted youth coalition were significantly more likely than those without one to have engaged in several specific implementation activities (see Table 4 for the six activities with the greatest differences in implementation; see also Table B.1, Appendix B, for all results).

Table 4. Examples of Specific Activities Implemented by Significantly More DFC Coalitions With, as Compared to Without, a Hosted Youth Coalition

Activity	% of DFC Coalitions With a Youth Coalition Reporting Activity	% of DFC Coalitions Without a Youth Coalition Reporting Activity	Percentage Point Difference
Alternative Social Events: Drug-free parties, other alternative events supported by the coalition*	73%	54%	19
Parent Education and Training: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.*	58%	42%	16
Youth Education and Training: Sessions focusing on providing information and skills to youth*	88%	75%	13
Teacher Training: Sessions on drug awareness and prevention strategies directed to teachers or youth workers*	44%	32%	12
Improved Signage/ Advertising by Suppliers: Suppliers making changes in signage, advertising, or displays*	31%	20%	11
Social Networking: Posts on social media sites (e.g., Facebook, Twitter)*	94%	83%	11

Notes: * indicates $p < .05$ (significant difference). See also Table B.1, Appendix B, for chi-square results.
Source: DFC August 2017 Progress Report

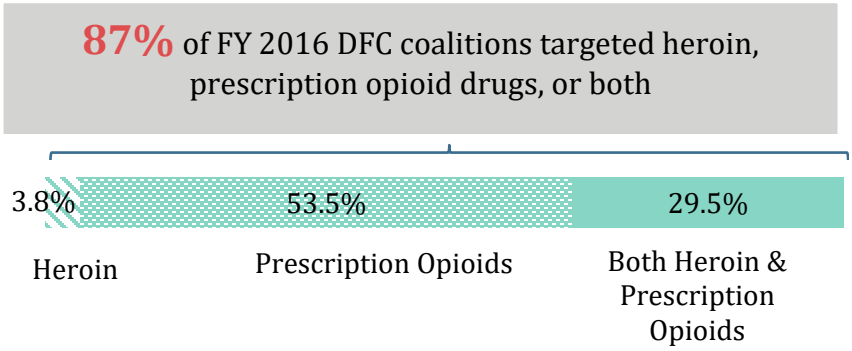
The greatest difference (19 percentage points) was for implementing alternative/drug-free social events, which is a *Providing Support* strategy.[33] While nearly three-fourths (73%) of DFC's with a youth coalition implemented at least one alternative social event activity during the 6 month reporting period, only just over one-half (54%) of DFC coalitions without a youth coalition did so. DFC coalitions with a youth coalition, versus those without one, were also significantly more likely to have conducted at least one youth training (88% versus 75%), parent training (58% versus 42%) and teacher training (44% versus 32%), each of which are *Enhancing Skills* strategies. In addition, activities implemented by significantly more DFC coalitions with a hosted youth coalition included a *Changing Physical Design* activity (i.e., improved signage) and a *Providing Information* activity (e.g., social networking). That is, while generally DFC coalitions with a youth coalition were

[32] See footnote 9.
[33] *Ibid*

more likely to engage in more youth-centered and family-centered activities, differences occurred across a broad range of the Seven Strategies for Community Change.

Building Capacity to Address Opioids

A primary goal of DFC is to establish and strengthen collaboration among the 12 sectors in order to support the efforts of community coalitions working to prevent and reduce substance use among youth. DFC coalitions are encouraged to focus on building capacity to identify local problems and address them with local solutions. One way to understand the extent to which DFC coalitions are meeting this goal is to examine how they address new substance challenges that arise in their communities. One potential new challenge that DFC coalitions may be facing are issues related to opioids. The Center for Disease Control and Prevention (CDC) has identified opioid use and opioid overdose deaths as an epidemic. In 2016, an estimated two-thirds (66%) of all drug overdose deaths were associated with opioids (e.g., prescription opioids, heroin, fentanyl) and the number of opioid related deaths in 2016 was five times higher than in 1999. On average, 115 people died every day from an opioid overdose in 2016 in America; this was an increase from 91 per day in 2015.[34]



In August 2017, 87 percent of the DFC coalitions selected prescription opioids, heroin, or both as one of their top five substances targeted (also see Figure 8).[35] Most (83%) DFC coalitions indicated that they were targeting prescription opioids while one-third (33%) of DFC coalitions indicated that they were targeting heroin. Put another way, a small percentage (4%) selected heroin but not prescription opioids as a target substance, half (54%) selected prescription opioids but not heroin, and just under one-third (30%) selected both heroin and prescription opioids.

[34] CDC (2016). Drug overdose deaths in the United States Continue to Increase in 2015. See https://www.cdc.gov/drugoverdose/epidemic/. For CDC data, see Wide-ranging online data for epidemiologic research (WONDER), available at http://wonder.cdc.gov. The only DFC coalitions in Idaho and in North Dakota also mentioned opioids.

[35] In August 2017, DFC coalitions were able to select prescription opioids and/or prescription non-opioids specifically. Previously, only the broader term of prescription drugs was an option. In August 2016, 88 percent of FY 2015 DFC coalitions selected prescription drugs, heroin or both, similar to the 87 percent of FY 2016 DFC coalitions reporting this focus.

The DFC National Evaluation Team examined qualitative data found in open-ended response items on the August 2017 Progress Reports for indications that DFC coalitions were responding to this new challenge by addressing opioids (see Figure 8 and Table C.1, Appendix C). Open-ended responses were searched for opioid-specific key terms (e.g., opiate, opioids, heroin, fentanyl, oxycodone). Just over one-third (36.2%) of all DFC coalitions specifically mentioned opioids in at least one open-ended response field. At least one DFC coalition in 44 of 54 States or Territories (82%) specifically mentioned opioids in response to open-ended items. This was an increase from August 2016 in the percentage (73%) of States or Territories where at least one DFC coalition mentioned opioids. At least half of the coalitions in nine States (Alaska, Georgia, Maine, Massachusetts, Montana, New Hampshire, North Carolina, Ohio, and Vermont) with more than one DFC per State, specifically referenced opioids in an open-ended response.[36]

In **82%** of FY 2016 States/Territories with a DFC coalition, **at least one DFC coalition mentioned opioids specifically.**

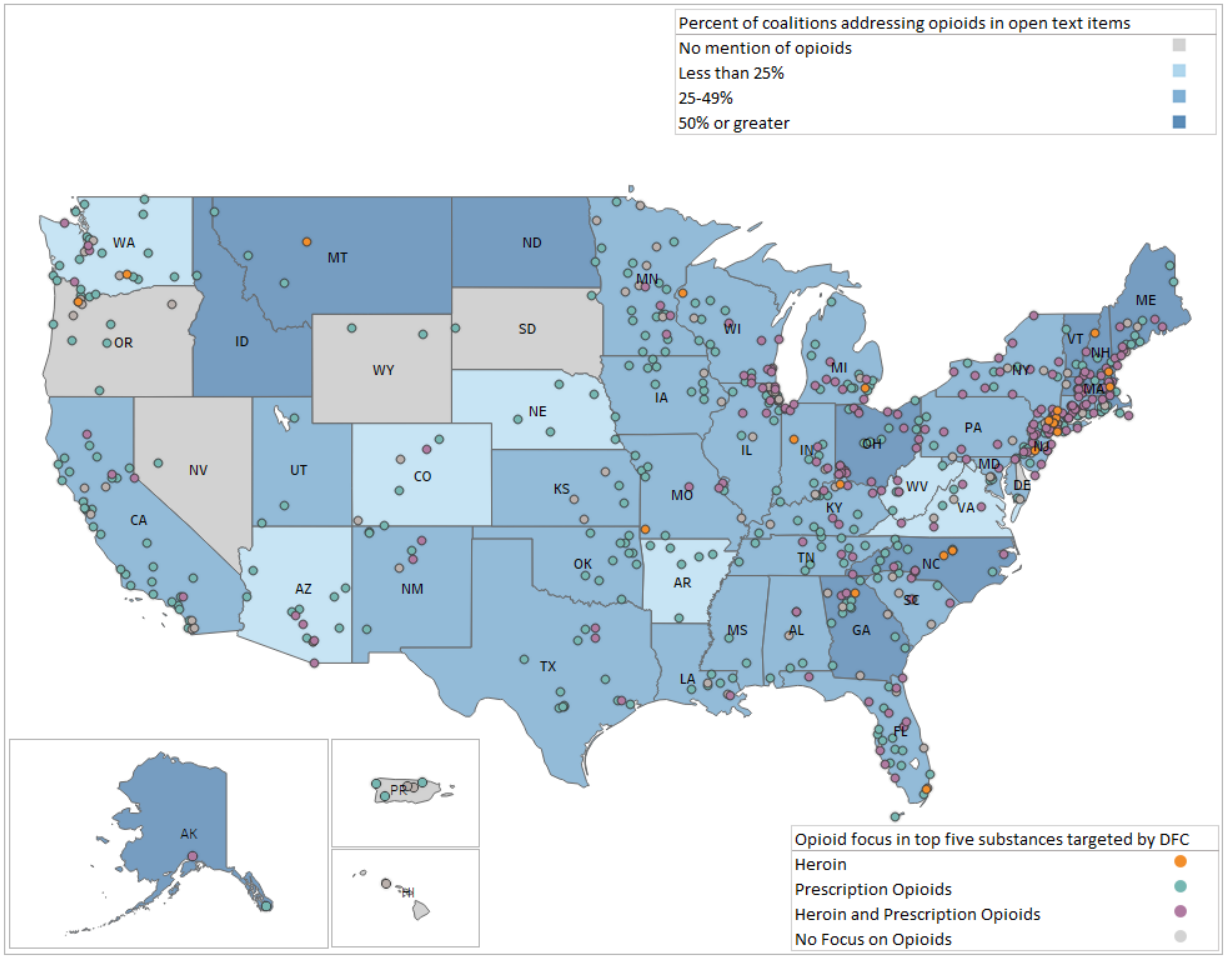
Of all FY 2016 DFC coalitions, **70%** **mentioned either prescription drugs or opioids**.

Given that most DFC coalitions indicated that their work with prescription drugs was focused on prescription opioids in target substances, open-ended responses also were searched for mention of prescription drugs (e.g., prescription, Rx). Of all 660 DFC coalitions with August 2017 Progress Report data, just over two-thirds (70%) mentioned either prescription drugs or opioids, far more than the just over one-third (36%) who specifically mentioned opioids.[37] Most (87%) DFC coalitions indicated addressing opioids (i.e., prescription opioids and/or heroin) as a top 5 substance versus far fewer (36%) that specifically mentioned opioids in an open-text response. Some DFC coalitions working on opioids may not have included descriptions of these efforts in any of their open-ended responses, while some may have described this work using only prescription drug terminology (i.e., without specifying prescription opioids).

[36] In FY 2016, there was at least one DFC coalition in all 50 States, plus the District of Columbia, Puerto Rico, Micronesia, and American Samoa.

[37] Of the 660 coalitions, 225 mentioned prescription drugs but not opioids, 42 mentioned opioids but not prescription drugs, and 197 mentioned both.

Figure 8. FY 2016 DFC Grant Award Recipients Mentioning Opioids by Percentage of DFC Coalitions in the State/Territory and by Selection of Prescription Opioids, Heroin, or Both as a Target Substance



Sources: DFC August 2017 Progress Report; DFC FY 2016 Grant Application coalition ZIP code information

Sample Activities to Address Opioids

Based on the qualitative data, DFC coalitions are engaging in a broad range of activities across the Seven Strategies for Community Change to address opioids. DFC coalitions reported disseminating information through various media to large numbers of community members. For example, one coalition reported sending more than 800 letters to parents in a specific school district with suggestions on how to be an advocate for their child when the child is prescribed opioid medication. A number of DFC coalitions reported that they planned, participated in, and/or presented at summits, forums, and town halls specifically on heroin and other opioids. Some of these provided an opportunity for community members, local substance abuse treatment providers, and others to discuss how to reduce access to prescription drugs, while others focused more broadly on educating attendees about the dangers of heroin and prescription opioid drug misuse. A few DFC coalitions

reported targeting forums specifically toward medical professionals. Some DFC coalitions also implemented community events on opioids: "We had an End Heroin walk in February where over 3,500 people attended to end the stigma and support their friend and family in recovery." One coalition in Ohio reported orchestrating the State's largest ever march against heroin that attracted more than 2,000 attendees and included nationally recognized recovery advocates.

In addition to hosting or participating in relevant forums, DFC coalitions implemented trainings. While multiple coalitions focused on training both youth and adults about the harmful effects of opioids, others chose to do the same with sectors such as Law Enforcement, often around naloxone training and/or prescription drug take-back boxes or events. As some DFC coalitions noted, these types of trainings were successful, in part, because of the relationship that already existed between the coalition and this sector, while also improving on that relationship: "We have been working very closely with our local police department to help them provide education and training on opioid use as well as the reversal drug Narcan. We are working with them to help lessen barriers to access and promote the medication drop box. We have formed an even stronger relationship with the police department and hope to continue our collaborative work."

DFC coalitions also reported more broadly on their engagement with prescription drug take-back days or general prescription drug safe disposal practices. One coalition mentioned hosting national drug take-back day events at nine locations in 2017. Several coalitions noted their successes at these types of events:

- "Collected over 75 pounds of medication in 4 hours and attracted over 600 community members."
- "A take-back event, in collaboration with a new state Senator and the police department, collected 700 pounds of pharmaceuticals with 200 cars receiving fact cards highlighting safe medicine practices."
- "Pharmaceutical take-back events at schools were held in September, collecting approximately 1,500 pounds. Event held in October collected 1,650 pounds."

In addition to drug take-back and disposal, many DFC coalitions mentioned the creation or use of a heroin and/or opioid multi-sector task force. The intent of these task forces is often, as one coalition put it, "to open the lines of communication between entities to share data and work on strategies to prevent [an] opioid epidemic." The creation of a task force was noted as increasing engagement of the sectors on the issue. Some DFC coalitions introduced epidemiology task forces focused on data, a strategy that may be useful to those DFC coalitions that report they are struggling to collect data around heroin and other opioid misuse.

In addition to forming official task forces, several DFC coalitions focused on engaging new sector members from within their communities. For example, two coalitions looked specifically for non-traditional partners to participate in coalition efforts to encourage the

participation of an organization with a different perspective. As a result, one DFC coalition engaged a State Hotel and Lodging Association, while another began working with realtors and hospice staff. Another DFC coalition partnered with a photojournalism class at their local high school to implement a course that taught students about the opioid epidemic. During this course, students participated in interviews and took photographs with key stakeholders in their community. The project culminated in a community-wide gallery presentation of their artwork, at which local media and elected officials were present.

DFC coalitions helped to educate and inform local and State policymakers about the opioid epidemic. For example, one coalition was asked to sit in on an elected official's task force to help "educate key leaders about effective prevention." In other instances, DFC coalitions worked to educate and inform the community about laws and ordinances passed in recent months. For example, one DFC coalition saw local laws passed regarding "the proper disposal of prescription drugs and limits on prescribing opioids, expansion of public access to naloxone, and the banning of 19 additional synthetic opioids." Similarly, another coalition worked with their local district attorney who decided that his/her office would not "automatically prosecute a person caught with possession of opiates [sic] if that person agrees to be assessed and volunteers [to] complete any necessary treatment."

Innovative Approaches

In addition to the prevention strategies listed above, DFC coalitions described a variety of innovative approaches to heroin and other opioid problems within their community. Examples include the following:

- Strengthened the coalition's partnership with law enforcement to identify drug routes and access points.
- Worked with the medical examiner's office to implement a more sensitive drug screening on an individual once it was determined that opioids were the cause of death.
- Sent letters to veterinarians in two counties, highlighting prescription recommendations from the CDC and sharing information from pharmacists who reported that pet owners were filling opioid and benzodiazepine prescriptions for their pets that they, too, had prescriptions for as adults.
- Led in developing and supporting alternative sentencing programs or regular programming within their local jails that provide medication assisted treatment and other re-entry services to inmates with opioid addictions.
- Built member capacity to implement effective substance use prevention strategies by starting every coalition meeting with what they call a "7 minute clinic" on topics such as local strategies addressing the opioid epidemic, mindfulness, and local treatment resources.

Strategy Implementation

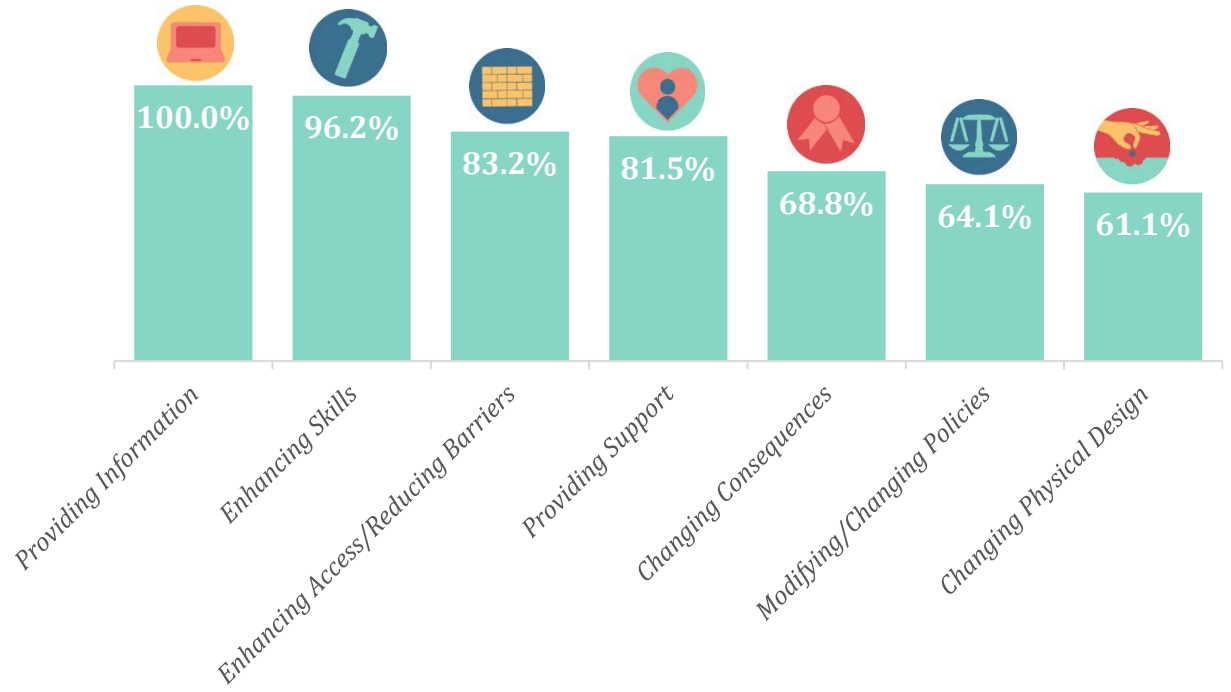
A primary purpose of collaboration across sectors that traditionally work independently is leveraging skills and resources in planning and implementing prevention strategies. To assess what DFC coalitions are doing, 41 unique prevention activities have been identified. These activities were grouped into the Seven Strategies for Community Change, with any given activity linked to a single strategy.[38] As previously noted, the seven strategies are *Providing Information*, *Enhancing Skills*, *Providing Support*, *Enhancing Access/Reducing Barriers*, *Changing Consequences*, *Changing Physical Design*, and educating or informing the community about *Modifying/Changing Policies*. This section of the report provides an overview of the specific activities and strategies that DFC coalitions have implemented and reported in the August 2017 Progress Report. These reflect all activities that were implemented by DFC coalitions during the 6-month window from February 1, 2017 through July 31, 2017. Information on the numbers of activities and community members they reach is also provided. Finally, the engagement of youth in activities implemented by DFC coalitions is highlighted.

Overview: Implementation of Strategies

The activities of DFC coalitions reported in August 2017 document the comprehensive presence of DFC coalitions in their communities (see Figure 9). All (100%) of the 660 DFC coalitions that submitted an August 2017 Progress Report indicated they had engaged in *Providing Information* dissemination activities. Nearly all (96%) provided services related to *Enhancing Skills*. Activities within these two strategies tend to build credibility in the community, identify the coalition as a reliable source of information, and serve to build capacity both by informing people about the coalition and training community members to engage in prevention work directly. Lower percentages of DFC coalitions engaged in *Enhancing Access/Reducing Barriers* to prevention and treatment services (83%), *Providing Suppo*rt (82%), and *Changing Consequences* (69%) activities. DFC coalitions were least likely to report engaging in activities to educate and inform on *Modifying/Changing Policies* to decrease substance use and associated negative behaviors (64%) and *Changing Physical Design* to decrease opportunities for and encouragement of substance use (61%).

[38] See CADCA publication on the seven strategies at http://www.cadca.org/resources/coalition-impact-environmental-prevention-strategies CADCA derived the strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. See http://www.udmo.com/powerup/faq/7%20strategies.pdf for additional information.

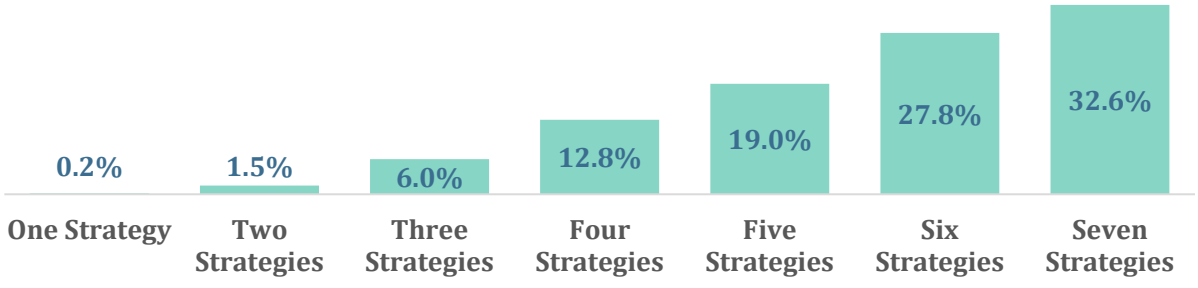
Figure 9. Percentage of DFC Coalitions Engaged in Any Activity Within Each of the Seven Strategies for Community Change



Source: DFC August 2017 Progress Report

DFC coalitions engaged in a comprehensive mix of strategies with more than half (60%) implementing at least one activity within 6 of the 7 strategies (28%) or in all 7 strategies (33%; see Figure 10). Conversely, few (less than 2%) DFC coalitions reported implementing activities within only 1 or 2 of the 7 strategies. Table 5 provides an overview of the five combinations of strategies implemented most often by DFC coalitions. All five of these most common combinations included implementing *Providing Information*, *Enhancing Skills*, *Providing Support*, and *Enhancing Access/Reducing Barriers* activities. Next, DFC coalitions' implementation of activities within each of the seven strategies are provided in more detail.

Figure 10: DFC Coalitions Engaged in a Comprehensive Mix of Activities Across the Seven Strategies for Community Change



Source: DFC August 2017 Progress Report

Table 5. Five Most Common Mixes of the Seven Strategies for Community Change Utilized by DFC Coalitions

	Strategy Mix 1	Strategy Mix 2	Strategy Mix 3	Strategy Mix 4	Strategy Mix 5
Providing Information	✓	✓	✓	✓	✓
Enhancing Skills	✓	✓	✓	✓	✓
Providing Support	✓	✓	✓	✓	✓
Enhancing Access / Reducing Barriers	✓	✓	✓	✓	✓
Changing Consequences	✓	✓	✓		✓
Educating and Informing About *Modifying/Changing Policies*	✓	✓		✓	
Changing Physical Design	✓		✓	✓	

Source*:* DFC August 2017 Progress Report

Providing Information

Activities within this strategy provide individuals with information related to youth substance use, preventing youth substance use, and the consequences of youth substance use. Examples include public service announcements, brochures, and presentations during community meetings. *Providing Information* activities are one way that DFC coalitions establish themselves in the community as experts on youth substance use prevention. All DFC coalitions reported engaging in activities to *Provide Information* to community members (see Table 6).

Coalition Voices: Providing Information

"[A parent who lost his son to heroin] has worked together with the coalition and partnering organizations throughout [our county] to print athletic water bottles with the overdose hotline, student-designed drug-free message and coalition logo. Most recently added is an educational message printed and stuffed into the bottles. Over 10,000 bottles have been printed and distributed. This initiative has gone worldwide through Baseball Little League International…Little League organizations are taking up the same initiative with our parent representative's guidance."

"Rite Aid, CVS, Walgreens, and other independent pharmacies will insert informational postcards [from the coalition] in every prescription bag. The postcards will have information regarding the permanent medication drop box location and the importance of disposing of unused prescription medication."

Providing Information is the most pervasive activity in which DFC coalitions engage. During this reporting period more than half (57%) of coalitions estimated that *Providing Information* was the strategy on which staff spent most of their effort. Together, coalitions reported 12,322 events at which an estimated 1.3 million members came into contact with their coalition. For those indirect information channels (social networking and website hits) for which individual exposure could be estimated, DFC coalition information reached some 8.2 million community members.[39]

[39] This overall estimate is based on the data, but is inevitably inexact. For example, some participants in face-to-face information sessions may have attended more than one event during the reporting period; distributed materials may not have been read or may have been further circulated and read by additional community members.

Nearly all DFC coalitions (94%) disseminated prevention materials (including brochures and flyers). In addition, some 6,400 media spots via print, billboard, television, radio, and other methods were run by 548 DFC coalitions (80%), and half of the coalitions (50%) reported posting new materials on coalition websites that garnered an estimated 616,000 hits.

In addition to *Providing Information* via print and electronic media, DFC community coalitions also directly engaged youth and adults in their communities. For example, DFC coalitions reported that they held just over 9,500 face-to-face information sessions. The sessions reached an estimated 177,000 adults and 222,000 youth. DFC coalitions also held or contributed to just over 2,700 special events that served an estimated 574,000 adults and 361,000 youth.

Enhancing Skills

Coalition Voices: *Enhancing Skills*

"[A] a nationally recognized speaker…conducted an afternoon presentation for youth. He covered a range of topics, including: drug prevention (alcohol & marijuana), and the importance of healthy lifestyle choices."

"Two of the coalition members attended a statewide training on marijuana curriculum education. The course was designed to train the trainer and provide marijuana education to youth."

The purpose of activities within this strategy is to enhance the skills of participants, members, and staff regarding substance use prevention. Examples include youth conferences, parenting workshops, staff training, and technical assistance (see Table 7). The majority of DFC coalitions (96%) engaged in activities related to *Enhancing Skills* during the 6- month reporting window. Providing youth education and training programs was the most common activity completed by coalitions with 550 (83%) delivering some 6,100 sessions to an estimated 175,000 youth. The one-half (53%) of all DFC community coalitions that reported conducting a total of just over 1,700 parent training sessions about drug awareness, prevention strategies, and parenting skills estimated reaching a total of 50,800 parents. Training also was provided to an estimated 56,200 community members, 16,300 teachers, and 8,800 workers at businesses that sell alcohol or tobacco.

Other than *Providing Information*, DFC coalitions overall devoted more staff effort to *Enhancing Skills* than any other strategy. Nearly half (49%) of coalitions reported that *Enhancing Skills* was one of the top two strategies receiving staff effort. Overall, they reported reaching an estimated 307,000 community members in these interpersonal *Enhancing Skills* training contacts.

Table 6. DFC Coalitions' Accomplishments Related to *Providing Information*

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Information Dissemination: Brochures, flyers, posters, etc. distributed	620	93.9%	--[a]	--[b]	--[b]
Media Coverage: TV, radio, newspaper stories covering coalition activities	548	83.0%	6,354	--[b]	--[b]
Informational Materials Produced: Brochures, flyers, posters, etc. produced	559	84.7%	112,764	--[b]	--[b]
Direct Face-to-Face Information Sessions	588	89.1%	9,589	176,999	221,777
Media Campaigns: Television, radio, print, billboard, bus or other posters aired/placed	533	80.8%	720,244	--[b]	--[b]
Special Events: Fairs, celebrations, etc.	548	83.0%	2,733	573,691	360,516
Social Networking: Posts on social media sites (e.g., Facebook, Twitter)	594	90.0%	58,936	6,014,151 followers	1,550,086 followers
Information on Coalition Website: New materials posted	327	49.5%	6,419	614,429 hits[c]	--[b]
Summary: *Providing Information*	**660**	**100.0%**	**917,039**	**N/A**	**N/A**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported data. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond three standard deviations were removed.
[a] DFC coalitions reported distributing a total of 1,006,537 brochures, flyers, posters, etc.
[b] Data on the number of persons served was not reported because it could not be collected consistently and reliably by all DFC coalitions.
[c] Number of web hits. Note that some DFC coalitions report they are unable to track hits.
N/A = Not Applicable
Source: DFC August 2017 Progress Report

Table 7. DFC Coalitions' Accomplishments Related to *Enhancing Skills*

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Youth Education and Training: Sessions focusing on providing information and skills to youth	550	83.3%	6,098	N/A	175,204
Community Member Training: Sessions on drug awareness, cultural competence, etc. directed to community members, (e.g., law enforcement, landlords)	434	65.8%	1,542	56,169	N/A
Parent Education and Training: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.	349	52.9%	1,715	50,726	N/A
Business Training: Sessions on server compliance, training on youth-marketed alcohol products, tobacco sales, etc.	254	38.5%	980	8,830	N/A
Teacher Training: Sessions on drug awareness and prevention strategies directed to teachers or youth workers	266	40.3%	638	16,265	N/A
Summary: *Enhancing Skills*	**635**	**96.2%**	**10,973**	**131,990**	**175,204**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activities. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond three standard deviations were removed. N/A = Not Applicable
Source: DFC August 2017 Progress Report

Providing Support

DFC coalitions *Provide Support* for people to participate in activities that reduce risk or enhance protection associated with substance use.[40] Examples include providing substance-free activities, mentoring programs, and support groups (see Table 8). Most DFC coalitions (82%) engaged in activities related to *Providing Support*. Two-thirds of the DFC coalitions (67%) sponsored or supported drug-free alternative social events, such as after-prom events, attended collectively by 132,000 youth. DFC coalitions also supported 1,400 youth organizations and clubs serving 178,000 youth, and an additional 1,200 youth recreation programs with 29,000 participants. DFC coalitions held or supported 908

[40] 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 examples provided for each of the Strategies for Community Change. See https://www.samhsa.gov/sites/default/files/grants/pdf/sp-18-002-dfc-foa-1-30-18.pdf for the most recent DFC grant application funding opportunity announcement describing funding limitations.

community service events providing opportunities for 82,300 family and youth to participate. DFC coalitions also supported 1,300 youth and family support groups helping 10,700 participants. During this reporting period, DFC coalitions supported opportunities for protective activities that served an estimated 360,000 community members. More than half (60%) of DFC coalitions reported that *Providing Support* activities was one of the top three strategies on which staff effort was spent.

Coalition Voices: *Providing Support*

"We are building relationships with our EMS agencies to be able to collaborate on naloxone education, Good Samaritan education, and referrals to treatment after overdose, and support for families."

"Our coalition partners have begun sharing what they're learning about prevention science and applying it to their own spheres of influence. They are working on policies and recommendations related to our overall mission..."

Table 8. DFC Coalitions' Accomplishments Related to *Providing Support*

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Alternative Social Events: Drug-free parties, other alternative events supported by the coalition	441	66.8%	1,586	73,209	132,378
Youth/Family Community Involvement: Community events held (e.g., neighborhood cleanup)	239	36.2%	908	37,164	45,175
Youth Recreation Programs: Recreational events (e.g., athletics, arts, outdoor activities) supported by coalitions	174	26.4%	1,175	9,270	29,384
Youth/Family Support Groups: Leadership groups, mentoring programs, youth employment programs, etc. supported by coalitions	137	20.8%	1,288	5,582	5,129
Youth Organizations: Clubs and centers supported by coalitions	137	20.8%	1,352	4,588	17,655
Summary: *Providing Support*	**538**	**81.5%**	**6,309**	**129,813**	**229,721**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activity data. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond three standard deviations were removed.

Source: DFC August 2017 Progress Report

Enhancing Access/Reducing Barriers

The purpose of activities within this strategy is to improve the ease, ability, and opportunity for community members to utilize systems and services providing substance use prevention and treatment resources. Examples include providing transportation to treatment; providing childcare; reducing the availability of tobacco, alcohol, and drugs; and cross-cultural outreach, e.g. language translation (see Table 9).[41] A large majority of DFC coalitions (83%) engaged in activities related to *Enhancing Access/Reducing Barriers*.

Coalition Voices:
Enhancing Access/Reducing Barriers

"The coalition assembles Drug Testing resource kits made available free to parents who request them. They are distributed by our PD and also at community events."

"100% of our towns participated in DEA Rx Take-Back Day in the spring, over 520 pounds of drugs were collected."

"Provided leadership and guidance to help schools establish a school-based accessible Student Life Center to have a full range of support services available to youth and families. Local foundation and school providing funding."

The activities within this strategy used by the most (71%) DFC coalitions were intended to reduce home and social access.[42] One-third (33%) of DFC coalitions reported increasing access to substance use services. More than 111,000 adults and youth were referred to substance use services. Thirty percent of DFC coalitions engaged in activities to improve access through culturally sensitive outreach (e.g., providing services and materials in languages other than English). More than 30,000 adults and youth received supports such as transportation or access to childcare that facilitate participation in prevention and treatment.

[41] Please see footnote 40 regarding limitations on uses of DFC funding. DFC grant funds may not necessarily fund all of the activities in examples provided for each of the Strategies for Community Change.

[42] Many prescription drug take-backs involve drop boxes that are not monitored on a 24/7 basis, making it difficult for DFC coalitions to estimate the number of adult/youth participants.

Table 9. DFC Coalitions' Accomplishments Related to *Enhancing Access/Reducing Barriers*

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Adults Served	Number of Youth Served
Reducing Home and Social Access: Adults and youth participating in activities designed to reduce access to alcohol and other substances (e.g., prescription drug take-back programs)	466	70.6%	1,184,563	233,310
Improve Access Through Culturally Sensitive Outreach: People targeted for culturally sensitive outreach (e.g., multilingual materials)	196	29.7%	177,405	47,065
Increased Access to Substance Use Services: People referred to employee assistance programs, student assistance programs, treatment services	216	32.7%	64,215	30,831
Improved Supports: People receiving supports for enhanced access to services (e.g., transportation, child care)	91	13.8%	13,646	16,908
Summary: *Enhancing Access/Reducing Barriers*	**549**	**83.2%**	**1,439,829**	**328,114**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activity data. Outliers beyond three standard deviations were removed.
Source: DFC August 2017 Progress Report

Changing Consequences

Activities within the *Changing Consequences* strategy promote community practices that encourage positive organizational or individual behaviors to reduce the risk of substance use and the resulting harms, and discourage behaviors that increase this risk. For example, public recognition of business practices that reduce the risk of harmful substance use (e.g., passing compliance checks) is an incentive to adopt behaviors that reduce risk; increasing surveillance for substance use violations (e.g., drinking under the influence [DUI] checks) is a disincentive. Table 10 presents an overview of the number of DFC coalitions that conducted activities related to *Changing Consequences* and businesses affected by these activities. More than two-thirds of the DFC coalitions (69%) engaged in activities related to changing consequences. One-half (50%) of DFC coalitions engaged in activities focused on strengthening enforcement of existing laws; just under one-third (30%) strengthened surveillance activities.

Coalition Voices: *Changing Consequences*

"The coalition met with [*another coalition*] to learn how to implement a Social Host ordinance in their community. A local police officer assisted the coalition in its efforts to gain interest in having the ordinance in the community."

"The coalition collaborated with local law enforcement agencies and schools to conduct K9 locker checks."

"The coalition shared data from their Alcohol Purchase Study with local ABC Board and Law Enforcement."

Within this strategy, DFC coalitions reported more engagement in recognizing positive business behavior than in publicizing negative business behavior. Specifically, one-third (34%) of DFC coalitions implemented recognition programs that rewarded nearly 5,700 local businesses for compliance with local ordinances linked with the sale of alcohol and tobacco. In comparison, fewer (14%) DFC coalitions engaged in activities to publicly identify nearly 2,600 establishments that were noncompliant with local ordinances.

Table 10. DFC Coalitions' Accomplishments Related to *Changing Consequences*

Activity	Number of DFC Coalitions Engaged[a]	Percentage of DFC Coalitions Engaged	Number of Businesses Reached
Strengthening Enforcement (e.g., DUI checkpoints, shoulder tap, open container laws)	331	50.2%	N/A
Strengthening Surveillance (e.g., "hot spots," party patrols)	200	30.3%	N/A
Recognition Programs: Businesses receiving recognition for compliance with local ordinances (e.g., pass compliance checks)	226	33.6%	5,698
Publicizing Non-Compliance: Businesses identified for non-compliance with local ordinances	91	13.8%	2,592
Summary: *Changing Consequences*	**454**	**68.8%**	**8,290**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activity data. Outliers beyond three standard deviations were removed.
[a] Data on the number of persons served were not collected because it could not be collected consistently and reliably by all grant award recipients.
N/A = Not Applicable
Source: DFC August 2017 Progress Report

Educating and Informing About *Modifying/Changing Policies*

The educating and informing about *Modifying/Changing Policies* strategy involves engaging in activities to educate and inform the community concerning the effects of current and potential laws, rules, policies, and practices influencing substance use and the accompanying harmful outcomes for the community (see Table 11).[43] Examples of activities include educating about school drug testing policies and local use ordinances. Nearly two-thirds (64%) of DFC coalitions engaged in activities related to educating or informing about *Modifying/Changing Policies* that were associated with a change. Educating or informing related to school policies was most common, with just over one-fourth (28%) of DFC coalitions engaged in this activity to successfully bring change to 147 drug-free school policies.

[43] 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 more information refer to Restrictions on Grantee Lobbying (Appropriations Act Section 503; see https://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html).

DFC coalitions also successfully educated about laws/policies concerning: access to treatment or prevention services as an alternative to sentencing (71 policies); drug-free workplaces (69 policies); sales restrictions (68 policies); underage use, possession, or behavior under the influence (64 policies); supplier advertising/liability (51 policies), and parental liability/ enabling behaviors (40 policies).

Coalition Voices:
Educating and Informing about *Modifying/Changing Policies*

"Youth are very engaged in working on alcohol and marijuana issues to make their community healthier and safe. Youth wrote and filmed a PSA… in three languages: English, Spanish, and Portuguese."

"We have worked with our parish council members on revising our local alcohol ordinances. We successfully held a forum and a town hall meeting where we informed our local, State, and Federal representatives about emerging drug trends and the cost it has on our communities."

Table 11. DFC Coalitions' Accomplishments Related to Educating and Informing About *Modifying/Changing Policies*

Activity: Laws or Policies Passed/Modified Concerning:	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Policies Passed/ Modified
School: Drug-free schools	182	27.6%	147
Citizen Enabling/Liability: Parental liability or enabling	115	17.4%	40
Underage Use: Underage use, possession, or behavior under the influence	132	20.0%	64
Supplier Promotion/Liability: Supplier advertising, promotions, or liability	76	11.5%	51
Cost: Cost (e.g., alcohol taxes/fees, tobacco taxes)	53	8.0%	21
Treatment and Prevention: Sentencing alternatives to increase treatment or prevention	91	13.8%	71
Sales Restrictions: Restrictions on product sales	114	17.3%	68
Workplace: Drug-free workplaces	71	10.8%	55
Outlet Location/Density: Density of alcohol outlets	52	7.9%	24
Summary: *Modifying/Changing Policies*	**423**	**64.1%**	**541**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activity data. Outliers beyond three standard deviations were removed.
Source: DFC August 2017 Progress Report

School Policies

Given that work on educating and informing about school policies was frequently reported, descriptions of the types of school policies were examined to better understand these efforts. DFC coalitions described adding school policies around the use of specific substances, educational programs, randomized drug tests for students (in school and at school events), and consequences to students for substance use. Some DFC coalitions also modified existing school policies to include new substances, more clearly define

consequences, and identify resources for support. A common substance-specific change to school policy was related to adding e-cigarettes to existing school policies or creating new policies that ban e-cigarettes from school grounds.

DFC coalitions also reported working on policies around mandatory educational programs. For example, "all coaches must present a standardized Power Point educating on the negative performance effects of alcohol, marijuana, and other drugs to athletes and parents at the start of each season." Another DFC coalition described the addition of drug education to Grade 6 health classes as a result of the partnership between the school and the coalition.

Randomized drug testing school policies described by DFC coalitions were often limited to student athletes, but some coalitions noted that these policies also applied to a subset of students who consented to random drug testing or, in some cases, all students. As one DFC coalition described, "Our youth coalition worked to change school district-wide policy regarding breathalyzing prior to students entering the annual prom dance. All students and their guests are now required to take a breathalyzer test prior to their entrance." Another coalition "changed the drug testing to include middle school students for the 1st time [in] the history of the schools. We added drug testing for 5th and 6th grade students in elementary schools, only if they participate in middle school sports or other activities (band, etc.)."

Other types of school policies reported by coalitions involved how consequences are handled once students are found to be using substances. Specifically, coalitions have worked to shift school policies on consequences from being punitive to rehabilitative. One coalition worked with their local school district to develop a "diversion program that refers students that have had incidences either being under the influence or having [alcohol or other drugs] in possession on campus." This program was described as an "alternative to suspension or expulsions and offers early intervention and appropriate [substance use disorder] treatment, as well as connecting students and families in need of additional mental health supports." Other DFC coalitions noted working with schools on policies that referred students to counseling before they were suspended for violating the school's existing substance use policy.

Changing Physical Design

For this strategy, activities involve *Changing Physical Design* features of the community environment to reduce risk or enhance protection. Examples of activities within this area include cleaning up blighted neighborhoods, adding lights to parks, and regulating alcohol outlet density (see Table 12).[44] *Changing Physical Design* activities were engaged in by less

[44] Please see footnote 40regarding limitations on uses of DFC funding. DFC grant funds may not necessarily fund all of the activities examples provided for the *Changing Physical Design* strategy.

than two-thirds (61%) of DFC coalitions, less than any other strategy. Identifying physical design problems was the activity used by most coalitions (33%); nearly as many worked on improving signage or advertising by suppliers (27%). Nearly 800 physical design problems were identified and more than 1,600 improvements in signage, advertising, or displays corresponding to alcohol or tobacco sales were reported. In addition, DFC coalitions completed 279 neighborhood cleanup and beautification events, encouraged 440 businesses to designate alcohol and tobacco free zones, and improved 146 public places to facilitate surveillance (e.g., improving visibility of "hot spots" for substance dealing or use).

Coalition Voices: Changing Physical Design

"The Coalition has been very successful with its middle school group who ran a "Lock Up Your Liquor" campaign. The group designed a post card that was mailed home and/or featured on principal's webpages. The post card talked about the risks of underage drinking and the importance of locking up your liquor. In addition, free locks were distributed to any parent interested."

"Coalition staff worked with local youth to develop a safe walking trail."

Table 12. DFC Coalitions' Accomplishments Related to *Changing Physical Design*

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities
Identifying Physical Design Problems: Physical design problems (e.g., hot spots, clean-up areas, outlet clusters) identified through environmental scans, neighborhood meetings, etc.	219	33.2%	769
Improved Signage/Advertising by Suppliers: Suppliers making changes in signage, advertising, or displays	181	27.4%	1,608
Cleanup and Beautification: Clean-up/beautification events held	133	20.2 %	279
Encourage Designation of Alcohol-Free and Tobacco-Free Zones: Businesses targeted or that made changes	99	15.0%	440
Identify Problem Establishments: Problem establishments identified (e.g., drug houses) and closed or modified practices	48	7.3%	97
Improved Ease of Surveillance: Areas (public places, hot spots) in which surveillance and visibility was improved (e.g., improved lighting, surveillance cameras, improved line of sight)	55	8.3%	146
Summary: *Changing Physical Design*	**403**	**61.1%**	**3,339**

Notes: In the August 2017 Progress Report, 660 DFC grant award recipients reported activity data. Outliers beyond three standard deviations were removed.
Source: DFC August 2017 Progress Report

Summary of Coalition Strategy Implementation

DFC coalitions provide a broad range of activities that recognize and address the complex and inter-related factors that influence initiation and degree of substance use among youth. These activities encompass broad information dissemination, efforts to enhance individual skills and inter-personal supports that reduce substance use, and changing the institutional and behavioral environmental factors that contribute to or mitigate substance use among youth. Each DFC coalition is encouraged to focus on a comprehensive range of the Seven Strategies for Community Change that best addresses local needs and challenges in order to find local solutions to local problems. The comprehensiveness of these strategies is important because substance use has no one, single cause. During the 6-month window that is reflected by the August 2017 Progress Report, the majority of DFC coalitions clearly engaged in this comprehensive range, with nearly two-thirds (60%) engaging in at least some activity within 6 or 7 of the 7 strategy types and another one-fifth (19%) engaging in 5 of 7. DFC coalitions recognize and meet the need for comprehensive and complementary prevention activities to improve the likelihood that youth will have protective supports that are associated with decreased initiation and ongoing engagement by youth in substance use.

The mix of community members/sectors engaged by DFC coalitions is further evidence of their comprehensive scope. While the focus is youth preventing substance use, DFC coalitions also engage adults to make family and community environments more supportive of youth choosing to remain or become drug-free. In the most recent data, 660 coalitions documented contact with more than seven million adults. DFC coalitions used a range of public information outlets (e.g., public service announcements, news stories, brochures, posters, social media) to increase information and awareness in their communities.

The strategy data also documents the implementation of complementary strategies that focus activities where they will have the greatest impact. Informed adults help to facilitate the community and family environmental changes that are critical to substance use prevention. Skills enhancement contacts typically differentiate youth and adult audiences because the skills needed by each concerning prevention are distinct. DFC coalitions also engage in activities that create opportunities for social interaction between adults and youth. An example of a complementary strategic orientation is the engagement of both adults (1.4 million) and youth (328,000) in activities aimed at *Increasing Access/Reducing Barriers*, which included programs such as prescription drug take-back events and access to culturally appropriate community services (e.g., recovery services). Collectively, these contribute to family and community environments that are more protective of positive youth behavior (and substance use prevention).

Engaging Youth in DFC Implementation Strategies

These detailed data on activities and community participation demonstrate a particularly important principle of addressing youth substance use prevention at the community level. DFC coalitions are a strong example of working *with* youth, and providing opportunities for positive youth contributions and development, rather than solely doing things *for* or *to* youth. As noted in the section on DFC Youth Coalitions, two-thirds (66%) of DFC coalitions report hosting a youth coalition to engage active involvement of youth, and three-fourths (76%) of these youth coalitions are highly or very highly involved in planning and implementing prevention activities. Many DFC coalitions also reported anecdotally on the involvement of youth in planning activities across strategy types, indicating that youth were the agents of change as well as the target of activities. In addition, DFC coalitions with a youth coalition were significantly more likely to have engaged in 18 specific activities across a range of strategy types such as alternative social events and youth training (see Table 4 and Table B.1, Appendix B).

DFC Coalitions' *Engagement with Youth*

Youth were involved with or directly impacted by a broad range of DFC Coalitions' activities. Examples based on approximate number of participants include:

- **175,000** youth participated in training.
- **132,000** youth participated in alternative social events.
- **29,400** youth were involved through youth recreation programs.
- **17,700** youth were involved through youth organizations.
- **233,000** youth participated in activities to reduce home and social access.
- **28%** of DFC coalitions educated/informed about **147** new school policies addressing substance use issues.

Across the Seven Strategies for Community Change, more DFC coalitions engaged in activities targeting youth than those targeting any other community group: alternative drug-free activities for youth were the most implemented *Enhancing Support* activity; reducing home and social access to substances was the most implemented *Enhancing Access/Reducing Barriers* activity; and more DFC coalitions focused on educating about school policies (where youth are centrally located) than on any other category of *Modifying/Changing Policies*. In summary, DFC coalitions engage youth directly in building stronger and more positive community connections that are associated with substance use prevention.

Core Measures Findings From the Outcome Evaluation

This section provides findings related to changes in core measures outcomes from DFC coalitions' first report to the most recent report.[45] For core measures not changed or introduced in 2012, DFC coalitions have reported data from 2002 to 2017. For core measures approved in 2012, including peer disapproval and all outcomes for misuse of prescription drugs, DFC coalitions have reported data between 2012 and 2017. Only currently approved core measures are presented in this report. Core measures data were first analyzed including all available data from DFC coalitions since the inception of the grant. Next, data were analyzed including only the DFC coalitions funded in FY 2016.[46] The findings provide a reflection of the relationship between coalition activities and community outcomes.

The data are presented visually within the body of this report using dot plots (see Appendix D for data presented in tables). Change in the core measure where the most recent report (green dot) is to the right of the first report (gray dot) represents increased past 30-day prevalence of non-use, perception of risk/harm of use, and perception of parental and peer disapproval—changes that are in line with the goals of the grant. The farther apart the dots are, the more likely it is that the difference was significant, while the more overlap there is, the more likely it is that the difference was not significant.[47] The scale across all dot plots is from 50 percent to 100 percent (see Figures 11 and 14 to 17).

Past 30-Day Prevalence of Non-Use

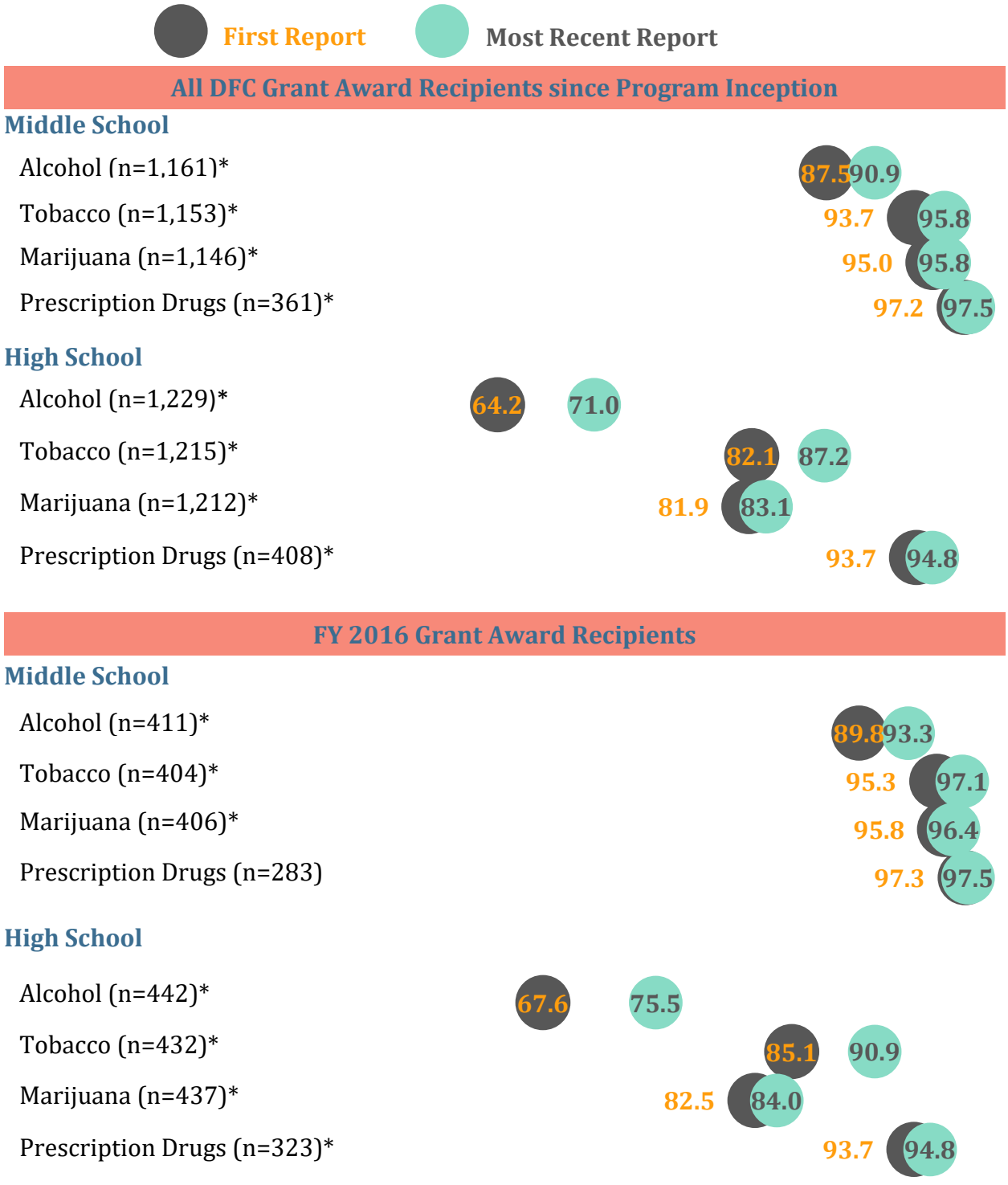
One of the key goals of the DFC grant is to prevent and reduce youth substance use. For all substances—for both middle school and high school age groups for all DFC coalitions since inception—there was a significant increase in past 30-day prevalence of non-use (see Figure 11 and Table D.2, Appendix D). That is, within communities with a DFC coalition, more youth reported not using each of the core measure substances at most recent report than at first report. The same was true for the FY 2016 sample, with the exception of the past 30-day prevalence of non-misuse of prescription drugs by middle school youth, which was unchanged from the first report to the most recent report (97% and 98%, respectively). That is, very few middle school youth reported misuse of prescription drugs at any time.

[45] 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 coalitions. Outliers with change scores greater than three standard deviations were excluded from the analyses. Significance is indicated when the statistical significance reached a value of $p < .05$ or less.

[46] For core measures in place only since 2012, most of the DFC coalitions in the all DFC ever-funded sample are also in the FY 2016 only sample. For example, to date 361 DFC coalitions ever funded have two data points reported on past 30-day prevalence of use of prescription drugs for middle school youth. Of these 361, 283 (78%) also were in the FY 2016 only sample. In comparison, only 411 of the 1,161(25%) DFC coalitions who have reported past 30-day prevalence of alcohol use among middle school youth were in the FY 2016 only sample.

[47] Significant differences at the $p < .05$ level are indicated with an asterisk.

Figure 11. Past 30-Day Prevalence of Non-Use From First Report to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates $p < .05$ (significant difference); numbers are percentages.
Source: Progress Report, 2002–2017 core measures data

Several aspects of the past 30-day prevalence of non-use data are worth noting. First, while there were significant increases over time, the majority of youth reported that they did not use each of the given core measure substances at each report (first report and most recent report). While most youth choose not to use substances, the significant changes associated with having a DFC coalition translate to thousands of additional youth making the choice not to use a given substance. These numbers are based on extrapolating from the percentage change for the FY 2016 sample to the potential reach of DFC based on capture area census estimates (see Table 13). The estimated number of middle school youth reporting past 30-day alcohol non-use from first report to most recent report increased from 2,155,000 to 2,238,000 which is approximately an additional 83,000 middle school youth reporting past 30-day alcohol non-use. The approximate number of high school youth who reported past 30-day alcohol non-use increased from 2,208,000 to 2,482,000, an increase of approximately 274,000 high school youth not consuming alcohol.

Among middle school youth, past 30-day non-use of tobacco increased from approximately 2,287,000 to 2,330,000, an increase of 43,000; past 30-day non-use of marijuana increased from 2,300,000 to 2,315,000, an increase of approximately 15,000 middle school youth. The approximate number of high school youth who reported past 30-day non-use of tobacco increased from 2,795,000 to 2,983,000, an increase of 188,000. For marijuana, high school youth reports of past 30-day non-use increased from 2,716,000 to 2,765,000, an increase of 49,000. For the FY 2016 sample, there was no significant change in reports of past 30-day non-misuse of prescription drugs among middle school students with almost all (97%) reporting not misusing at each time point. Among high school youth, reported past 30-day non-misuse of prescription drugs increased from approximately 3,089,000 to 3,129,000, an increase of approximately 40,000 youth.

Table 13: FY 2016 DFC Coalitions *Significantly Increased* the Number of Youth Who Reported Past 30-Day Non-Use

Past 30-Day Non-Use of…	Estimated Increase in Number of Middle School Youth	Estimated Increase in Number of High School Youth
Alcohol	83,000	274,000
Tobacco	43,000	188,000
Marijuana	15,000	49,000
Prescription Drug (misuse)	No Change	40,000

Note: Number of estimated youth is based on extrapolating percentage change to potential reach based on census estimates.
Source: Progress Report, 2002–2017 core measures data

Second, while most youth reported non-use of alcohol within the past 30-days (see Table D.2, Appendix D), alcohol was the substance with the lowest past 30-day prevalence of non-use among middle school and high school youth, at first report and at most recent report, both for all DFC coalitions ever funded and FY 2016 DFC coalitions only. That is, alcohol was the substance that youth were most likely to report having used during the past 30-days

(also see Table D.1, Appendix D). Across all DFC coalitions funded since inception, just under three-fourths (71%) of high school youth reported past 30-day alcohol non-use at most recent report. In comparison, at most recent report, more high school youth in the all DFC coalitions funded since inception sample reported not using marijuana, not using tobacco, and not misusing prescription drugs (83%, 87%, and 95%, respectively). In both samples, most (90% or more) middle school youth reported that they had not used each of the given substances at most recent report, including alcohol, although alcohol again had the lowest prevalence of non-use as compared with tobacco, marijuana, and prescription drug non-misuse (e.g., 91% versus 96%, 96%, and 98%, respectively in the all DFC coalitions funded since inception sample). The relatively high rates of past 30-day prevalence of alcohol use (e.g., within the FY 2016 sample at most recent report 7% of middle school youth and 25% of high school youth reported past 30-day use) suggests the need for ongoing prevention efforts targeting youth alcohol use such as those provided by DFC coalitions.

Third, reported past 30-day prevalence of non-misuse of prescription drugs was higher than for all other substances. Most middle school and high school youth (97% and 94%, respectively) report not misusing prescription drugs the past 30-days. Prevalence of non-misuse of prescription drugs was high at first report and significantly increased from the first report to the most recent report among youth in communities targeted by DFC coalitions (with the exception of middle school youth in the FY 2016 sample which was unchanged). Finally, the percentage of high school youth reporting past 30-day non-use of marijuana was lower than the percentage of these youth reporting past 30-day non-use of tobacco, in most cases. That is, more high school youth reported past 30-day use of marijuana than of tobacco. The exception to this was for first report across all DFC recipients since inception in which prevalence of non-use was similar for tobacco and marijuana (82%). Among middle school youth, prevalence of non-use of tobacco and marijuana were similar within each time point within each sample.

Percentage Change in Prevalence of Past 30-Day Use

The amount of change in past 30-day prevalence of use (from first report to most recent report) can also be considered as a percentage change relative to the first report. That is, given that past 30-day prevalence of non-use has increased, what was the percentage decrease in past 30-day prevalence of use? Figure 12 (all DFC grant award recipients ever funded) and Figure 13 (FY 2016 grant award recipients) present percentage change data (see Table D.1, Appendix D for the underlying data used to calculate the percentage change).[48]

[48] 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 percentage].

As shown in Figure 12, the past 30-day prevalence of alcohol use declined by 27 percent, past 30-day prevalence of tobacco use declined by 33 percent, past 30-day prevalence of marijuana use declined by 16 percent, and past 30-day prevalence of prescription drug misuse declined by 11 percent from the first report to the most recent report among middle school youth across all DFC coalitions ever funded. High school past 30-day prevalence of use for alcohol declined by 19 percent, tobacco declined by 29 percent, marijuana declined by 7 percent, and prescription drug prevalence of misuse declined by 18 percent. All of these reductions in past 30-day prevalence of use for this sample were significant.

Figure 12: Percentage Change in Past 30-Day Alcohol, Tobacco, and Marijuana Prevalence of Use and in Prescription Drug Prevalence of Misuse: Long-Term Change Among All DFC Grant Award Recipients Since Grant Inception

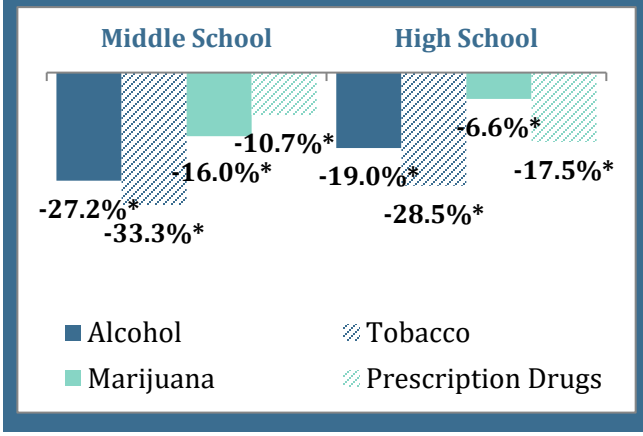
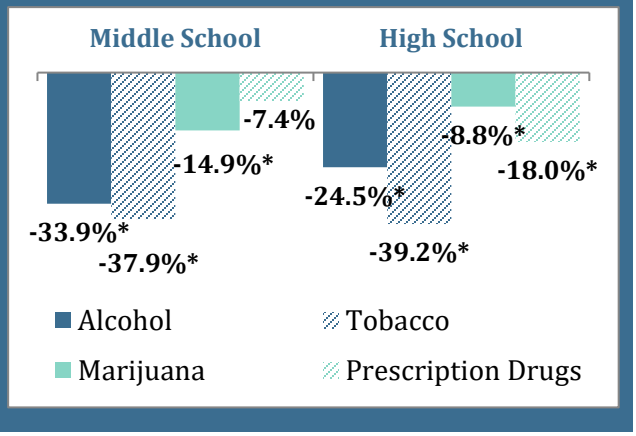


Figure 13: Percentage Change in Past 30-Day Alcohol, Tobacco, and Marijuana Prevalence of Use and in Prescription Drug Prevalence of Misuse: Long-Term Change Among FY 2016 DFC Grant Award Recipients



Notes: * p<.05; Percentage change outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding the number of youth surveyed at first observation to the number of youth surveyed at most recent observation). Change scores were rounded as presented in Table D.1 for these calculations.

Source: Progress Report, 2002–2016 core measures data

Percentage decreases in past 30-day prevalence of use among the FY 2016 grant award recipients (see Figure 13) followed similar patterns to those for all DFC grant awards to date (see Figure 12). In this sample, the percentage decreases were greatest for reports of tobacco use for both middle school (38%) and high school (39%) youth. The next highest decreases were for past 30-day prevalence of alcohol use in middle school and high school youth (34% and 25%, respectively). Marijuana use decreased for both middle school and high school youth (15% and 9%, respectively). Each of these changes was significant. For prescription drugs, there was a significant decrease in high school youth past 30-day misuse (18%), but no significant change for middle school youth within the FY 2016 sample.

Alcohol Core Measures Findings

Figure 14 provides the alcohol core measures data findings (also see Appendix D). For alcohol, both perception of risk and parental disapproval core measures were redefined in 2012 and peer disapproval was first introduced as a core measure in this year. Therefore, these change data have been collected only from 2012 to 2016 and a much smaller number of DFC coalitions have change data for these three alcohol core measures compared with past 30-day prevalence of non-use (collected from 2002 to 2016). For all DFC grant award recipients since inception and for the FY 2016 DFC coalitions, most of the alcohol core measures differences between the first and the most recent report were significant increases. One exception in both samples was for middle school youth's perception of parental disapproval which was high at both time points (approximately 94%) and did not change significantly. Perception of risk associated with alcohol use also was unchanged for middle school youth in the FY 2016 sample only.

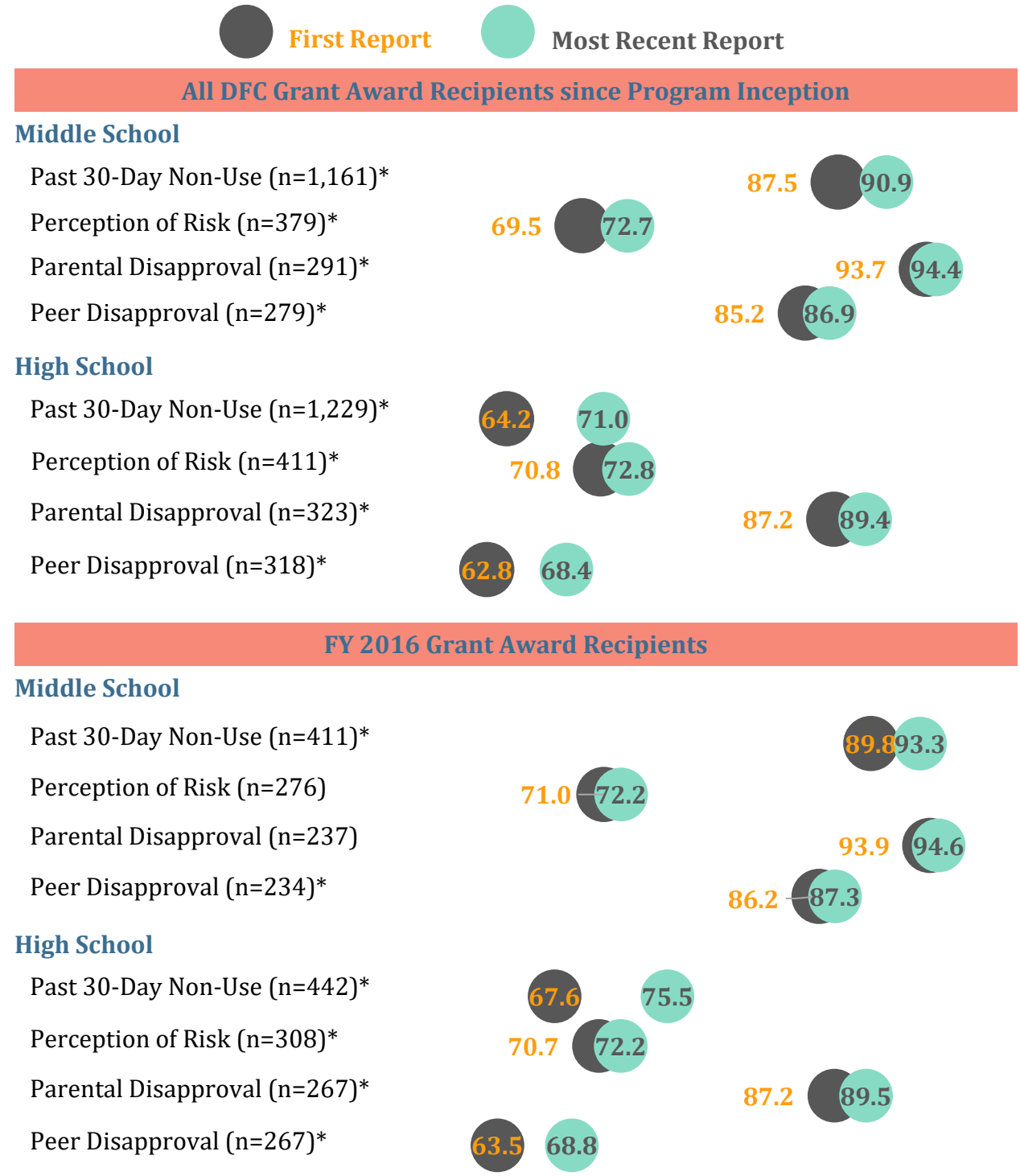
As noted in the prior section, alcohol was the substance with the lowest prevalence of past 30-day nonuse among both middle school and high school youth, across both samples, and across both time points (see Figure 14 and Table D.2, Appendix D). Percentages of youth reporting past 30-day non-use of alcohol also decreased from middle school to high school. From first report to most recent report, past 30-day nonuse of alcohol increased significantly for both age groups and for both samples.

Alcohol: Perception of Risk

Beginning in 2012, perception of risk of alcohol use was defined as being associated with binge alcohol use (five or more drinks of an alcoholic beverage [beer, wine, or liquor] once or twice a week). As can be seen (see Figure 14 and Table D.3, Appendix D), among middle school youth, perception of risk increased significantly from the first report to the most recent report for all DFC coalitions since inception (3.2 percentage points) but not within the FY 2016 DFC coalitions (1.2 percentage points). Perception of risk of alcohol use (binge drinking) increased significantly from first report to most recent report among high school youth within both all DFC coalitions and within the FY 2016 DFC coalitions (2.0 and 1.5 percentage points, respectively). There was no difference in perceived risk between middle school and high school youth at each time point. Just under three-fourths of both middle school and high school youth perceived risk associated with this type of alcohol use. However, by high school, the percentage of youth who reported use was much higher than in middle school. Together, these findings suggest that DFC coalitions may need to identify strategies, beginning in middle school, to help youth understand the risks associated with binge drinking. That is, the relatively low perception of risk among middle school youth of alcohol use may be one potential explanation for the lower percentage of high school youth reporting past 30-day alcohol non-use. The approximately 30 percent of middle school

youth who do not perceive risk in drinking alcohol (binge use) may be at increased risk for drinking alcohol, including binge use, once in high school.

Figure 14. Alcohol Core Measures: Percentage Point Change from First Report to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference); numbers are percentages.
Source: Progress Report, 2002–2017 core measures data

Alcohol: Perception of Parental and Peer Disapproval

Perception of parental disapproval of alcohol use for middle school youth in both samples of DFC grant award recipients was high at both first report and most recent report (approximately 94%) and increased significantly across all DFC coalitions (0.7 percentage point increase), but was unchanged in the FY 2016 sample (see Figure 14 and Table D.4, Appendix D). High school youth's perceptions of parental disapproval of alcohol use at first report also were high (approximately 87%), and increased significantly by similar amounts in the all DFC coalitions since inceptions and FY 2016 only samples (2.2. and 2.3 percentage points, respectively).

Perception of peer disapproval of alcohol use increased significantly in both samples for both middle school and high school youth. Within middle school youth, the increase was from 85 percent and 86 percent, respectively, to 87 percent across the two samples (increases of 1.7 and 1.1 percentage points, respectively). Fewer high school youth than middle school youth perceived peer disapproval associated with alcohol use. At first report, just under two-thirds (63%) of high school youth in both all DFC ever funded and the FY 2016 only DFC coalitions perceived disapproval although this increased significantly to just over two-thirds (68-69%) by most recent report (increases of 5.6 and 5.3 percentage points, respectively). The percentage of high school youth perceiving peer disapproval were approximately similar to those reporting non-use. This suggests that it is possible that high school youth who are not using alcohol perceive disapproval, although it is not possible to connect an individual youth's responses on these items at the national level.

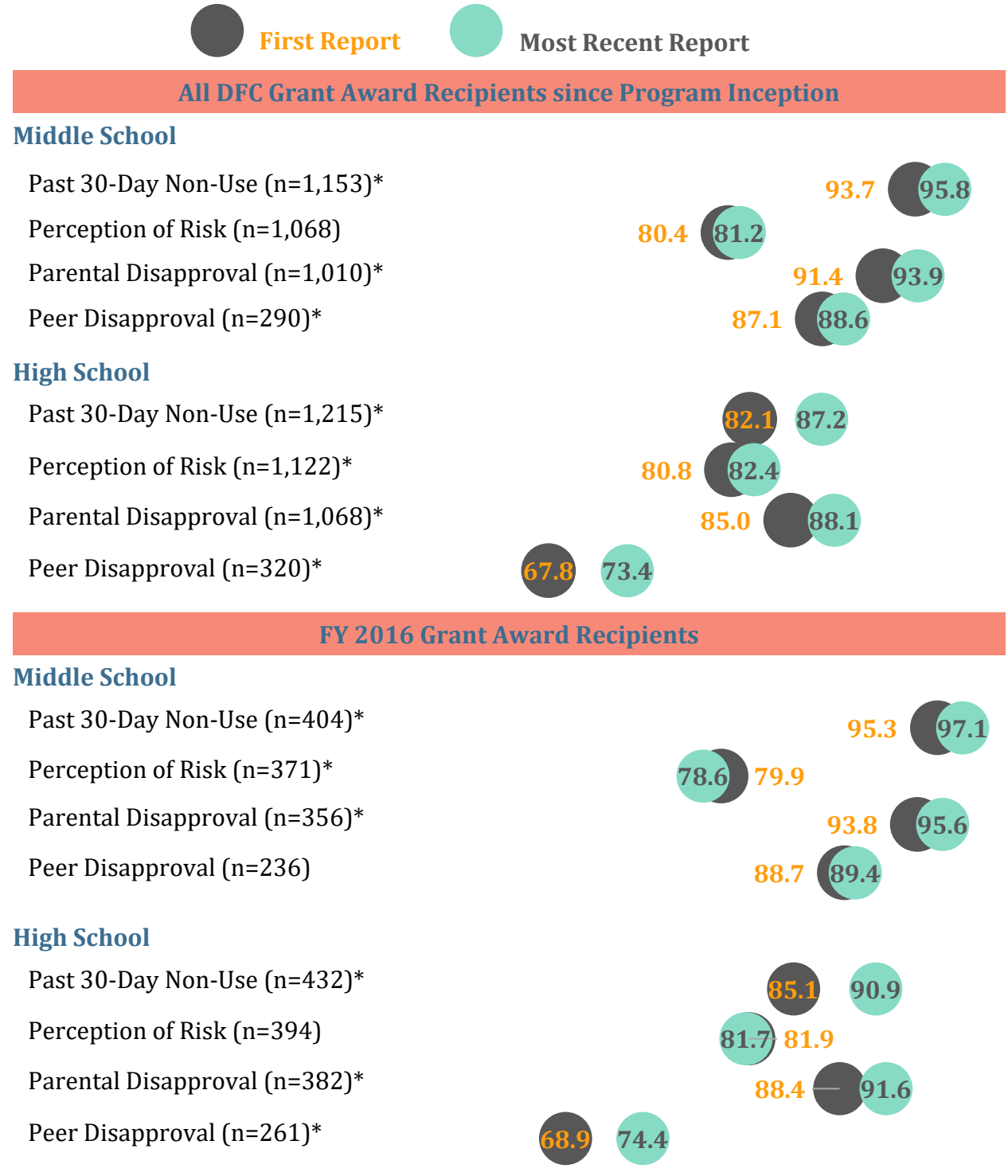
Within both middle school and high school youth, perceived disapproval of alcohol use was lower relative to peers as compared with parents (see Figure 14 and Tables D.4 and D.5, Appendix D). Within middle school youth, the difference was approximately 7 percentage points lower depending on the time of the report and the sample. By high school, only about two-thirds of high school youth perceived peers as disapproving of alcohol use while 87 to 89 percent perceived parents as disapproving at any given time point, a difference of 20 percentage points compared with middle school youth depending on the time of report and the sample.

Tobacco Core Measures Findings

Figure 15 provides the tobacco core measures data findings. The past 30-day prevalence of non-use of tobacco increased significantly for both age groups and both samples (see Figure 15 and Table D.2, Appendix D). In general, percentages of youth reporting not using tobacco, perceiving risk in tobacco use, and perceiving parental and peer disapproval were high (80% or greater) at both first report and most recent report for both age groups and for both all DFC and FY 2016 only grant award recipients. The notable exception to this was high school youth's perceptions of peer disapproval for both samples, hovering between 68

percent and 74 percent (also see Table D.5, Appendix D). Middle school youth's perception of risk in the FY 2016 sample at first report was just under 80 percent.

Figure 15. Tobacco Core Measures: Change from First Report to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference)**:** numbers are percentages.
Source: Progress Report, 2002–2017 core measures data

Tobacco: Perception of Risk

While perceived risk of tobacco use was unchanged for middle school youth in the all DFC since inception sample, there was a significant *decrease* in perceived risk for middle school youth in the FY 2016 sample (1.3 percentage point decrease; see Figure 15 and Table D.3, Appendix D). Perceived risk of tobacco use increased significantly for high school youth in the all DFC coalitions since inception sample (1.6 percentage points) but was unchanged in the FY 2016 sample. Together, these findings in the FY 2016 sample with regard to perceived risk of tobacco use suggest that DFC coalitions may need to increase the focus on risk associated with tobacco use in their work.

Tobacco: Perception of Parental and Peer Disapproval

Perception of both parental and peer disapproval of tobacco use (tobacco use is wrong or very wrong) increased significantly for both middle school and high school youth in both samples (see Figure 15 and Tables D.4 and D.5, Appendix D). Parental disapproval was perceived at similar rates by middle school (91-96%) and high school youth (85-92%). Middle school youth's perception of peer disapproval of tobacco use was similar to these perceptions of parental disapproval (87-89%). However, by high school, fewer youth perceived peer disapproval (68-74%) associated with tobacco use compared with both peer disapproval in middle school youth and parental disapproval in both age groups.

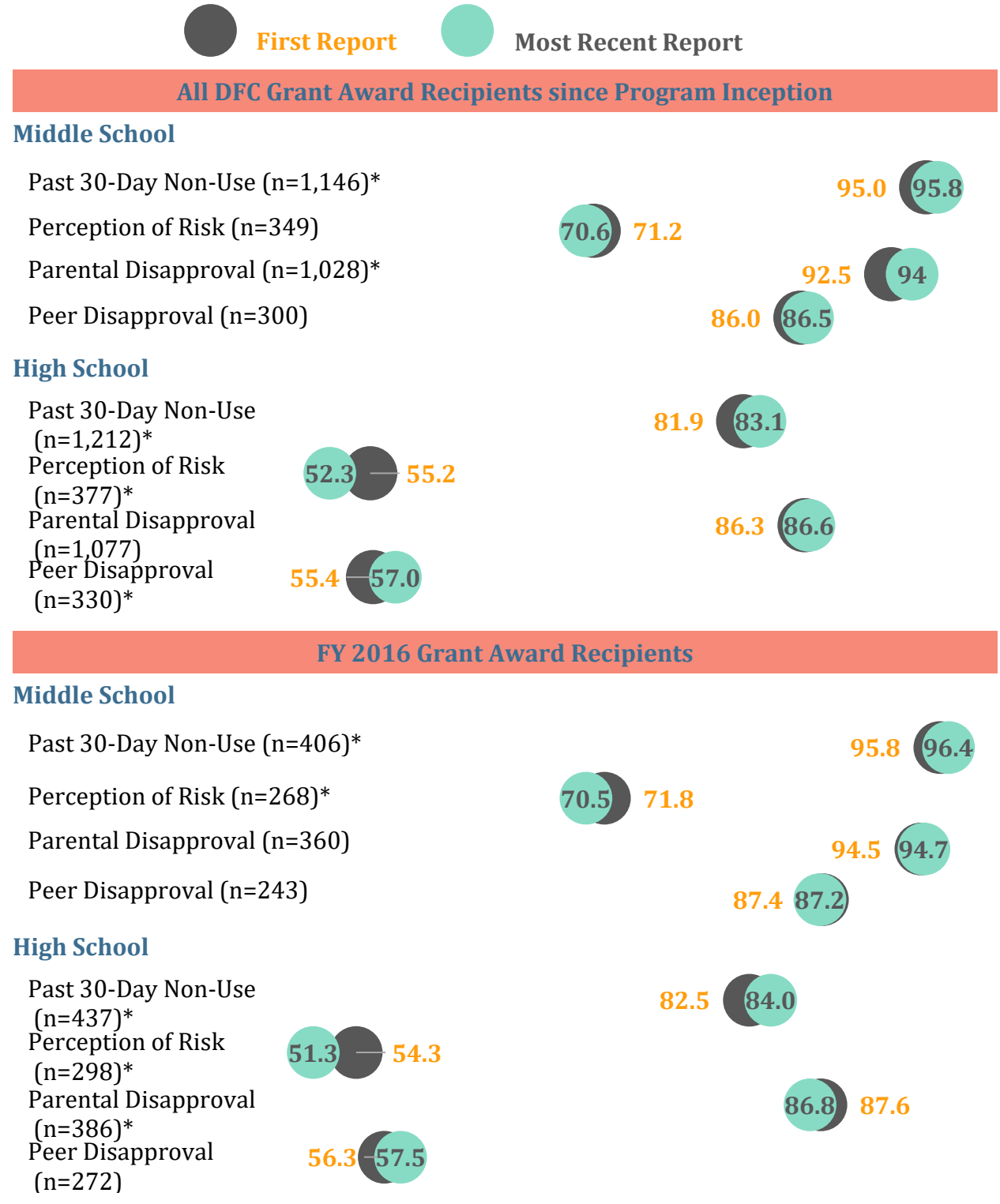
Marijuana Core Measures Findings

Figure 16 provides the marijuana core measures data findings (also see Appendix D). The majority of both middle school and high school youth reported not using marijuana within the past 30-days within both samples, and past 30-day prevalence of non-use increased significantly from first report to most recent report (see also Figure 13 and Table D.2, Appendix D). The percentages of middle school youth who perceived risk, parental disapproval and peer disapproval in both samples also were generally high at both first report and most recent report (approximately 70%, 93%, and 86%, respectively). By high school, smaller percentages of youth than in middle school perceived risk, parental disapproval, and peer disapproval associated with marijuana use (52-55%, 86-88%, and 55-58%, respectively) in both samples.

Marijuana: Perception of Risk

The measure for perception of risk as currently worded (smoke marijuana once or twice a week) was introduced in 2012 (see Figure 16 and Table D.3, Appendix D). To date, 349 coalitions have collected this data at two time points for middle school youth while 377 have collected it for high school youth. The majority of all DFC coalitions included in the marijuana perception of risk analyses are also FY 2016 DFC coalitions (i.e., 77% for the middle school samples, 79% for the high school samples). That is, the analyses for the two samples are very similar given the amount of overlap between the two samples.

Figure 16. Marijuana Core Measures: Change from First Report to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference)**:** numbers are percentages.
Source: Progress Report, 2002–2017 core measures data

Among middle school youth, the decrease in perceived risk of marijuana use did not change significantly from first report to most recent report within the all DFC since inception sample. However, within the FY 2016 sample, there was a significant *decrease* in perceived risk from first report to most recent report for middle school youth (decrease of 1.3 percentage points). For high school youth, perceived risk of marijuana use *decreased* significantly from first report to most recent report within both samples (decreases of 2.9 and 3.0 percentage points, respectively). That is, significantly fewer high school youth perceived risk associated with smoking marijuana once or twice a week at most recent report compare to first report, in both samples. The same was true for middle school youth, although only in the most recent sample. Together, these findings suggest that DFC coalitions may need to increase the focus on the risks associated with youth marijuana use.

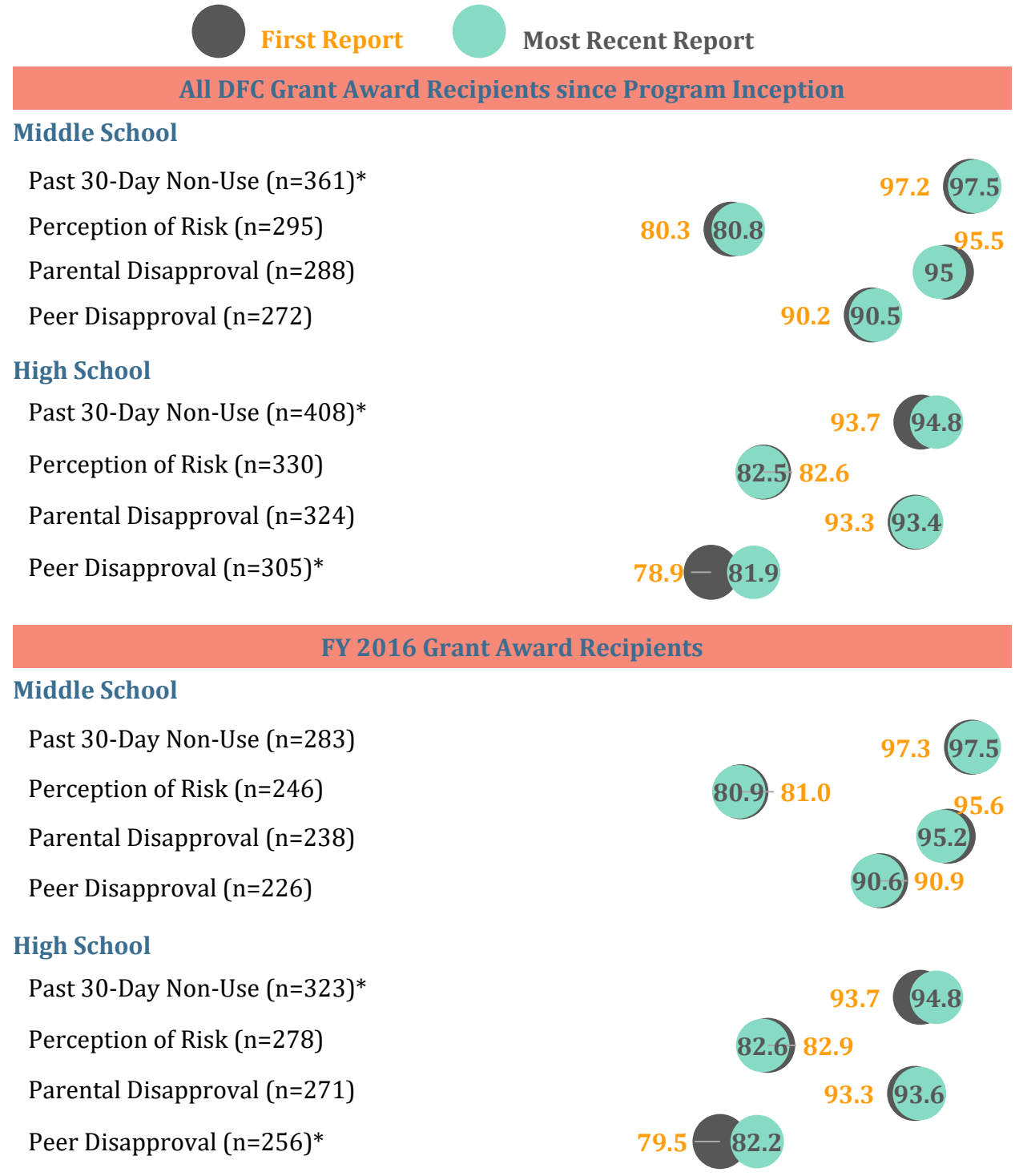
Marijuana: Perception of Parental and Peer Disapproval

Both middle school and high school youth reported relatively high levels of perceived parental disapproval of marijuana use (92-95% of middle school youth and 86-88% of high school youth, see Figure 16 and Table D.4, Appendix D). For middle school youth, there was a significant increase in perceived parental disapproval across all DFC coalitions ever funded (1.5 percentage points) but not for the FY 2016 sample. Perceived parental disapproval was unchanged among high school youth across all DFC coalitions, but increased significantly within the FY 2016 sample (0.8 percentage points). Within high school youth, the percentage reporting perceived parental disapproval of marijuana use at most recent report was high (86%) but was slightly lower than for any other substance, including alcohol (87-89% perceived parental disapproval of alcohol use). Perception of peer disapproval of marijuana use was generally unchanged from first report to most recent report (see Figure 16 and Table D.5, Appendix D). The one exception to this was a significant increase in high school youth's perception of peer disapproval in the all DFC coalitions sample (1.6 percentage points). While perceived peer disapproval of marijuana use increased significantly, it was still only 57 percent in high school youth at most recent report. The percentage of high school youth perceiving peer disapproval was generally lower for marijuana (55-58%) than for any other substance, including alcohol (63-69%; see Table D.5, Appendix D). For middle school youth, perceptions of peer disapproval of marijuana use were similar to perceptions of peer disapproval of alcohol use, both of which were lower than for the remaining core measure substances (tobacco and prescription drug use).

Prescription Drugs (Misuse) Core Measures Findings

Figure 17 provides the misuse of prescription drugs (use of prescription drugs not prescribed to you) core measures data findings (also see Appendix D). Misuse of prescription drugs was introduced as a core measure substance in 2012. Therefore, the data for all core measures for this substance reflects a generally smaller sample of DFC

Figure 17. Prescription Drugs (Misuse) Core Measures: Change from First Report to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference); numbers are percentages.
Source: Progress Report, 2002–2017 core measures data

coalitions than for other core measure substances (and the two samples include many of the same coalitions). As noted previously, past 30-day prevalence of misuse for prescription drugs was higher than for any other substance at both time point and for both age groups and both samples. At least 97 percent of middle school and 94 percent of high school youth report that they have not misused prescription drugs within the past 30-days, a high percentage that increased significantly from first report to most recent report for both age groups in both samples (see Figure 17 and Table D.2, Appendix D), except for a non-significant change among middle school youth within the FY 2016 sample (0.2 percentage points).[49]

Prescription Drugs: Perception of Risk

Perception of risk of prescription drug misuse was generally high (80-83%), but did not change significantly from first report to most recent report (see Figure 17 and Table D.3, Appendix D). This was true for both middle school and high school youth and for both samples. Perceived risk of misuse of prescription drugs (80-83%) was very similar to perceived risk of tobacco use (79-82%), but was higher than for both alcohol (70-73%) and marijuana use (51-71%; see Table D.3, Appendix D).

Prescription Drugs: Perception of Parental and Peer Disapproval

Youth perceptions of parental disapproval of prescription drug misuse for both age groups and both samples were high (more than 95% in middle school youth and more than 93% in high school youth) and were unchanged from first report to most recent report (see Figure 17 and Table D.4, Appendix D). Peer disapproval increased significantly for high school youth within all DFC coalitions and FY 2016 coalitions (3.0 and 2.6 percentage points, respectively), but was unchanged among middle school youth within both samples. For both middle school and high school youth, perceived peer disapproval was higher for prescription drug misuse than for any other substance. The same was true for parental disapproval among high school youth, while middle school youth perception of parental disapproval was similar across substances.

Comparison With National Data[50]

The results for past 30-day prevalence of use within DFC coalitions were compared to findings from a nationally representative sample of high school students taking the Youth Risk Behavior Survey (YRBS: see Figure 18).[51] Note that there may be some overlap

[49] The change in middle school youth across all DFC since inception was also small (0.3 percentage points), but did reach statistical significance. This finding is likely due in part to the large sample size and to the relatively low variability in reporting prescription drug misuse.

[50] These findings were first published in the previous DFC National Evaluation 2016 End-of-Year report. YRBS data from 2017 are not yet available but will be included in future reports.

[51] 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

between samples; these comparisons are conservative estimates of the difference that DFC is making in communities.[52]

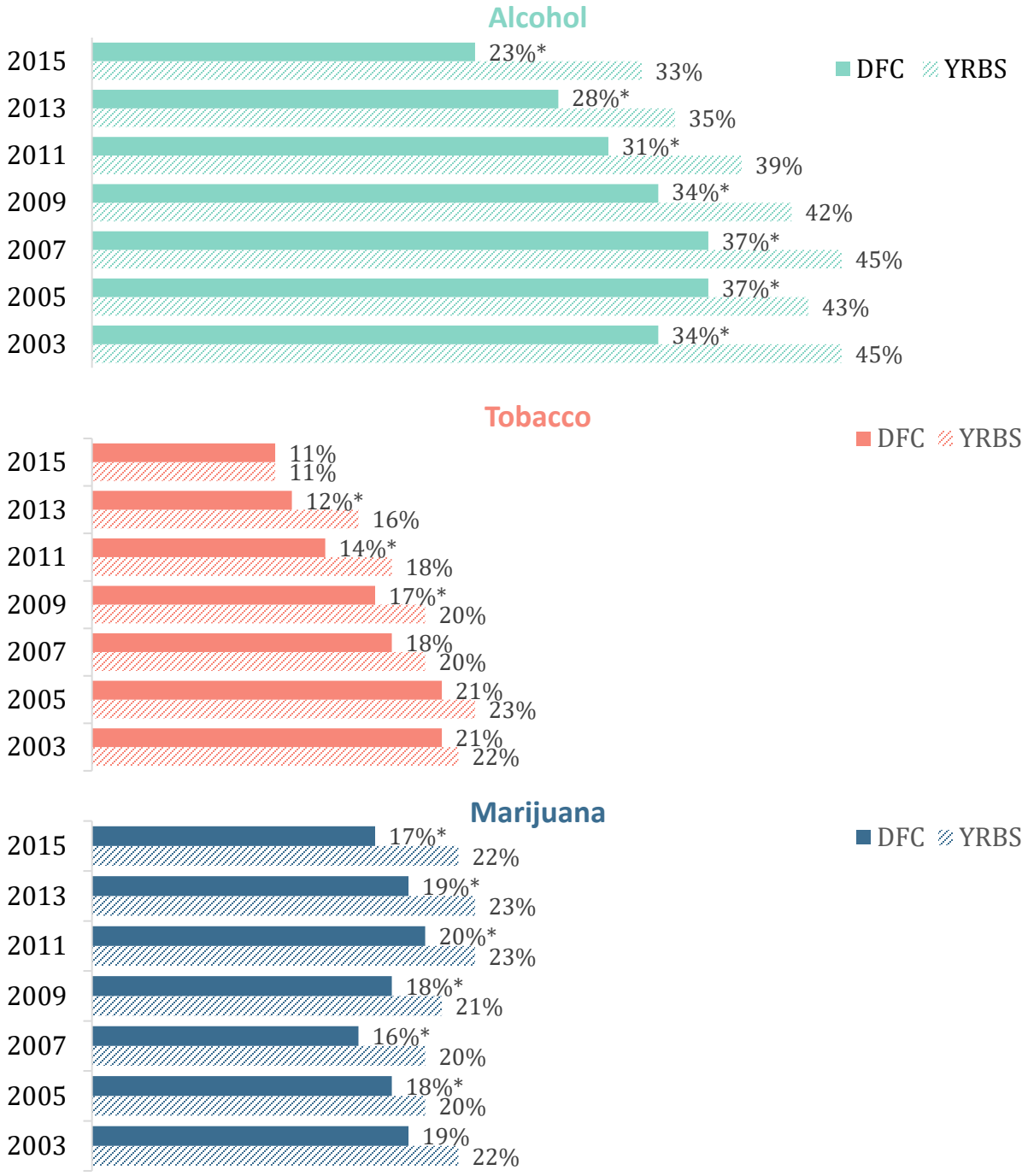
Prevalence rates of past 30-day alcohol use among high school students were significantly lower in communities with a DFC coalition than in the national YRBS in all seven years compared (i.e., 2003, 2005, 2007, 2009, 2011, 2013, and 2015). In 2015, the difference between the DFC and YRBS samples on the mean past 30-day prevalence of alcohol use was 10 percentage points (23% and 33%, respectively). Prevalence rates for marijuana use also were significantly lower in DFC communities than in the YRBS national sample in all years, except 2003. In 2015, 17 percent of high school youth reported past 30-day marijuana use compared with 22 percent in the YRBS national sample. Marijuana use by high school youth in the national sample was relatively unchanged from 2011 to 2015 while high school youth in the DFC sample decreased from 20 percent in 2011 to 17 percent in 2015.

For high school tobacco use, there was no significant difference between the YRBS and DFC samples in 2015 (11% reported past 30-day use in each sample). Fewer youth in DFC communities than in the YRBS national sample reported tobacco use in 2009, 2011, and 2013, while in all other years there was no difference. In general, youth tobacco use trended toward a decrease from 2005 to 2015, but use by youth in the DFC coalitions' communities dropped more quickly early on, then had less change between 2013 and 2015.

and marijuana. YRBS data are collected only in odd years. 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.

[52] Some DFC coalitions report using YRBS data to track local trends and thus may be included in the national YRBS data. That is, some change in YRBS data may occur in part due to efforts from DFC coalitions. Comparisons with the national sample also are influenced by both the range of survey instruments that DFC coalitions use to collect core measures data and the year in which DFC coalitions collect their core measure data. While to be included in the DFC evaluation data the survey must use appropriate DFC core measure wording, the order of core measure items and the length of the surveys can vary widely across DFC coalitions. DFC coalitions are required to collect core measures data every 2- years and not all collect in odd years aligned to YRBS, further limiting the comparison between the two national samples.

Figure 18. Comparison of DFC and National (YRBS) Reports of Past 30-Day Alcohol, Tobacco, and Marijuana Prevalence of Use Among High School Students



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

Source: DFC Progress Report, 2003–2015 core measures data; CDC 2015 Youth Risk Behavior Survey Data downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm.

Community Assets Findings

Every August, DFC coalitions complete the Coalition Classification Tool (CCT), a survey that asks them to provide information on coalition structure, performance, objectives, and local characteristics. In August 2017, 546 FY 2016 DFC coalitions completed the CCT (81% of all FY 2016 DFC coalitions). One section of the CCT asks grantees to identify which of 44 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 in place as a result of receiving the grant, and those not yet in place in the DFC community to date.[53] Examples from the list of potential community assets that DFC grantees may put into place include billboards warning against the use of alcohol, tobacco, or other drugs, media literacy training, shoulder tap operations,[54] and party patrols.[55]

While each of these community assets may enhance the coalition's capacity to prevent or reduce youth substance use, those that were implemented as a result of DFC coalition efforts provide an additional source of information about the local impact of the grant. That is, these assets may not have been in place in the community if not for the DFC grant award. Table 14 presents the top five community assets put into place as a result of the DFC grant by FY 2016 DFC grantees as reported in the August 2017 CCT.[56]

Town hall meetings were the most common asset put into place by DFC grantees as a result of the DFC grant (71%). Only one-fifth (19%) of DFC coalitions reported having town hall meetings prior to DFC grant award and only one-tenth (10%) reported still not having town hall meetings as a community asset. DFC coalitions also reported that they were able to create culturally competent materials to educate the community about substance use as a result of the grant (68%). Most (95%) DFC coalitions also offered prescription drug disposal programs. While just under one-third (31%) of the responding DFC coalitions already had a prescription drug disposal program in place prior to receiving the grant, about two-thirds (64%) of coalitions initiated this activity only after receiving their DFC grant. Other community assets that were put into place by high percentages of DFC

[53] DFC coalitions report on which of the community assets have been put into place in their community in the past year as a result of being a DFC coalition as well as indicating those ever put into place as part of the DFC grant. For the purposes of this report, these two categories were combined.

[54] Shoulder tap operations are designed to curtail the problem of adults providing alcohol to minors in and around licensed alcohol outlets. Typically, Youth and Law Enforcement sectors collaborate on these operations. A youth, under direction from law enforcement, approaches an adult entering the outlet and requests that they buy alcohol for them. Adults who agree and provide alcohol to the youth are then held accountable by law enforcement. Alcohol is the substance this activity is most commonly used with, but it can apply to other substances as well.

[55] Party patrols involve law enforcement regularly visiting (patrolling) an area where youth are suspected to gather together to engage in substance use. A range of coalition sectors are often involved with identifying areas to patrol. Law enforcement acts to stop the behavior if it occurs, although the increased surveillance also decreases the likelihood of a party occurring.

[56] These were the only five assets where more than 50% of DFC coalitions put the asset into place after a DFC grant award.

coalitions as a result of receiving a DFC grant included social norms campaigns (70%) and youth substance use warning posters (54%).

Table 14: Most Frequently Community Assets Implemented after DFC Grant Award

Community Asset	n of DFC Coalitions Responding to item	% With Asset Put into Place as a Result of DFC Coalition Grant Award	% With Asset in Place Before DFC Grant	% With Asset Not in Place in Community
Town hall meetings on substance problems within the community	546	71.2%	19.2%	9.5%
Social norms campaigns	546	70.3%	14.8%	14.8%
Culturally competent materials that educate the public about issues related to substance use	546	67.8%	23.1%	9.2%
Prescription drug disposal programs	546	64.3%	30.6%	5.1%
Youth substance use warning posters	546	54.4%	24.4%	21.2%

Note: The number of DFC coalitions reporting CCT data in August 2017 was 660. For a small number of items, only 546 DFC coalitions responded.
Source: Coalition Classification Tool Data, August 2017

Social norms campaigns stand out as a top five asset added by DFC coalitions given the reported increases in peer disapproval measures in DFC coalitions' communities, particularly among high school youth. Most (85%) DFC coalitions have a social norm campaign in their community, but most (70%) of these DFC coalitions put a social norms campaign into place only after receiving DFC funding, compared with those already engaging in a social norms campaign prior to receiving funding (15%). Social norms campaigns generally focus on giving youth factual and motivational information about the positive behaviors engaged in by peers with the intention of helping youth recognize that most youth are not engaging in negative behaviors. Continued efforts on social campaigns may help to counter beliefs that might otherwise contribute to possible increases in past 30-day prevalence of use.

Conclusions

This report provides a summary of findings for the DFC program through the August 2017 progress reporting window. Following is an overview of key takeaways from this report.

Nearly half of the US population has lived in a community with a DFC coalition since 2005 and 1 in 5 Americans lived in a community with a DFC coalition in 2017.

Since inception, a wide range of people and communities have been exposed to the federally-funded DFC Support Program. Based on DFC coalitions reports of ZIP codes served as compared with Census data, DFC grant award recipients have targeted areas that covered nearly half (48%) of the U.S. population between 2005 and 2017. In 2017 alone, the 677 DFC coalitions funded in FY 2016 targeted services to communities with 58.6 million people, nearly one-fifth (19%) of the population of the United States. This includes 2.4 million middle school and 3.3 million high school aged youth. DFC locations implemented activities in rural (53%), suburban (42%), and urban (25%) community settings.

DFC coalitions reported significantly increased past 30-day prevalence of non-use (decreased use) of alcohol, tobacco, marijuana and prescription drugs not prescribed to you.

DFC coalitions made significant progress toward achieving the goal of preventing and reducing youth substance use. DFC coalitions reported targeting efforts toward addressing alcohol (97%), marijuana (90%), misuse of prescription drugs (86%), and tobacco use (60%), which are the DFC core measure substances. The majority of both middle school and high school youth in communities with a DFC coalition report that they have not used each of these core substances within the past 30-days, and prevalence of non-use increased significantly from first report to most recent report. This was true for both middle school and high school youth based on data from all DFC coalitions since inception and on data from only FY 2016 DFC coalitions. The one exception to significant increases was that non-misuse of prescription drugs by middle school youth within the FY 2016 sample was unchanged from first report to most recent report (97.3% and 97.5%, respectively). Among middle school youth, prevalence of past 30-day non-use at most recent report within the FY 2016 sample was high (over 93% for each of the substances), with increases from first report to most recent report ranging from 0.6 percentage points for marijuana non-use to 3.5 percentage points for alcohol non-use. Among high school youth at most recent report in the FY 2016 sample, there was similarly high prevalence of non-use for tobacco (91%) and of non-misuse of prescription drugs (95%), with significant increases of 5.8 and 1.1 percentage points from first report to most report, respectively.

Within the FY 2016 sample, fewer high school youth reported past 30-day non-use of alcohol (76%) and marijuana (84%) at most recent report compared with tobacco non-use and prescription drug non-misuse. For both middle school and high school youth, alcohol was the substance with the lowest reported past 30-day prevalence of non-use, while prescription drugs had the highest reported non-misuse.

Social norms campaigns are one activity utilized by the majority (85%) of DFC coalitions to prevent use. These campaigns focus on giving youth factual and motivational information about the positive behaviors engaged in by peers with the intention of helping youth recognize that most youth are not engaging in negative behaviors. The finding that the majority of youth are not engaging in substance use, with respect to each core measure substance, may be useful in supporting DFC coalitions in using social norms campaigns.

While increased non-use is promising, the prevalence of youth who report past 30-day use, including one in four (25%) high school youth who reported past 30-day use of alcohol and one in six (16%) high school youth who reported past 30-day use of marijuana at most recent report in the FY 2016 sample, suggests the need for programs like DFC that support communities in engaging in ongoing strategies to address prevention.

Youth in DFC communities generally reported high and/or increased perceptions of parental and peer disapproval. One concern was that high school youth reported relatively lower perception of peer disapproval for marijuana and alcohol use.

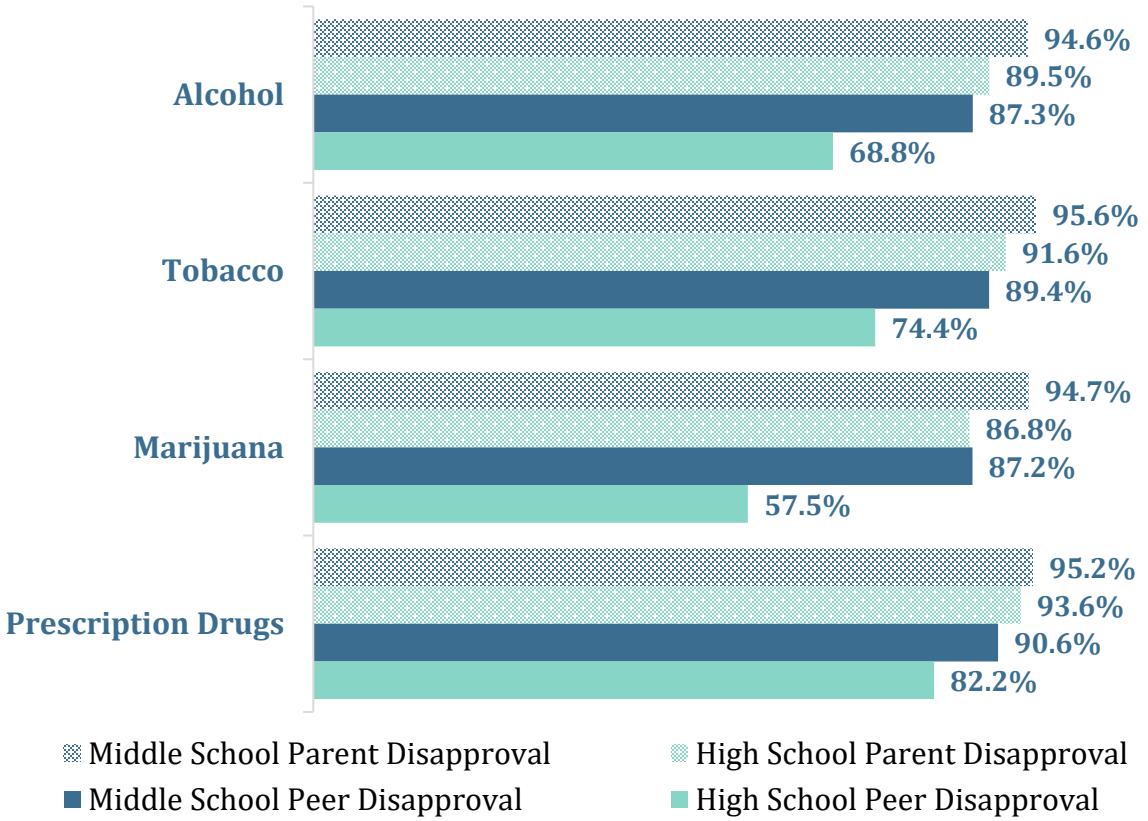
Among middle school youth in communities served by DFC coalitions, 91 percent or more in both samples (all DFC and FY 2016 only) perceived parental disapproval of substance use across substances (alcohol, tobacco, marijuana, and misuse of prescription drugs) at both first report and most recent report. Perceived parental disapproval for tobacco use increased significantly among middle school youth in both samples. Middle school youth's perceived parental disapproval for alcohol use and for marijuana use increased significantly for all DFC coalitions funded (but not for the FY 2016 only sample). Perception of parental disapproval for misuse of prescription drugs was unchanged in both samples. For middle school youth in both samples, there were significant increases in perceived peer disapproval for alcohol use. Perceived peer disapproval of tobacco use increased significantly in the all DFC coalitions sample, but not in the FY 2016 sample. Middle school youth in both samples had no change in perceptions of peer disapproval of marijuana use and misuse of prescription drugs.

For high school youth in both samples, there were significant increases in perceived parental disapproval for both alcohol use and tobacco use while there was no change in perceived parental disapproval for misuse of prescription drugs. Perceived parental disapproval for marijuana use was unchanged in the all DFC coalitions since inception

sample, but decreased significantly in the FY 2016 sample (-0.8 percentage points). For high school youth in both samples, there were significant increases in perceived peer disapproval for all substances, with the exception of perception of peer disapproval of marijuana use in the FY 2016 sample which was unchanged.

Perceived parental disapproval was similar across middle school and high school youth and also was similar to perceived peer disapproval in middle school youth. Using the FY 2016 sample at most recent report as an example, the largest gap between middle school and high school youth's perceptions of parental disapproval was for marijuana use (8 percentage points; see Figure 19 and Table D.4, Appendix D). However, perceived peer disapproval for substance use was lower among high school youth than middle school youth for all substances (see Figure 19; see also Table D.5, Appendix D).

Figure 19. High School Youth's Perceptions of Peer Disapproval Were Lower Than Perceptions of Parental Disapproval (Both Age Groups) and Lower Than Middle School Youth's Perceptions of Peer Disapproval



Notes: Numbers indicate percentages perceiving disapproval (wrong or very wrong). Similar patterns were seen for all DFC coalitions ever funded and for first report.
Source: Progress Report, 2002-2017 core measures data

Compared with middle school youth, high school youth's perceptions of peer disapproval of marijuana use were nearly 30 percentage points lower, 18 percentage points lower for alcohol use, and 15 percentage points lower for tobacco use. The smallest difference

between the age groups for perceived peer disapproval was for misuse of prescription drugs, which was 8 percentage points lower for high school than for middle school youth.

These findings suggest the need for DFC coalitions to continue efforts to help youth understand peer disapproval, as well as to influence it. For example, far fewer high school youth report past 30-day use of marijuana than report perceiving peers would disapprove of such use. Social norms campaigns may be one strategy to inform high school youth about the extent to which peers may disapprove of use given their own unwillingness to use a given substance. As can be seen in Figure 19, perceived peer disapproval among high school youth was lower for marijuana than for any other substance at most recent report. This finding, in conjunction with findings on perception of risk presented next, suggest the need to further inform middle and high school youth about the potential consequences of marijuana use, especially marijuana use at these ages.

Perception of risk data suggest that DFC coalitions may need to engage in additional activities to help youth understand the risk associated with use, especially the risk associated with marijuana

Perceived risk of tobacco use was generally high (80% to 82% across grade levels and samples). For middle school youth, recent data based on the FY 2016 sample suggest that perceived risk of tobacco use has *decreased* significantly although this was unchanged across all DFC since inception. Perceived risk of tobacco use increased significantly from first report to most recent report for high school youth across all DFC since inception but was unchanged for high school youth in the FY 2016 sample. Together these findings suggest there may be a renewed need to ensure that youth, beginning in middle school, understand risks associated with tobacco use.

Across grade levels and samples, most youth (80% to 83%) perceived risk associated with misuse of prescription drugs and this was unchanged from first to most recent report. Interestingly, high school youth were somewhat more likely than middle school youth to report perceiving risk associated with misuse of prescription drugs. Anecdotally, some DFC coalitions reported that high school youth participating in sports received education with regard to prescription drug misuse, while others had increased inclusion of this topic during health classes. These types of activities may be contributing to an understanding of the risks associated with prescription drug misuse in high school youth.

The findings for perception of risk of alcohol (binge use) suggest several needs. Slightly less than three-fourths (69-73%) of middle school and high school youth perceived risk associated with binge alcohol use, although this increased significantly in middle school youth in the all DFC since inception sample and for high school youth in both samples. That is, middle school youth and high school youth were very similar in their perceptions of risk of alcohol use, and perceived risk associated with alcohol use was lower than for either

tobacco or prescription drug misuse. One explanation for why more youth may not perceive risk may be that youth did not understand what binge drinking is and why it may be particularly harmful. That is, they may not understand that "five or more drinks at a single time" (core measure wording) is a high amount of alcohol consumption. DFC coalitions may want to engage in activities that explain specific risks associated with binge alcohol use to youth in both age groups. Given that alcohol is the most commonly used substance by both middle and high school youth, increased understanding of associated risks may also contribute to decreased use over time, or at least to decreased binge use. DFC national evaluation data do not separate binge alcohol use from taking a single sip of alcohol so it is unknown the extent to which youth are engaging in higher risk alcohol use behaviors. These efforts need to begin in middle school, because reported past 30-day prevalence of alcohol use increases from middle school to high school.

High school youth in both samples reported perceptions of risk of marijuana use that *decreased* significantly from first report to most recent report. Middle school youth in the most recent FY 2016 sample also reported a significant *decrease* in perceived risk of marijuana use, while this was unchanged for the all DFC coalition sample. That is, perceptions of risk of marijuana use among youth general changed in the wrong direction. In addition, while nearly three-fourths (71%) of middle school youth perceived risk in marijuana use at most recent report, by high school at most recent report only half (51-52%) perceived moderate or great risk associated with marijuana use. In fact, high school youth's perceived risk of marijuana use at most recent report was lower than for any other substance, including alcohol. This was also true for middle school youth, although the difference between perceived risk of marijuana and alcohol use was smaller. One reason for concern is that this decreased perception or risk may eventually be associated with increased past 30-day prevalence of use, although that has not yet occurred in DFC coalition communities. DFC coalitions may need to improve or increase efforts to develop appropriate materials and training strategies to help youth better understand risk associated with marijuana use in order to better inform youth.

DFC coalitions successfully mobilized communities to address substance use, including addressing opioids, in line with the goals of DFC. Evidence suggests that hosting a youth coalition is a promising practice for mobilizing and engaging youth.

The findings of this report provide valuable insights into the makeup of DFC coalitions and their effectiveness in mobilizing their communities. On average, FY 2016 DFC coalitions were led by 2 paid staff, with support from 3 unpaid staff members, in mobilizing 40 community members from across 12 sectors to actively engage in the work of the coalition. Collectively, an estimated 30,500 community members were mobilized in the 6 months preceding the reporting submission (August

2017). Youth and School sectors provided the highest median number (5 and 4, respectively) of active coalition members, followed by Law Enforcement, Healthcare, and Parent sectors providing 3 members each, on average. The School and Law Enforcement sectors were the two highest rated sectors on involvement (mean of 4.3).

An examination of DFC coalitions' engagement on addressing opioids provides further evidence that DFC is succeeding at mobilizing communities and building capacity to address substance use issues as they arise in the community. Almost all DFC coalitions (87%) were targeting efforts to some extent to address opioids, including heroin and prescription opioids. Much of this work was related to education around prescription opioids and providing prescription drug take-back events. Almost all DFC coalitions reported holding a prescription take-back event (95%) and nearly two-thirds (64%) of DFC coalitions implemented these events as a result of receiving their DFC grant award. That is, prescription drug take-back events were not occurring in many communities until the DFC coalition was implemented. DFC coalitions also are implementing or are active in task forces/subcommittees that focus on addressing opioids.

Approximately two-thirds (66%) of DFC coalitions reported hosting a youth coalition with the majority (76%) of these providing participating youth with the opportunity to lead on planning and implementing activities with support from the broader coalition. Collectively, analyses comparing DFC coalitions with a youth coalition, versus those without one, suggest that these youth coalitions are a promising practice for mobilizing and engaging youth with the community coalition. For example, DFC coalitions with a hosted youth coalition, versus those without one, were significantly more likely to perceive youth as very highly involved with the coalition and less likely to perceive youth as having only some or low involvement. The level of Youth sector involvement for DFC coalitions with a hosted youth coalition was similarly high to that for the School and Law Enforcement sectors.

DFC coalitions with a hosted youth coalition, versus those without one, also reported a significantly higher levels of involvement for the School and Law Enforcement sectors. In addition, DFC coalitions hosting a youth coalition were more likely than those DFC coalitions without one to have at least one member representing every sector (95% versus 88%), at least one active member in every sector (78% versus 69%), and at least one active member in the youth sector (97% versus 89%).

Finally, DFC coalitions hosting a separate youth coalition also were significantly more likely to have engaged in a number of activities. Most notably, DFC coalitions with a youth coalition, versus those without one, were significantly more likely to have implemented at least one alternative/drug-free social event (73% versus 54%), at least one youth training (88% versus 75%), at least one parent training (58% versus 42%), and at least one teacher training (44% versus 32%).

DFC coalitions engaged in a comprehensive range of strategies for developing local solutions to a range of local problems.

Activities engaged in by the DFC coalitions fall under each of the Seven Strategies for Community Change, with just under two-thirds (60%) of DFC coalitions implementing at least one activity within each of the seven strategies. Most (79%) DFC coalitions implemented at least one activity within at least five of the seven strategy types. Not surprisingly, a large number of activities were specifically engaged in with youth or were intended to have direct impacts on youth. These included trainings, alternative social events, and recreation programs. The most common policies/laws that DFC coalitions reported working to educate and inform the community about were associated with school policies. Collectively, these have resulted in high engagement of youth in DFC coalition activities and may have contributed to an increase in youth in DFC communities who do not report engaging in substance use within the past 30-days.

Limitations

In examining the findings, it is worth noting several limitations or challenges. First, while DFC coalitions' grant activities were designed and implemented to cause a reduction in youth substance use, it is not possible to establish a causal relationship because there is not an appropriate comparison or control group of communities from which the same data are available. Comparisons were made to national YRBS data, but only for past 30-day use and only for high school youth. There are not comparable national data for the remaining core measures or for middle school youth. In addition, this report includes analyses on core measures data provided for core measures that were introduced in 2012. Some core measures were unchanged in 2012 and data from 2002–2017 from a large number of DFC coalitions are available. The number of coalitions with change data on new core measures introduced in 2012 was typically much smaller (in many cases fewer than 300 DFC coalitions have change data for new measures). This was especially true for the core measures on misuse of prescription drugs. As additional data becomes available, it will become clearer whether the findings to date are representative of the broad range of DFC coalitions.

Another challenge is that each DFC coalition makes local decisions regarding how to collect core measure data, including the length of the survey used and the order in which survey items are written. However, all surveys are reviewed by the DFC National Evaluation Team for the core measures and core measures data may only be entered if the item has been approved on the survey. Small variations are allowed (e.g., coalitions may ask youth to report on how many days within the past 30-days they used a given substance [from 0-30] rather than just the yes/no DFC question on past 30-day use). 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 scores are calculated within each DFC coalition to generate the national average, this challenge is somewhat addressed.

While most report collecting data in schools, this is not always the case. 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 because these samples are harder to locate and may be less willing to complete surveys. Each DFC coalition's survey also varies in length and content. Youth responding to longer surveys or to surveys where core measures are later in the survey, for example, may respond differently than youth whose surveys are shorter or where core measures appear earlier in the survey. Finally, DFC coalitions are encouraged to collect representative data from their capture area; however, each coalition is ultimately responsible for their own sampling strategies. DFC coalitions indicate any concerns about the representativeness of samples when reporting the data.

Appendix A. Core Measure Items

The following is the recommended wording for each of the core measure items, in place since 2012. DFC coalitions submit surveys for review to ensure that 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 that the youth used the given substance. Any use is counted as "yes" and therefore the data are to be submitted.

TABLE A.1. Core Measure Items Recommended Wording (2012 to Present)

Past 30-Day Prevalence of Use	Yes	No
During the past 30 days did you drink one or more drinks of an alcoholic beverage?	❑	❑
During the past 30 days did you smoke part or all of a cigarette?	❑	❑
During the past 30 days have you used marijuana or hashish?	❑	❑
During the past 30 days have you used prescription drugs *not prescribed to you*?	❑	❑

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

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

Perception of Peer Disapproval

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

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

Appendix B. Comparison of Engagement in Activities by Youth Coalition Status

Table B.1. Activities Implemented by Significantly More DFC Coalitions With a Hosted Youth Coalition Versus Those Without One

Activity	% of DFC Coalitions With a Youth Coalition Reporting Activity	% of DFC Coalitions Without a Youth Coalition Reporting Activity	Chi-square, *p* value
Alternative Social Events: Drug-free parties, other alternative events supported by the coalition	73.3%	54.2%	$\chi^2(1) = 24.4, p < .0001$
Parent Education and Training: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.	58.4%	42.2%	$\chi^2(1) = 15.6, p < .0001$
Youth Education and Training: Sessions focusing on providing information and skills to youth	87.6%	75.1%	$\chi^2(1) = 16.6, p < .0001$
Reducing Home and Social Access: Adults and youth participating in activities designed to reduce access to alcohol and other substances (e.g., prescription drug take-back programs)	74.9%	62.2%	$\chi^2(1) = 11.6, p = .0001$
Teacher Training: Sessions on drug awareness and prevention strategies directed to teachers or youth workers	44.4%	32.4%	$\chi^2(1) = 8.8, p < .01$
Improved Signage/Advertising by Suppliers: Suppliers making changes in signage, advertising, or displays	31.3%	20.0%	$\chi^2(1) = 9.5, p < .01$
Social Networking: Posts on social media sites (e.g., Facebook, Twitter)	93.6%	83.1%	$\chi(1)^2 = 18.0, p < .0001$
Information on Coalition Website: New materials posted	52.6%	43.6%	$\chi^2(1) = 4.9, p < .05$
Recognition Programs: Businesses receiving recognition for compliance with local ordinances (e.g., pass compliance checks)	36.8%	27.6%	$\chi^2(1) = 5.7, p < .05$
Youth Recreation Programs: Recreational events (e.g., athletics, arts, outdoor activities) supported by coalitions	29.4%	20.4%	$\chi^2(1) = 6.2, p < .05$
Youth Organizations: Clubs and centers supported by coalitions	23.7%	15.1%	$\chi^2(1) = 6.6, p = .01$
Media Coverage: TV, radio, newspaper stories covering coalition activities	85.7%	77.8%	$\chi^2(1) = 6.7, p = .01$
School policy: Drug-free schools	30.3%	22.2%	$\chi(1)^2 = 4.9, p < .05$
Identifying Physical Design Problems: Physical design problems (e.g., hot spots, clean-up areas, outlet clusters) identified through environmental scans, neighborhood meetings, etc.	35.9%	28.0%	$\chi(1)^2 = 4.1, p < .05$

Activity	% of DFC Coalitions With a Youth Coalition Reporting Activity	% of DFC Coalitions Without a Youth Coalition Reporting Activity	Chi-square, *p* value
Encourage Designation of Alcohol-Free and Tobacco-Free Zones: Businesses targeted or that made changes	17.2%	10.7%	$\chi(1)^2 = 5.0, p < .05$
Media Campaigns: Television, radio, print, billboard, bus or other posters aired/placed	83.2%	76.0%	$\chi(1)^2 = 5.0, p < .05$
Treatment and Prevention: Sentencing alternatives to increase treatment or prevention	15.9%	9.8%	$\chi(1)^2 = 4.6, p < .05$
Information Dissemination: Brochures, flyers, posters, etc. distributed	95.6%	90.7%	$\chi(1)^2 = 6.4, p < .05$

Source: DFC August 2017 Progress Report

Table B.2. Activities with No Significant Difference in Implementation of Specific Activities by DFC Coalitions With a Hosted Youth Coalition Versus Those Without One

Activity	% of DFC Coalitions With a Youth Coalition Reporting Activity	% of DFC Coalitions Without a Youth Coalition Reporting Activity
Business Training: Sessions on server compliance, training on youth-marketed alcohol products, tobacco sales, etc.	40.9%	33.8%
Community Member Training: Sessions on drug awareness, cultural competence, etc. directed to community members, (e.g., law enforcement, landlords)	67.8%	61.8%
Improve Access through Culturally Sensitive Outreach: People targeted for culturally sensitive outreach (e.g., multilingual materials)	31.7%	25.8%
Informational Materials Produced: Brochures, flyers, posters, etc. produced	86.4%	81.3%
Direct Face-to-Face Information Sessions	90.6%	86.2%
Strengthening Enforcement (e.g., DUI checkpoints, shoulder tap, open container laws)	52.0%	46.7%
Supplier Promotion/Liability: Supplier advertising, promotions, or liability	13.1%	8.4%
Youth/Family Community Involvement: Community events held (e.g., neighborhood cleanup)	37.5%	33.8%
Cleanup and Beautification: Clean-up/beautification events held	21.4%	17.8%
Publicizing Non-Compliance: Businesses identified for non-compliance with local ordinances	14.9%	11.6%
Citizen Enabling/Liability: Parental liability or enabling	18.2%	16.0%
Improved Supports: People receiving supports for enhanced access to services (e.g., transportation, child care)	14.0%	13.3%
Workplace: Drug-free workplaces	11.0%	10.2%

Activity	% of DFC Coalitions With a Youth Coalition Reporting Activity	% of DFC Coalitions Without a Youth Coalition Reporting Activity
Youth/Family Support Groups: Leadership groups, mentoring programs, youth employment programs, etc. supported by coalitions	21.4%	19.6%
Sales Restrictions: Restrictions on product sales	17.5%	16.9%
Underage Use: Underage use, possession, or behavior under the influence	19.8%	20.4%
Increased Access to Substance Use Services: People referred to employee assistance programs, student assistance programs, treatment services	32.6%	32.9%
Special Events: Fairs, celebrations, etc.	83.0%	83.1%
Improved Ease of Surveillance: Areas (public places, hot spots) in which surveillance and visibility was improved (e.g., improved lighting, surveillance cameras, improved line of sight)	8.0%	8.9%
Strengthening Surveillance (e.g., "hot spots," party patrols)	29.9%	31.1%
Cost: Cost (e.g., alcohol taxes/fees, tobacco taxes)	7.6%	8.9%
Outlet Location/Density: Density of alcohol outlets	7.4%	8.9%
Identify Problem Establishments: Problem establishments identified (e.g., drug houses) and closed or modified practices	7.1%	7.6%

Source: DFC August 2017 Progress Report

Appendix C. DFC Coalitions Addressing the Opioid Epidemic

Table C.1. DFC Coalitions August 2017 Progress Report Data (FY 2016 coalitions) on Opioids Relative to August 2016 (FY 2015 Coalitions) Progress Report Data and Center for Disease Control's Drug Overdose Death Data from 2016

CDC Notes[a]	State	Number of Coalitions With FY 2016 Progress Report Data	Number of FY 2016 Coalitions That Mention Opioids in Open Text Response	% of Coalitions Mentioning Opioids in FY 2016	% of Coalitions Mentioning Opioids in FY 2015	Change in Percent of Coalitions Mentioning Opioids From FY 2015 to FY 2016
	ID	1	1	100.0%	N/A	N/A
	ND	1	1	100.0%	N/A	N/A
A,B,C	OH	22	15	68.2%	79.2%	-11.0%
C	NC	17	11	64.7%	53.3%	11.4%
A,B,C	NH	12	7	58.3%	40.0%	18.3%
B,C	ME	18	10	55.6%	55.6%	0.0%
B,C	MA	27	14	51.9%	48.4%	3.5%
B	VT	4	2	50.0%	25.0%	25.0%
	AK	2	1	50.0%	50.0%	0.0%
	MT	4	2	50.0%	0.0%	50.0%
	GA	16	8	50.0%	21.4%	28.6%
B,C	CT	23	11	47.8%	61.9%	-14.1%
C	NY	50	22	44.0%	51.1%	-7.1%
B	NM	7	3	42.9%	28.6%	14.3%
B,C	MI	21	9	42.9%	32.0%	10.9%
B,C	NJ	28	11	39.3%	41.7%	-2.4%
B,C	FL	28	11	39.3%	28.6%	10.7%
A,B,C	PA	16	6	37.5%	26.3%	11.2%
B,C	TN	14	5	35.7%	14.3%	21.4%
	TX	14	5	35.7%	20.0%	15.7%
A,B,C	KY	21	7	33.3%	30.0%	3.3%
B,C	RI	9	3	33.3%	57.1%	-23.8%
B	UT	3	1	33.3%	0.0%	33.3%
	AL	6	2	33.3%	20.0%	13.3%
	WI	21	7	33.3%	33.3%	0.0%

[a] N/A indicates Not Applicable; CDC Notes:

A= State in CDC Top 5 opioid overdose deaths in 2016 **(dark orange cells).** Note that the District of Columbia would be in the Top 5 if it were a State.

B=State in CDC highest category of opioid overdose deaths in 2016 (age adjusted rates of 21.1–52.0 deaths per 100,000 population). Note that all States in the Top 5 are also in the highest category **(light orang cells, if B but not A)**

C=State with statistically significant increase in opioid deaths from 2014 to 2015 **(yellow cell if only C)**

Appendix C. Table C.1 (continued)

CDC Notes[a]	State	Number of Coalitions With FY 2016 Progress Report Data	Number of FY 2016 Coalitions That Mention Opioids in Open Text Response	% of Coalitions Mentioning Opioids in FY 2016	% of Coalitions Mentioning Opioids in FY 2015	Change in Percent of Coalitions Mentioning Opioids From FY 2015 to FY 2016
	MS	3	1	33.3%	50.0%	-16.7%
B,C	MD	6	2	33.3%	28.6%	4.7%
B	MO	12	4	33.3%	22.2%	11.1%
C	SC	10	3	30.0%	25.0%	5.0%
C	IL	24	7	29.2%	16.0%	13.2%
B,C	IN	14	4	28.6%	42.9%	-14.3%
	CA	39	11	28.2%	17.1%	11.1%
B,C	OK	11	3	27.3%	15.4%	11.9%
	IA	11	3	27.3%	9.1%	18.2%
C	MN	28	7	25.0%	11.1%	13.9%
	KS	4	1	25.0%	0.0%	25.0%
B,C	LA	8	2	25.0%	0.0%	25.0%
A,B,C	WV	9	2	22.2%	25.0%	-2.8%
	WA	27	6	22.2%	3.8%	18.4%
C	VA	9	2	22.2%	14.3%	7.9%
	AZ	14	3	21.4%	6.7%	14.7%
	CO	6	1	16.7%	50.0%	-33.3%
	AR	6	1	16.7%	0.0%	16.7%
	NE	6	1	16.7%	0.0%	16.7%
B,C	DE	1	0	0.0%	0.0%	0.0%
B	NV	1	0	0.0%	0.0%	0.0%
B,C	DC	3	0	0.0%	0.0%	0.0%
	WY	2	0	0.0%	0.0%	0.0%
	OR	13	0	0.0%	16.7%	-16.7%
	HI	1	0	0.0%	0.0%	0.0%
	SD	2	0	0.0%	0.0%	0.0%

Sources: August 2016 DFC Progress Report, CDC data https://www.cdc.gov/drugoverdose/data/statedeaths.html. CDC data does not include US territories but does include the District of Columbia.

[a] N/A indicates Not Applicable; CDC Notes:

A= State in CDC Top 5 opioid overdose deaths in 2016 **(dark orange cells).** Note that the District of Columbia would be in the Top 5 if it were a State.

B=State in CDC highest category of opioid overdose deaths in 2016 (age adjusted rates of 21.1–52.0 deaths per 100,000 population). Note that all States in the Top 5 are also in the highest category **(light orang cells, if B but not A)**

C=State with statistically significant increase in opioid deaths from 2014 to 2015 **(yellow cell if only C)**

Appendix D. Core Measures Data Tables

Table D.1. Long-Term Change in Past 30-Day Prevalence of Use[a]

School Level and Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception				Long-Term Change: First Observation to Most Recent FY 2016 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	1161	12.5	9.1	-3.4*	411	10.2	6.7	-3.5*
Tobacco	1153	6.3	4.2	-2.1*	404	4.7	2.9	-1.8*
Marijuana	1146	5.0	4.2	-0.8*	406	4.2	3.6	-0.6*
Prescription Drugs	361	2.8	2.5	-0.3*	283	2.7	2.5	-0.2
High School								
Alcohol	1229	35.8	29.0	-6.8*	442	32.4	24.6	-7.9*
Tobacco	1215	17.9	12.8	-5.1*	432	14.9	9.1	-5.8*
Marijuana	1212	18.1	16.9	-1.2*	437	17.5	16.0	-1.5*
Prescription Drugs	408	6.3	5.2	-1.1*	323	6.3	5.2	-1.1*

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.

Source: Progress Report, 2002-2016 core measures data

TableD.2 provides the same data as in Table D.1, but data are calculated as prevalence of non-use of substances in the prior 30-days. These are calculated as 100 percent minus the prevalence of past-30-day use (Table D.1).

Table D.2. Long-Term Change in Past 30-Day Prevalence of Non-Use[a]

School Level and Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2016 DFC Grant Award Recipients n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change
Middle School								
Alcohol	1161	87.5	90.9	3.4*	411	89.8	93.3	3.5*
Tobacco	1153	93.7	95.8	2.1*	404	95.3	97.1	1.8*
Marijuana	1146	95.0	95.8	0.8*	406	95.8	96.4	0.6*
Prescription Drugs	361	97.2	97.5	0.3*	283	97.3	97.5	0.2
High School								
Alcohol	1229	64.2	71.0	6.8*	442	67.6	75.5	7.9*
Tobacco	1215	82.1	87.2	5.1*	432	85.1	90.9	5.8*
Marijuana	1212	81.9	83.1	1.2*	437	82.5	84.0	1.5*
Prescription Drugs	408	93.7	94.8	1.1*	323	93.7	94.8	1.1*

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.

Source: Progress Report, 2002–2016 core measures data

Table D.3. Long-Term Change in Perception of Risk/Harm of Use[a]

School Level and Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2016 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	379	69.5	72.7	3.2*	276	71.0	72.2	1.2
Tobacco	1068	80.4	81.2	0.8	371	79.9	78.6	-1.3*
Marijuana	349	71.2	70.6	-0.6	268	71.8	70.5	-1.3*
Prescription Drugs	295	80.3	80.8	0.5	246	81.0	80.9	-0.1
High School								
Alcohol	411	70.8	72.8	2.0*	308	70.7	72.2	1.5*
Tobacco	1122	80.8	82.4	1.6*	394	81.9	81.7	-0.2
Marijuana	377	55.2	52.3	-2.9*	298	54.3	51.3	-3.0*
Prescription Drugs	330	82.6	82.5	-0.1	278	82.9	82.6	-0.4

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 1 or more packs of cigarettes per day

[d] Perception of risk of smoking marijuana 1-2 times per week

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

Source: Progress Report, 2002-2016 core measures data

Table D.4. Long-Term Change in Perception of Parental Disapproval[a]

School Level and Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2016 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	291	93.7	94.4	0.7*	237	93.9	94.6	0.6
Tobacco	1010	91.4	93.9	2.5*	356	93.8	95.6	1.8*
Marijuana	1028	92.5	94.0	1.5*	360	94.5	94.7	0.2
Prescription Drugs	288	95.5	95.0	-0.5	238	95.6	95.2	-0.4
High School								
Alcohol	323	87.2	89.4	2.2*	267	87.2	89.5	2.2*
Tobacco	1068	85.0	88.1	3.1*	382	88.4	91.6	3.3*
Marijuana	1077	86.3	86.6	0.3	386	87.6	86.8	-0.8*
Prescription Drugs	324	93.3	93.4	0.1	271	93.3	93.6	0.3

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 you

Source: Progress Report, 2002-2016 core measures data

Table D.5. Long-Term Change in Perception of Peer Disapproval[a]

School Level and Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2016 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	279	85.2	86.9	1.7*	234	86.2	87.3	1.1*
Tobacco	290	87.1	88.6	1.5*	236	88.7	89.4	0.8
Marijuana	300	86.0	86.5	0.5	243	87.4	87.2	-0.2
Prescription Drugs	272	90.2	90.5	0.3	226	90.9	90.6	-0.2
High School								
Alcohol	318	62.8	68.4	5.6*	267	63.5	68.8	5.3*
Tobacco	320	67.8	73.4	5.6*	261	68.9	74.4	5.5*
Marijuana	330	55.4	57.0	1.6*	272	56.3	57.5	1.2
Prescription Drugs	305	78.9	81.9	3.0*	256	79.5	82.2	2.6*

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.

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

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

Source: Progress Report, 2002-2016 core measures data