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

Cohort 1 Final Report

Published August 2022

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Table of Contents

Table of Tables

Table of Figures

CARA Executive Summary

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

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

BUILDING CAPACITY

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

~3,700
people mobilized

84%
maintained their DFC 12-sector model

10
youth members on average

98%
invited new members with opioid/ methamphetamine expertise

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

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

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

CHANGING CULTURE AND CONTEXT

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

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

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

YOUTH SUBSTANCE USE

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

LIMITATIONS AND CHALLENGES

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

CARA Program

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

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

Key findings presented here include:

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

slight" stress.

Stress in general and living with someone with a substance use disorder are factors that may put youth at risk for substance use, especially if protective factors are not in place in the home and/or community. These risk factors are included in adverse childhood experiences (ACEs), along with a range of other risk factors.[15] Experiencing ACEs, particularly multiple risk factors, has been associated with a range of negative outcomes including an increased risk of substance use problems, both during adolescence and into adulthood. CARA and other community coalitions work to address ACEs by engaging in activities intended to increase the likelihood that youth experience protective factors, including helping connect youth with their community, a positive adult, and/or school.

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

Data

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

Progress Report Data

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

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

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

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

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

Core Measures Data

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

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

Past 30-Day Prevelance of Use

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

Perception of Risk

Percentage of respondents who perceived people who misuse prescription drugs or use heroin or methamphetamine risk harming themselves to a moderate or great extent.

Perception of Parent Disapproval

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

Perception of Peer Disapproval

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

Key Finding

Community Context

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

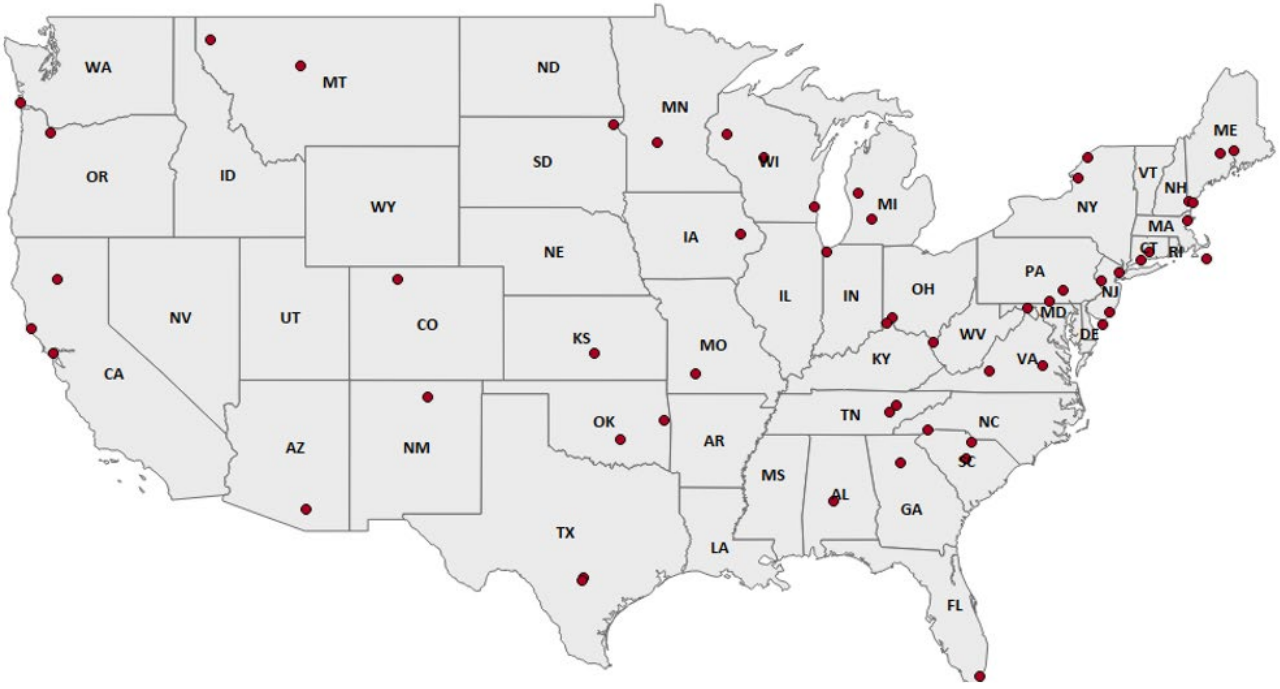
did not report any further data in their final report including the qualitative description of implementation activities. Thus, the number of coalitions included in most analyses in this report was 54 rather than 55.

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

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

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

FIGURE 1. MAP OF CARA COHORT 1 RECIPIENTS



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

TABLE 1. NUMBER OF CARA COHORT 1 COALITIONS BY STATE

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

Source: CARA Cohort 1 Award List

Community Demographics

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

Focus on Specific Subgroups of Youth

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

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

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

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

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

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

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

Substance Focus

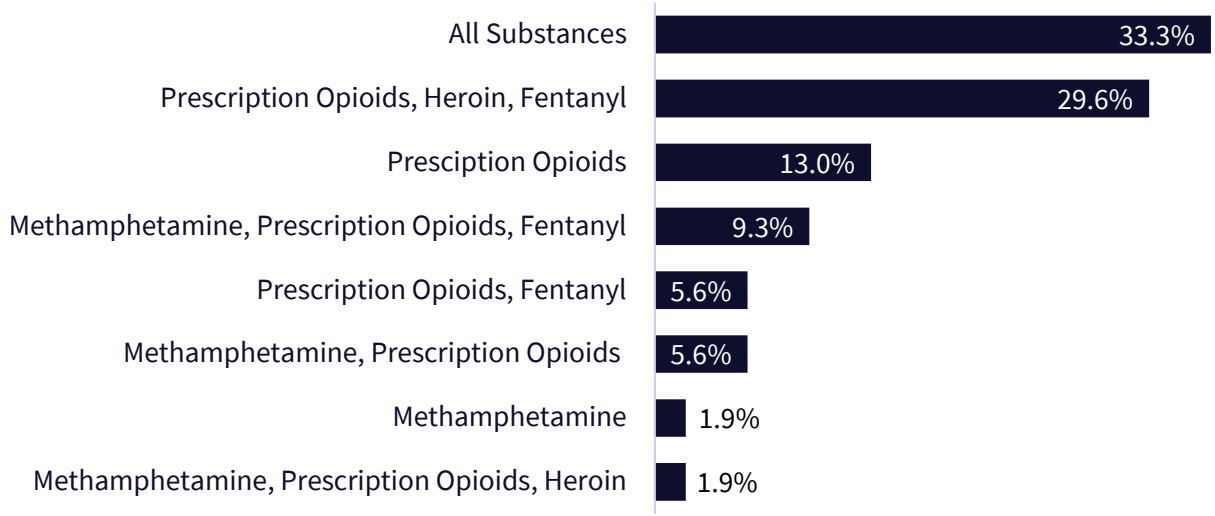
CARA funded coalitions identified from a list of substances (see Table 2) the focus of their prevention efforts.[22] Almost all (98%) coalitions were focused on prescription opioids. The primary focus by CARA coalitions on prescription opioids was also illustrated by the combination of substances the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

TABLE 2. SUBSTANCES FOCUSED ON BY CARA COALITIONS

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

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

FIGURE 2. MIX OF SUBSTANCES ADDRESSED BY COALITIONS



Source: CARA June 2021 Progress Report

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

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

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

Key Finding

Building Capacity to Prevent and Reduce Substance Use

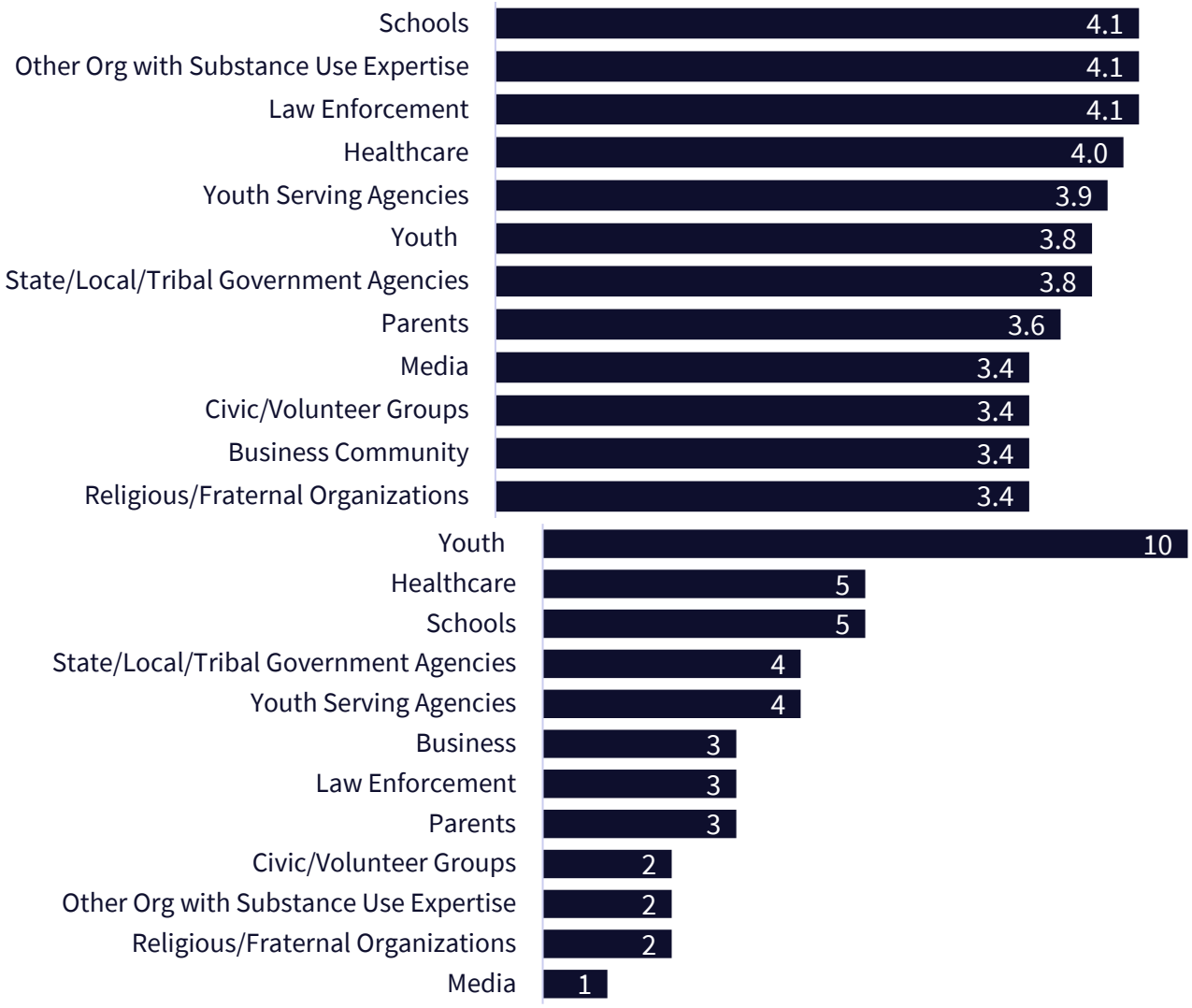
CARA coalitions *mobilized nearly 3,700 people to engage in youth substance use prevention and generally (84%) maintained the DFC Program's 12-sector community coalition model while engaging new partners.*

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

Active Sector Members and Sector Involvement

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

FIGURE 3. MEDIAN NUMBER OF MEMBERS BY SECTOR



Source: CARA June 2021 Progress Report

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

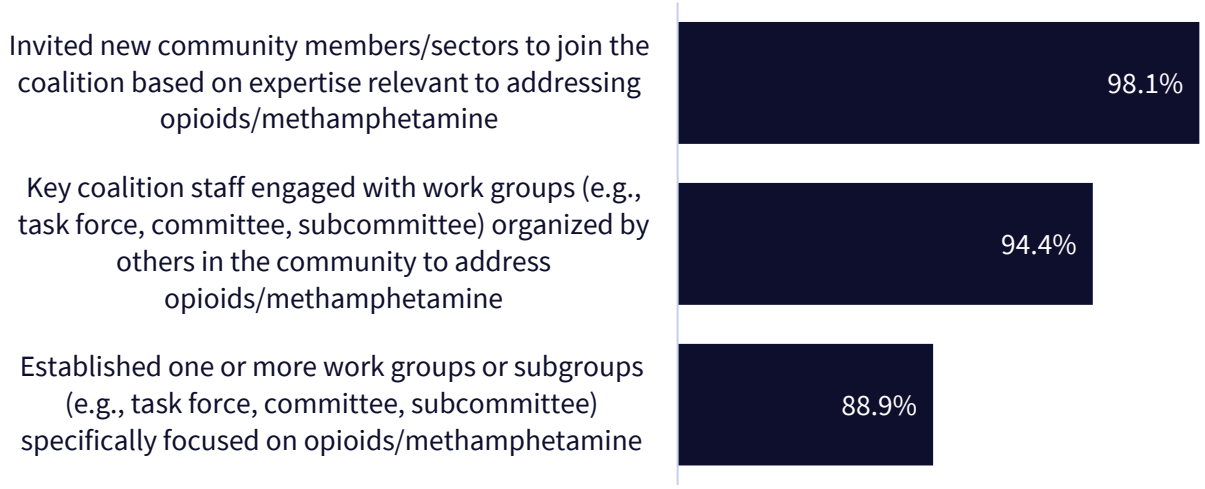
FIGURE 4. AVERAGE RATINGS OF SECTOR INVOLVEMENT

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

Activities to Build Capacity

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

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



Source: CARA June 2021 Progress Report

Data Collection and Sharing

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

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

CARA Innovation in Sector Engagement

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

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

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

Treatment and Recovery Sector Engagement

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

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

Key Finding

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

Strategy Implementation

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

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

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

Overview: Implementation of Strategies

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

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

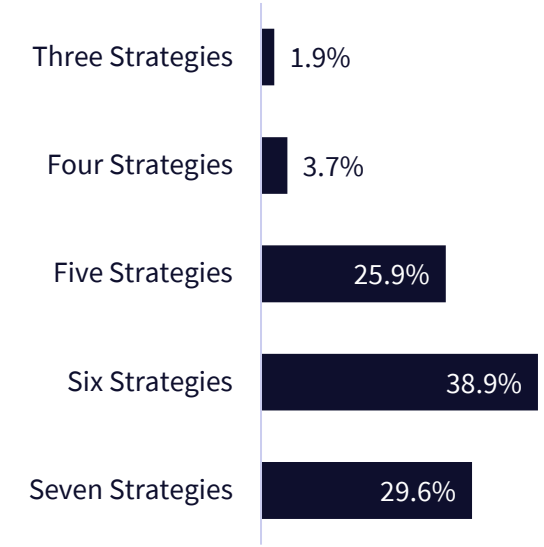
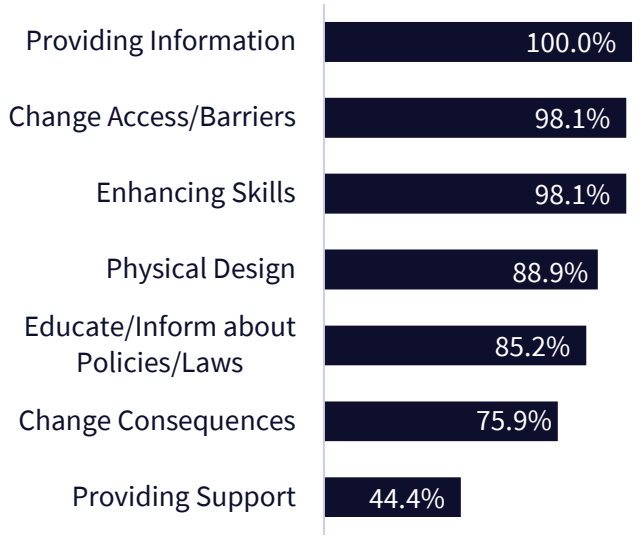


FIGURE 7. PERCENT OF COALITIONS ENGAGED IN AT LEAST 1 ACTIVITY BY STRATEGY TYPE



Source: CARA June 2021 Progress Report

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

[24] Community Anti-Drug Coalitions of America (CADCA) derived the seven strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. For more information, see https://www.cadca.org/resources/implementation-primer-putting-your-plan-action. CARA grant funds may not necessarily fund all the indicated examples provided for each of the 7 Strategies for Community Change. For the most recent description of CARA grant funding limitations, see https://www.grants.gov/web/grants/view-opportunity.html?oppId=329980

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

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

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

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

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

Source: CARA June 2021 Progress Report

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

TABLE 4. TOP FIVE ACTIVITIES LEAST IMPLEMENTED BY STRATEGY TYPE

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

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

Source: CARA June 2021 Progress Report

Implementation Highlights and Innovation

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

Evidence-Based Practices

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

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

Social Norms Campaign

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

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

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

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

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

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

Focus on Methamphetamine Prevention

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

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

Harm Reduction: Comprehensive Naloxone Training

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

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

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

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

Implementation During COVID-19

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

Challenges Experienced by Coalitions

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

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

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

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

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

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

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

Successes in Overcoming Challenges Experienced by Coalitions

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

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

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

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

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

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

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

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

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

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

Core Measures

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

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

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

Key Finding

TABLE 5. CORE OUTCOME HIGHLIGHTS BY SCHOOL LEVEL

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

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

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

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

Limitations and Challenges

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

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

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

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

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

APPENDIX A. CARA Annual Progress Report

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

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

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

COALITION STRUCTURE AND PROCESSES SECTION

Subsection: Coalition Information

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

Project Coordinator Contact Information:

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

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

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

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

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

Twitter handle: _____

Facebook page/URL: _____

Instagram handle: _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BUILDING CAPACITY SECTION

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

Subsection: Sectors

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

LOCAL DRUG CRISES SECTION

Subsection: Addressing Opioids/Methamphetamine

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

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

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

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

Strategy/Activity	Yes	No
Building Capacity		
Established one or more work groups or subgroups (e.g., task force, committee, subcommittee) specifically focused on opioids/methamphetamine		
Invited new community members/sectors to join the coalition based on expertise relevant to addressing opioids/methamphetamine		
Key coalition staff engaged with work groups (e.g., task force, committee, subcommittee) organized by others in the community to address opioids/methamphetamine		
Providing Information (e.g., community education, increasing knowledge, raising awareness		
Prescribing guidelines		
Promotion of Prescription Monitoring Program		
Promotion of prescription drug drop boxes/take back events		
Information about opioids (heroin, fentanyl, fentanyl analogs or other synthetic opioids) currently identified as an issue in the community or surrounding community		
Information about methamphetamine currently identified as an issue in the community or surrounding community		
Information about methamphetamine risks		
Information about sharing/storage of prescription opioids		
Information delivered via a town hall forum or conference related to methamphetamine		
Distribution of treatment referral cards/brochures/stickers		
Enhancing Skills (e.g., building skills and competencies)		
Community education and training on opioid risks for various community members (e.g., train youth/parents on risks associated with taking prescriptions not prescribed to you, train school athletic staff/players/families on addressing pain following injury or surgery, train realtors on working with clients to properly store medications prior to showing homes		
Community education and training on signs of opioid/methamphetamine use (e.g., Hidden in Plain Sight trainings)		
Prescriber education and training		
Education, training, and/or technical assistance on monitoring compliance for the Prescription Monitoring Program		
Education and training to reduce stigma associated with opioid use disorder		
Providing Support (e.g., increasing involvement in drug-free/healthy alternative activities)		
Youth/family support groups for those who have relationships with individuals who use/misuse opioid/methamphetamine		
Recovery groups/events		
Enhancing Access/Reducing Barriers (e.g., improving access, availability, and use of systems and services)		
Make available or increase availability of local prescription drug take-back boxes		
Make available or increase availability of local prescription drug take-back events		
Make available or increase availability of judicial alternatives for individuals with an opioid/ methamphetamine use disorder who are convicted of a crime (e.g., drug court, teen court)		
Drop-in events/centers to connect individuals with opioids/methamphetamine use disorders and/or their families to treatment/recovery opportunities		
Make available or increase availability of transportation to support opioid prevention, treatment, or recovery services (e.g., medication assisted treatment, counseling, drug court)		
Home visit follow-ups after an overdose/overdose reversal (e.g., safety official and healthcare provider visit to share and connect to treatment options)		
Improving access to opioid/methamphetamine prevention, treatment, and recovery services through culturally sensitive outreach (e.g., multilingual materials, culturally responsive messaging)		
Make available or increase availability of Narcan/naloxone		
Make available or increase availability of medications for opioid use disorder (e.g., suboxone, Vivitrol, methadone)		
Make available or increase availability of substance use screening programs (e.g., SBIRT)		

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

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

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

COMMUNITY AND POPULATION-LEVEL OUTCOMES SECTION

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

Subsection: Core Measures

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

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

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

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

Month and Year Data Were Collected: __/__

Core Measure: Past 30-Day Use

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

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

Core Measure: Perception of Risk

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

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

Core Measure: Perception of Peer Disapproval

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

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

Core Measure: Perception of Parent Disapproval

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

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

Subsection: Outcomes Summary

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

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

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

Does your data represent your population of focus?

- ❍ Yes
- ❍ No

If no, please explain: _____

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

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

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

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

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

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

(ENTER Data Management Plan in this field)

Recommended Core Measures Wording

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

Perception of Risk				
How much do you think people risk harming themselves physically or in other ways if they use prescription drugs that are not prescribed to them?	No Risk	Slight Risk	Moderate Risk	Great Risk
How much do you think people risk harming themselves physically or in other ways if they use heroin?	No Risk	Slight Risk	Moderate Risk	Great Risk
How much do you think people risk harming themselves physically or in other ways if they use methamphetamine?	No Risk	Slight Risk	Moderate Risk	Great Risk

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

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

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