DRUG-FREE COMMUNITIES (DFC) SUPPORT PROGRAM

END-OF-YEAR 2024 REPORT
NATIONAL CROSS-SITE EVALUATION

PUBLISHED JUNE 2025

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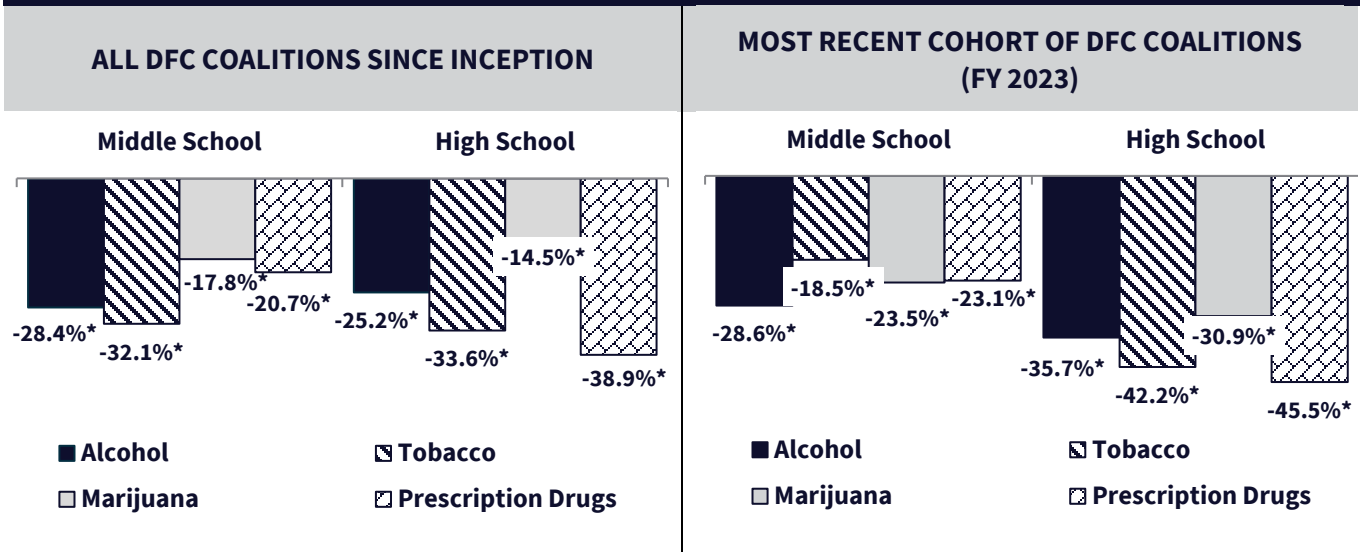
Executive Summary

Administered by the Office of National Drug Control Policy (ONDCP), the Drug-Free Communities (DFC) Support Program grant funds community coalitions to build the capacity needed to prevent and reduce youth substance use. The contributions of DFC coalitions constitute a critical part of the Nation's drug prevention infrastructure, as they are a catalyst for building capacity to implement local solutions to effect change. This summary of findings is based on national evaluation data regarding implementation from August 2023 to July 2024 and core measures data from 2002 to 2024. Additional details about the program and findings are presented in full in the report.

- **DFC coalitions met the goal of significantly preventing and reducing youth substance use in their community(ies).[1] This was true for the DFC program collectively (all coalitions ever funded) and for the most recent DFC cohort (awarded in Fiscal Year [FY] 2023).**

Figure ES1. Percentage Change in Past 30-Day Prevalence of Substance Use

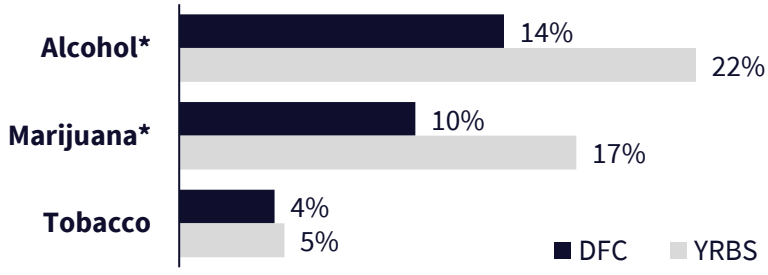


Source: DFC 2002–2024 core measures data. Only coalitions who have at least two core measures reports included with change evaluated based on the difference between first report and most recent report for each coalition.

Note: * indicates $p < .05$

- Nationally, high school youth in DFC communities reported significantly lower past 30-day use of both alcohol and marijuana as compared to national Youth Risk Behavior Survey (YRBS) rates.[1]

Figure ES2. Past 30-Day Use among High School Youth in 2023: Comparison between DFC and National YRBS Samples



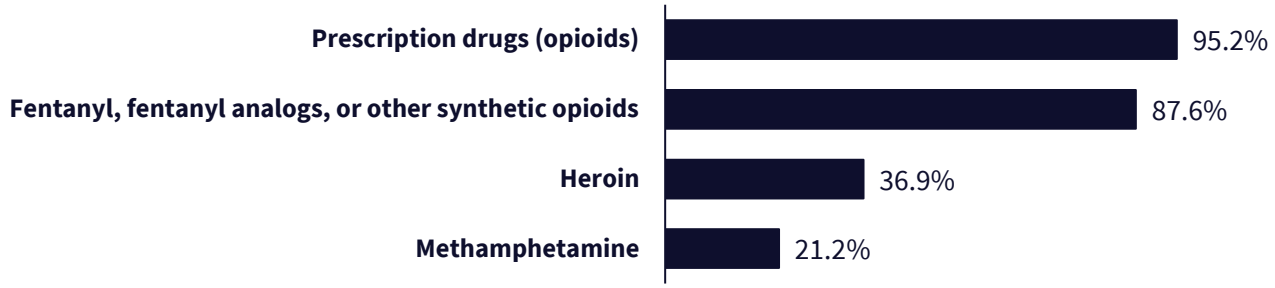
[1] CDC 2023 Youth Risk Behavior Survey Data (YRBS) downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm. Comparisons are between YRBS and DFC data examining confidence intervals for overlap between the two samples; * indicates $p < .05$ (significant difference); numbers are percentages of youth reporting past 30-day substance use.

- **Nearly 1 in 5 Americans (19%; ~64 million people) lived in a community with a DFC coalition in 2024, including approximately 2 million middle school aged youth and approximately 3 million high school aged youth. DFC's are found in all types of geographic settings**
    - Over half of Americans (56%; ~188 million people) have lived in a community with a DFC coalition since 2005.

Figure ES3. Percentage of DFC Coalitions Working in Each Type of Geographic Setting in 2024 (Selected all that Applied)

- **DFC coalitions focused prevention efforts on a range of substances, including core measure substances (alcohol [95%], marijuana [91%], tobacco/nicotine [80%], and/or prescription drug misuse [70%]).[2] DFC coalitions also reported that they implemented activities to address opioid and/or methamphetamine use (76%) and to address vaping (83%).**

Figure ES4. Substance Focus among DFC Coalitions working to Address Opioids and/or Methamphetamine



    - Activities to address opioids including fentanyl included informational resources on fentanyl and counterfeit medications, collecting/mapping overdose data to identify areas to focus prevention efforts, and supporting fentanyl family summit events.
    - Among coalitions who implemented activities to address vaping, 98% were focused on vaping nicotine/tobacco and 91% focused on vaping marijuana.
- **DFC coalitions were meeting the program goal of building community capacity to prevent and reduce youth substance use, successfully mobilizing approximately 41,000 community members to actively engage in evidence-based youth substance use prevention/reduction efforts.**
    - In total, DFC coalitions reported mobilizing approximately 9,000 youth to actively engage in substance use prevention efforts.
    - Most coalitions (93%) reported having at least one member from each of twelve sectors, although fewer reported active members from all sectors (76%). The Youth and School sectors contributed the

[2] Coalitions selected up to five substances focused on from a list of substances.

highest median number of sector members to coalitions (8 and 5, respectively). The School sector was selected most often as the sector leading the coalition (18%).

- Almost all coalitions (99%) reported working with at least one school, with most (88%) working with multiple schools either in a single or multiple districts. Just under 1 in 5 (18%) DFC coalitions were being led by the school sector.

- **Over two-thirds of DFC coalitions (69%) reported hosting a youth coalition, an effective strategy for increasing youth sector engagement.**
  - Hosting a youth coalition was linked to rating youth engagement as significantly higher.
  - Just over half (57%) of DFC coalitions who hosted a youth coalition included youth members at coalition/leadership meetings, with 46% reporting youth coalition representatives being involved in coalition decision making.
  - Hosting a youth coalition appears to be one way coalitions support youth in being better connected to their families, schools, and communities—connections that are correlated with lower likelihood of substance use engagement.[3]

Figure ES5. Percentage of DFC Coalitions Working to Strengthen Youth Positive Connections

- **Addressing risk factors and enhancing protective factors present in their communities was a guiding focus for the work of DFC coalitions.**
  - DFC coalitions perceived community norms favorable toward substance use as the risk factor present to the greatest extent in their communities while access to safe, high-quality schools was the protective factor present to the greatest extent.
  - DFC coalitions were highly focused on addressing favorable attitudes toward substance use and on enhancing perceptions that peers would disapprove of such use. As reported in the core measures, these efforts in DFC communities appear to have been effective among high school youth demonstrated by an increase in perceived peer disapproval across substances. Coalitions (71%) implemented social norms campaign as part of these efforts.
- **DFC coalitions worked to bring about change by implementing a comprehensive mix of strategies, with more than three-fourths (79%) implementing at least one activity in at least five of the seven strategy types, including about one-third of coalitions (33%) implementing at least one activity in each of the seven strategy types.**
  - *Providing Information* remains the most common strategy with virtually all coalitions (99%) conducting at least one activity of this strategy type. *Changing Access/Barriers* was the most engaged in environmental strategy, with 85% of coalitions implementing at least one activity of this type (e.g., reducing home and social access; improved access to overdose prevention materials).

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

DFC Program

Created through the Drug-Free Communities (DFC) Act of 1997, the DFC Support Program funds community coalitions to prevent and reduce youth substance use emphasizing local solutions for local problems. DFC is funded and directed by the Office of National Drug Control Policy (ONDCP). The DFC National Cross-Site Evaluation Team prepared this report to provide findings related to DFC coalitions' progress on meeting the two key grant program goals:[4]

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

DFC Program Partners and Funding

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

- **Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC)** provides grant management services and government project officer support and monitoring.
- **National Coalition Academy (NCA),** a grant funded by ONDCP, provided training and technical assistance to strengthen the capacity of DFC coalitions. Through August 2024, **CADCA**, a nonprofit organization, provided the NCA.[5]
- **DFC National Cross-Site Evaluation Team** conducts the national evaluation and provides related technical assistance (e.g., data collection and reporting) to DFC coalitions. In addition to high level annual reports such as this, additional evaluation information is shared in issue briefs on specific topics.

DFC grant award recipients receive up to $125,000 annually for up to 5 years per award, with a maximum of 10 years of grant award funding per grant recipient.[6] Since 1998, DFC grants have been awarded to community-based coalitions that represent all 50 States and several Territories and Tribal communities. Each year, some grants end while new grants are awarded. This report primarily focuses on the efforts and outcomes associated with the 745 community coalitions awarded DFC grants in Fiscal Year (FY) 2023[7]. Of these, 382 (51%) were funded through an initial 5-year grant; the

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

[5] CADCA is the name of the organization, not an acronym.

[6] DFC coalitions must demonstrate they have matching funds from non-Federal sources. In Years 1 through 6, a 100% match is required. In Years 7 and 8, this increases to a 125% match; in Years 9 and 10 it increases to a 150% match. For further information see the most current notice of funding opportunity here: https://www.cdc.gov/overdose-prevention/php/drug-free-communities/nofo-faq.html. For information on the FY 2022 awards please see CDC-RFA-CE22-2205 and CDC-RFA-CE20-2004-CC22 at https://www.grants.gov/.

[7] Initially, 750 grants were awarded in FY 2023, however five of those grants were either returned or suspended.

remaining 363 (49%) were in Years 6 to 10 of funding. As of 2023, nearly 3,500 DFC grants have been awarded in nearly 2,300 communities.[8]

Background

National data consistently suggests that middle school and high school youth (ages 12-18), the focus of DFC prevention efforts, are at risk for both initiating substance use, engaging in regular substance use and, in some cases, developing substance use disorders. For example, findings from the 2023 Youth Risk Behavior Survey (YRBS) suggest that among high school youth, 22% reported current (past 30-day) alcohol use, 17% current marijuana use, 4% current prescription opioid misuse, and 10% reported ever using illicit drugs.[9] The 2022 National Survey on Drug Use and Health (NSDUH) reported that among youth aged 12-17, 7.3% reported any past month (30-day) illicit drug use, including 6.4% who reported past-month marijuana use.[10] The 2024 Monitoring the Future (MTF) study found that 42% of 12th graders, 26% of 10th graders, and 13% of 8th graders consumed alcohol in the past year (12-month period). Youth in 12th, 10th, and 8th grade also reported on any past year illicit drug use (26%, 17%, and 9% respectively) and past year marijuana use (26%, 16%, and 7% respectively). The MTF study shows encouraging trends in which use of almost all measured substances among youth declined or held steady.[11] However, substance use still poses significant concerns for youth and adults.

Across national surveys, including DFC data, alcohol is the most commonly used substance among youth. Although youth use of alcohol is generally trending downward, it remains a leading cause of preventable death in the United States.[12] A recent study estimated that the average annual number of deaths from excessive alcohol use in the United States increased by 29% from 2016-2017 to 2020-2021 (137,927 deaths versus 178,307 deaths respectively).[13] From 2015-2019, an estimated 1 in 5 deaths among adults aged 20 to 49 years in the United States were attributed to excessive alcohol use.[14] Given the rise in deaths found during 2020-2021, which includes adults in the age group of 20 to 49 years, excessive alcohol use may have contributed to an even greater share of total deaths during this 2-year timeframe. Excessive drinking contributes to about 4,000 deaths among people below the

[8] Based on available data through FY 2023, 2,284 communities have received DFC grant awards, with 1,099 communities receiving a Year 1 to Year 5 award and 1,185 communities receiving an additional Year 6 to Year 10 award. Combined, these total 3,469 DFC grant awards. This is a conservative estimate of awards through FY 2023 as much award data pre-2009 were not available.

[9] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023.* U.S. Department of Health and Human Services; 2024.

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

[11] Miech, R. A., Johnston, L. D., Patrick, M. E., O'Malley, P. M. (2024). Monitoring the Future national survey results on drug use, 1975–2024: Overview and detailed results for secondary school students (PDF). Monitoring the Future Monograph Series. Ann Arbor, MI: Institute for Social Research, University of Michigan.

[12] Centers for Disease Control and Prevention. About Underage Drinking.. Accessed January 30, 2025https://www.cdc.gov/alcohol/underage-drinking/index.html

[13] Esser MB, Sherk A, Liu Y, Naimi TS. Deaths from Excessive Alcohol Use — United States, 2016–2021. MMWR Morb Mortal Wkly Rep 2024;73:154–161. DOI: http://dx.doi.org/10.15585/mmwr.mm7308a1

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

age of 21 in the U.S. each year. Youth alcohol use is linked to alcohol dependence later in life, death from alcohol poisoning, unintentional injuries, such as car crashes, falls, burns, and drownings. Prevention may reduce premature death and other consequences related to alcohol use.[15]

DFC Program Model

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

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

A central focus for DFC coalitions is to understand what factors in the community may be contributing to youth substance use. That is, substance use is seen as being associated with a range of potential risk and protective factors (or social determinants), which are conditions in each of the places where youth/people live, learn, work and play.[16] Coalitions may be able to implement activities by addressing risk factors and/or by enhancing protective factors, which contributes to the increased likelihood of youth making positive choices (in this case not to engage in substance use). Risk factors include adverse childhood experiences (ACEs).[17] Experiencing ACEs, particularly two or more, has

[15] Centers for Disease Control and Prevention. About Underage Drinking. Accessed January 30, 2025. https://www.cdc.gov/alcohol/underage-drinking/index.html

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

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

been associated with a range of negative outcomes including an increased risk of substance use problems, both during adolescence and into adulthood. Conversely, exposure to a range of protective factors (positive childhood experiences) may contribute to youth avoiding substance use and other negative outcomes. Some DFC coalitions work to address ACEs by engaging in activities intended to increase the likelihood that youth experience protective factors, including helping connect youth with their family, school, and/or community. Research consistently suggests that youth who feel positively connected to their families, schools and communities are far less likely to engage in a range of risky behavior, including substance use, than those who are not.[18] Recent findings (YRBS, 2023) suggest that just over half (55%) of high school students agreed or strongly agreed they felt close to individuals at their school.[19] DFC coalitions may bring about community change by creating increased opportunities for youth to be positively connected to their families, schools, peers, and communities.

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

Data

DFC coalitions receive guidance from the national evaluation team throughout the year regarding data collection and submission of required reporting: progress reports, core measures, and the coalition classification tool (CCT). Beginning in 2023, DFC coalitions moved to a single annual progress report (as compared to every six months previously). To support accurate reporting of grant implementation, coalitions receive regular guidance and ongoing support, including free tracking systems.[20] This report includes all core measures data submitted through August 2024, as well as detailed analysis of coalition efforts reflected in the coalitions' submission of their August 2024 progress report and the CCT.[21]

Progress Report

DFC coalitions collect and submit a broad range of data through annual progress reports including information about the community context, building capacity, and implementation of substance use prevention activities. The progress reports support grant monitoring as well as the national evaluation. Throughout the progress report, DFC coalitions answer specific questions but also report

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

[19] Ibid

[20] Additional information about the progress report can be requested from ICF at dfc_evaluators@icf.com. Free supports include the online reporting system, a data entry tool and word versions of the progress report.

[21] All coalitions (745 FY 2023) required to submit progress reports did so.

qualitatively about their work, successes, and challenges during the reporting period in open-text response fields.[22]

- *Coalition Structure & Process* includes information regarding the potential reach of the program (associated with ZIP codes served), community context (e.g., geographic setting, school setting, HIDTA collaboration), and focus of coalition efforts (e.g., substances focused on).
- *Building Capacity* includes data on the number of members (total and active), level of member involvement by sectors, and changes in sector involvement. Coalitions also report on hosting (or not) a youth coalition and their capacity building activities. The 12 required community sectors[23] are:
    - Youth (age 18 or younger), Parent, School, Law Enforcement, Healthcare Professional or Organization (e.g., primary care, hospitals), Business, Media, Youth-Serving Organization, Religious/Fraternal Organization, Civic/Volunteer Group (e.g., a member from a local organization committed to volunteering), State, Local, or Tribal Governmental Agency with expertise in the field of substance use, and Other Organization involved in reducing substance use.
- The *Risk & Protective Factors* measure was introduced in 2023 and includes 33 risk factors and 32 protective factors across four broad categories: community factors, school, faith, and peer factors, family/parent/caregiver factors, and individual factors (see Appendix A). Generally, each risk factor is matched to a corresponding protective factor (e.g., low school connectedness risk and high school connectedness protective).[24] For each factor, coalitions were asked to indicate the extent to which the factor is an issue in their community and to indicate yes/no if they are working to address/enhance the factor.
- *Strategy Implementation* includes details and descriptions of activities implemented during the reporting period. For each completed activity type within a given strategy, DFC coalitions provide information (e.g., number of completed activities, number of youths/adults participating). Activities are grouped into the Seven Strategies for Community Change, which are divided into individual-focused strategies and environmental-focused strategies.[25] DFC recipients are encouraged to prioritize implementing environmental strategies as they are most effective for long-term, community-level

[22] Throughout this report, when incorporating qualitative anecdotes with findings, DFC coalitions will be identified by their FY 2023 funding year (1–10) and by the U.S. census region where they are located (see Census Regions and Divisions of the United States).

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

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

[25] CADCA derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see https://www.cadca.org/wp-content/uploads/2023/08/implementationcompressed.pdf. DFC grant funds may not necessarily fund all the indicated examples provided for each of the Seven Strategies for Community Change. For the most recent description of DFC grant funding limitations, see Apply for DFC Funding | Overdose Prevention | CDC.

change (e.g., efforts that result in a policy change such as drug-free school zones potentially impacts both current and future cohorts of youth).

Coalition Classification Tool

In the CCT, coalitions identify prevention assets that have been put into place in the community as a result of DFC funding. That is, these are assets that some communities might not otherwise have available if DFC funding had not been provided to the community.

Core Measures Data

DFC coalitions are required to collect and submit new youth core measures data at least every two years from at least three grades.[26] Briefly, the core measures are defined as follows (see Appendix B for specific wording for each of the core measure items):

Past 30-Day Prevelance of Use

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

Perception of Risk

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

Perception of Parent Disapproval

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

Perception of Peer Disapproval

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

Data associated with each core measure are summarized by substance and time of report (first versus most recent report), allowing for the calculation of change in response patterns over time. Coalitions are encouraged to provide first report data that were collected within three years prior of grant receipt as a baseline but are not required to submit data until Year 2 of their award. In addition, these data are reported by school level (i.e., middle school grades 6 through 8; high school grades 9 through 12). Finally, given that core measures are a key outcome of the program, analyses are conducted for two samples: all DFC coalitions since inception and the FY 2023 cohort only.

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

Community Context

Key Findings

In 2024, one in five (19%) Americans lived in a community with a DFC-funded coalition, with prevention efforts tailored to a wide range of geographic settings and demographics.

Just over half of coalitions (57%) worked in rural and/or frontier communities, just under half (43%) worked in suburban communities, and just over one-fourth (27%) worked in urban and/or inner-city communities.

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

The following sections summarize DFC coalitions' responses to questions pertaining to the communities with whom they work on prevention including the potential reach of the DFC geographic settings, substance focus and focus on addressing/enhancing risk and protective factors that may contribute to youth substance use.

DFC Reach

In 2024, there were DFC coalitions in each of the 50 states, as well as in the District of Columbia and three United States territories (Guam, Puerto Rico, and Virgin Islands). Given the number and broad geographic distribution of DFC coalitions, many Americans potentially benefit from the program as they live in communities served by grant recipients. An estimated 63 million people (19% of the U.S. population) lived in communities served by DFC coalitions receiving funding in 2024.[27] This included approximately 2 million middle school youth ages 12 to 14 (19% of all middle school youth) and about 2 million high school youth ages 15 to 18 (19% of all high school youth). Since 2005, approximately 188 million people, or 56% of the U.S. population, have lived in a community with a DFC coalition.

Geographic Setting

Based on selecting all that apply, DFC coalitions reported serving on average between one and two of the five geographic settings (frontier, rural, suburban, urban, and inner city). Just over half of coalitions (57%) served rural and/or frontier communities, with most selecting rural (56%) as

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

compared to selecting frontier communities (4%). Just under half (43%) were working in suburban communities. Approximately one-fourth (27%) served urban and/or inner-city communities including one-fourth (24%) working in urban communities and just under one-tenth (9%) serving inner city communities.[28]

Substance Focus

DFC coalitions were asked to select up to five (of sixteen) substances on which their coalition focuses prevention efforts in their community (see Table 1). On average, DFC coalitions reported focusing on 4.2 substances. Nearly all coalitions reported addressing alcohol (95%) and marijuana (91%). Coalitions also reported addressing tobacco/nicotine (80%) and nearly three-fourths focused on any prescription drugs (70%).[29] The next most common substance focused on was heroin, fentanyl, fentanyl analogs or other synthetic opioids (36%).

Table 1: Percentage of DFC Coalitions Focused on a Given Substance

SUBSTANCE	PERCENT
Alcohol	95.2%
Marijuana	91.0%
Tobacco/Nicotine	80.4%
Any Prescription Drugs	70.1%
Prescription Drugs (Opioids)	67.2%
Heroin, Fentanyl, Fentanyl Analogs or Other Synthetic Opioids	36.1%
Prescription Drugs (Non-Opioids)	25.8%
Synthetic Drugs/Emerging Drugs	9.3%
Over-the-Counter (OTC) Drugs	6.6%
Methamphetamine	5.4%
Inhalants	1.5%
Stimulants (Uppers)	1.2%

Source: DFC August 2024 Progress Report

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

Community Protective and Risk Factors

Protective factors are the characteristics of individuals, families, or community that *decrease the likelihood* of substance use and its associated harms while risk factors are the characteristics that may *increase the likelihood* of substance use and its associated harms or may increase the difficulty of mitigating these dangers. The risk and protective factors measure includes a broad range of these factors (see Appendix A) to better understand both the extent to which factors are present in a community and to identify those factors coalitions are focused on engaging in addressing/enhancing within their communities. The responses provide insights into areas DFC coalitions identify as

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

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

requiring more focused intervention and highlight the strengths that can be used to facilitate a healthier and more supportive environment for all community members.

The questions are divided into four main categories: 1. Community Factors, 2. School, Faith, and Peer Factors, 3. Family/Parent/Caregiver Factors, and 4. Individual Factors. For each category, coalitions indicate the extent of each risk and protective factor in the community and if they are engaged in efforts to address or strengthen each factor.[30]

Table 2 identifies those risk and protective factors that were identified as being an issue in DFC communities to the greatest and least extent (see Table A.1, Appendix A for data for all factors). Note that for risk factors, being present to a low extent indicates the factor is less likely to need to be addressed. Conversely, when protective factors are present to a low extent, coalitions are less able to build on the factor as already present in the community.

Table 2. Risk and Protective Factors Identified as Present to the Greatest and Least Extent in DFC Communities

Highest Rated Risk Factors (≥1.2)	Mean	Highest Rated Protective Factors (≥1.1)	Mean
Perceived community norms favorable toward substance use	1.5	High/Broad access to safe, high-quality schools across the lifespan	1.2
High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	1.3	High commitment to staying in school and attending school	1.2
Easy availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing	1.3	High rates of youth academic success	1.2
Families/parents/caregivers lack ability/confidence to speak to their children about substance use	1.3	Broad access to a range of faith-based services in the community	1.2
Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use	1.2	Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors	1.1
Lack of local treatment services for substance use and/or poor access to mental health services generally in the community	1.2	Youth value education and work and engages in habits to succeed in these settings.	1.1
Family trauma/stress (e.g., parental/sibling substance use, domestic violence, death of family member)	1.2		
Individual youth have favorable attitudes towards substance use/misuse	1.2		
Available treatment/recovery services for substance use insufficient to meet needs in timely manner	1.2		
Youth have easy access to peers who engage in negative, unhealthy, or delinquent behavior	1.2		

[30] The extent to which each factor was perceived as a risk or protective element in the community was coded as 0: No/Low, 1:Moderate Extent, or 2:High Extent (higher means indicate perception as present to a greater extent. Engagement was coded as 1: Yes or 0: No.

Table 2. Continued

Risk Factors Present to Lowest Extent (≤0.6)	Mean	Protective Factors Present to Lowest Extent (≤0.7)	Mean
Youth has little/no interest in education and work and has poor school and work habits that may contribute to failure.	0.6	Few youth who have experienced two or more risk factors/stressors	0.7
Youth experience death of peer/classmate/close friend	0.5	Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use	0.7
Low access to safe, high-quality schools across the lifespan	0.4	Perceived Community norms promote non-use/misuse of substances	0.7
Poor access to a range of faith-based services in the community	0.4	Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing	0.6
		Sufficient access to mental health and treatment/recovery services in the community	0.6
		Treatment/recovery services for substance use are sufficient to meet demand in a timely manner	0.6

Source: DFC August 2024 Progress Report

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

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

Table 3 provides an overview of the risk and protective factors coalitions were engaged in addressing/enhancing to the greatest extent (see Table A.2, Appendix A for data on all factors). DFC coalitions were highly focused on addressing favorable attitudes toward substance use and on enhancing perceptions that community norms were present that promote non-use/misuse of substances. A sign that these efforts were working was significant increases among high school youth over time in perceiving peer disapproval of substance use (see Core Measures section and Table E.5).

Table 3. Risk and Protective Factors that Ninety Percent or More (≥90%) of DFC Coalitions were Engaged in Addressing/Enhancing

Highest Rated Risk Factors	%	Highest Rated Protective Factors	%
Perceived Community norms favorable toward substance use	96.9%	Perceived Community norms promote non-use/misuse of substances	96.2%
Individual youth have favorable attitudes towards substance use/misuse	96.9%	Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use	96.0%
High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	96.0%	Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	95.7%
Families/parents/caregivers lack ability/confidence to speak to their children about substance use	94.4%	High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations	95.0%
Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use	94.0%	Families/Parents/Caregivers encourage youth to engage in healthy behaviors including avoiding substance use	94.0%
Early initiation of negative or unhealthy behavior, including substance use	91.7%	Youth seek out and engages in available positive, healthy, or prosocial behaviors	93.2%
Low rates of youth connection to the community; little sense that youth have a voice in the community/active in community organizations	90.9%	Youth have good life skills such as good decision-making and problem-solving skills	92.1%
		Delayed or no initiation of negative or unhealthy behavior, including substance use	92.1%
		Prevention, Advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community	90.7%

Source: DFC August 2024 Progress Report

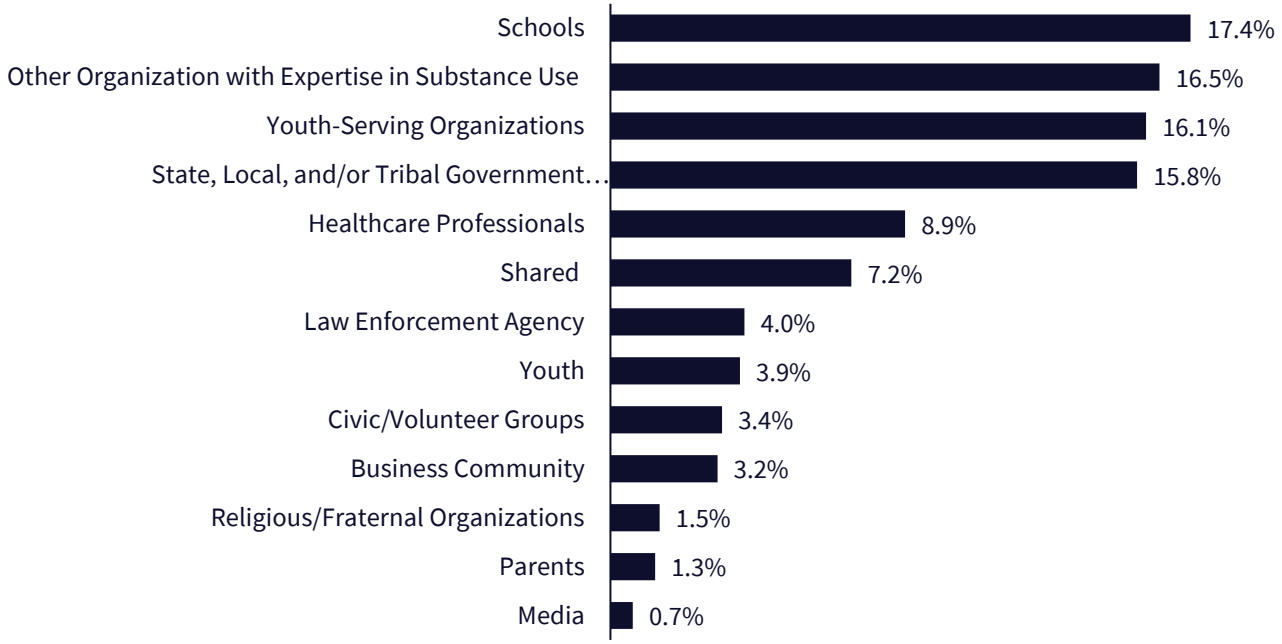
Building Capacity to Prevent and Reduce Substance Use

Key Findings

In 2024, DFC coalitions successfully mobilized approximately 41,000 community members to actively engage in youth substance use prevention/reduction efforts. Most (93%) coalitions report having at least one member from each of twelve sectors, although fewer (76%) reported active members from all sectors. Over two-thirds (69%) of coalitions reported hosting a youth coalition, a promising practice associated with significantly higher levels of Youth sector involvement.

Comprehensive community collaboration is a fundamental premise of effective community prevention and the DFC program.[31] Building capacity in the community to address substance use prevention work is an ongoing process aligned with the DFC goals. The average coalition in 2024 had 59 active members, with two paid and two unpaid staff. Across the 745 DFC coalitions a total of approximately 41,000 active members were mobilized to engage in prevention effort, including approximately 9,000 youth. Paid and unpaid staff add approximately 3,000 community members (a total of approximately 44,000 active members).[32] When asked to identify which sector leads the coalition, DFC coalitions were most likely to identify the Schools sector (17.5%) and Other Organizations with Expertise in Substance Use (16.5%) sectors (see Figure 1). Just under one-tenth of coalitions (7.3%) reported that leadership was shared across a combination of sectors.

Figure 1. Sector Identified as Leading the DFC Coalition



Source: DFC August 2024 Progress Report, n=745

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

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

DFC coalitions selected the six most common activities they had engaged in during the reporting period to build capacity from a list of twelve activities (see Table 4). Over half of DFC coalitions selected outreach (76%), recruitment (69%), engaging the general community in substance use prevention initiatives (65%), strengthening strategies (64%), and training for coalition members (59%).

Table 4. Engagement in Activities to Build Capacity

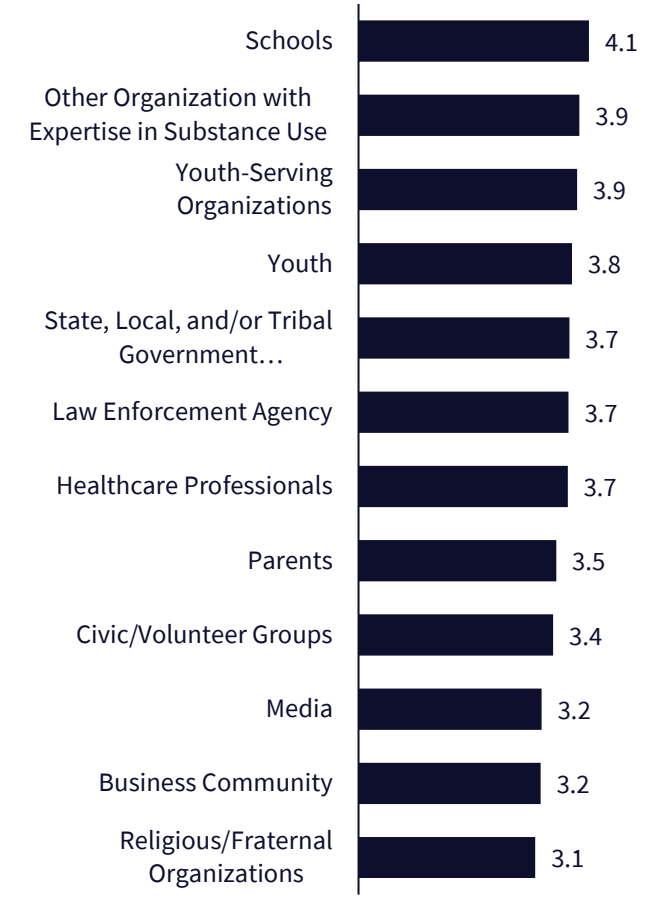
BUILDING CAPACITY ACTIVITY	PERCENTAGE
Outreach (e.g., engaging key partners in substance use prevention initiatives)	76.2%
Recruitment (e.g., increasing coalition membership and participation)	69.1%
Engaging the general community in substance use prevention initiatives	64.6%
Strengthening strategies (e.g., planning/executing substance use/misuse prevention initiatives)	64.2%
Training for coalition members (e.g., building leadership capacity among coalition members)	58.7%
Building shared vision/consensus (e.g., attaining an agreement among coalition members regarding goals, planned initiatives, etc.)	44.3%
Working with other coalitions	35.0%
Increasing fiscal resources (e.g., attaining funding for substance use prevention initiatives)	30.3%
Improving information resources (e.g., engaging in research or evaluation activities)	26.7%
Gathering community input (e.g., holding hearings on drug problems)	24.0%
Key coalition staff engaged with work groups (e.g., task force, committee, subcommittee) organized by others in the community to address opioids/methamphetamine	23.2%
Invited new community members/sectors to join the coalition based on expertise relevant to addressing opioids/methamphetamine	18.1%
Strengthening data connections across coalition sectors	14.9%
Established one or more work groups or subgroups (e.g., task force, committee, subcommittee) specifically focused on opioids/methamphetamine	12.0%
Other capacity building activity	1.9%

Source: DFC August 2024 Progress Report Data, n=745
Note: Coalitions selected their top six building capacity activities from this list.

Sector Level of Involvement and Active Sector Members

While almost all (93%) DFC coalitions report compliance with having at least one member from each of the twelve sectors, fewer (76%) reported at least one active member in all sectors. DFC coalitions rated each sector's average level of involvement with the coalition (on a scale 1 to 5). Schools (4.1), Other Organizations with Substance Use Expertise (3.9), and Youth-Serving Organizations (3.9) were on average rated as the most highly involved sectors, although all sectors averaged ratings of medium or higher involvement (see Figure 2). On average, Youth contribute the largest number of active members (7) followed by Schools (4; see Figure 3).

Figure 2. Average Ratings of Active Member Sector Involvement



Source: August 2024 Progress Report; n=745
Note: 1=Very Low, 2=Low, 3=Medium, 4=High, 5=Very High

Figure 3. Median Number of Active Members by Sector

Source: August 2024 Progress Report; n=745

Engagement with the Schools Sector

Individual schools and school districts are important partners for DFC coalitions and almost all coalitions (99%) report working with at least one school with most (88%) working with multiple schools either in a single or multiple districts (see Table 5).[33] The few DFC coalitions not working with schools (<1%) may still be working on building a relationship or may be working at broader regional/state levels. Just under one-fifth of coalitions (18%) reported that schools were the coalition's lead sector. Through schools, coalitions can reach students/youth, as well as their parents and families. The coalitions implemented each of the Seven Strategies for Community Change with or within the school sector. Much of this work focused on the nexus of substance use and mental health in youth.

Table 5: Engagement with Schools

NUMBER OF SCHOOLS AND DISTRICTS THAT COALITIONS WORKED WITH	PERCENTAGE
Multiple schools in a single district	46.0%
Multiple schools in multiple districts	41.9%
Single school in a single district	11.4%
Not applicable/Not working directly with schools	0.7%

Source: DFC August 2024 Progress Report Data, n=745

Hosting a Youth Coalition

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

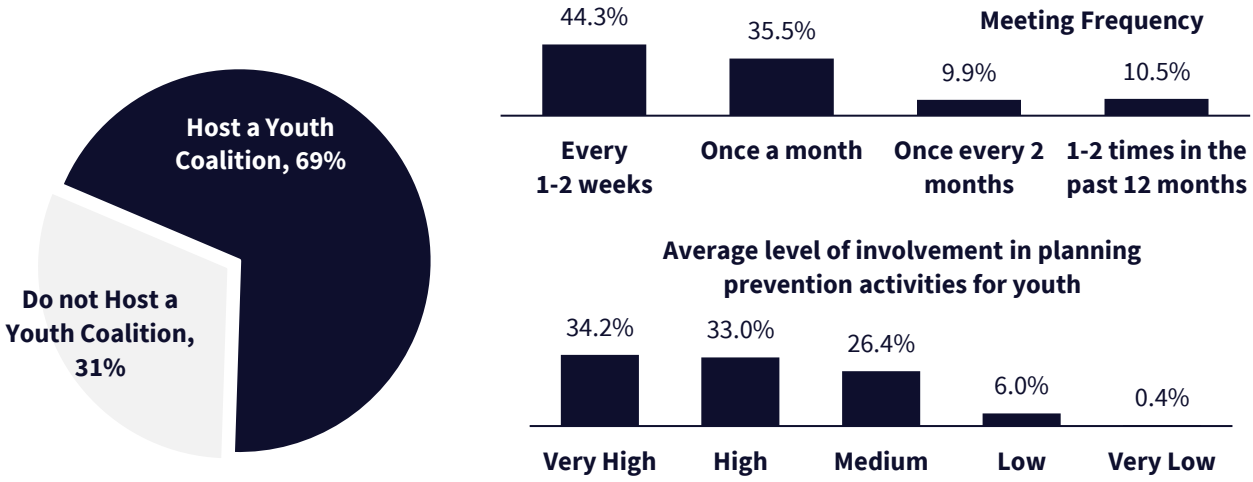
> A group of youth who work together to plan and implement activities related to the mission of the full coalition. An adult coalition member serves as a mentor or leader, but the youth have key leadership roles. The youth coalition is integral to the full coalition, but generally meets independently.

n August 2024, over two-thirds (69%) of DFC coalitions reported hosting a youth coalition (see Figure 4). Most (80%) reported the youth coalition met at least once a month and rated youth coalition involvement in planning prevention activities as high or very high (67%).[34] Of the coalitions not hosting a youth coalition (31%), more than two-thirds (78%) were working to host a youth coalition within the next twelve months, while the remaining had no plans to host a youth coalition.

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

[34] Of these coalitions, 44.3% met once every 1- or 2 weeks while 35.5% met once a month, for a total of 79.8%.

Figure 4. DFC Coalitions Reporting Hosting a Youth Coalition, Meeting Frequency, and Level of Involvement of the Youth Coalition



Source: DFC August 2024 Progress Report

Hosting a youth coalition continues to be a promising practice for engaging youth. DFC coalitions hosting a youth coalition reported youth sector involvement as significantly higher on average (4.2, high to very high involvement) as compared to those not hosting a youth coalition (2.9, medium involvement).[35] That is, for those coalitions hosting a youth coalition, their average youth sector level of involvement was higher than the other most highly rated sectors. This level of engagement was similar to that of schools (4.2) who overall were rated highest on engagement (see Figure 2).

Making it clear that youth coalitions are central to the work of DFC coalitions who host them, just under half (46%) of these coalitions indicated that a youth coalition representative attended leadership meetings and had a say in coalition decision making while 11% indicated that youth members attended leadership meetings but did not have a say in coalition decisions. In addition, within those coalitions that hosted a youth coalition, 9% identified Youth sector as their lead sector as compared to 4% for all DFC coalitions. This engagement in decision making by youth may contribute to the overall higher level of involvement by youth in youth coalitions. Just over one-third (34%) indicated that no youth members attended coalition meetings.

Youth Coalition Activities

A common strategy among youth coalitions are the various events and campaigns hosted to engage other youth in the community. Key components of the success of these events and campaigns are involving the youth coalition in the planning and execution of these campaigns and uplifting youth voices to gain insight on what strategies will be most impactful to the youth sector. Youth coalitions often hosted mental health campaigns promoting prosocial activities, as well as campaigns such as "Red Ribbon Week" to promote drug-free activity and equip youth with tools to say no to drugs.

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

Youth coalitions also facilitated presentations at schools to inform youth on substance use dangers and statistics, motivating their peers to choose healthy prosocial alternatives. Below are two examples of this.

- "Youth worked to develop strategy plans, including PSA messages, social media messages, and volunteer at events throughout the community, and they distribute educational materials to their peers. Their expertise on youth access allows the coalition to pinpoint and intercept the locations who are providing youth vaping/THC, and alcohol products."
  (Year 3, South Region)
- "The youth coalition has been instrumental in helping the coalition meet its goals. The coalition focuses many efforts on involving the youth coalition, and the youth are always ready to engage in coalition activities. They did 5 anti-vaping presentations throughout the year in a 7th-grade health class, reaching 98 students. They volunteered at 10 coalition events over the past year. One youth coalition member regularly attends coalition meetings to provide updates and collaborate with coalition members." (Year 10, Midwest Region)

A Year 10 coalition from the South Region provided an example of youth coalition engaged in activities around their community.

> "The youth Coalition has planned and implemented a Rock Campaign. This campaign required the youth to paint "no use" messages on the rocks and place them around the neighborhood and the around the city at parks, bus stops, trees, parking lots and schools. Youth also planned and implemented a photovoice project that depicted neighborhoods in the city. Youth painted drug messages on t-shirts and wore them to school as a campaign."

Youth Coalition Recruitment and Retention

To foster engagement with youth coalitions, DFC coalitions found success when accommodating youth school and activity schedules, so young people could contribute time to coalition meetings and engage in coalition activities. Coalitions noted more engagement from youth after finding better methods to weave coalition activities into youth schedules, making it easier for youth to participate. For instance, a Year 3 coalition (Northeast Region) described adjusting their coalition schedule to accommodate committed youth coalition members,

> "Our youth coalition started last fall with pretty good membership. We began with 12 youth that had very good ideas and were excited by the development of this type of engagement. Over the next 5 months membership began to decrease due to the commitments that the teens were already involved in. Athletics, 4H, drivers dd, etc. pulled the students in too many directions and the youth coalition had to take a pause to re-evaluate the best time and frequency for the kids to stay involved."

A Year 6 coalition (West Region) described overcoming a similar scheduling challenge to retain and involvement a strong youth coalition,

> "Beginning this school year, we will be adding evening Coalition meetings to our schedule as well, which will enable more youth to attend the full group Coalition meetings. We have also gained a new

Alternative School which has opened their doors to us. They would like us to be involved as much as possible."

Youth Leadership Development in DFC Coalitions

A common leadership development activity among youth coalitions was attending youth leadership activities at a national conference.[36] At these events, youth were described as gaining insights, feeling empowered to start a youth coalition in DFC coalitions that do not already have one, and bringing innovative ideas back to coalitions with a youth coalition to boost youth engagement. DFC coalitions who bring youth report that the teens learn youth substance use statistics and trends and collaborate on substance use prevention strategies. For example, a Year 4 coalition (Northeast Region) described,

> "[Our coalition] was able to attend CADCA Mid-Year with three youth who went through Key Essential training to gain the skills they need to make a difference in their community."

A Year 6 coalition (West Region) also described how the youth from their coalition brought what they learned at the national event back to their home community,

> "Three youth joined us for the CADCA Leadership Forum in D.C. and helped disseminate what they learned by presenting in their classrooms and to community groups."

Similarly, a Year 10 coalition (West Region) reported leadership opportunities their youth received, including speaking with congressional representatives and attending trainings, that the youth brought back to their home community.

> "This year, we also attended CADCA's National Leadership Forum in Washington D.C., where they met with [several Senators and a Congressman]. They provided crucial information on current underage substance use trends in [our state], community needs, and prevention efforts. In addition to the Capitol Hill Day meetings, they attended four days' worth of training, doing the youth leadership track at CADCA, to learn how to improve their work in our community."

[36] Coalitions most commonly mentioned youth attendance at the CADCA National Leadership Forum and the CADCA Mid-Year Training Institute. For more information see https://www.cadca.org/signature-events/

Strategy Implementation

Key Findings

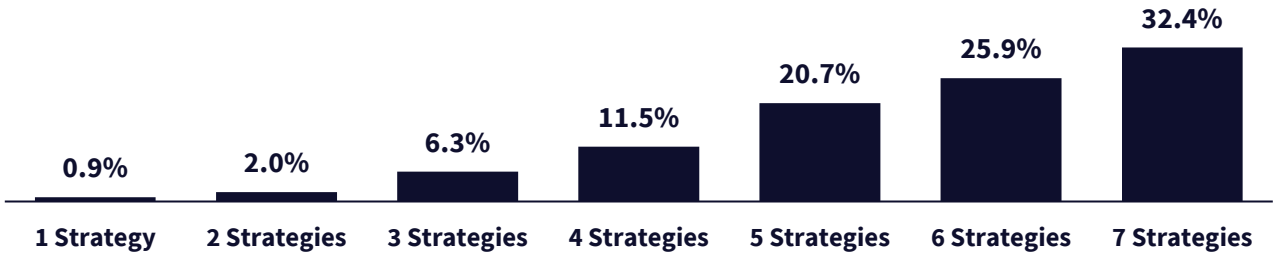
DFC coalitions implemented a comprehensive mix of strategies, with most (79%) implementing at least one activity in at least five of the strategy types. Over 76% of DFC coalitions implemented activities to address the emerging drug issues of opioid/methamphetamine use and youth vaping (76% and 83%, respectively).

Each DFC coalition is expected to develop and implement an annual action plan to meet grant goals. DFC coalitions focus on selecting and implementing activities from the range of the Seven Strategies for Community Change that best address local needs and challenges.[37] A primary purpose of collaboration across sectors is to leverage skills and resources in the innovative planning and implementation of prevention. DFC coalitions vary in the extent to which the range of sectors is involved in the development and implementation of the action plan. This section of the report provides an overview of the activities and strategies implemented by DFC coalitions as reported in their August 2024 Progress Report.[38] This is followed by information on community assets put into place in the community as a result of DFC funding. Next, strategies implemented to address emerging drug issues are described.

Comprehensive Strategy Implementation

To assess how DFC coalitions are implementing their action plans, 46 unique prevention activities were linked to one of the Seven Strategies for Community Change. In line with addressing prevention comprehensively, most (79%) DFC coalitions implemented at least one activity in at least five of the seven strategy types (see Figure 5)[39].

Figure 5. Percentage of DFC Coalitions Implementing the Seven Strategies for Community Change by Number of Strategies Engaged



Source: DFC August 2024 Progress Report; n=745

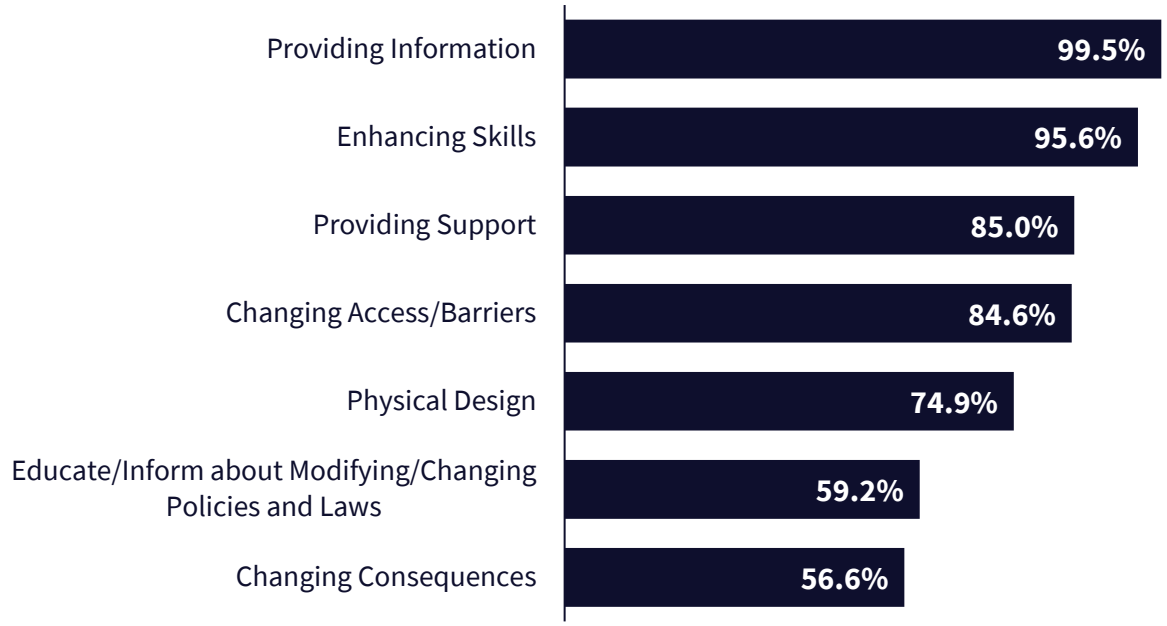
[37] The activities were identified based on coding of coalition descriptions of activities during an earlier phase of the DFC National Evaluation. DFC coalitions also have the option to add 'Other' activities for each of the seven strategies, bringing the total to 53 activities. Community Anti-Drug Coalitions of America (CADCA) derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see Implementation Primer: Putting Your Plan into Action | CADCA

[38] Coalitions were asked to report on activities that were implemented from August 1st, 2023 through July 31st, 2024.

[39] This is the sum of 20.7+25.9+32.4=79.0

Implementation of each of the seven strategies ranged from over half to almost all coalitions (see Figure 6). Two of the three individual strategies (*Providing Information* and *Enhancing Skills)* were implemented by almost all coalitions (99% and 96% respectively). *Providing Support* was implemented by over four-fifths of coalitions (85%). The most implemented environmental strategy was *Changing Access/Barriers* (85%). Coalitions were least likely to have implemented at least one activity in *Changing Consequences*, although over half of coalitions did so (56.6%).

Figure 6. Percentage of DFC Coalitions Implementing the Seven Strategies for Community Change by Number of Strategies Engaged



Source: DFC August 2024 Progress Report, n=745

Activities Implemented by Strategy and Strategy Type

Table 6 provides an overview of the most common activities engaged in by DFC coalitions by strategy (see also Tables C.1 to C.7, Appendix C).[40] In addition to coalitions being generally more likely to have implemented individual strategies as compared to environmental strategies, activities within each of these strategy types were generally also implemented by high percentages of coalitions. Working in the community to *Change Access/Barriers* was the most common environmental strategy, and the most common activity in this strategy included efforts to reduce home and/or social access of substances, implemented by 69% of DFC coalitions.

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

Table 6: Top Two Activities by Strategy Type

INDIVIDUAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***Providing Information*:** activities provide community members with information related to youth substance use, including prevention strategies and the consequences of use.		
Informational Materials Disseminated:	91.5%	"Hockey Day Minnesota was hosted in our County this year, bringing over 10,000 athletes and fans to one of our small communities. We used geo-targeting to send our messages to everyone who used a device within the event. We gave out an infographic about marijuana use along with sunglasses with our message to all athletes in the bags of swag gear they received." (Midwest Region, Year 9)
Social Networking: (e.g., Facebook, Twitter, etc.)	88.3%	"From September to March our social media was primarily being used to promote community discussions and repost assets from other organizations and creators. In March we hired a social media manager and began generating our own branded content and posting with more consistency in an effort to clearly state our mission and offer education to the community. We've continued to increase across all metrics from this point. Our most popular content for gaining new followers has been Instagram reels. We are in the process of adapting our YouTube shorts as Instagram reels, as well. With the data we've gathered over the last few months, we began creating new campaigns around: Substance Spotlights, Sector Spotlights, How to talk to your kids, and Mythbusters, and our Let's Talk Campaign complete with a social media kit that has been shared with our partners." (West Region, Year 7)
***Enhancing Skills*:** activities designed to increase the skills of participants.		
Youth Education and Training Programs: Sessions focused on providing information and skills to youth	70.1%	"Implement Teen Driving: A Family Affair. A locally developed program that brings the Victim Impact Panel (VIP) model into local high schools as part of the student's application for their parking permit, which allows them to drive to school. The program mandates that both the student and a parent attend this modified VIP, which includes victims of substance-related crashes as well as representatives from the District Attorney's Office, the insurance industry and the medical community. Parents and students gain an understanding of the serious legal, medical, insurance, and emotional costs of driving distracted and of driving under the influence." (Northeast Region, Year 5)
Implementation/ Supported Implementation of an Evidence-Based Curriculum in School Setting	53.3%	"The evidence-based educational program Too Good for Drugs and Violence has been implemented in three high school classrooms to approximately 75 students last school year. Several units of instruction address the effects that substances such as alcohol, nicotine, marijuana and other street drugs have on the brain and body. The program also has several units geared toward social and emotional learning. Enhanced skills in goal setting, responsible decision making, managing emotions, effective communication, and building strong relationships are highlighted. The program also teaches refusal skills, respect for yourself and others. Pre and Posttest surveys were conducted with the students and provided to our evaluator." (West Region, Year 3)

Table 6: Continued

ACTIVITY	PERCENT	COALITION VOICES
***Providing Support*:** activities to support community members participating in activities that reduce risk or enhance protection.		
Alternative/Drug-Free Social Events: Drug-free parties, other alternative events supported by the coalition	65.6%	"[We] had the pleasure of working with the two different school districts within our area to provide support toward the end of the year drug free lock in, substance free prom for juniors and seniors and the graduation celebration. These programs were able to highlight the resources and educational material that youth can has available. It was also able to get the students involved to provide incentives to attend their end of the school year celebrations in a safe manner." (Northeast, Year 3)
Youth/Family Community Involvement: Community events held (e.g., school or neighborhood cleanup)	31.1%	"[The coalition] staff partnered with the Middle and High School Project Based Learning group and Community Hope and Action event planning group to plan, organize and implement a community clean up, free lunch, and concert where 74 participants attended. [The coalition] planned, organized, funded and implemented 3 events for the school RTU program with a documentary viewing and motivational speaker, where 210 parents and students attended. [The coalition] provided 4 opportunities for coalition members to get together, share a meal and engage with coalition activities. [The coalition] supported Community Hope and Action to recruit 3 new members to join the planning committee and plan, organize and implement a Community Outdoor Movie Night with a free dinner." (Northeast Region, Year 9)
ENVIRONMENTAL STRATEGIES		
ACTIVITY	**PERCENT**	**COALITION VOICES**
***Changing Access/Barriers*:** activities designed to improve systems and processes to increase the ease, ability, and opportunity to utilize those systems and services or designed to create systemic barriers to accessing substances.		
Reducing Home and Social Access (e.g., prescription drug disposal/storage; alcohol storage; make available or increase availability of local prescription drug take-back events and/or prescription drug take-back boxes)	58.1%	"We supported National Drug Take Back Days. We addressed Rx drug misuse and distributed lock boxes/bags, Rx mailers, and drug deactivation kits as well as collected 64 pounds of medications." (Midwest Region, Year 4)
Improve access to overdose prevention materials (e.g., distribution of naloxone)	49.9%	"The coalition staff and volunteers from the steering committee also participated in two separate National Night Out events throughout the city. These family focused community building events again allowed the coalition staff and volunteers to provide education information on substance use and substance use disorders, safe medication disposable and Deterra bags, and recruit volunteers for the coalition." (Midwest Region, Year 5)

TABLE 6: CONTINUED

ACTIVITY	PERCENT	COALITION VOICES
***Changing Consequences*:** activities designed to increase or decrease the probability of a specific behavior that reduces risk or enhances protection by altering the consequences/incentives for performing that behavior.		
Recognition Programs (e.g., programs for merchants who pass compliance checks, drug-free youth)	34.5%	"We performed alcohol purchase survey checks, tobacco/vape educational inspections, where a "mystery shopper" who was 21, but looked under 21 attempted to purchase alcohol at 12 businesses that hold a liquor license. 12/12 businesses asked the "mystery shopper" for identification and passed the purchase survey checks. A press release was published in the local paper, each employee was gifted a $10 gift card for a job well done, and each business was given a window cling celebrating their success which all posted in visible sight of customers. (Northeast Region, Year 4)
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap, open container laws)	23.6%	"[Our coalition] Reduce Access/Enhance Barriers by conducting High Visibility Enforcement Campaign (roadblocks) and shoulder-tap/alcohol retailer compliance checks to change consequences and increase youth perception of risks associated with alcohol use." (South Region, Year 10)
***Changing Physical Design*:** activities to change the physical design or structure of the environment to reduce risk or enhance protection.		
Increase safe storage solutions in homes or schools (e.g., lock boxes, drug deactivation kits)	48.3%	"We have focused on distributing drop box location information, distributing prescription drug deactivation kits at health fairs and other events (supplied as an in kind donation by a coalition partner), and distributing lock boxes. We expanded our messaging on lock boxes beyond Rx drugs to also include tobacco/vapes and marijuana to address the problem of youth stealing both from parents. We were able to discuss this with the lone operating marijuana retailer in the county and they began selling lock boxes for this purpose." (Northeast Region, Year 2)
Identifying Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	32.0%	"[Our coalition] conducted an environmental scan of signage across the County, revealing a significant disparity between underserved areas and more economically secure neighborhoods. The data was presented to city commission, school boards, social services agencies, and civic organizations." (Midwest Region, Year 4)
Educating/Informing about Modifying/Changing Policies or Laws: activities to educate and inform with the goal of creating formal change in policies or laws.		
School: Policies promoting drug-free schools	22.6%	"It began with educating school policymakers and piloting at one High School in October 2023. Now, two school districts have policy in place to implement diversion for students caught with substances or using substances. Out-of-school suspension is reduced by 4 days with completion of the diversion program." (West Region, Year 1)
Citizen enabling/Liability	16.4%	"Both the social host and smoke-free park ordinances were revised to include marijuana, alcohol, and other illegal drugs. These updates also introduced stricter penalties, such as increased fines, jail time, and a community service option for first-time and subsequent offenders, ensuring that accountability and public safety remain a priority. Youth were instrumental in this process, engaging directly with city officials to advocate for the policy changes. They shared powerful statements on the importance of these updates, discussing how substance use has affected their lives and how the new policies would help reduce access to and visibility of these products in the community." (Northeast Region, Year 6)

Source: DFC August 2024 Progress Report Data, n=745

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

Newly Added Activities

Coalitions had the option to report engaging in five new activities beginning in 2023: three in *Enhancing Skills*, one in *Changing Access/Barriers* and one in *Changing Physical Design*. During 2024, Two of the five were in the top two activities presented in Table 8. Specifically, improving access to overdose prevention materials (50%, *Changing Access/Barriers)* and increasing safe storage solutions in homes or schools (48%, *Changing Physical Design).* One of the new *Enhancing Skills* activities was in the top two activities presented in Table 6, specifically, Implementation/Supported Implementation of an Evidence-Based Curriculum in School Setting (53%). While the other two *Enhancing Skills* activities were not in the top two activities for this strategy, coalitions were engaged in these activities as well including:

- Trainings specifically on identifying signs of potential drug use and/or risks associated with drug use (51%; e.g., risks of adolescent marijuana use; opioid risks/signs of use for various community members; signs of methamphetamine use/sales)
- Education and training specifically to reduce stigma associated with substance use/substance use disorder (44%)

Community Assets

Once a year, DFC coalitions complete the Coalition Classification Tool (CCT).[41] In the CCT, DFC coalitions identify community assets commonly associated with youth substance use reduction and prevention as being in place in their community before they received the DFC grant, those that were put into place after receiving the grant, and those not yet in place in the community to date. While each of these community assets may enhance the coalition's capacity to prevent or reduce youth substance use, those that were implemented after coalitions received their DFC grant awards provide an additional source of information about the local impact of the grant on communities. Table 7 presents community assets put into place after receiving the DFC grant award funding by at least 45% of DFC coalitions (see also Table D.1, Appendix D), including social norms campaigns (71%). DFC coalitions also provide opportunities for local youth prevention champions to be recognized (50%). Table 8 highlights examples of coalition work around these assets.

[41] In August 2024, 741 DFC coalitions completed the CCT in time for inclusion in this report.

Table 7: Community Assets Implemented After DFC Grant Award

COMMUNITY ASSET	PERCENTAGE OF COALITIONS WITH ASSET PUT IN PLACE AS A RESULT OF DFC GRANT AWARD	PERCENTAGE OF COALITIONS WITH ASSET IN PLACE BEFORE DFC GRANT	PERCENTAGE OF COALITIONS WITH ASSET NOT IN PLACE IN COMMUNITY
Social norms campaigns	70.7%	12.7%	16.6%
Substance use warning posters	64.4%	21.7%	13.9%
Town hall meetings on substance use and prevention within the community	59.5%	19.7%	20.8%
Recognition programs for drug-free youth	49.9%	12.3%	37.8%

Source: DFC 2024 Coalition Classification Tool Data; n=741

Table 8: Examples from Coalitions of Implemented Community Assets

COMMUNITY ASSET	COALITION VOICESON ACTIVITY
Social norms campaigns	"We launched an innovative partnership with the Family Dinner Project a nationally known program of the Hospital's Division of Psychiatry to partner on our social norms campaign Make Mealtime Matter. The Family Dinner Project completed a community training for our social norms campaign subcommittee, and we purchased rights to use the Family Dinner Project materials, saving time and development costs. The Family Dinner Project also cross-promoted our social media and did a pro-bono blog on our social norms campaign on their webpage." (Northeast Region, Year 5)[42]
Substance use warning posters	"The Black Poster Project was held at the High School, drawing an audience of 1,200 students and 50 parents. This event included a daytime session for students and an evening session for parents. The event was divided into two parts: first, a powerful display of posters representing individuals who lost their lives to opioid addiction, and, following the display, two guest speakers, a recovering addict and the parent of a child who passed away from an overdose, shared their personal stories. The program was deeply impactful, and the message resonated with the students. To facilitate ongoing conversations, teachers were provided with talking points to discuss with students when they returned to their classrooms." (Northeast Region, Year 5)[43]
Town hall meetings on substance use and prevention within the community	"To foster open dialogue and community involvement, we regularly organize public forums and town hall meetings. These events provide an opportunity for community members to learn about substance abuse issues, share their experiences, and contribute to the development of local solutions. They also serve as a platform for discussing the progress of our initiatives and gathering feedback to refine our strategies. (South Region, Year 6)
Recognition programs for drug-free youth	"Our coalition's recognition programs involve public recognition of local teen leaders who pledge to be alcohol, tobacco, and drug-free. One recognition program is a $5,000 merit-based scholarship provided by [community organization]. This year, 35 teens applied for the scholarship and our Teen Advisory Board (TAB) selected the recipient through a de-identified process. Recipients are selected based on volunteer experience, academic dedication, community involvement, and leadership skills and must pledge to be alcohol and drug free. Senior leaders in our TAB are also recognized as youth staff at Teen Leadership Summits, where they are given roles of responsibility among their peers. TAB seniors who participate on TAB for more than one year are also provided a $500 honorarium to recognize their dedication to being alcohol, tobacco, and drug free." (South Region, Year 9)

Source: DFC 2024 Progress Report data.

[42] For more on the Family Dinner Project see https://thefamilydinnerproject.org/
[43] For more information on the Black Poster Project see https://www.theblackposterproject.com/

Addressing Emerging Drug Issues

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

Opioids and Methamphetamine

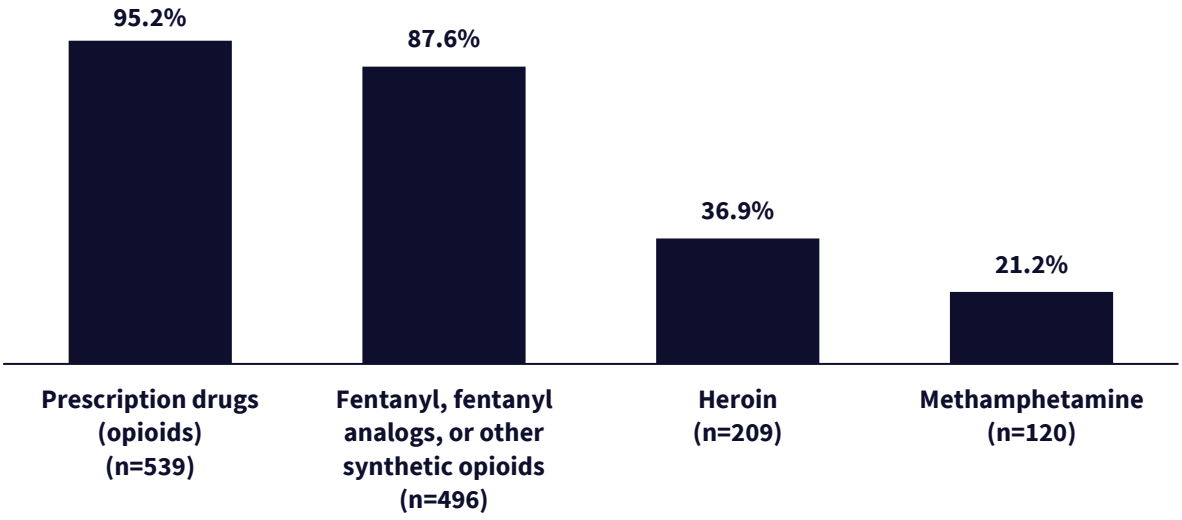
The CDC has identified opioid use and opioid overdose deaths as an epidemic.[44] Data from CDC's National Center for Health Statistics show that the age-adjusted rate of drug overdose deaths (per 100k population) decreased by 4% between 2022 and 2023 (32.6 vs 31.3 respectively); this is the first annual reduction in drug overdose deaths in the United States since 2018. Overdose deaths (per 100k population) involving synthetic opioids such as fentanyl and fentanyl analogs decreased by 2.2% (22.7 in 2022 vs. 22.2 in 2023). This data also suggests there was at 17.1% decrease in the rate of drug overdose deaths involving natural and semisynthetic opioids such as morphine, oxycodone, and hydrocodone (3.5 in 2022 vs. 2.9 in 2023) and a 33.3% decrease in deaths involving heroin (1.8 in 2022 vs. 1.2 in 2023). Although there have been promising decreases in overdose deaths amongst many of the substances measured, overdose deaths involving psychostimulants such as methamphetamine have continued to increase, a trend that first started around 2011. This includes a slight increase of 1.9% between 2022 and 2023 (10.4 vs. 10.6 per 100k population respectively).[45]

Just over three-fourths of DFC coalitions (76%) indicated they engaged in activities to address opioids and/or methamphetamine in 2024. Almost all of these coalitions were working to address prescription opioids (95%) and or fentanyl (88%, see Figure 7). Only one coalition indicated a focus solely on methamphetamine. In open-text, coalitions often noted that they were informing the community about concerns around counterfeit pills being laced with fentanyl, in part driving the connection between focusing on both pills and fentanyl. Coalitions working to address vaping also noted raising awareness that anything that can be vaped can potentially be laced with fentanyl as an area of concern.

[44] See Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. MMWR Morb Mortal Wkly Rep 2021;70:202–207. NVSS - Drug Overdose Deaths (cdc.gov)

[45] Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2003–2023. NCHS Data Brief, no 522. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/170565.

Figure 7. Substances Selected by Coalitions Who Implemented Activities Specifically to Address Opioids/Methamphetamine



Source: DFC August 2024 Progress Report
Note: Totals do not add to 100% because DFC coalitions could select more than one substance. Coalitions could also select Prescription Drugs (non-Opioids; 72%) but all who selected this were also focused on prescription opioids;

Coalitions efforts to address opioids in their community were also highlighted in their efforts to work with High Intensity Drug Trafficking Area (HIDTA) regions and with the Drug Enforcement Agency (DEA). Just over half of communities served by DFC coalitions (57%) were located in a HIDTA region in 2024. Of these, nearly two-fifths (38%) were working with their HIDTA in various ways. Coalitions noted focusing on opioids and specifically fentanyl in several ways including:

- Developing and promoting informational resources on fentanyl and counterfeit medications
- Connecting on current overdose trends and using the overdose mapping system to identify areas in the community for primary prevention overdose education and training on Naloxone
- Collaborating to share information about overdoses and the danger of fentanyl at community and school events
- Supporting DEA Fentanyl Family Summit events
- Partnering on Operation Overdrive, a DEA and HIDTA initiative focused on combatting high rates of fentanyl-related trafficking and overdose, including providing evidence-based prevention curriculum to youth and families
- Educating youth about the signs and symptoms of potential opioid overdose and how to respond as well as about Good Samaritan laws that protect when responding and therefore supports willingness to intervene

Vaping

The most recent National Youth Tobacco Survey (NYTS) found that e-cigarettes and other vaping devices remain the most common strategy for consuming tobacco products among youth although

use continues to decrease nationally.[46] Between 2023 and 2024, NYTS trends showed that current use of e-cigarettes among middle and high school youth declined from 7.7% to 5.9%. This includes 7.8% of high school students and 3.5% of middle school students who reported current e-cigarette use in 2024. Among youth who currently used e-cigarettes, just over one-third (38.4%) used them frequently and just over one-fourth (26.3%) used them daily. Most youth who currently use e-cigarettes reported using flavored products (87.6%). Common flavors used among youth who currently use include fruit, candy, and mint (62.8%, 33.3% and 25.1% respectively). While NYTS data suggest a decline in youth vaping, data from the 2024 MTF survey suggest that the percentage of 8th and 12th graders who vaped nicotine in the past 12 months remained steady (9.6% and 21% respectively). Amongst 10th graders, there was a decline in past 12-month use of e-cigarettes from 2023 to 2024 (17.6% vs. 15.4% respectively).[47]

Addressing youth vaping of substances remains a priority for many coalitions. Over three-fourths (83%) of DFC coalitions reported their coalition engaged in activities to address vaping locally, which is similar to rates in 2023 (82%). Of those coalitions who addressed vaping, 98% reported their work focused on vaping of nicotine/tobacco, and 91% reported their work addressed vaping marijuana. Of all coalitions that reported addressing vaping locally, 89% reported addressing both nicotine and marijuana, 8% of coalitions addressed nicotine/tobacco only, and 2% of coalitions addressed marijuana only. Youth who use vapes for nicotine have almost five-time-higher odds of using vapes for cannabis use. Cannabis and nicotine vaping has been associated with a higher frequency of engaging in other substance use, including cigarettes, alcohol, and illicit or prescription drug misuse.[48] Additionally, 73 coalitions (12% of those who addressed vaping) reported addressing other substances such as synthetic marijuana and alcohol.

Newly Emerging Drugs

As noted, coalitions were able to enter information about any other newly emerging drugs they faced in their communities with just over one-tenth responding yes (10%). The most commonly mentioned emerging substance was xylazine, identified by 5% of all DFC coalitions. Community concerns about xylazine are in line with what has been found nationally. Between 2021 and 2022, the presence of xylazine in drugs that were tested in labs increased in every United States region, with the South region being the largest increase.[49] Among adults evaluated for substance use treatment, individuals who reported xylazine use reported higher percentages of other recent substance use and

[46] Park-Lee E, Jamal A, Cowan H, et al. *Notes from the Field:* E-Cigarette and Nicotine Pouch Use Among Middle and High School Students — United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:774–778. DOI: http://dx.doi.org/10.15585/mmwr.mm7335a3

[47] Ibid

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

[49] Drug Enforcement Administration. *The growing threat of xylazine and its mixture with illicit drugs*. 2022. The Growing Threat of Xylazine and its Mixture with Illicit Drugs (dea.gov)

polysubstance use compared to those who did not report using xylazine.[50] The reemergence of certain forms of illegally manufactured fentanyl (IMFs) has also become a concern, with carfentanil overdose deaths increasing approximately sevenfold from January-June 2023 to January-June 2024 (29 vs. 238 deaths respectively).[51] Coalitions were aware of these concerns. For example, a Year 5 (West Region) coalition described, ”Xylazine is emerging as a new drug threat in the community. It is often paired with fentanyl, whether that substance is knowingly or unknowingly consumed... We have implemented educational materials on the dangers of this substance.”

In open-text, coalitions described their efforts to address the emergence of Xylazine in their communities. These activities commonly include providing information and enhancing skills. For example, a Year 8 coalition (South Region) stated, “Our coalition members have continued energy in addressing xylazine as well as tianeptine. Healthcare providers who directly interface with people who use drugs report that these substances are a cause for concern in our area... Primarily, the focus has been to distribute educational materials at coalition meetings and encourage members to talk to their networks about these substances. There also continues to be efforts on the healthcare provider training side, meaning that we have scheduled a training about xylazine for providers in the fall.” Another Year 6 coalition (Northeast Region) described their activities, stating, “Law enforcement partners have been tracking the increase in fentanyl found in cocaine in our county, as well as the presence of Xylazine. Our coalition has created PSA's and social media posts on Xylazine and we have included information about emerging drug threats in our monthly newsletter, indicating that fentanyl can be found in just about everything.”

Other dugs mentioned included psychedelics, synthetics, Kratom, and Delta 8 and similar hemp products with THC, often referred to collectively as gas station drugs. For example, a Year 7 (South Region) noted, “We try to stay on top of emerging threats and new trends. The biggest trend we are seeing is with the use of synthetic "gas station" drugs by youth and adults alike who assume if it's legal, then it's okay. Many different products, sold as herbal supplements and dietary aids, are finding their way into our elementary and middle schools. These products targeting youth have resulted in an increase of youth visits to the emergency department. Several of our coalition members have attended training on synthetic drugs … Others have attended webinars and workshops to further educate us on what's here and trending. We are planning some activities to educate our community parents, guardians and other adults that are responsible for children/teens.” Similarly, a Year 5 (South Region) noted, “Our coalition has been actively educating on the dangers associated with the legal substances found in Gas Stations. Our state legislature did pass a law last year that required all of these substances to be behind glass or counters that were inaccessible to the

[50] Jiang X, Connolly S, Strahan AE, et al. Reported Xylazine Use Among Adults Aged ≥18 Years Evaluated for Substance Use Treatment — United States, July 2022–September 2023. MMWR Morb Mortal Wkly Rep 2024;73:594–599. DOI: http://dx.doi.org/10.15585/mmwr.mm7326a2

[51] Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O’Donnell J. Detection of Illegally Manufactured Fentanyls and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. MMWR Morb Mortal Wkly Rep 2024;73:1099–1105. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a2.

public. The coalition provides an updated webinar/presentation each year on the new substances found in gas stations that are posing a threat to our youth. We have had great attendance with these webinars and notifications from attendees that they share the information and presentations within their networks. We also provide the presentation on our YouTube channel. These substances just recently were given an age restriction from the state legislature. The biggest challenge is working with the gas stations because they just care about the money made from these products and not the risk they pose."

Coalitions reported engaging in individual and environmental change strategies specific to Kratom and substances in the Delta family (e.g., 8, 9, 11), with an emphasis on modifying and changing policy. One Year 4 (Northeast Region) noted, "A crowning achievement, in partnership with the Director of Public Health, was the passing of regulations banning Delta-8, Delta-10, synthetic cannabinoids and Kratom by the Board of Health. The DFC Program Director collaborated with the Director of Public Health (also the government sector rep.) in researching these products and presenting our findings to the Board of Health. We attended 4 meetings before the Board of Health ultimately passed the regulations." Similarly, a Year 7 coalition (Midwest Region) reported, "The City Council passed two ordinances, making it unlawful for those under the age of 21 to purchase hemp-derived intoxicants and kratom, and requires businesses to display these products behind the counter or in an area that customers could not have possession of the product before purchasing them. Since marijuana is now a substance of focus for this grant, this is very relevant to the coalition's work. Coalition members provided education that led to the passing of these ordinances, along with increased visibility of compliance checks, and they are the first of their kind in the geographic area." Altogether, coalitions are responding to new and emerging substance use trends in their local areas with individual and environmental strategies for community change.

Core Measures

Key Findings

DFC coalitions (all since inception and most recent cohort) reported significant decreases in past 30-day use across all substances from first to most recent report among both middle and high school youth.

Among high school youth, perceived peer disapproval significantly increased across the four substances in both samples from first to most recent report. In the most recent DFC cohort, high school youths' perception of risk for alcohol and marijuana use increased significantly from first to most recent report. Findings related to middle school youths' perceptions were more mixed.

This section summarizes the core measures data reported by DFC coalitions.[52] The core measures data were analyzed in two ways: 1) using all available data from DFC coalitions since the grant's inception, and 2) using data from the most recent (FY 2023) cohort of DFC coalitions. The first set of analyses provides information on changes in community outcomes since DFC was first funded, whereas the second set of analyses focuses on outcomes associated with the current context of DFC coalitions. Key data are presented in the body of this report, with full tables available in Appendix E.

Core Measures Findings Summary

Figure 8 provides a high-level summary of the core outcomes results for the sample of all coalitions since inception and for the FY 2023 cohort of coalitions. Arrows indicate statistically significant increases (up arrows) or decreases (down arrows). A value of 'NC' or No Change indicates there was no statistically significant difference between the first and most recent report for that outcome. For past 30-day use, significant decreases reflect findings in line with DFC goals. For perceptions of risk, parental disapproval, and peer disapproval, significant increases reflect findings in line with DFC goals. Notably, in both samples (all DFC coalitions since inception and the FY 2023 sample), past 30-day use decreased significantly across all substances and for both middle and high school youth.

[52] DFC coalitions have reported data as it becomes available from 2002 to 2024. For core measures changed or introduced in 2012, including peer disapproval and all measures for misuse of prescription drugs, data have been reported from 2012 to 2024. Data were analyzed using paired *t*-tests. The first and the most recent outcomes were weighted based on the number of students surveyed by DFC grant award recipients. Outliers with change from first report to most recent report scores greater than three standard deviations were excluded from the analyses. Significance is indicated when the statistical significance reached a value of at least $p < .05$.

Figure 8. Overview of Core Outcomes Findings
ALL DFC GRANT RECIPIENTS SINCE INCEPTION

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

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

MOST RECENT COHORT OF DFC GRANT RECIPIENTS (FY 2023)

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

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

Source: DFC 2002–2024 core measures data. Only coalitions who have at least two core measures reports included with change evaluated based on the difference between first report and most recent report for each coalition.
Note: Arrows indicate significant increases (up arrows) or decreases (down arrows); NC=no change

Past 30-Day Prevalence of Use and Percentage Change

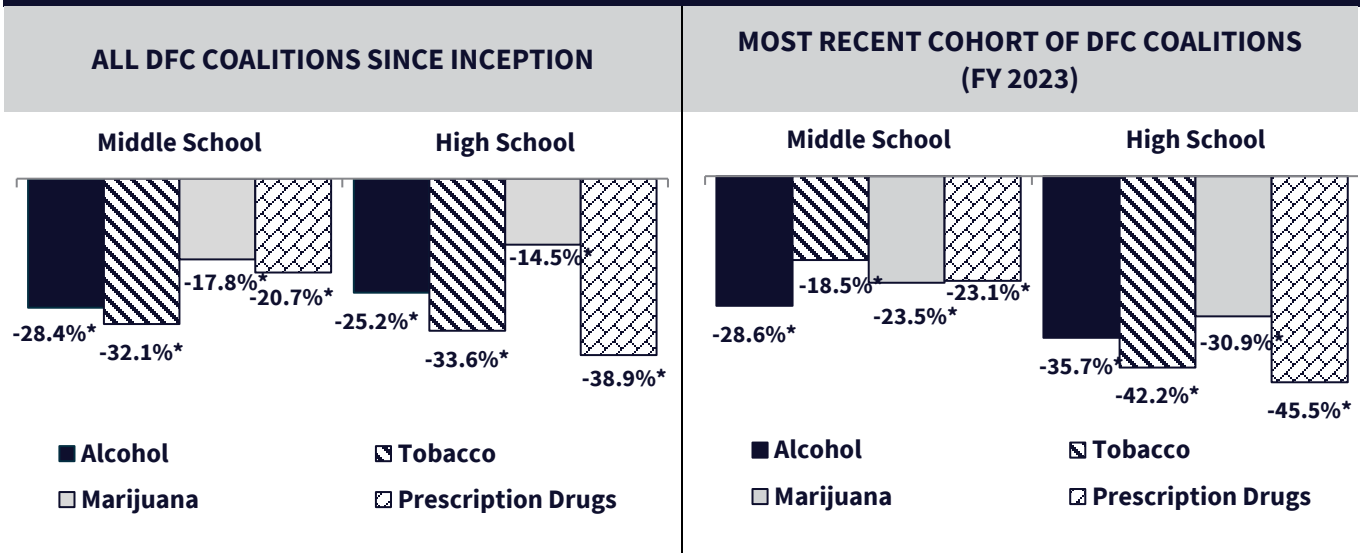
For all coalitions since inception, past 30-day use rates significantly decreased from first to most recent report across all substances at both the middle and high school levels, indicating that that DFC coalitions are successfully meeting their goal of preventing youth substance use. In other words, significantly more youth in DFC communities were choosing positive behaviors and were avoiding substance use. This same pattern was also observed in the FY 2023 cohort. Past 30-day use decreased at both middle school and high school levels (see Tables E.1, Appendix E). Alcohol remained the most commonly used substance at both school levels, followed by marijuana. Prescription drug misuse was relatively low for both school levels, with less than 3% reported in the most recent data.

Figure 9 presents the percentage change in past 30-day prevalence of substance use among middle and high school students.[53] The data are shown for both samples: all DFC coalitions since the program's inception and the most recent cohort of DFC coalitions (FY 2023).

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

For all DFC since inception, the largest percentage decrease in past 30-day substance use among middle school youth was for tobacco (32%) and the largest percentage decrease among high school youth was for prescription drugs (39%) followed by tobacco use (34%). In the most recent DFC cohort, among middle school youth the percentage change decreases were greatest for alcohol use (29%), while for high school youth percentage change declines were again greatest for past 30-day prescription drug misuse followed by tobacco use (46% and 42%, respectively). Extrapolating non-substance use percentages based on census data reflecting the potential reach of DFC, the estimated reductions in the number of middle and high school youth reporting past 30-day use of each substance are quite large (see Table 9).

Figure 9. Percentage Change in Past 30-Day Prevalence of Substance Use



Source: DFC 2002–2024 core measures data. Only coalitions who have at least two core measures reports included with change evaluated based on the difference between first report and most recent report for each coalition.

Note: * indicates $p < .05$

Table 9. FY 2023 DFC Coalitions Estimated Increases in the Number of Youth Reporting Past 30-Day Non-Use by Substance

SUBSTANCE	MIDDLE SCHOOL	HIGH SCHOOL
Alcohol	49,000	269,000
Tobacco	13,000	114,000
Marijuana	20,000	154,000
Prescription Drug (misuse)	15,000	66,000

Notes: Number of estimated youth impacted based on extrapolating percentage change to potential reach based on census estimate (see DFC Reach section for details).

Source: DFC 2002–2024 core measures data. Only coalitions who have at least two core measures reports included with change evaluated based on the difference between first report and most recent report for each coalition.

Perception of Risk

Highlights of findings related to changes from first to most recent report in perception of risk, with increases in perceived risk a positive outcome (see Table E.3, Appendix E):

- At the middle school level, perceived risk associated with prescription drug misuse significantly increased in both samples. Across all DFC since inception, perceived risk associated with alcohol use also increased significantly. Across both samples, perceived risk associated with marijuana use declined significantly from first report to the most recent report. In all other cases, perceived risk was unchanged.
- Among high school youth, perceived risk associated with alcohol use and with marijuana use increased significantly in the most recent cohort. Perceived risk associated with tobacco use decreased significantly in this sample. In the sample of all DFC coalitions since inception, there was no significant change in perceived risk associated with substance use across all substance among high school youth. Perceived risk associated with prescription drug misuse was also unchanged in the most recent cohort of DFC coalitions.
- At most recent report, across both samples and school levels, perception of risk associated with marijuana use was lower than for any other substance. This trend was particularly pronounced among high school youth. For example, in the most recent cohort of DFC coalitions, there was nearly a 20-percentage point difference between perceived risk associated with marijuana use and that associated with alcohol use (53% and 71%, respectively).

Perception of Parental Disapproval

Highlights of findings related to changes from first to most recent report in perception of parent disapproval include (see Table E.4, Appendix E):

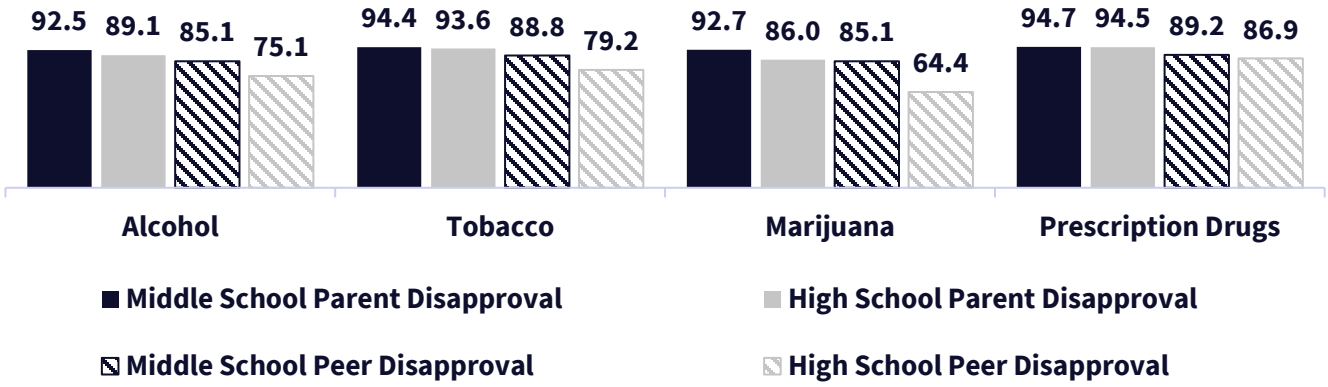
- Generally, the reported rates of perceived parental disapproval were high across samples, grade levels, and substances, with middle school rates of at least 93% and high school rates of at least 86% at most recent report. That is, most youth perceived parents as disapproving of substance use.
- Among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

Perception of Peer Disapproval

Highlights of findings related to changes from first to most recent report in perception of peer disapproval include (see Table E.5, Appendix E):

- Perceptions of peer disapproval were generally lower than perceptions of parental disapproval across substances, particularly for high school youth (see Figure 10 for an example and Tables E.4 and E.5, Appendix F). This means that, for example, while most high school youth reported not using substances and believed their parents would disapprove of such use, they were less likely to perceive of their peers disapprove if they used substances. This trend was most profound for high school youth perceptions of peer disapproval associated with marijuana use.
- For middle school youth, perception of peer disapproval was generally unchanged or decreased significantly. Across all DFC since inception, there was a significant increase in perception of peer disapproval of marijuana use.
- Across both samples, among high school youth there were significant increases in perceptions of peer disapproval across all substances.

Figure 10. Percentage of Youth Reporting Perceiving Parent and Peer Disapproval at Most Recent Report by Substance and Schook Level (FY 2024 DFC Cohort)



Source: DFC 2002–2024 core measures data. Most recent report data are included only for those coalitions who have at least two time points of data collection

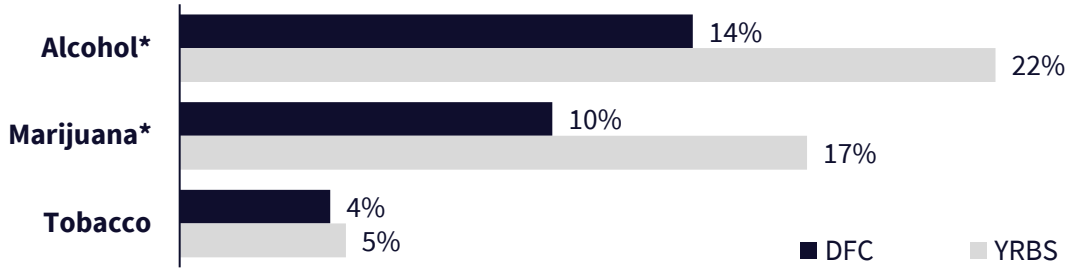
Comparison with National Data

Past 30-day substance use data from DFC coalitions were compared to national data where appropriate (see Figure 11 for comparisons in 2023 and Figure E.1, Appendix E for comparisons across years):[54] For DFC coalitions, only coalitions with change data are included in the analyses,

[54] . For more information on YRBS data see https://www.cdc.gov/healthyYouth/data/yrbs/index.htm and https://www.cdc.gov/healthyyouth/data/yrbs/data.htm. Comparison between DFC and Youth Risk Behavior Survey data at the high school level were possible as the two use the same wording. Comparisons examine confidence intervals (95%) for overlap between the two samples. CDC YRBS data corresponding to DFC data are available only for high school students on the past 30-day use measures and only for alcohol, tobacco, and marijuana. Some DFC coalitions report using YRBS data to track local trends and thus may be included in the national YRBS data. That is, some change in YRBS data may occur in part due to efforts from DFC coalitions. Comparisons with the national sample also may also be influenced by the range of survey instruments that DFC

reflecting the potential impact of the DFC in the community. Based on data collected in 2023, past 30-day use of alcohol among high school youth was significantly lower in DFC communities as compared to the national Youth Risk Behavior Survey (YRBS) sample (14% vs. 22%). The same was true for past 30-day use of marijuana among high school youth (10% vs. 17%). Rates of tobacco use were very low and not statistically different between the DFC and YRBS samples (4% and 5%).

Figure 11. Past 30-Day Use among High School Youth in 2023: Comparison between DFC and National YRBS Samples



Source: 2003–2024 core measures data (with only data collected in odd years included in comparisons); CDC 2023 Youth Risk Behavior Survey Data (YRBS) downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm

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

coalitions use to collect core measures data. Although surveys must use appropriate DFC core measures wording to be included in the DFC National Evaluation data, the order of core measure items and the length of the surveys can vary widely across DFC coalitions. While DFC coalitions are required to report core measures data every 2 years, each coalition may determine their own data collection schedule, further limiting the comparison between the two national samples. Because there is likely some overlap between samples, these comparisons are conservative estimates of the difference that DFC is making in communities.

Limitations and Challenges

One limitation to the DFC National Cross-Site Evaluation is that while the evaluation provides evidence of the overall DFC model is effective in preventing and/or reducing youth substance use, it is not possible to establish a causal relationship in core measure changes over time because there is not an appropriate comparison or control group of communities from which the same data are available. Overall, multiple years of findings from the DFC National Evaluation support the conclusion that DFC coalitions are associated with decreased youth substance use across a range of substances providing evidence for this community-based approach to prevention. DFC coalitions' core measures data have typically been significantly lower than national data, where comparisons are possible. Historically this was true for past 30-day use of tobacco and it continues to be true for past 30-day use of alcohol and marijuana. While the overall model is considered effective, given the comprehensive range of strategies coalitions implement, it is not possible to clearly establish the relationship between a single activity and its outcome(s).

DFC coalitions continue to progress in overcoming challenges related to collecting core measures data. For example, nearly two-thirds of DFC coalitions (64%) submitted at lease some new past 30-day use core measure data in 2024.[55] While many DFC coalitions successfully collect core measures data, DFC coalitions also report facing a range of challenges in collecting core measures data and are provided supports in identifying strategies to overcome these challenges, including:

- Staff turnover at both the coalition and the school which contributes to additional time needed to build a strong working relationship. DFC coalitions must focus on maintaining and/or rebuilding positive relationships with the school sector to support both implementing activities with youth in this setting and collecting data from youth
- Schools are sometimes concerned about students being over-surveyed and time not spent on academics. DFC coalitions are encouraged to work to limit lengths of surveys, with the core measures requiring only 17 items (core measures plus grade). In addition, coalitions are provided with resources that include understanding the potential relationship between engagement in substance use and poorer academic performance. In some cases, cases also work with their youth coalitions to summarize deidentified local data and to share the data with other youth, further supporting math skill and communication skill development.
- Changes in state engagement in conducting public health surveys, with some eliminating them and others making them optional rather than required for schools to have youth complete. Schools may opt out when they are unaware of the importance of this type of data for the grant program.

[55] Data submitted in any given year includes baseline data for new DFC coalitions (collected within past three years) as well as any new data that were not available at the time of the August 2023 data collection utilized in a previous report. This generally includes data collected primarily in both the current and prior year. Note that Year 1 coalitions have until the end of Year 2 to be in compliance with core measures, although they are strongly encouraged to submit baseline data and nearly half (48%)had done so by August 2024.

- Several states have introduced legislation requiring active parent consent, rather than passive consent where parents return only if they want to opt out of surveys. It can be difficult to identify strategies that ensure that schools or youth, particularly high school youth, will provide consent forms to parents and then return them. This also can add burden on the schools to track responses, although DFC coalitions are able to support such tracking. This has resulted in some DFC coalitions struggling to collect representative data, even if they are able to collect data in the schools.

Another challenge related to core measures is that each DFC coalition makes local decisions regarding how to collect core measures data, such as where to administer the survey, what grades to collect data from, the length of the survey used, and the order in which survey items are presented. While surveys vary, the DFC National Evaluation Team reviewed all surveys for core measures, and core measures data may only be entered if the item was approved on the survey. Small variations are allowed (e.g., coalitions may ask youth to report on how many days in the past 30 days they used a given substance [from 0–30] rather than just a yes-or-no question on past 30-day use). Some coalitions collect all core measures, whereas others have been approved for only some of the core measures. These variations across surveys may influence how youth respond to a survey. However, because most DFC coalitions make only small changes to their survey over time and because change from first report to most recent report are calculated in each DFC coalition to generate the national average, this challenge is somewhat addressed.

Most coalitions report collecting core measures data in schools, this is not always the case. Additionally, youth not currently in school may report different experiences with substance use than youth attending school. Few, if any, DFC coalitions collect data from youth not attending schools, in part because these individuals are harder to locate and may be less willing to complete surveys. In addition, data are reported by school level, emphasizing that data collection is predicated on school attendance. Finally, DFC coalitions are encouraged and receive training to collect representative data from their area of focus; however, each coalition is ultimately responsible for their own sampling strategies.

Appendix A. Risk and Protective Factors Focused on by Coalitions

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

Table A.1: Average Extent of Protective and Risk Factors in DFC Communities

Community Risk (R) and Protective (P) Factors	Average Extent of **Protective** Factor in Community	Average Extent of **Risk** Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
Community			
P: High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations R: Low rates of youth connection to the community; little sense that youth have a voice in the community/active in community organizations	0.90	0.99	-0.09*
P: Plentiful community activities for young people R: Few community activities for young people	0.78	1.13	-0.35*
P: Laws, regulations, and policies in place related to substance use/access R: Inadequate laws/ordinances related to substance use/access	1.04	0.83	**0.21***
P: Adequate law enforcement presence sufficient to enforce laws/ordinances related to substance use R: Inadequate enforcement of laws/ordinances related to substance use	0.96	0.87	**0.09***
P: Perceived community norms promote non-use/misuse of substances R: Perceived community norms favorable toward substance use	0.68	1.51	-0.83*
P: Prevention, advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community R: Advertising promoting substance use highly visible in the community	0.85	1.07	-0.22*
P: Strong community organization (e.g., low rates of crime/violence, high access to safe, stable housing) R: Weak community organization (e.g., High rates of violence/crime, little access to safe, stable housing)	0.96	0.70	**0.26***

Community Risk (R) and Protective (P) Factors	Average Extent of **Protective** Factor in Community	Average Extent of **Risk** Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
P: Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing R: Easy Availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing	0.64	1.27	-0.63*
P: High rates of economic stability and access to educational/economic opportunities R: High rates of poverty and limited access to educational/economic opportunities; High unemployment and/or underemployment	0.85	0.95	-0.1*
P: Sufficient access to mental health and treatment/recovery services in the community R: Lack of local treatment services for substance use and/or poor access to mental health services generally in the community	0.64	1.22	-0.58*
P: Treatment/recovery services for substance use are sufficient to meet demand in a timely manner R: Available treatment/recovery services for substance use insufficient to meet needs in timely manner	0.57	1.18	-0.61*
School, Faith, Peer			
P: High school connectedness: Youth feel a sense of connection to schools/teachers; Youth have adults who are mentors/someone they can confide in at school R: Low school connectedness: Youth do not feel a sense of connectedness to schools/teachers; Youth unlikely to have adults who are mentors/someone to confide in at school	1.01	0.92	**0.09***
P: High commitment to staying in school and attending school R: Low commitment to attend/stay in school; High rates of truancy and/or extended time missing school or dropping out of school	1.20	0.73	**0.47***
P: High rates of youth academic success R: High rates of youth struggling in school; Academic failure	1.16	0.74	**0.42***
P: High/Broad access to safe, high-quality schools across the lifespan R: Low access to safe, high-quality schools across the lifespan	1.24	0.39	**0.85***
P: Most youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult R: Few youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult	0.88	0.71	**0.17***
P: Broad access to a range of faith-based services in the community R: Poor access to a range of faith-based services in the community	1.16	0.35	**0.81***
P: Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use R: High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	0.76	1.29	-0.53*

Community Risk (R) and Protective (P) Factors	Average Extent of **Protective** Factor in Community	Average Extent of **Risk** Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
P: High/easy access to adult or peer-to-peer mentoring for youth in need of a mentor or someone to provide help/advise R: Poor access to adult or peer-to-peer mentoring for youth in need of a mentor; youth have poor access to someone to turn to when help is needed in schools or peer group	0.78	0.97	-0.19*
P: Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors R: Youth have easy access to peers who engage in negative, unhealthy, or delinquent behavior	1.07	1.16	-0.09*
P: Low rates of bullying schools/peer group R: High rates of bullying schools/peer group	0.78	1.05	-0.27*
Family			
P: Family connectedness (youth feel connected to families/caregivers – feel can talk to them about range of feelings/issues) R: Low family connectedness: youth do not feel connected to their families/parents/caregivers do not perceive family as a source of support	0.97	0.84	**0.13***
P: Families/parents/caregivers engage in prosocial behaviors and maintain healthy stable relationships R: Family trauma/stress (e.g., parental/sibling substance use, domestic violence, death of family member)	0.93	1.22	-0.29*
P: Families/parents/caregivers encourage youth to engage in healthy behaviors including avoiding substance use R: Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use	0.95	1.23	-0.28*
P: High engagement by families/parents/caregivers in monitoring and supervision of youth R: Family/parental/guardian attitudes favorable to antisocial behavior	0.77	0.78	-0.01
P: Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use R: Families/parents/caregivers lack ability/confidence to speak to their children about substance use	0.70	1.25	-0.55*
Individual			
P: Few youth who have experienced two or more risk factors/stressors R: High rates of youth who have experienced two or more risk factors/stressors (e.g., abuse, homelessness, school failure)	0.71	1.07	-0.36*
P: Delayed or no initiation of negative or unhealthy behavior, including substance use R: Early initiation of negative or unhealthy behavior, including substance use	0.76	1.12	-0.36*

Community Risk (R) and Protective (P) Factors	Average Extent of **Protective** Factor in Community	Average Extent of **Risk** Factor in Community	Average Difference between Extent of Protective and Risk Factor[a]
P: Youth have good life skills such as good decision-making and problem-solving skills R: Individual youth have favorable attitudes towards substance use/misuse	0.90	1.19	-0.29*
P: Youth generally follow and appreciate rules related to substance use at home, in school and other settings even without supervision R: Youth only follow rules around substance use when appropriately supervised; Breaks rules related to substance use across settings (school, home, other settings)	0.82	1.00	-0.18*
P: Youth seek out and engages in available positive, healthy, or prosocial behaviors R: Youth have few if any appropriate, prosocial, healthy activities or interest	1.01	0.78	**0.23***
P: Youth value education and work and engages in habits to succeed in these settings R: Youth as little/no interest in education and work and has poor school and work habits that may contribute to failure	1.06	0.59	**0.47***
R: Youth experience death of peer/classmate/close friend	NA	0.51	NA

Source: DFC 2024 Progress Report)

Notes: Extent scored as No/Low (0), Moderate (1), or High (2);

[a]Mean difference calculated by subtracting the average risk score from the average protective score. Therefore, a positive difference indicates the average protective score was higher than the risk score. Conversely, a negative score signifies the risk score exceeded the protective score.; significance based on paired test with all differences significant at least at *p < .05

Table A.2: Percentage of DFC Coalitions Engaged in Efforts to Enhance Protective and Address Risk Factors

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
Community			
P: High rates of youth connection to the community; youth have a voice in the community are actively engaged with community organizations R: Low rates of youth connection to the community; little sense that youth have a voice in the community/active in community organizations	95.0%	90.9%	**4.16***
P: Plentiful community activities for young people R: Few community activities for young people	88.7%	88.3%	**0.40**
P: Laws, regulations, and policies in place related to substance use/access R: Inadequate laws/ordinances related to substance use/access	78.7%	68.1%	**10.61***
P: Adequate law enforcement presence sufficient to enforce laws/ordinances related to substance use R: Inadequate enforcement of laws/ordinances related to substance use	63.0%	65.2%	-2.28
P: Perceived community norms promote non-use/misuse of substances R: Perceived community norms favorable toward substance use	96.2%	96.9%	-0.67
P: Prevention, advertising, and other promotion of information related to preventing/ reducing substance use highly visible in the community R: Advertising promoting substance use highly visible in the community	90.7%	63.4%	**27.38***
P: Strong community organization (e.g., low rates of crime/violence, high access to safe, stable housing) R: Weak community organization (e.g., High rates of violence/crime, little access to safe, stable housing)	46.9%	34.4%	**12.49***
P: Low availability of substances (drugs, tobacco, alcohol) that can be misused; low visibility of drug dealing R: Easy availability of substances (drugs, tobacco, alcohol) that can be misused and/or high visibility of drug dealing	83.0%	86.3%	-3.36*
P: High rates of economic stability and access to educational/economic opportunities R: High rates of poverty and limited access to educational/economic opportunities; High unemployment and/or underemployment	38.0%	39.1%	-1.07

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
P: Sufficient access to mental health and treatment/recovery services in the community R: Lack of local treatment services for substance use and/or poor access to mental health services generally in the community	73.0%	68.3%	**4.7***
P: Treatment/recovery services for substance use are sufficient to meet demand in a timely manner R: Available treatment/recovery services for substance use insufficient to meet needs in timely manner	60.7%	53.3%	**7.38***
School, Faith, Peer			
P: High school connectedness: Youth feel a sense of connection to schools/teachers; Youth have adults who are mentors/someone they can confide in at school R: Low school connectedness: Youth do not feel a sense of connectedness to schools/teachers; Youth unlikely to have adults who are mentors/someone to confide in at school	77.9%	77.3%	**0.53**
P: High commitment to staying in school and attending school R: Low commitment to attend/stay in school; High rates of truancy and/or extended time missing school or dropping out of school	55.2%	45.8%	**9.4***
P: High rates of youth academic success R: High rates of youth struggling in school; Academic failure	48.2%	40.4%	**7.79***
P: High/Broad access to safe, high-quality schools across the lifespan R: Low access to safe, high-quality schools across the lifespan	32.5%	18.5%	**13.96***
P: Most youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult R: Few youth feel connected to a faith-based community or see the faith-based community as the source of a positive adult	39.7%	36.6%	**3.09***
P: Broad access to a range of faith-based services in the community R: Poor access to a range of faith-based services in the community	31.4%	22.6%	**8.86***
P: Low rates of youth perceiving peer acceptability (or lack of disapproval) of substance use R: High rates of youth perceiving peer acceptability (or lack of disapproval) of substance use	95.7%	96.0%	-0.27

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
P: High/easy access to adult or peer-to-peer mentoring for youth in need of a mentor or someone to provide help/advise R: Poor access to adult or peer-to-peer mentoring for youth in need of a mentor; youth have poor access to someone to turn to when help is needed in schools or peer group	76.1%	73.8%	**2.28**
P: Youth have easy access to/strong friendships with peers who engage in positive and healthy behaviors R: Youth have easy access to peers who engage in negative, unhealthy, or delinquent behavior	85.1%	79.2%	**5.91***
P: Low rates of bullying schools/peer group R: High rates of bullying schools/peer group	65.0%	63.9%	**1.08**
Family			
P: Family connectedness (youth feel connected to families/caregivers – feel can talk to them about range of feelings/issues) R: Low family connectedness: youth do not feel connected to their families/parents/caregivers do not perceive family as a source of support	84.0%	74.8%	**9.26***
P: Families/parents/caregivers engage in prosocial behaviors and maintain healthy stable relationships R: Family trauma/stress (e.g., parental/sibling substance use, domestic violence, death of family member)	78.9%	73.7%	**5.24***
P: Families/parents/caregivers encourage youth to engage in healthy behaviors including avoiding substance use R: Perceived parental acceptability (or lack of disapproval) of unhealthy behaviors, including substance use	94.0%	94.0%	0.00
P: High engagement by families/parents/caregivers in monitoring and supervision of youth R: Family/parental/guardian attitudes favorable to antisocial behavior	78.9%	56.8%	**22.15***
P: Families/parents/caregivers feel able/confident to speak to youth about healthy behaviors including avoiding substance use R: Families/parents/caregivers lack ability/confidence to speak to their children about substance use	96.0%	94.4%	**1.61***

Risk (R) and Protective (P) Factors	Percent Engaged in Enhancing **Protective** Factor in Community	Percent Engaged in Addressing **Risk** Factor in Community	Percent Point **Difference** between Engagement as Protective and Risk Factor[a]
Individual			
P: Few youth who have experienced two or more risk factors/stressors R: High rates of youth who have experienced two or more risk factors/stressors (e.g., abuse, homelessness, school failure)	78.8%	67.7%	**11.14***
P: Delayed or no initiation of negative or unhealthy behavior, including substance use R: Early initiation of negative or unhealthy behavior, including substance use	92.1%	91.7%	**0.40**
P: Youth have good life skills such as good decision-making and problem-solving skills R: Individual youth have favorable attitudes towards substance use/misuse	92.1%	96.9%	-4.83*
P: Youth generally follow and appreciate rules related to substance use at home, in school and other settings even without supervision R: Youth only follow rules around substance use when appropriately supervised; Breaks rules related to substance use across settings (school, home, other settings)	83.8%	78.8%	**4.97***
P: Youth seek out and engages in available positive, healthy, or prosocial behaviors R: Youth have few if any appropriate, prosocial, healthy activities or interest	93.2%	79.9%	**13.28***
P: Youth value education and work and engages in habits to succeed in these settings R: Youth as little/no interest in education and work and has poor school and work habits that may contribute to failure	69.7%	45.6%	**24.02***
R: Youth experience death of peer/classmate/close friend	NA	39.3%	NA

Source: DFC 2024 Progress Report

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

Appendix B. Core Measure Items

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

Table B.1. Core Measure Items Recommended Wording (2012 to Present)

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

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

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

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

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

Appendix C. Implementation Strategies Tables

Table C.1: *Providing Information* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Informational materials disseminated	600	80.5%
Social networking (Facebook, Twitter, etc.)	658	88.3%
Direct, face-to-face information sessions	631	84.7%
Conduct or promote special programs and/or special events (e.g., prescribing guidelines, PDMP, drop boxes/take back events, fairs, town halls, community celebrations)	598	80.3%
Informational materials prepared/produced (e.g., information about marijuana; information about opioids, fentanyl, and methamphetamine; information on sharing/ storage of prescription drugs; treatment referrals)	600	80.5%
Media campaigns: Television/radio/print/billboards/bus or other posters	578	77.6%
Media coverage: TV/radio/newspaper stories	475	63.8%
New Information on Coalition website	393	52.8%
Other Providing Information activities	81	10.9%
Summary: Providing Information	*741*	*99.5%*

Source: DFC 2024 Progress Report

Table C.2: *Enhancing Skills* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Youth Education and Training Programs	522	70.1%
Community Member Education and Training Programs	395	53.0%
Trainings specifically on identifying signs of potential drug use and/or risks associated with drug use (e.g., risks of adolescent marijuana use; opioid risks/signs of use; signs of methamphetamine use/sales)	387	52.0%
Implementation/ Supported Implementation of an Evidence-Based Curriculum in School Setting	397	53.3%
Parent Education and Training Programs	376	50.5%
Education and training specifically to reduce stigma associated with substance use/substance use disorder	328	44.0%
Sector-based Training (e.g., responsible beverage service/vendor training, prescription drug monitoring trainings, prescriber education & training; training on use and how/where to access naloxone)	292	39.2%
Teacher/Youth Worker Education and Training Programs	266	35.7%
Other Enhancing Skills Activities	82	11.0%
Summary: Enhancing Skills	*712*	*95.6%*

Source: DFC 2024 Progress Report

Table C.3: *Providing Support* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Alternative/drug-free social events	489	65.6%
Youth/family community involvement (e.g., school or neighborhood cleanup)	232	31.1%
Organized youth recreation programs (e.g., athletics, arts, outdoor activities)	208	27.9%
Youth/family support groups (e.g., for those who have relationships with individuals who use/misuse substances and recovery groups/events)	150	20.1%
Youth organizations/drop-in centers	154	20.7%
Other Providing Support Activities	101	13.6%
Summary: Providing Support	*633*	*85.0%*

Source: DFC 2024 Progress Report

Table C.4: *Changing Access/Barriers* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Reducing Home and Social Access (e.g., prescription drug disposal/storage; alcohol storage; make available or increase availability of local prescription drug take-back events; make available or increase availability of local prescription drug take-back boxes)	507	68.1%
Improve access to overdose prevention materials (e.g., distribution of naloxone)	372	49.9%
Increased Access to Substance Use Services (e.g., court mandated services, assessment and referral, recovery services; make available or increase availability of substance use screening programs (e.g., SBIRT); judicial alternatives for individuals with a substance use disorder who are convicted of a crime (e.g., drug court, teen court)	202	27.1%
Improve supports for service use (e.g., childcare, transportation; make available or increase availability of transportation to support prevention, treatment, or recovery services [e.g., medication assisted treatment, counseling, drug court])	97	13.0%
Other Changing Access Activities	68	9.1%
Summary: Changing Access/Barriers	*422*	*56.7%*

Source: DFC 2024 Progress Report

Table C.5: *Changing Consequences* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Recognition programs (e.g., programs for merchants who pass compliance checks, recognizing drug-free youth; physicians exercising responsible prescribing practices; individuals in recovery)	257	34.5%
Strengthening Enforcement (e.g., supporting DUI checkpoints, shoulder tap programs, open container laws; drug task forces to reduce access to opioids/methamphetamine in community)	176	23.6%
Strengthening Surveillance (e.g., monitoring "hot spots," party patrols; identify and/or increase monitoring of opioid/methamphetamine use "hot spots")	125	16.8%
Publicize Non-Compliance (e.g., highlighting businesses not compliant with local ordinances)	52	6.98%
Other Changing Consequences Activities	68	9.13%
Summary: Changing Consequences	*422*	*56.6%*

Source: DFC 2024 Progress Report

Table C.6: Educating/Informing about Modifying/Changing Policies or Laws Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
School: Policies promoting drug-free schools	168	22.5%
Citizen enabling/Liability: Laws/public policies concerning adult (including parent) social enabling or liability such as social host ordinances; policies regarding Narcan/naloxone administration; Good Samaritan Laws)	122	16.38%
Underage Use: Laws/public policies focusing on use, possession, or behavior under the influence for minors	119	16.0%
Supplier Promotion/Liability: Laws/public policies concerning supplier advertising, promotion, liability, (e.g., server liability, product placement, happy hours, drink specials, mandatory compliance checks, responsible beverage service; Prescription Drug Monitoring Programs)	81	10.9%
Outlet Location/Density: Laws/public policies concerning limitation and restrictions of location and density of alcohol or marijuana outlets	78	10.5%
Treatment/Prevention: Laws/public policies promoting treatment or prevention alternatives (e.g., diversion treatment programs for underage substance use)	81	10.9%
Sales Restrictions: Laws/public policies concerning restrictions on product sales (e.g., alcohol at gas stations)	75	10.1%
Cost: Laws/public policies concerning cost (e.g., alcohol, tobacco, or marijuana tax, fees)	50	6.7%
Workplace: Policies promoting drug-free workplaces	40	5.4%
Other Educating and Informing about Modifying/Changing Policies Activities	67	9.0%
Summary: Educating and Informing about Modifying/Changing Policies or Laws	*441*	*59.2%*

Source: DFC 2024 Progress Report

Table C.7: *Changing Physical Design* Activities

ACTIVITY	NUMBER OF COALITIONS ENGAGED	PERCENTAGE OF COALITIONS ENGAGED
Increase safe storage solutions in homes or schools (e.g., lock boxes, drug deactivation kits)	360	48.3%
Identify Physical Design Problems (e.g., environmental scans, neighborhood meetings, windshield surveys)	238	32.0%
Promote improved signage/advertising/practices by suppliers (e.g., Decrease signage or advertising, change product locations; post no smoking/no vaping signage)	201	27.0%
Cleanup and Beautification (e.g., Improve parks and other physical landscapes, neighborhood clean-ups; clean needles and other waste related to substance use from parks and neighborhoods)	157	21.1%
Encourage business/supplier designation of "no alcohol," "no tobacco," or "no marijuana" zones	51	6.9%
Improve visibility/ease of surveillance in public places and substance use hotspots (e.g., improved lighting, surveillance cameras, improved lines of sight)	48	6.4%
Identify problem establishments for closure (e.g., close drug houses)	25	3.4%
Other Physical Design Activities	60	8.1%
Summary: Physical Design	*558*	*74.9%*

Source: DFC 2024 Progress Report

Appendix D. Coalition Classification Tool

Table D.1: Community Assets

COMMUNITY ASSET	PERCENTAGE OF DFC COALITIONS WITH ASSET PUT IN PLACE AS A RESULT OF DFC GRANT AWARD	PERCENTAGE OF DFC COALITIONS WITH ASSET IN PLACE BEFORE DFC GRANT	PERCENTAGE OF DFC COALITIONS WITH ASSET NOT IN PLACE IN COMMUNITY
Social norms campaigns	70.7%	12.7%	16.6%
Substance use warning posters	64.4%	21.7%	13.9%
Town hall meetings on substance use and prevention within the community	59.5%	19.7%	20.8%
Recognition programs for drug-free youth	49.9%	12.3%	37.8%
Prescription drug disposal programs	46.7%	47.9%	5.4%
Recognition programs for businesses that comply with local ordinances	39.3%	12.7%	48.0%
Billboards warning youth about/against substance use	39.1%	16.9%	44.0%
Drugged driving prevention initiatives	34.8%	34.3%	30.9%
Vendor/retailer compliance training	31.7%	35.1%	33.2%
Formalized school substance use policies	30.8%	59.2%	10.0%
Media literacy training	30.2%	12.1%	57.6%
Compliance checks: Alcohol	26.3%	53.6%	20.1%
Responsible beverage server training	24.4%	39.5%	36.0%
Compliance checks: Marijuana	24.0%	54.3%	21.7%
Alcohol restrictions at community events	18.5%	45.2%	36.3%
Compliance checks: Tobacco	17.3%	18.4%	64.4%
Prescription monitoring program	17.0%	50.2%	32.8%
Secret shopper programs for alcohol outlets	15.8%	26.9%	57.4%
Social host laws	15.8%	51.6%	32.7%
Ordinances on teen parties	11.6%	36.0%	52.4%
Party patrols	8.8%	20.8%	70.4%

Source: CCT 2024 Data; n=741 DFC coalitions completing the CCT

Appendix E. Core Measure Data Tables

Table E.1. Change in Past 30-Day Prevalence of Substance Use[a]

FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				
SCHOOL LEVEL AND SUBSTANCE	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	1579	1579	7.8	-3.1*
Tobacco	1553	1553	3.6	-1.7*
Marijuana	1558	1558	3.7	-0.8*
Prescription Drugs	830	830	2.3	-0.6*
Methamphetamine	11	0.6	0.6	0.0
Heroin	17	0.4	0.4	0.0
HIGH SCHOOL				
Alcohol	1683	31.8	23.8	-8.0*
Tobacco	1658	14.9	9.9	-5.0*
Marijuana	1670	17.2	14.7	-2.5*
Prescription Drugs	917	5.4	3.3	-2.1*
Methamphetamine	22	0.9	0.8	-0.1
Heroin	25	0.6	0.6	0.0
CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2023 DFC GRANT AWARD RECIPIENTS				
SCHOOL LEVEL AND SUBSTANCE	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	438	7.0	5.0	-2.0*
Tobacco	411	2.7	2.2	-0.5*
Marijuana	422	3.4	2.6	-0.8*
Prescription Drugs	404	2.6	2.0	-0.6*
Methamphetamine	11	0.6	0.6	0.0
Heroin	17	0.4	0.4	0.0
HIGH SCHOOL				
Alcohol	479	23.0	14.8	-8.2*
Tobacco	462	8.3	4.8	-3.5*
Marijuana	479	15.2	10.5	-4.7*
Prescription Drugs	452	4.4	2.4	-2.0*
Methamphetamine	22	0.9	0.8	-0.1
Heroin	25	0.6	0.6	0.0

Source: Progress Report, 2002–2024 core measures data

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

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

Table E.2. Change in Past 30-Day Prevalence of Non-Substance Use[a]

FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				
SCHOOL LEVEL AND SUBSTANCE	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	1579	89.1	92.2	3.1*
Tobacco	1553	94.7	96.4	1.7*
Marijuana	1558	95.5	96.3	0.8*
Prescription Drugs	830	97.1	97.7	0.6*
Methamphetamine	11	99.4	99.4	0.0
Heroin	17	99.6	99.6	0.0
HIGH SCHOOL				
Alcohol	1683	68.2	76.2	8.0*
Tobacco	1658	85.1	90.1	5.0*
Marijuana	1670	82.8	85.3	2.5*
Prescription Drugs	917	94.6	96.7	2.1*
Methamphetamine	22	99.1	99.2	0.1
Heroin	25	99.4	99.4	0.0
CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2023 DFC GRANT AWARD RECIPIENTS				
SCHOOL LEVEL AND SUBSTANCE	n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	438	93.0	95.0	2.0*
Tobacco	411	97.3	97.8	0.5*
Marijuana	422	96.6	97.4	0.8*
Prescription Drugs	404	97.4	98.0	0.6*
Methamphetamine	11	99.4	99.4	0.0
Heroin	17	99.6	99.6	0.0
HIGH SCHOOL		77.0	85.2	8.2*
Alcohol	479	91.7	95.2	3.5*
Tobacco	462	84.8	89.5	4.7*
Marijuana	479	95.6	97.6	2.0*
Prescription Drugs	452	99.1	99.2	0.1
Methamphetamine	22	99.4	99.4	0.0
Heroin	25	77.0	85.2	8.2*

Source: Progress Report, 2002–2024 core measures data

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

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

Table E.3. Change in Perception of Risk/Harm of Substance Use[a]

FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	876	70.1	71.1	1.0*
Tobacco	1505	80.5	80.3	-0.2
Marijuana	846	69.6	67.9	-1.7*
Prescription Drugs	798	79.8	80.7	0.9*
HIGH SCHOOL				
Alcohol	941	70.8	71.5	0.7
Tobacco	1583	80.9	81.2	0.3
Marijuana	913	52.0	51.6	-0.4
Prescription Drugs	874	82.1	82.5	0.4
CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2023 DFC GRANT AWARD RECIPIENTS				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	422	70.4	70.7	0.3
Tobacco	423	78.9	79.0	0.1
Marijuana	417	69.1	67.7	-1.4*
Prescription Drugs	412	79.1	80.4	1.3*
HIGH SCHOOL				
Alcohol	461	70.1	71.3	1.2*
Tobacco	454	80.4	79.4	-1.0*
Marijuana	456	50.4	52.7	2.3*
Prescription Drugs	448	82.2	82.5	0.3

Source: Progress Report, 2002–2024 core measures data

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

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

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

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

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

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

Table E.4. Change in Perception of Parental Disapproval of Substance Use[a]

FIRST TO MOST RECENT REPORT, ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	791	94.1	93.3	-0.8*
Tobacco	1420	93.1	94.2	1.1*
Marijuana	1445	93.2	93.4	0.2
Prescription Drugs	791	95.6	94.9	-0.7*
HIGH SCHOOL				
Alcohol	863	88.7	89.2	0.5*
Tobacco	1521	87.6	90.5	2.9*
Marijuana	1542	86.1	86.1	0.0
Prescription Drugs	860	93.8	94.4	0.6*
CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2023 DFC GRANT AWARD RECIPIENTS				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	408	94.2	92.5	-1.7*
Tobacco	406	96.2	94.4	-1.8*
Marijuana	415	94.5	92.7	-1.8*
Prescription Drugs	409	95.7	94.7	-1.0*
HIGH SCHOOL				
Alcohol	449	89.4	89.1	-0.3
Tobacco	439	92.9	93.6	0.7*
Marijuana	459	85.8	86.0	0.2
Prescription Drugs	442	94.2	94.5	0.3

Source: Progress Report, 2002–2024 core measures data

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

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

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

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

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

Table E.5. Change in Perception of Peer Disapproval of Substance Use[a]

ALL DFC GRANT AWARD RECIPIENTS SINCE PROGRAM INCEPTION				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	791	85.5	85.7	0.2
Tobacco	796	88.4	88.8	0.4
Marijuana	804	85.1	86.1	1.0*
Prescription Drugs	784	90.4	89.8	-0.6*
HIGH SCHOOL				
Alcohol	868	66.7	73.0	6.3*
Tobacco	863	73.1	77.8	4.7*
Marijuana	873	56.6	61.3	4.7*
Prescription Drugs	850	81.8	85.8	4.0*
CHANGE OVER TIME FROM FIRST TO MOST RECENT REPORT, FY 2023 DFC GRANT AWARD RECIPIENTS				
SCHOOL LEVEL AND SUBSTANCE	n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
MIDDLE SCHOOL				
Alcohol	416	86.0	85.1	-0.9*
Tobacco	415	89.1	88.8	-0.3
Marijuana	418	85.0	85.1	0.1
Prescription Drugs	414	90.6	89.2	-1.4*
HIGH SCHOOL				
Alcohol	458	68.4	75.1	6.7*
Tobacco	447	75.5	79.2	3.7*
Marijuana	459	56.8	64.4	7.6*
Prescription Drugs	452	82.9	86.9	4.0*

Source: 2002–2024 core measures data

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

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

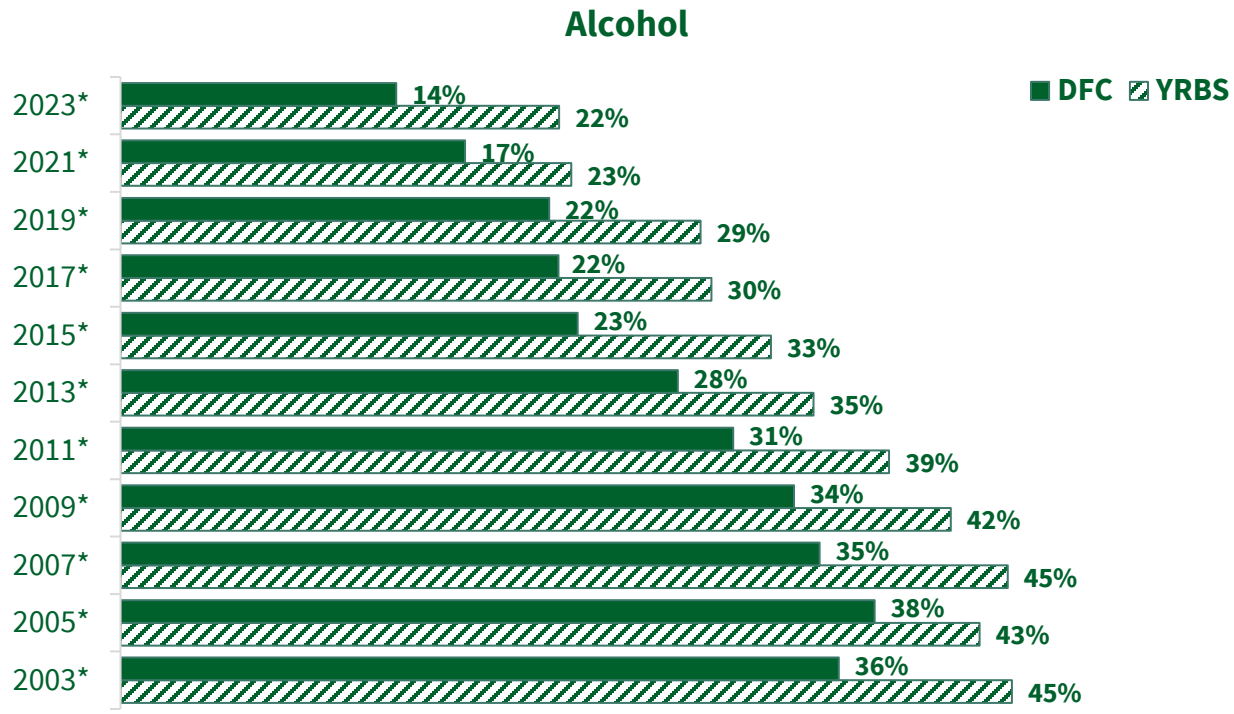
[b] Perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

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

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

Figure E.1. DFC Comparison to National YRBS Past 30-Day Alcohol, Tobacco & Marijuana Use Among High School Youth

ALCOHOL



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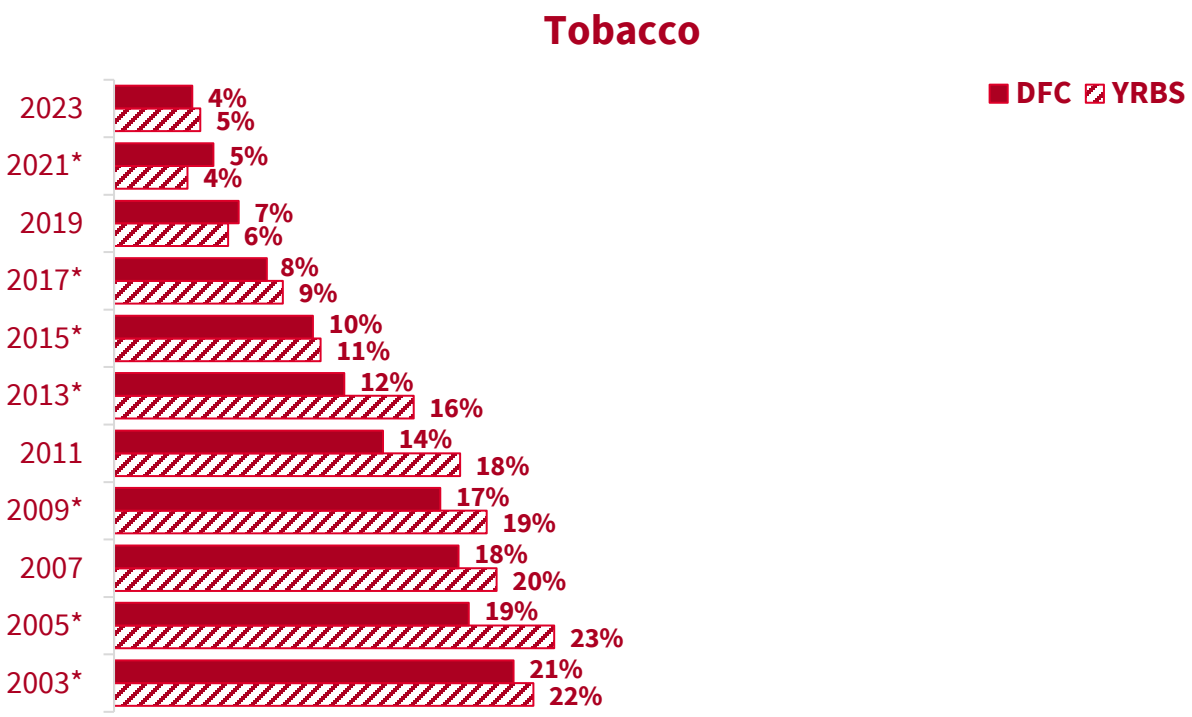
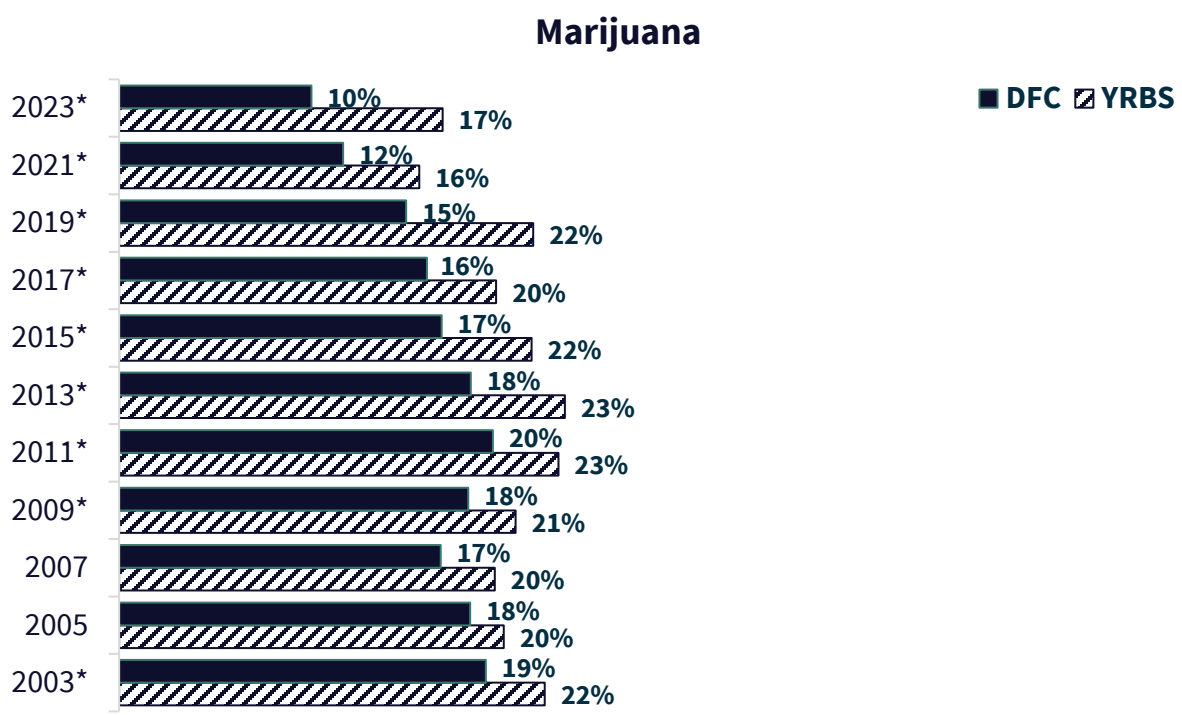


MARIJUANA



Source: 2003–2024 core measures data (with only data collected in odd years included in comparisons); CDC 2023 Youth Risk Behavior Survey Data (YRBS) downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm

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

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