Indiana Partnerships For Success (PFS)

Final Report

June 2020

Indiana University Richard M. Fairbanks School of Public Health at IUPUI

Department of Health Policy & Management
Center for Health Policy (CHP)

IUPUI

RICHARD M. FAIRBANKS
SCHOOL OF PUBLIC HEALTH
INDIANA UNIVERSITY
Indianapolis

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA

Table of Contents

Prepared by: Samantha Childress, BSPH; Tamara Leech, PhD; Dennis Watson, PhD; Lisa Robison, MPH; Marion Greene, PhD, MPH

Layout by Angela Evertsen, BS

Acknowledgement

This work is supported by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Award # 1U79SP020788. The collection and evaluation of Partnerships for Success (PFS) data across the life of the grant would not have been accomplished without the involvement of key organizations and individuals. First, we would like to thank the Rutgers University Eagleton Center for Public Interest Polling (ECPIP) for conducting both baseline and follow-up surveys and providing the research team with the methodological resources to effectively use these data. We would like to acknowledge the many young adult survey participants who provided their time and experiences, and which through them data collection was ultimately possible. We would also like to acknowledge Indiana's State Epidemiological Outcomes Workgroup (SEOW) and the PFS agencies for their input in survey question development. And, finally, we would like to thank DMHA and the PFS agencies for their continued assistance in our evaluative efforts throughout the grant cycle, including participation in the exit interviews conducted as a reflection on this grant.

Introduction

This is the final report discussing work carried out by Indiana University researchers as part of the Indiana Partnerships for Success (PFS) project. PFS is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Indiana's PFS initiative was funded in 2015 through the Indiana Division of Mental Health and Addiction (DMHA) to provide support to counties that (a) were at an increased risk for alcohol and prescription drug misuse among individuals aged 12-25 and who were not able to qualify for other DMHA funding, or (b) lacked the proper infrastructure to support substance misuse initiatives. These communities were: Cass, Clark, Floyd, Knox, Lake, Madison, Marion, Porter, Scott, and Vanderburgh counties.

The ten PFS-funded counties were tasked with administering sustainable, culturally competent, evidence-based interventions to address prescription drug use and underage and problematic drinking objectives using SAMHSA's Strategic Prevention Framework (SPF) as a guide. The SPF has five steps: (1) assessment, (2) capacity, (3) planning, (4) implementation, and (5) evaluation, all of which are underscored by two defining principles: cultural competence and sustainability [1]. Furthermore, these five steps and two principles that create the SPF have unique characteristics; the SPF is: (a) dynamic and iterative, recognizing that steps are interconnected, and issues and communities evolve through time; (b) data-driven, using reliable data sources to inform chosen efforts and approaches; and (c) reliant on and encourages a team approach, ensuring prevention efforts are championed by a variety of community partners and part of a larger community effort [1].

As part of these activities, DMHA contracted with researchers at the Indiana University Richard M. Fairbanks School of Public Health at IUPUI (FSPH) to help inform substance misuse prevention efforts in the 10 communities. This included (a) efforts to improve use of existing data through development of local epidemiological profiles, and (b) collection of original data on young adults ages 18-25 in these communities. This final report presents a comparison of findings from two waves of the survey that was developed and administered, as well as exit interviews with stakeholders from the funded PFS agencies and the DMHA PFS Project Coordinator.

Community Survey

Methods

The Indiana PFS Young Adults survey was developed by FSPH researchers and administered by the Rutgers University Eagleton Center for Public Interest Polling (ECPIP). The goal of the survey was to fill noted gaps in data collection among young adults ages 18-25 residing in the 10 PFS communities. DMHA funds the Indiana Youth Survey (INYS), which measures substance use among Indiana students in grades six through twelve. While this survey covers the younger half of the age group targeted by the PFS initiative, this also meant gaps were present in data collection among young adults who were out of the primary school system; especially for young adults who did not enroll in secondary education, join the armed forces, or connect with another outlet

that otherwise made them a captive audience for data collection. In addition, education is one of the most substantial social determinants of health, affecting multiple pathways that influence an individual's life trajectory, including opportunities to engage in healthy behaviors [2]. For these dual reasons, the PFS Young Adult Survey focused on collecting data that allow comparisons of "college" and "non-college" individuals ages 18 to 25, living in the 10 PFS-funded communities.

In 2016, the baseline survey (Wave 1) of the Indiana PFS Young Adults Survey was administered, and a follow-up survey (Wave 2) was administered in early 2019. For Wave 1, participant sampling was completed in two stages of randomized text messaging. Recruitment of the Wave 2 survey was similar, with ECPIP using randomly drawn samples from two listed cell phone samples of registered and non-registered young adult voters in the 10 counties. Randomization ensured researchers would obtain a demographically diverse sample of young adults, including varying education levels. Additionally, a small subset of participants who completed Wave 1 and agreed to be re-contacted for Wave 2 of the survey were recruited through two email attempts and one text attempt. Recruiting individuals to participate in both waves of the survey provided a greater level of consistency compared to solely drawing a new random sample at each time point, and it allowed us to conduct additional analyses specifically looking at changes over time at the individual level rather than the community level. All respondents were offered a $10 amazon gift card. Contact information for the gift card was collected in a separate instrument to ensure identifiable information could not be linked back to survey responses. A more detailed description of the methods guiding each survey wave can be found in prior reports provided to DMHA [3, 4].

Regarding the survey instruments, Wave 1 survey questions were developed by FSPH researchers with input from Indiana's SEOW and PFS staff from the 10 priority counties. When considering additional questions for Wave 2, FSPH once again consulted with Indiana's SEOW and the PFS communities. Additions to the follow-up survey included questions around Sunday alcohol sales and Sunday consumption of alcohol, housing/living situations while attending college, marital status, and employment. Different from the Wave 1 report, data tables in this report include marital status and employment data. While PFS objectives center on alcohol and prescription drug use, questions were included regarding such factors as tobacco and other drug use, stress, social support, and social status, due to SEOW and community input. Skip logic was programmed into the surveys and certain questions were displayed/not displayed based on prior respondent answers. The full Wave 2 survey instrument can be found in **Appendix A**.

We analyzed data from both Waves using StataSE 15, and significance was determined at a 95% certainty level. We conducted two types of analyses, (1) repeated cross-sectional and (2) matched sample. First, using the repeated cross-sectional design, responses at Wave 1 were compared to responses at Wave 2 using a "chi square test of independence." In other words, we compared young people's responses to questions in 2017 to young people's responses in 2019 to determine if there were any differences. Second, we also examined a subset of the data; i.e., those that were limited to the same respondents at Wave 1 and 2, we performed a 1:1 matched pairs McNemar's test.

These analyses allowed us to focus on "discordant" pairs where answers from the same person differed at Waves 1 and 2.

Repeated Cross-Sectional Survey Results

Below, we present a comparison of results from both survey waves, highlighting how responses changed for the 10 PFS communities combined over the time period. Frequency (N) and proportion (%) of responses are reported for each survey item. Areas of focus include overall participant demographics, alcohol use, prescription drug misuse, tobacco use, other substance use, and stress and social support. Statistically significant differences between participants in Wave 1 and participants in Wave 2 are discussed in each section, as well as overall trends in the data. A detailed presentation of the results from each wave were submitted in two prior reports [5, 6].

Overall participant demographics

Table 1 displays total respondent demographics for each wave. Respondents across both waves were primarily female, representing approximately 62 percent of respondents in each survey wave. White individuals represented the majority of respondents

TABLE 1: Total Respondent Demographics

	Wave 1	Wave 2
Demographic	**N (%)**	**N (%)**
Sex		
Male	421 (37.9%)	333 (37.7%)
Female	691 (62.1%)	551 (62.3%)
Race		
White	763 (70.0%)	630 (73.4%)
Black	189 (17.3%)	138 (16.1%)
Other	138 (12.7%)	90 (10.5%)
Average age*		
	22.2 years	22.0 years
Education		
HS Grad or Less	337 (30.0%)	230 (26.1%)
Some College/Associate's	483 (43.1%)	387 (43.9%)
College +	302 (26.9%)	264 (30.0%)
Currently enrolled in college		
	468 (46.7%)	449 (50.9%)
Could cover expenses in past year		
Always	568 (50.9%)	442 (50.3%)
Sometimes	481 (43.1%)	373 (42.4%)
Never	66 (5.9%)	64 (7.3%)

** indicates significant difference between groups (p <.05); reported by mean rather than proportion*

by race, followed by Black respondents and respondents of Other races. The average age of participants was the only demographic item that differed significantly between survey time points, with participants in Wave 1 being slightly older than participants in Wave 2. The level of educational attainment remained similar, particularly among those who reported having attended some college or who hold an Associate's degree. The level at which respondents reported being able to cover their expenses in the past year was also similar. It is important to point out that in both waves about half of participants were only "Sometimes" or "Never" able to cover their expenses.

Alcohol use

Tables 2 & 3 display comparisons of past 30-day alcohol use and past 30-day binge drinking for each survey wave. While proportions of respondents who reported alcohol use and binge drinking appear slightly higher in Wave 1, no significant differences in either category of alcohol use were found between the two time points.

TABLE 2: Past 30-day alcohol use

	Wave 1	Wave 2
Used alcohol? (past 30 days)	**N (%)**	**N (%)**
Yes	766 (68.3%)	575 (66.0%)
No	355 (31.7%)	296 (34.0%)

TABLE 3: Past 30-day binge drinking

	Wave 1	Wave 2
Binge drank? (past 30 days)	**N (%)**	**N (%)**
Yes	466 (41.6%)	334 (38.4%)
No	654 (58.4%)	537 (61.7%)

TABLE 4: Self-perceived risk of binge drinking

	Wave 1	Wave 2
Perceived risk*	**N (%)**	**N (%)**
No risk	90 (7.9%)	44 (5.0%)
Slight risk	282 (24.9%)	223 (25.3%)
Moderate risk	455 (40.1%)	351 (39.8%)
Great risk	307 (27.1%)	264 (29.9%)

**indicates significant difference between groups (p <.05)*

TABLE 5: Respondent thinks binge drinking poses great risk

	Wave 1	Wave 2
Great risk?	**N (%)**	**N (%)**
Yes	307 (27.1%)	264 (29.9%)
No	827 (72.9%)	618 (70.1%)

Tables 4 & 5 display a comparison of respondents' level of perceived risk of harm from binge drinking, as well as a specific comparison of whether or not respondents perceived binge drinking as posing a "Great risk," to individuals engaging in this behavior. The most notable change (a 37% decrease from 7.9% of respondents in Wave 1 to 5.0% of respondents in Wave 2) is in the percentage of young people who reported that binge drinking poses no risk. This decrease in the proportion of respondents who perceive no risk was accompanied by increases in the proportion of young people who think binge drinking poses a slight or great risk.

In addition to asking respondents about their self-perceived risk of binge drinking harm, we also asked how their close friends feel (or would feel) about binge drinking. **Table 6** displays a comparison of perception of friends' concern, by survey wave. The level of perception of friends' concern about binge drinking behavior differed significantly by time point. Those in Wave 1 were more likely to rate the level of their friends' concern about their binge drinking as being "Not at all concerned" or "Slightly concerned" compared to those in Wave 2, with those in Wave 2 more likely to report that their friends would be "Very concerned" about this type of behavior. **Table 7** displays a comparison of this highest level of perceived concern, which, again, differed significantly between the two waves, with survey respondents in the second wave significantly more likely to report their friends would be very concerned about their binge drinking.

TABLE 6: Perception of friends' concern of binge drinking

	Wave 1	Wave 2
Perceived concern*	**N (%)**	**N (%)**
Not at all concerned	337 (29.8%)	228 (25.9%)
Slightly concerned	432 (38.2%)	313 (35.6%)
Very concerned	362 (32.0%)	338 (38.5%)

**indicates significant difference between groups (p <.01)*

TABLE 7: Respondent thinks friends would be very concerned about binge drinking

	Wave 1	Wave 2
Very concerned?*	**N (%)**	**N (%)**
Yes	362 (32.0%)	338 (38.5%)
No	769 (68.0%)	541 (61.6%)

**indicates significant difference between groups (p <.01)*

TABLE 8: Past year prescription drug misuse

	Wave 1	Wave 2
Misused Rx drugs? (past year)	**N (%)**	**N (%)**
Yes	122 (10.9%)	81 (9.3%)
No	1000 (89.1%)	788 (90.7%)

Prescription drug use

Table 8 displays a comparison of reported prescription drug misuse in the past year by survey wave. Reported prescription drug misuse did not differ significantly between Waves 1 & 2. We also looked specifically at past year pain killer misuse, displayed in

TABLE 9: Past year pain killer misuse

	Wave 1	Wave 2
Misused pain killers? (past year)*	**N (%)**	**N (%)**
Yes	82 (7.4%)	42 (4.8%)
No	1034 (92.7%)	828 (95.2%)

**indicates significant difference between groups (p <.05)*

Table 9. Those who reported misusing pain killers in the past year differed significantly between the two waves, with the proportion of reported misuse decreasing in Wave 2.

Table 10 displays the average number of days individuals misused prescription drugs in the past 30 days, among those who reported misusing prescription drugs, as displayed in **Table 8**. The average number of days individuals reported misuse in the past month did not differ significantly by survey wave. **Table 11** displays a comparison of the source by which individuals obtained prescription drugs they misused, by survey wave. In Wave 1, the most common sources for obtaining prescription drugs was through using one's own prescription or getting them from a friend or family member. In Wave 2, using one's own prescription was still one of the top ways individuals obtained prescription drugs, but contrary to Wave 1, the proportion of individuals who bought their prescription drugs increased while obtaining them from a friend or family member decreased. None of these trends were statistically significant. However, when the results were limited to a comparison of the two most common sources at Wave 2, results were significant, as displayed in **Table 12**. The proportion of individuals who reported using their own prescription decreased while the proportion who bought their prescription drugs increased, demonstrating a significant shift

TABLE 10: Average number of days misused in past 30 days

	Wave 1	Wave 2
Average number of days	5.2 days	4.6 days

TABLE 11: Source by which respondent obtained prescription drugs

	Wave 1	Wave 2
Source	**N (%)**	**N (%)**
Friend/family member gave them to me	26 (24.8%)	9 (20.9%)
I bought them	17 (16.2%)	13 (30.2%)
Took them from a friend without permission	1 (1.0%)	0 (0.0%)
Took them from a family member without permission	3 (2.9%)	3 (7.0%)
Used my Rx	58 (55.2%)	18 (41.9%)

TABLE 12: Respondent bought prescription drugs versus misused own prescription drugs

	Wave 1	Wave 2
Source*	**N (%)**	**N (%)**
I bought them	17 (22.7%)	13 (41.9%)
Used my Rx	58 (77.3%)	18 (58.1%)

**indicates significant difference between groups (p <.05)*

between the two time points from using one's own to buying these drugs.

Similar to binge drinking, we asked respondents about their self-perceived risk of harm of prescription drug misuse, as well as their perception of friends' concern towards their real or hypothetical misuse. **Tables 13 & 14** display self-perceived risk of harm from prescription drug misuse as well as perception of great risk towards misuse. No statistically significant differences were found between the two waves, with similar perception of risk reported. Across both waves, the vast majority of respondents perceived misusing prescription drugs as posing moderate or great risk. Displayed in **Tables 15 & 16**, no significant differences were found between the two waves in relation to friends' concern about prescription drug misuse. Approximately 70 percent of respondents at both time points felt their friends would be very concerned about their misuse of prescription drugs.

TABLE 13: Self-perceived risk of prescription drug misuse

	Wave 1	Wave 2
Perceived risk	**N (%)**	**N (%)**
No risk	52 (4.6%)	25 (2.8%)
Slight risk	116 (10.3%)	95 (10.8%)
Moderate risk	304 (27.1%)	243 (27.6%)
Great risk	652 (58.0%)	518 (58.8%)

TABLE 14: Respondent thinks prescription drug misuse poses great risk

	Wave 1	Wave 2
Great risk?	**N (%)**	**N (%)**
Yes	652 (58.0%)	518 (58.8%)
No	472 (42.0%)	363 (41.2%)

TABLE 15: Perception of friends concern of prescription drug misuse

	Wave 1	Wave 2
Perceived concern	**N (%)**	**N (%)**
Not at all concerned	117 (10.5%)	90 (10.3%)
Slightly concerned	226 (20.2%)	168 (19.2%)
Very concerned	777 (69.4%)	618 (70.6%)

TABLE 16: Respondent thinks friends would be very concerned about prescription drug misuse

	Wave 1	Wave 2
Very concerned?	**N (%)**	**N (%)**
Yes	777 (69.4%)	618 (70.6%)
No	343 (30.6%)	258 (29.5%)

Tobacco use

Table 17 displays a comparison of past 30-day tobacco use, by survey wave. The proportion of respondents who reported cigarette use and use of smoking tobacco from a hookah or waterpipe decreased significantly in Wave 2. Meanwhile, the proportion of respondents who reported using e-cigarettes or some sort of other electronic vapor product increased significantly in Wave 2.

Other substance use

The proportion of respondents who reported past year use of any substance, excluding alcohol, marijuana, and tobacco, remained the same, as displayed in **Table 18**. **Table 19** displays a comparison of other past year substance use, by type. Tranquilizers were the only substance that differed significantly by survey wave, with a smaller proportion of respondents reporting use in Wave 2.

TABLE 17: Past 30-day tobacco use

	Wave 1	Wave 2
Type of tobacco	**N (%)**	**N (%)**
Chewing tobacco, snuff, or dip	34 (3.2%)	20 (2.3%)
*Cigarettes**	188 (17.6%)	90 (10.3%)
Cigars, cigarillos, or little cigars	93 (8.7%)	63 (7.2%)
*Electronic cigarettes (e-cigarettes) or some other electronic vapor product**	101 (9.6%)	135 (15.4%)
*Smoking tobacco from a hookah or waterpipe***	59 (5.5%)	29 (3.3%)

**indicates significant difference between groups (p <.001)*
***indicates significant difference between groups (p <.05)*

TABLE 18: Any substance other than alcohol, marijuana, and tobacco

	Wave 1	Wave 2
Used other substance?	**N (%)**	**N (%)**
Yes	203 (17.7%)	157 (17.7%)
No	942 (82.3%)	730 (82.3%)

TABLE 19: Past year substance use by type

	Wave 1	Wave 2
Substance Used	**N (%)**	**N (%)**
Sedatives	10 (0.9%)	3 (0.3%)
*Tranquilizers**	74 (6.7%)	37 (4.2%)
Stimulants	81 (7.3%)	69 (7.9%)
Meth	13 (1.2%)	11 (1.3%)
Cocaine/Crack	37 (3.3%)	33 (3.8%)
Heroin	13 (1.2%)	4 (0.5%)
Other substances (hallucinogens, synthetics, & inhalants)	52 (4.6%)	56 (6.4%)

**indicates significant difference between groups (p <.05)*

Stress and social support

Table 20 displays a comparison of significant sources of stress among respondents, by survey wave. Quite a few significant differences were seen among the two waves of respondents. Those in Wave 2 were significantly more likely to rate work, personal health, and job stability as significant sources of stress than those in Wave 1. Conversely, Wave 1 participants were significantly more likely to report that family and relationships were significant sources of stress for them, compared to those in Wave 2. **Table 21** displays the proportion of respondents in each survey wave that reported they always have someone to turn to for social support. No significant differences were seen among these two groups. Important to note is that approximately 42 percent of respondents in each wave reported they did not always have someone to turn to for social support when they are feeling stressed.

TABLE 20: Significant sources of stress

	Wave 1	Wave 2
Stressor	**N (%)**	**N (%)**
Money	935 (82.2%)	747 (85.1%)
*Work**	797 (71.1%)	661 (75.2%)
Political issues	537 (47.5%)	396 (45.0%)
*Family***	750 (66.3%)	529 (60.1%)
*Relationships***	762 (67.3%)	542 (61.6%)
*Personal health***	491 (43.6%)	440 (49.9%)
Housing	476 (42.2%)	395 (44.8%)
*Job stability****	458 (40.7%)	452 (51.6%)
Safety	401 (35.7%)	320 (36.3%)

**indicates significant difference between groups (p <.05)*
***indicates significant difference between groups (p <.01)*
****indicates significant difference between groups (p <.001)*

TABLE 21: Respondent always has someone to turn to for social support

	Wave 1	Wave 2
Social support?	**N (%)**	**N (%)**
Yes	660 (58.0%)	514 (58.1%)
No	479 (42.1%)	371 (41.9%)

Matched-Sample Survey Results (Subset Analysis)

Below, we present comparisons of responses only for individuals who participated in both waves of the survey. Thus, *demonstrating how responses changed for these individuals as a group between time points*. Like the full sample results, we look at survey items surrounding alcohol use, prescription drug use, tobacco use, other substance use, and stress and social support. Statistically significant differences between results in Wave 1 and results in Wave 2 are discussed in each section, as well as overall trends in the data.

Alcohol use

Tables 22 & 23 display comparisons of past 30-day alcohol use and past 30-day binge drinking among the same respondents, by survey wave. Full sample data displayed no significant differences among respondent alcohol use in either category. However, both past 30-day alcohol use and past 30-day binge drinking significantly increased in Wave 2

among matched participants. Respondents' past 30-day alcohol use increased by approximately 8 percent from Wave 1 to Wave 2, and their reported past 30-day binge drinking increased by nearly 11 percent from Wave 1 to Wave 2.

While alcohol use differed among survey waves, respondents' perceptions of risk of binge drinking and friends' concern towards binge drinking did not differ significantly across the time points, as displayed in **Tables 24 & 25**. Approximately 28 percent of respondents perceived binge drinking as posing a "Great risk" in both waves, with over one-third of participants in both waves perceiving their friends would be "Very concerned" about their binge drinking.

Prescription drug use

Tables 26 & 27 display comparisons of past year prescription drug misuse, and, more specifically, past year pain killer misuse. From Wave 1 to Wave 2, reported prescription drug misuse and pain killer misuse did not differ significantly among matched respondents.

Respondent perceptions of risk of harm from prescription drug misuse and friends' concern toward their real or potential misuse did not differ significantly across the time

TABLE 22: Past 30-day alcohol use (N=167)

	Wave 1	Wave 2
Used alcohol (past 30 days)*	**N (%)**	**N (%)**
	115 (68.9%)	129 (77.2%)

**indicates significant difference between groups (p <.05)*

TABLE 23: Past 30-day binge drinking (N=170)

	Wave 1	Wave 2
Binge drank (past 30 days)*	**N (%)**	**N (%)**
	67 (39.4%)	85 (50.0%)

**indicates significant difference between groups (p <.05)*

TABLE 24: Respondent thinks binge drinking poses great risk (N=170)

	Wave 1	Wave 2
Great risk	**N (%)**	**N (%)**
	47 (27.6%)	48 (28.2%)

TABLE 25: Respondent thinks friends would be very concerned about binge drinking (N=169)

	Wave 1	Wave 2
Very concerned	**N (%)**	**N (%)**
	65 (38.5%)	59 (34.9%)

TABLE 26: Past year prescription drug misuse (N=168)

	Wave 1	Wave 2
Misused Rx drugs (past year)	**N (%)**	**N (%)**
	17 (10.1%)	15 (8.9%)

TABLE 27: Past year pain killer misuse (N=165)

	Wave 1	Wave 2
Misused pain killers (past year)	**N (%)**	**N (%)**
	12 (7.3%)	10 (6.1%)

points, as displayed in **Tables 28 & 29.** The majority of respondents at the time of both survey waves perceived prescription drug misuse as posing a "Great risk," with an even larger majority of participants in both waves perceiving their friends would be "Very concerned" about their misuse.

Tobacco use

Table 30 displays a comparison of past 30-day tobacco use. In the full sample results, the proportion of respondents who reported cigarette use decreased significantly in Wave 2, and the proportion of respondents who reported using e-cigarettes or some sort of other electronic vapor product increased significantly in Wave 2. Full sample results also showed the proportion of those using smoking tobacco from a hookah or waterpipe also decreased significantly. However, the only significant difference in matched sample data was that the proportion of those who reported using smoking tobacco from a hookah or waterpipe decreased significantly by nearly 4 percent between the two time points.

Other substance use

Tables 31 & 32 display past year use of any substance, excluding alcohol, marijuana, and tobacco, as well as past

TABLE 28: Respondent thinks prescription drug misuse poses great risk (N=171)

	Wave 1	Wave 2
Great risk	**N (%)**	**N (%)**
	101 (59.1%)	110 (64.3%)

TABLE 29: Respondent thinks friends would be very concerned about prescription drug misuse (N=169)

	Wave 1	Wave 2
Very concerned	**N (%)**	**N (%)**
	114 (67.5%)	123 (72.8%)

TABLE 30: Past 30-day tobacco use

	Wave 1	Wave 2
Type of tobacco	**N (%)**	**N (%)**
Chewing tobacco, snuff, or dip	3 (1.9%)	2 (1.3%)
Cigarettes	19 (11.9%)	13 (8.2%)
Cigars, cigarillos, or little cigars	8 (5.1%)	11 (7.0%)
Electronic cigarettes (e-cigarettes) or some other electronic vapor product	16 (9.9%)	23 (14.2%)
*Smoking tobacco from a hookah or waterpipe**	8 (4.9%)	2 (1.2%)

**indicates significant difference between groups (p <.05)*

TABLE 31: Any substance other than alcohol, marijuana, and tobacco (N=171)

	Wave 1	Wave 2
Used other substance	**N (%)**	**N (%)**
	39 (22.8%)	36 (21.1%)

year use of a number of other substances. Among matched participants, there were no significant differences among the proportion of individuals who reported use of other substances from Wave 1 to Wave 2.

Stress and social support

Tables 33 & 34 display the proportion of respondents who selected items as being significantly stressful as well as the proportion of respondents who reported always having someone they can turn to for support when experiencing stress. The proportion of respondents who selected work and job stability as significant sources of stress increased significantly across the time points, with the proportion selecting work as a significant stressor increasing by 16 percent and the proportion selecting job stability as a significant stressor increasing by 22 percent. Conversely, the proportion of respondents who indicated relationships were a significant source of stress decreased from Wave 1 to Wave 2 by about 12 percent. These significant increases and decreases in sources of stress among matched sample participants were also similar to trends seen in the full sample. Respondents who reported always having someone they can turn to for social support did not differ

TABLE 32: Past year substance use by type

	Wave 1	Wave 2
Substance used	**N (%)**	**N (%)**
Sedatives	2 (1.2%)	0 (0.0%)
Tranquilizers	15 (9.1%)	12 (7.3%)
Stimulants	15 (9.0%)	13 (7.8%)
Meth	2 (1.2%)	2 (1.2%)
Cocaine/Crack	6 (3.6%)	11 (6.5%)
Heroin	3 (1.8%)	0 (0.0%)
Other substances (hallucinogens, synthetics, & inhalants)	15 (8.8%)	10 (5.9%)

TABLE 33: Significant sources of stress

	Wave 1	Wave 2
Stressor	**N (%)**	**N (%)**
Money	142 (84.5%)	152 (90.5%)
*Work**	109 (64.5%)	136 (80.5%)
Political issues	74 (43.3%)	78 (45.6%)
Family	104 (61.2%)	95 (55.9%)
*Relationships***	117 (68.4%)	97 (56.7%)
Personal health	73 (42.9%)	87 (51.2%)
Housing	62 (36.3%)	72 (42.1%)
*Job stability**	55 (32.2%)	93 (54.4%)
Safety	57 (33.9%)	56 (33.3%)

**indicates significant difference between groups (p <.001)*
*** indicates significant difference between groups (p <.05)*

TABLE 34: Respondent always has someone to turn to for social support (N=170)

	Wave 1	Wave 2
Social support	**N (%)**	**N (%)**
	95 (55.9%)	99 (58.2%)

significantly across time points. However, as with the full sample data, it is important to note that at each wave a large percentage of respondents did not always have someone to which they could turn for support.

Exit Interviews

As part of DMHA's evaluative efforts at the end of the five-year PFS grant cycle, researchers at the Richard M. Fairbanks School of Public Health (FSPH) conducted phone exit interviews with Executive Directors and/or Project Coordinators from each PFS-funded agency, as well as the DMHA PFS Project Coordinator, to learn about their specific experiences over the five-year grant cycle. Interview questions were guided by the Consolidated Framework for Implementation Research (CFIR) Interview Guide Tool, which focuses on five domains believed to impact the implementation process (intervention characteristics, outer setting, inner setting, characteristics of individuals, and process) [7]. The PFS exit interviews incorporated SPF components, specifically focused on the planning and implementation phase of each strategy or initiative, community capacity and engagement, assessment of readiness and resources, evaluation of goals and outcomes, and sustainability. The full exit interview protocols are included in **Appendix B**.

Interviews lasted approximately 45-60 minutes and were recorded and transcribed. MAXQDA qualitative data analysis software was utilized by the research team to analyze interviews for common themes. Because of the limited number of interviewees, interview quotes are attributed to participants/communities by a numbering system (i.e. Participant #1 = P1) to protect anonymity. Just as PFS utilized the SPF process to drive grant efforts, findings are reported by key SPF components.

Planning and Implementation

Choosing programs and strategies

PFS agencies reported implementing a variety of programs and environmental strategies in their communities that targeted a range of populations, such as school-aged youth, young adults, parents, older adults, and entire communities. Programs and environmental strategies were dependent on the chosen focus area of alcohol use and/or prescription drug use and ranged in evidence-base, as PFS communities were able to explore innovative programming with up to 30% of their PFS funding. Specific programs and strategies mentioned by the PFS communities included:

• All Stars	• LifeSkills Training	• Sticker Shock
• Be the Majority	• Media Ready	• Strengthening Families
• Conquer the CHAOS	• Overdose Lifeline	• Talk. They Hear You.
• eCHECKUP TO GO	• Parents Who Host Lose the Most	• Theatre Troupe
• Family Connections	• Positive Tickets	• This is (Not) About Drugs
• Hidden in Plain Sight	• Project MAGIC	• Too Good for Drugs and Violence
• In It to Win It	• Project Towards No Drug Abuse	• Wellness Initiative for Senior Education (WISE)
• INSPECT Training	• REAL Media	• What's Your Side Effect?

PFS communities also discussed a variety of efforts to generate further action and community conversations around alcohol use, prescription drug use, and overall quality of life issues. These efforts included: prescription take back efforts (e.g., take back events, increasing availability of disposal or lock boxes), development of a harm reduction committee, development of a podcast, binge drinking prevention activities and positive norms campaigning at a local college, an underage drinking/binge drinking town hall, prescribing protocol guidance, photovoice projects, geo-fenced ads targeting physicians and patients, environmental strategies promoting overall wellness, and creation of a university coalition.

When asked about how they chose their programs, such as characteristics, appropriateness, and sources, PFS communities named a number of different factors, including: past success with and characteristics of the programs and strategies themselves; data on risk and protective factors, as well as data that assisted communities in working with health disparate populations; discussions between communities about programs that proved successful; and discussions within communities, such as asking for direction from coalition leadership or conducting focus groups with coalition members.

Because some PFS communities have been doing prevention work for decades, it was commonly voiced that past success of certain programs factored into their decision about which PFS programs to implement. For example, multiple communities spoke about choosing LifeSkills programming because of past experiences and/or the characteristics of the program they felt were appealing:

> *And we went with LifeSkills again, to begin with, because we already had the curriculum, and we had a history, and people already liked it. So, we just had to get more people trained, and we could start using it again. (P9)*

Additionally, communities focused on choosing programming driven by their current community-level data, with most communities referencing the risk or protective factors as driving planning and implementation. One respondent described looking at and collecting a range of measures when assessing community needs, stating *"So, we got it from the Indiana Youth Survey, emergency room data, youth deaths, treatment episodes, arrest records. We'd use some qualitative data by talking to some youths within the school systems and asking what they see."* (P6). Another community perfectly captured utilizing the SPF process, also discussed by other communities, when looking at their data to inform efforts:

> *Yeah, I mean I think that's probably the easiest explanation is by going just through the SPF process, looking at the data, looking at where those specific, kind of, high points are with our data like, where is youth starting, where is youth getting worse with, especially under age? Who is supplying it? Those types of things with the availability. (P2)*

Communities gave a number of examples showing how they had used data to uncover racial and ethnic health disparities and purposefully sought out to work with underserved groups, integrating the importance of the SPF cultural competence principle into their efforts. One community talked about using the Indiana Department of Education website to identify schools with higher African American and Latinx populations as possible program sites. Another community discussed how, using their evaluation data, they were able to successfully implement a family-focused program to an underserved population:

> *With the Strengthening Families program, we have done a huge, successful Hispanic cohort that have 17 families and the majority of the parents did not speak English. So. we had translators and we translate all the material and translated the videos. And so that was really powerful to see...But the reason we were able to do it was because the data from our evaluation showed, we were missing a piece of the population in [our] County. (P7)*

Finally, PFS communities described speaking with community members and leaders outside their agencies when considering programs and strategies. One interviewee discussed relying on their coalition to assist with program planning, providing the group with a list of evidence-based curricula for review, conducting focus groups with members, and overall, collaboratively using their expertise to choose effective programming. Other communities mentioned working with coalition leadership in their area, again, drawing on community expertise.

PFS communities were encouraged to utilize Indiana's list of evidence-based programs, created by a DMHA workgroup made up of State, organizational, and community-level partners. This list of evidence-based programs was pulled from various databases such as the National Registry of Evidence-based Programs and Practices (NREPP) and Blueprints. When asked of their sources, communities also discussed directly using databases such as NREPP (prior to its suspension) or Blueprints. Additionally, some talked generally about utilizing SAMHSA's lists of evidence-based programming. A couple respondents specifically discussed difficulty with finding evidence-based programming related to prescription drug use, with some communities needing to find programming targeting some of their risk and protective factors, and then incorporating prescription drug use curriculum. One community discussed using SAMHSA's recommended list for their prescription drug activities. This specific community also discussed the difficulty with finding evidence-based programming compared to the past:

> *There's--the lists of evidence-based programs are getting harder to find. So it's not--we prefer the old days where there was actually several different places, like NREPP. I know Blueprints is still active and I know that there's a couple of other websites. But NREPP really had a nice way of searching programs based upon your determinants, so we miss that. (P2)*

Influential stakeholders

From the start, PFS communities utilized their coalitions and other influential stakeholders to help plan and implement programs and inform their

ideas. PFS communities needed to directly involve entities they were focused on working with, such as school corporations, which all communities worked with in some capacity. One community stated, *"And the answer to your question is we didn't, we received virtually no push back from the administration level, the highest administration level from any three of the school corporations, because they were involved in the development of the framework".* (P4).

The majority of PFS communities spoke highly of how influential stakeholders reacted to and adopted their PFS programs and strategies. In addition to communities already having established rapport with their key stakeholders and partners from past work, this can be attributed to really embedding PFS work into their communities and coalitions. One interviewee stated, *"So, and so we really tied our PFS grant in with [our] coalition. So, that way, you know, we were working with other people in prevention, treatment and law enforcement,"* (P5). Another respondent described key stakeholders in their community as highly motivated about one of their strategies, and they would not accept "no" as an answer when a police department's leader was reluctant to install a drop box:

> *That's because he was pressured by some of the key officials in his community, the judge, and the school board member, and someone on the city council all kinda said "No you're going to have a drug drop box. We need to know where you want it and how you're gonna do it." (P6)*

A few communities spoke of some pushback from their coalitions, with concerns of how certain programs would successfully work, such as a Strengthening Families program; they stated that, *"The duration of the program was something they thought was going to be an issue, they thought that having the families come together and actually recruiting them was going to be hard... that part was very true. And they didn't think it was going to be appealing to families."* (P7). Overall, however, communities spoke positively of the willingness of influential stakeholders to support community programming and strategies and partner with PFS agencies in this work.

Existing programs

When asked to compare the PFS programs to previously existing programs, a handful of communities talked about how their past work compared to current PFS work. Communities discussed how some programs and strategies implemented through PFS funding were a continuation and allowed them to sustain or expand programming that had already been happening on a smaller scale, while other programming brought in through PFS was new to their county or region. One interviewee discussed that while implementing curriculum was familiar to them, expanding to environmental campaigns, *"was a way for us to try to go for larger reach,"* (P5). Similarly, another community spoke about how this grant pushed them to broaden their population focus. In the past, this community had implemented curriculum in schools where children came from more affluent families, *"...but, after the PFS grant, we did kind of go to some more of the high-risk kind of schools where families had a lot more of a need,"* (P10).

When comparing their programs to others in their community, most pointed out there was not a lot to compare them to, because they were the primary (or only) organization implementing this kind of work: *"I think that there's, there's other programming that goes on, but it's not, for the most part, like substance abuse prevention focused."* (P2). However, a couple of communities discussed other organizations that had implemented similar programming, such as another group implementing Too Good For Drugs in a different school district,

or community partners who also implemented Strengthening Families. Other community groups who implemented or expressed interest in implementing programming often reached out to PFS agencies for their expertise.

Creating an implementation plan

Next, communities were asked to describe the process of creating an implementation plan. Interviewees described weighing the pieces of the planning process, including the community data, coalition member feedback, partnership availability, and programming familiarity. One community discussed how a community-level data assessment highlighted areas of focus, as data demonstrated low perception of risk from youth and parents. This community wanted to "layer the elements" of their implementation plan, working to set their community up for success by targeting both groups with efforts, explaining:

> *We looked at kind of like who our partners were, we worked with our coalition to identify, you know, what schools would be a good pick because we had to be very selective with our schools, we're a very large county, and we have a lot of schools, so we could not afford to do hardly any of them. So, we identified two school corporations that had greater needs, and, you know, that were interested in working with us and that's where we went. (P5)*

Another PFS community echoed this community's statement about strategically layering efforts and creating a multi-dimensional implementation plan to ensure the most success, asking the questions: *"How much programming can we push out to the community? How many different audiences can we reach in different domains?"* (P2). Further, another community considered the data, but made it a priority to develop relationships with, and be able to deliver programming to, the schools. This same community also described how another portion of their community's plan was dependent on an updated curriculum they wanted to implement, saying, *"And we actually wrote the grant on that perspective, that we were getting the newer version that I talked about, which included bullying, dating violence, vaping, and things like that,"* (P7). Finally, one community talked about planning for implementation with their community partners with the end goal in mind from the start: *"This is where we are at the end of the project and you sort of back up the wagon to see what sort of steps you gotta take to continue to consume that apple,"* (P4). While the communities followed the same SPF model when designing their implementation plans, key factors weighed-in differently in each community, based on their data, partnerships, and goals.

Engaging stakeholders

Regarding the discussion of program implementation, when coding interviewee responses, the code most commonly used was "engaging stakeholders." During the interviews, interviewees were asked to not only describe their process for engaging stakeholders, but also to describe outreach efforts and strategies to increase program awareness. The fact that this was the most commonly used code during analysis makes a statement in itself, as one of the primary themes presented directly relates to the name and purpose of the grant; it is partnerships that ultimately drive successful efforts.

Communities described engaging a variety of key stakeholders, ranging from organizational stakeholders to potential program participants. Further, communities mentioned a myriad of different ways they engaged communities, including: attending a variety of community events/meetings; talking to groups when invited; using the credibility of and working within schools to reach parents; providing food at programming; sharing

data with various groups to show community-level success; and disseminating prevention messaging and program information through a number of distribution channels, per their required marketing plan. Communities also mentioned a number of smaller touches that were a part of stakeholder engagement, like writing thank-you notes and checking in with partners. A staff member from one community sat outside elected officials' offices, hoping to get a chance to speak to these individuals, while another staff member from a different community recruited family to place yard signs with prevention information around the county. Communities were persistent and, needless to say, creative, in working to effectively engage with stakeholders.

As previously discussed, PFS agencies have been focused on prevention work for years and thus have been engaged with key stakeholders and groups for some time. Just as PFS agencies considered implementing previously successful programs, long-standing relationships also drove PFS partnerships in the communities. As one community pointed out, *"when it came to structuring this program, it really is an outgrowth from our work with school superintendents,"* (P4). However, PFS also encouraged agencies to work with groups they might not have worked with before, inherently forcing communities to take on the difficult task of building new partnerships. In doing so, one community discussed having to create partnerships at multiple levels for their Strengthening Families program, including with housing development representatives, community centers, neighborhood associations, and churches. Another community discussed how trying to form a relationship with their local university was a constant roadblock, fueled by reluctance to recognize the presence of any issues. Further, there was the difficulty of getting participants to consistently engage, as one PFS community described a lack of buy-in from parents, despite the investment of time in getting them to attend.

It's also important to acknowledge that the difficulty level of building or maintaining partnerships was not equal across PFS communities. One of the primary ways this manifested was in the structural differences of the partnering coalitions, as some communities led their coalitions and others were just members. As one respondent pointed out, this greatly affected partnership development, and thus, potential success:

> *And part of the problem, or the biggest problem, is that with any funding that you get there's certain requirements and things that you have to do. And there's certain coalition things that you have to do. And if you aren't kind of in charge of the coalition, and you're kind of at the whim of others within the group that may not necessarily share, you know, your, your piece of the pie, there's some work that has to be done to make sure that you can still get the work done within that, within that arena. (P3)*

Not all efforts to engage stakeholders, create partnerships, or work with the community were successful. For example, quite a few PFS communities talked about having to switch programs or strategies because agreements were broken or goals between partners did not align. While not every hard-fought battle to engage stakeholders resulted in great partnerships or endless success for communities, respondents did point out the value of relationship building. In addition to reaching a previously underserved population with programming, one community discussed how they partnered with a media business in their coalition to effectively push out environmental campaigns. Another PFS community mentioned that through networking, a local McDonald's has now provided the resources

they need to continue one of their programs, noting that, *"the community itself made the program completely sustainable,"* (P8). And another participant talked about how PFS partnerships will impact their agency long-term:

> *The biggest resources were the community partnerships, the "buy-ins" ...So, as far as resources, getting it started up wasn't difficult on our side, what was the hardest thing was the partnerships getting built...But then after a couple of years it's now our strength, is that we're called for everything for prevention in our community, we are the ones now referred to and called on. (P1)*

Program modifications and adaptations during implementation

When implementing programs and strategies, the SAMHSA SPF model encourages a balance between fidelity and adaptation, ensuring program effectiveness remains intact, while being flexible enough to meet the needs of the population served [1]. When asked to discuss any modifications or adaptations made to programs, all communities reported having to adapt or modify their chosen programs and strategies in some way. However, responses demonstrated consideration of the SPF guidelines when doing so. Communities frequently and consistently used the word "fidelity" when describing program implementation. In doing so, they first sought out ways to slightly modify rather than end programs, worked with DMHA and Prevention Insights for technical assistance, and added pieces to their efforts that made programs and strategies more robust. Moreover, modifications and adaptations made by PFS communities fell into a number of different categories and included, enhancing program reach; modifying programs to fit the cultures and norms of various populations; adapting to changes outside of the programs themselves, particularly with school-level changes, and replacing programming and strategies that were ultimately not successful.

One county discussed adding curriculum to focus on social and emotional learning. Another PFS community talked about how they modified an information dissemination program simply by expanding the typical distribution channels (e.g., displaying messaging on coffee holders). Another community also explained that they *"don't ever take anything away"* from the content but do *"add more hands-on activity to make it more interesting for the kids,"* to make programming more robust (P9).

Communities also spoke about adjusting programs to accommodate community norms. One PFS community discussed working with a Hispanic coalition before rolling out a campaign to this specific population in the community; this allowed them to learn appropriate messaging/imaging and to tell a culturally relevant narrative. Another community also modified messaging to fit the preferences of parents, as they learned their messages were misrepresented as a tool to be "better parents". In response, the interviewee stated that, *"We changed the framework and how we presented. So, we presented this as a tool to enhance the parenting they're already doing with their children,"* (P7). Additionally, another community discussed needing Spanish-translated materials, due to their large immigrant population, and having Spanish-speaking teachers leading youth and parent-focused programming.

Quite a few communities discussed having to adapt to changes outside of the programs themselves, often at the school-level. Despite communities reporting overall positive relationships with their schools, some had to make adjustments to the grade levels they were serving when school administrators discontinued their agreements to work with certain grade levels. For example, one community lost access to the high school grade

level after a new school administrator was hired. In addition to working with sixth graders already, they adapted to work with seventh graders as well. Another community also had to discontinue their programming at the high school because objectives between school leadership and the PFS agency were not aligning. This community was also able to transition their programming to the middle school level. The community discussed this positively, citing flexibility of PFS funding and strong relationships with school administrators as being facilitators to this change. Finally, another community ended a school program because of the lack of administrative/staff support: *"...it became a thing where they just wanted to get rid of the [Positive] tickets instead of rewarding the students for actual positive behavior because they just wanted to get rid of them,"* (P10). This community switched to a new program after realizing they were not getting the impact they wanted.

Lastly, communities reported that some programming simply did not resonate with certain populations and had to be switched out for other programming. One PFS community worked to modify one of their school-based programs, such as changing facilitators and modifying curriculum, before cutting it from their work plan completely:

> *But then after kind of year two we were still like "okay, that's—" even before we got the data back, the evaluation back, we knew that we needed just to cut our losses and move on, which we did. So, that was, that was a bit of a struggle. (P5)*

Finally, one PFS community talked about having to amend their programming to improve relevancy to youth, specifically the media programs, because, *"...the program itself is a little outdated and only covered magazines. Like, it covered mainly magazines and not social media, not TV advertisements,"* (P8). The updated program they chose better incorporated the types of media to which students could relate.

Difficulties and barriers during program implementation

Participants regularly discussed difficulties and barriers, and several have been previously mentioned, such as finding evidence-based programs, program modifications, and challenges forming new partnerships or working within their coalitions. However, we also explicitly asked participants about difficulties or barriers during the implementation process. Common difficulties or barriers included lack of awareness from the broader community about the importance prevention; limited program participation or engagement, particularly from parents; staff turnover; unexpected costs; and technical assistance.

A couple communities who worked on binge drinking or underage drinking efforts described challenges engaging the community, as "harder" substance use was perceived as an issue of larger concern, taking away from the willingness to discuss alcohol misuse. For example, one interviewee described alcohol as their community's main substance issue, but that, *"Our town has a very high heroin and meth problem and trying to get people to talk about alcohol when there is a very bad drug problem, all they want to talk about is heroin and meth,"* (P1). One community mentioned that the timing of the PFS grant did not help this, with communities, *"so energized over the opiate crisis,"* (P2). Further, these communities also expressed difficulties in getting their communities to fully grasp the concept or importance of prevention.

Communities that implemented programming with parents discussed difficulties engaging this population, due to a lack of participant interest or external barriers faced by the parents that limited

availability or access. One community addressed this issue by providing food at programming, as well as gas cards for transportation, as families reported that the extra resources were not factored into their budgets. Another community did something similar and assisted with transportation by paying for rides to and from programming. Still, communities consistently mentioned difficulties getting families and parents involved. One respondent discussed the consistent barrier of implementing programming when families have much greater needs, referencing the inability to address the larger social determinants of health:

> *...health outcomes are determined more by, of course, your zip code than your genetic code. So, when it comes to things like transportation, or, or, you know, food, you know, deserts and food instability and, and some of those things that cause, that cause problems within a community. And, and often our funding doesn't allow us to, to impact those in a, in a fantastic way. (P3)*

Additionally, multiple communities mentioned staff turnover as an issue with implementation, mainly because the staff member played a primary role in overseeing implementation or relationship development. Referencing staff turnover that occurred in the last year of the grant, one respondent discussed how a few employees worked to *"keep it afloat,"* while acknowledging that momentum was affected by this staff person's absence. Another respondent discussed the issue of grant funding being short-term, unfortunately causing staff to leave, taking the invested time, training, and agency's capacity with them. The loss of a staff member often meant an agency's capacity was limited until a new person was hired and trained. One community spoke about how even a small amount of staff turnover affected their work, saying:

> *And as far as--there were difficulties as far as turnover, like we don't have a lot of turnover. But when we did, that causes, of course it causes a lot of problems as far as you have to train a new person and get them indoctrinated into what you're doing. That takes a long time. (P8)*

While the majority of communities did not report unexpected costs, having included anticipated costs in their budgets, and paying for things like food and some incentives with donations or smaller grants, a couple communities discussed some unexpected costs of implementation. For example, one community mentioned purchasing program curriculum that was updated only a year and a half later. Because the updated curriculum included important topics, like vaping, they re-purchased the materials, which reduced their budget for campaign costs. Additionally, another community talked about how their projected costs for their Strengthening Families program was surprisingly underbudgeted, as families had more children than they initially allocated for: *"So, that would throw off the amount of food cost, amount of incentive costs, the daycare costs,"* (P7). This agency had to work within the community to get donations for these needed resources.

Lastly, some communities expressed challenges working with PFS technical assistance. One community thought the database or required evaluation system was *"cumbersome"* and *"not particularly user friendly."* Another community

desired more guidance in working with the college age or young adult populations. Further, one respondent felt there was a bit of disconnect between technical assistance provided by DMHA versus that by Prevention Insights in Bloomington, with these two entities doing the same work for different funded grants communities received (i.e., PFS versus block grant). Finally, one PFS community mentioned that they recently felt as though there was a potential communication disconnect between DMHA and Prevention Insights, as the community did not feel they were getting the information on outcomes they were asking for. This community additionally recommended not labeling calls non-mandatory or optional, when important information is being provided.

Community Engagement

In the next portion of the interview, interviewees were asked to consider their community's level of engagement in their PFS programs and strategies and to describe the community sectors involved in their coalitions, who have been the key influential players, and which sectors they wish had greater involvement in the coalition.

Community sector involvement

When asked about community representation within the coalitions, interviewees described having various community organizations or members involved that represented diverse expertise. Multiple communities pointed to SAMHSA's twelve community sectors, which includes youth, parents, businesses, media, schools, youth-serving organizations, law enforcement, religious or fraternal organizations, civic or volunteer groups, healthcare professionals, government agencies, and treatment providers working to reduce substance misuse, as being the core of their efforts. One stated, *"We have the standard 12 sectors... we have a wide range. I mean we have almost 50 to 60 member agencies and organizations with our coalition. So, we do have a really wide reach of people that we, we work with our coalition,"* (P4). Specifically, some examples of organizations mentioned by interviewees included prevention groups, recovery communities, school systems, treatment facilities, police officers, health clinics, local businesses, local sports and activities clubs, local arts groups, media, and churches.

Though several sectors appeared to be involved in the community efforts, involvement from each of these sectors proved to vary depending on the community at hand. For instance, a handful of interviewees praised the work of their local law enforcement and described their influence on the community. One community reported that a specific member of law enforcement took on a key role within their efforts:

> *Our law enforcement is absolutely amazing. The sector leader, he goes above and beyond to try to make sure everything is happening in the community from planning [program] to running our drunk driving task force, goggles and car driver simulation.... he really helped to work with the other police departments and other police officers and chiefs, to keep them on board with us and how important we are. He's great. And law enforcement is amazing. And they all support us, and this job would be a lot harder without the support we have from law enforcement. (P8)*

In addition to law enforcement, schools were commonly mentioned as sectors with a high-level of involvement, as many efforts utilized schools for program sites and recruitment purposes, but also pointed out the wide reach that schools have when influencing a community. Similarly, a few interviewees pointed out the importance of their recovery community. One described, *"We have a very strong recovery community and*

they're very active in our coalitions and, and they are big leaders in the movement," (P9). Another interviewee described the recovery community as a newer sector to become involved in their efforts but discussed it as a growing and beneficial partnership.

Areas for growth in sector representation

On the contrary, as to be expected, interviewees also described challenges engaging some community sectors. For instance, one interviewee reported the challenges of maintaining youth representation because of limited availability and the transition to college or moving away; thus, others reported representation from employees of youth-serving organizations. Other communities reported challenges involving government agencies or business sectors in their local efforts:

> *Our local government officials are nominally connected; we would like them to be more involved. And we would also love to have the business community more involved.... most of our elected officials -that's a part time gig and they have other full-time work, and they just can't get away. And businesses, most of our businesses around here are small businesses, and they also have a difficulty leaving their businesses in order to come to meetings. (P9)*

Another interviewee described similar challenges when trying to involve the community mental health sector and described capacity limitations: *"Community mental health centers across the state, they don't have sufficient capacity to provide for the intervention, especially substance abuse intervention, and especially with kid populations."* (P4).

Lastly, a few interviewees voiced challenges engaging the religious sector. One interviewee explained that a possible reason for this is that coalitions are strongly encouraged to utilize evidence-based programs or curriculums that often discuss or utilize non-abstinent routes to treatment. Thus, organizational values can vary and hinder partnerships. Another interviewee also discussed their experiences engaging local churches and described challenges maintaining a faith-based representative in their coalition:

> *We are constantly bringing in new ministers and they're not staying. So, I just feel like we need that aspect as a part of our coalition to reach more people that way. But I don't know... they just aren't staying. (P10)*

Assessment

Next, interviewees were asked to examine how community readiness has changed from the beginning of the PFS grant period. Interviewees were asked to discuss their community's knowledge of the substance misuse issues when the grant began, previous efforts to address this issue, previous support and resources available, and community attitudes. Subsequently, interviewees were asked to then consider how the PFS grant activities might have impacted these community factors.

Community readiness prior to PFS

The majority of interviewees reported a strong sense of community readiness at the beginning of the PFS grant period. These communities were described as being highly ready for change and aware of the issue at hand, often due to local data on substance-related deaths, media representation of substance use, and prior grant-funded initiatives

aimed at raising awareness. Further, the majority of interviewees also referenced the community preparedness for implementing programming and utilizing existing community infrastructure, as well as relying on the trust built between themselves and the community members.

Regarding community awareness of substance misuse, one interviewee indicated that their community was in the middle of a health crisis and very open to change:

> *I would say high. One of the things that--since 2015, our level of readiness is high. Prior to 2015, it was, it was more of a struggle. But 2015 was our, our pivotal year. And that's when our HIV crisis hit in our community. So, that kind of rallied all the troops for all kinds of things. But the need for prevention became very apparent. (P9)*

Another interviewee described their community infrastructure as the reason for their community readiness, in addition to an understanding of need:

> *As far as, like, our schools, we've been working with them for several years with different programs, so that was, they were ready for that, they were familiar with us, so that wasn't ever an issue. Law enforcement, I think, saw the need, for the prescription drug efforts, and the community has kind of grasped those take back efforts as well. (P2)*

Despite general readiness, some interviewees further explained that certain populations within the community were not completely on board with the initiatives when they began. For instance, one community explained that near the beginning of the PFS funding, they struggled with *"parent involvement and parent engagement"* and, thus, decided to begin the PFS initiatives by focusing on environmental campaigns before beginning programs more focused directly on families. Additionally, another community explained that while they felt their community was mostly ready, some medical professionals and physicians *"pushed back"* on changes made to their standard protocols regarding substance use prescribing and monitoring. Another community felt their readiness applied to the issue of prescription drug misuse but that the community was not ready to discuss the issue of alcohol misuse:

> *I think it differs. If we were talking about prescription drugs, I think our community was ready for changes and wanting information and wanting things to be done. Now if we're talking about alcohol, they definitely weren't ready then... So, I think we almost have to separate their readiness depending on what the topic is. (P10)*

Despite the consensus that counties were prepared, one interviewee did report that their community readiness was *"not very good."* The interviewee described their community as having limited previous programming focused on substance misuse, which meant their communities had not previously implemented larger programs, such as the PFS-funded initiatives, and did not have the resources or level of awareness that prepared community members to *"see it and buy into it."* (P1).

Community readiness changes post-PFS

Of the nine agencies involved in PFS grant funding, interviewees from all but three agencies reported community readiness had increased to some degree; the remaining three agencies reported that they had a high level of readiness from the beginning and remained this way throughout the period. Of the counties that reported changes, some reported drastic differences between the beginning of PFS to current day and others reported smaller, slower changes. For instance, one community explained that while they felt prepared in the beginning, their readiness grew over time:

> *We were already--we had the community readiness to implement these programs already, to be at that point. But this did help us continue to grow that readiness and grow those relationships better. And, I think it did help us be able to address the opioid problem and with youth in the area because that was something that I don't think the community's eyes were fully open to. And after this program, I think that it's gotten better. (P8)*

Those who discussed changes in community readiness described them in various ways and attributed these changes to several PFS-related factors, including education, relationship development, increased trust between organizations/personnel, promotions and advertisements, outreach, and supportive data. One community highlighted the work their staff did to improve community readiness:

> *"But with regards to the community's readiness for this, it has taken some time. And it has taken the work of our young professionals being in the community, participating in community forums, really working through a local coordinating council, working through our system of care, our SOC, collaborative effort." (P4)*

Another attributed their growth in readiness to the PFS programs, as they proved successful over time: *"I think also the community readiness has changed because we have successfully done these programs and have created a level of trust and expertise in the community."* (P7).

Lastly, the sole agency that reported low initial readiness discussed drastic changes in readiness as their community's knowledge of prevention increased. The interviewee explained that, *"The awareness is so much more, they understand what prevention is, they know what we do."* (P1).

Evaluation

Interviewees were next asked to describe whether they felt their PFS programs and strategies were able to meet their intended goals, any particular outcomes achieved, and to specify their biggest achievements.

Program success

All interviewees reported viewing their community's PFS initiatives as being successful throughout the grant period and considered their goals met. Outcomes described for the communities varied per community, as some focused on the data that demonstrated decreases in substance misuse or program outcomes achieved, while others focused on successful program implementation or partnerships developed.

Interviewees that focused on programs highlighted successful implementation, as well as the development of partnerships; they also pointed to the challenges, such as limited resources, hiring difficulties, or limited community support, they overcame to do so. One program that initially struggled to gain community support discussed the importance of their partnerships that came from the PFS initiative: *"Well, just the terminology itself, the partnership for success, we've developed so many partnerships in the community, and that was one of the big things, is getting more people engaged in the process of prevention,"* (P1). Another community highlighted similar achievements as they worked to improve their community's capacity: *"I think we've done exactly what PFS intended for us. We've leveraged new partnerships, we've leveraged new revenue sources (and we have significantly), and significantly improved our community's capacity to improve overall health outcomes in our community,"* (P4).

Further, some interviewees focused on the success of specific programs and reported that they received feedback from participants stating the programs impacted their lives in many ways, such as resiliency, and the ability to make healthy choices. One community that implemented the Strengthening Families program pointed to such feedback and felt as though the program was able to make a great difference in many lives: *"The kids walk away, and they have definitely a greater sense of like respect for themselves and in terms of their decision making. And the cool part is because we've been doing this grant for the last few years with the teens, we've followed up with them and we've seen them, how they're doing, and they'll tell us 'I really got something from the program because, now when this happens I'm prepared for it, I get it, I'm making better choices.'"* (P10).

Significant achievements

More specifically, each interviewee was then asked to narrow down their responses to identify their biggest success of the PFS initiative.

Responses to this question varied, as each county not only implemented different programs and utilized different strategies but did so in diverse environments. A couple of counties considered their main success to be relationships developed during the PFS period, as they were able to *"connect with groups that we have historically not worked with,"* (P5). Another interviewee indicated that the network developed during the PFS grant period was completely new to that county: *"The community really hasn't had anything like this. I've lived here all my life, and we've never really had any big grants that did a lot with prevention,"* (P1).

Further, another handful of interviewees considered a specific program to be their main success. For instance, one community highlighted their local podcast as their primary success because of outreach capabilities and its ability to be sustained post-PFS. Another pointed to their programs working directly with youth, as they have demonstrated to elicit passion in the youth to improve their community. And, another interviewee pointed to the impact of a youth program on their families, indicating that families have reported being impacted by the sessions years after completing the program.

Lastly, two communities described their main success being an overarching shift in focus within their community from action to prevention, which has allowed their community leaders to gain a larger public health lens when viewing the issue of substance misuse. One stated, *"I would say that the growth in and around prevention as a whole, viewing through the larger public health lens, I would say that has created a different kind of energy,"* (P4).

Sustainability

In the last section of each interview, we asked interviewees to describe any plans for sustainability, as well as any barriers or facilitators to long-term sustainability.

Plans post-funding

Communities spoke about applying for upcoming grants, using recently received grant funding, and identifying other funding streams for their agencies to continue or expand their PFS efforts. Funding applications varied by community and were dependent upon several factors, such as the organization's capacity to apply for or manage funding, agency resources, and which programs and strategies were being discarded or expanded by the agency or transferred to community partners. For example, one respondent discussed how their agency was currently writing a grant and planned to reapply for PFS funding, while another identified multiple grant applications that were in process or had been received.

Further, some communities seemed to have an advantage over other communities related to funding sources. One PFS community discussed there was limited community resources, which usually meant they went after government-level funding. Conversely, one agency discussed that their local community foundation had supplied funding for the last 8-10 years to continue one of their core programs, saying, *"...we know that, that money is going to be available to continue teaching LifeSkills in the middle schools without any kind of extra grant funding,"* (P9). In addition to a grant they already received, another respondent described plans to rely on a community donor who typically assists with funding. While all PFS communities require some sort of funding to continue their efforts, this looks different in each community, or as one participant put it, *"from soup to nuts, from one end to the other,"* (P3).

Another way that communities planned to sustain PFS efforts was by transferring programs and strategies to community partners who have the increased capacity. Communities who implemented programming within their school systems or through other community partners have worked to get those schools and individuals trained to deliver the curriculum. Supporting schools and community organizations to deliver this programming differed by community, with some communities taking a more hands-on approach to ensure the success of the programming, particularly around funding needed to continue implementation. For example, while speaking of the workbooks needed to continue their program, one community discussed they have been working with the schools to identify smaller sources of funding for which they can apply. Another respondent described how their agency, from the beginning of the grant, paid facilitators to train school staff and community partners in their program implementation. This community stated, *"And we also created a program in our agency that... once the community partner implemented the program three different times, then they earned their curriculum. So, we would buy extra curriculums and gift them the curriculum, in hopes that they could continue the programming,"* (P7). These two examples were juxtaposed by an agency who was unsure how their schools would continue the programs, mentioning the schools did not have the money to buy workbooks for the students. Regarding the environmental strategies, interviewees also discussed community partners absorbing these efforts. A coalition in one community discussed looking to adopt some of the campaigns through PFS. A couple communities discussed that drug drops or take back efforts will continue in their communities through the original, established partners. Similarly, one community reported embedding "What's Your Side Effect?" within their youth coalition to ensure sustainability, while another mentioned that a harm reduction committee composed of various community partners could pivot to address other harm reduction initiatives outside of its initial PFS focus. Additionally, a few PFS communities discussed the little or no cost it would take to continue some of these efforts themselves, particularly with environmental strategies. A couple communities mentioned having materials they used for their PFS strategies that they could continue sharing with the community through no cost dissemination channels, like social media, such as artwork and podcasts created for PFS.

Barriers to sustainability

Not surprisingly, one of the barriers mentioned to sustainability was funding; the universal barrier to sustaining programming and strategies. More specifically, a couple respondents mentioned concerns related to the longevity of funding or concerns around the application and management for further funding. For example, one agency mentioned this was one of the first big grants their community received to do prevention work, noting the effort it took to get the infrastructure built, only to have to reapply for something new:

> *...the only negative part is the grant isn't long enough. Because when you have it all built and started, now we're thinking "Ok now it's going to end", now we need to either apply for something different, so we can keep the momentum... you spend a lot of time and energy and effort to build something, and it goes for 4 years or 5 years and now you're looking to start over. (P1)*

Specifically concerning PFS funding, one respondent mentioned the switch in funding States to directly funding community agencies. This respondent noted that agencies vary in both experience and resources they have access to, to both apply for and manage federal-level grant funding, potentially making it more complicated in the long run for some communities to sustain their efforts.

Despite the majority of communities planning for partners to sustain some of their programs and strategies, as one respondent put it, partners need to have a certain "passion" to be able to continue on with efforts. A couple communities mentioned concerns that investing time in their partners to absorb efforts would not automatically equate to long-term sustainability. These communities ultimately acknowledged that it was up to the partner whether or not they wanted to continue on with efforts, with one community discussing they did not believe it would be as successful outside of their agency.

Finally, in addition to noting it as a barrier during program implementation, a couple communities again noted the barrier of staff turnover on sustaining PFS efforts. One community whose staff person left during implementation of the grant mentioned the difficulty with maintaining momentum without an anchor, stating, *"I think that is going to probably be one of the biggest barriers is when you don't have that one person who really keeps it moving forward and it gets, it starts to get broken out into more, many people. Sometimes that's hard to keep people all on the same page and moving forward collectively,"* (P5).

Facilitators to sustainability

While some communities were concerned about long-term sustainability of partners, these same communities, as well as other interviewees, were encouraged that strong partnerships and community support could be a facilitator to sustainability. Some respondents mentioned some of the schools in their community seem to really understand the importance of continuing programming, with a school in one community having already applied for and received grant dollars to sustain these efforts themselves before the larger grant ended. Another community spoke about the support they have received from their community to sustain programming, even when the agency itself is unsure it is making any sort of positive impact:

Definitely the community itself... Because we've talked about it in the past when we've struggled with recruitment for programs and we're like "Maybe we ought to discontinue this," ...So, even when we feel a little defeated there's others around us keeping us motivated to do it because they're like, "No it's working, and maybe we're just in a bit of a low period but it always improves." (P10)

Additionally, one community spoke of how a recently formed regional partnership between counties could help sustain PFS efforts into the future. This community specifically discussed how Align Southern Indiana, involving two PFS communities, will ensure better participation in the Indiana Youth Survey (INYS) as well as a commitment from school administration to try and create the space for prevention programming across all levels in all involved counties.

Finally, while a couple interviewees were concerned with staff turnover as a hindrance to sustainability, one community pointed out that a great team of staff is a large part of their sustainability plan. This agency has been able to build their team of staff from various backgrounds, including counseling, public health, and social work, who are interested in working in prevention long-term.

Conclusion

One of the overarching goals of the PFS grant was the reduction in underage drinking and prescription drug misuse among young adults in the 10 funded communities. The PFS Young Adults Survey was specifically designed to provide a snapshot of these and other substance use issues in the target population. Measuring statistically significant decreases in prevalence is challenging within such a short time period (2016-2019). However, we did find significant changes in both sets of analyses conducted (repeated cross-sectional and matched sample) for some of the measures.

At the community-level (repeated cross-sectional analysis), there was no change in the level of alcohol consumption. However, we found a change in the risk perception related to alcohol use; specifically, we saw a decrease in the percentage of young people who reported that binge drinking poses "no risk" (**Table 4**) and an increase in the percentage who felt that their friends are concerned about binge drinking (**Tables 6 and 7**). Furthermore, from 2016 to 2019, there was a drop in the percentage of 18- to 25-year-olds who reported having misused prescription pain reliever in the past year (**Table 9**). The study also showed a decrease in cigarette smoking and hookah/waterpipe use, as well as an increase in e-cigarette use (**Table 17**). Regarding other drugs, only tranquilizer use dropped significantly from 2016 to 2019 (**Table 19**). In terms of stressors, participants in Wave 2 reported more stress related to work, personal health, and job stability; and less stress related to family and relationships (**Table 20**).

At the group-level (subset of participants in both waves; matched-sample analysis), we saw an increase in both past-month alcohol use and binge drinking from 2016 to 2019 (**Tables 22 and 23**). The only other significant changes between the two time points in this group were a decrease in hookah/waterpipe use, as well as more reported stress related to work and job stability, and less stress involving relationships (**Table 33**).

We cannot quite speculate why alcohol and binge use increased in the matched sample. It could be self-selection bias, i.e., an underlying difference in those individuals who agreed not only to participate in Wave 1, but also Wave 2.

Exit interviews with PFS agency staff demonstrated that PFS planning and implementation was viewed to be largely successful by agency staff. The

SPF process was largely followed, with agencies identifying appropriate evidence-based practices from a variety of sources (e.g., prior experience, state-level guidance, federal guidelines and recommendations), developing and expanding community partnerships, targeted attempts to identify underserved groups, and appropriate consideration of the need to balance program adaptation and fidelity. In total, 24 specific prevention strategies were discussed in interviews, as well as a variety of other community-level prevention activities. Partnerships were seen as the main driver of successful implementation, with agencies expanding existing relationships and developing new relationships with a variety of different stakeholder groups. Finally, PFS agencies' sustainability plans relied on two main strategies, to (1) find additional funding, and/or (2) turn over PFS initiatives to community partners with more resources and capacity.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). A Guide to SAMHSA's Strategic Prevention Framework. Retrieved April 16, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.
2. Robert Wood Johnson Foundation (RWJF). (2011). Education and Health. Retrieved March 31, 2020, from https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html
3. Koning, A.; Borie-Holtz, D.; Rua, J. (2017). Indiana University Young Adult Study: Methodological Report. Rutgers University Eagleton Center for Public Interest Polling (ECPIP).
4. Koning, A.; Borie-Holtz, D.; Rua, J. (2019). Indiana Young Adults Study: Time 2. Rutgers University Eagleton Center for Public Interest Polling (ECPIP).
5. Watson, D.; Leech, T.; Greene, M.; Childress, S.; Nannery, R.; Adams, E. (2018). Indiana Partnerships for Success Young Adult Baseline Survey: Results related to alcohol and prescription drug use. Indiana University Richard M. Fairbanks School of Public Health at IUPUI.
6. Childress, S.; Watson, D.; Greene, M.; Leech, T. (2020). Indiana Partnerships for Success (PFS) Young Adults Follow-Up Survey (Wave 2): Findings on alcohol, prescription drugs, and other substance misuse. Indiana University Richard M. Fairbanks School of Public Health at IUPUI.
7. Consolidated Framework for Implementation Research. CIFR Technical Assistance Website. Retrieved February 1, 2016, from http://www.cfirguide.org/index.html.

Appendix A: Survey Instrument

Indiana University 2018 Young Adults Survey

Welcome to the Indiana University 2018 Young Adults Survey Please click next to begin the survey.

Amazon Gift Card

As a thank you for completing our survey, we would like to offer you a $10 Amazon gift card. If you are eligible to participate, you will be directed to a link upon completion where you can enter your contact information. Your contact information will only be used to send you the gift and will not be linked in any way to your survey responses.

BQ1 Browser Meta Info
- Browser (1)
- Version (2)
- Operating System (3)
- Screen Resolution (4)
- Flash Version (5)
- Java Support (6)
- User Agent (7)

SQ1 What county do you live in?
- ❍ Cass County (1)
- ❍ Clark County (2)
- ❍ Floyd County (3)
- ❍ Know County (4)
- ❍ Lake County (5)
- ❍ Madison County (6)
- ❍ Marion County (7)
- ❍ Porter County (8)
- ❍ Scott County (9)
- ❍ Vanderburgh County (10)
- ❍ My county isn't listed (11)

SQ2 What is your age? Enter 2 digits for your age.

Q97 What is your gender?
- ❍ Male (1)
- ❍ Female (2)

CONSENT
On behalf of Indiana University, we are asking for your help on an important study surveying young adults about public health issues, including the effectiveness of drug treatment and education programs among those between the ages of 18 to 25. Your participation is incredibly important, as only 800 adults in 10 Indiana counties have been selected to take part in this study. This should only take about 10 minutes.

Your answers are confidential. Confidential means that the research records will include some information about you, and this information will be stored in such a manner that some linkage between your identity and the response in the research exists.

To help us protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. We can use this Certificate as researchers to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, for example, if there is a court subpoena. We will also use the Certificate to resist any demands for information that would identify you, except for voluntary disclosure of information by yourself or any disclosure that you have provided written consent in writing.

The survey does include questions dealing with illegal drug use and sexual identification. Your participation is voluntary.

You may end the survey at any time and you may skip questions you do not want to answer.

If you have any questions about this research project, you may contact Ashley Koning at Eagleton Center for Public Interest Polling by email akoning@rutgers.edu or by phone. If you have any questions about your rights as a research participant, you can contact the Institutional Review Board at Rutgers (which is

a committee that reviews research studies in order to protect research participants) at: Arts & Sciences Institutional Review Board, Rutgers University, the State University of New Jersey. Liberty Plaza / Suite 3200 335 George Street, 3rd Floor, New Brunswick, NJ 08901, 732-235-9806, humansubjects@orsp.rutgers.edu. Selecting YES gives your consent for us to use your responses in our study. If you do not wish to participate, please select NO. CLICK NEXT when you have selected your answer.

- ❍ Yes (1)
- ❍ No (2)

AccessCode Please enter your personal access code from your [mode] invitation to gain access to the survey. This code is a 6-digit number, such as 123123 or 654321.

GenHealth We would like to begin by asking you some general questions about your health and wellness. You may skip questions you do not want to answer or are unsure about.

Q1 Would you say that in general your health is

- ❍ Excellent (1)
- ❍ Very Good (2)
- ❍ Good (3)
- ❍ Fair (4)
- ❍ Poor (5)

Q2 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good, if at all? Enter a 2 digit number for # of days. (For example, enter "01" if poor physical health kept you from doing your usual activities for 1 day during the past 30 days.)

Q3 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good, if at all? Enter a 2-digit number for # of days. (For example, enter "01" if your mental health was poor for 1 day during the past 30 days.

Display This Question:

If Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? Text Response Is Greater Than 0

Or Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? Text Response Is Greater Than 0

Q4 During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? Enter a 2 digit number for # of days. (For example, enter "01" if your physical health was poor for 1 day during the past 30 days kept you from doing your usual activities.

Q5 What do you consider to be the primary source of stress in your life?

Q6 Below is a list of things people say cause stress in their lives. For each one, please indicate how significant, if at all, each source of stress it is in your life.

	Very significant (1)	Somewhat significant (2)	Not very significant (3)	Not at all significant (4)
Money/finances (1)	❍	❍	❍	❍
Work (2)	❍	❍	❍	❍
Larger economic, political, or social issues (3)	❍	❍	❍	❍
Family responsibilities (4)	❍	❍	❍	❍
Relationships (5)	❍	❍	❍	❍
Personal health concerns (6)	❍	❍	❍	❍
Housing concerns (7)	❍	❍	❍	❍
Job stability (8)	❍	❍	❍	❍
Personal safety (9)	❍	❍	❍	❍
Other [Please specify] (10)	❍	❍	❍	❍

Q7 How often do you have individuals you can turn to for support if you are feeling stressed?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Never (3)

Tobacco. Next, we would like to learn about attitudes and behaviors related to tobacco, alcohol and prescription drug use. The answers that people give us about their use are important to this study's success. We know that this information is personal, but please remember your answers are confidential. None of the information you provide will be linked to your name or any other identifying information. You can also skip any questions you do not want to answer or unsure about.

Q8 For each of the following tobacco products, please tell us whether or not you have ever tried it, even if you have only tried it once.

	Yes (1)	No (2)
Cigarettes (1)	❍	❍
Chewing tobacco, snuff, or dip (2)	❍	❍
Cigars, cigarillos, or little cigars (3)	❍	❍
Smoking tobacco from a hookah or waterpipe (4)	❍	❍
Electronic cigarettes (e- cigarettes) or some other electronic vapor product (5)	❍	❍
Some other tobacco product (6)	❍	❍

If Yes Is Not Selected, Then Skip To Click to write the question text
Carry Forward Selected Choices from "For each of the following tobacco products, please tell us whether or not you have ever tried it, even if you have only tried it once."

Q9 Now, please tell us whether or not you have used any of the following tobacco products at least once in the past 30 days.

	Yes (1)	No (2)
1 (1)	❍	❍
Cigarettes (x1)	❍	❍
Chewing tobacco, snuff, or dip (x2)	❍	❍
Cigars, cigarillos, or little cigars (x3)	❍	❍
Smoking tobacco from a hookah or waterpipe (x4)	❍	❍
Electronic cigarettes (e- cigarettes) or some other electronic vapor product (x5)	❍	❍
Some other tobacco product (x6)	❍	❍

Q10 At what age did you first try a tobacco product?

Q11 Next, for each of these tobacco products, please tell me whether or not you have ever tried it, even if you have only tried it once. Just tell me yes or no.

	Yes (1)	No (2)
Roll-your-own cigarettes (1)	❍	❍
Flavored cigarettes, such as Camel Crush (2)	❍	❍
Clove cigars (3)	❍	❍
Flavored little cigars (4)	❍	❍
Snus, such as Camel or Marlboro Snus (6)	❍	❍
Dissolvable tobacco products, such as Ariva, Stonewall, Camel orbs, Camel sticks, or Camel strips (7)	❍	❍
Some other tobacco products not listed here (9)	❍	❍
I have never tried any of the products listed above or any new tobacco product (10)	❍	❍

Alcohol. You may skip questions you do not want to answer or are unsure about.

Q12 During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage? Enter a 2 digit number for # of days. (For example, enter "01" if you had one or more drinks of an alcoholic beverage on 1 day during the past 30 days.)

Q14 During the past 30 days, on how many days did you have 5 or more drinks on the same occasion? By "occasion", we mean at the same time or within a couple hours of each other. Enter a 2 digit number for # of days. (For example, enter "01" if you had 5 or more drinks of an alcoholic beverage on 1 day during the past 30 days.)

During the past 30 days, on how many Sundays did you drink on or more drinks of an alcoholic beverage at a bar or restaurant?

During the past 30 days, on how many Sundays did you purchase alcohol to be consumed at your home or the home of a friend or family member?
Text5. Next, we would like to ask you some questions about your opinions and the views of others around you.

Q15 In your opinion, how much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?

- ❍ No Risk (1)
- ❍ Slight Risk (2)
- ❍ Moderate Risk (3)
- ❍ Great Risk (4)

Q16 How do you think your close friends feel (or would feel) about you having five or more drinks of an alcoholic beverage once or twice a week?

- ❍ Not at all concerned (1)
- ❍ Slightly concerned (2)
- ❍ Very concerned (3)

Drugs. I would also like to ask you some questions about the use of prescription drugs. All your answers are confidential. Please remember you may skip any questions that you do not want to answer or are unsure about.

Q17 During the past year, did you use prescription drugs only for the experience or feeling they caused?

- ❍ Yes (1)
- ❍ No (2)
- ❍ I'd rather not say (3)

If Yes Is Not Selected, Then Skip To Click to write the question text

Q18 During the past 30 days, on how many days did you use prescription drugs only for the experience or feeling they caused? Enter a 2-digit number for # of days.

If During the past 30 days, on... Is Equal to 0, Then Skip To Click to write the question text

Q19 Were these drugs prescribed to you?

- ❍ Yes (1)
- ❍ No (2)

If No Is Not Selected, Then Skip To During the past year, which of these ...

Q20 Where do you typically obtain these prescription drugs?

- ❍ Took them from a friend without permission (1)
- ❍ Took them from a family member without permission (2)
- ❍ A friend or family member gave them to me (3)
- ❍ I bought them from someone (4)
- ❍ Online/Internet (5)
- ❍ Other [Please specify] (6)_____

Q21 During the past year, which of these substances have you used for non-medical reasons or to get high?

	Yes (1)	No (2)
Sedatives such as barbiturates like Amytal or Luminal? (1)	❍	❍
Tranquilizers or Anti-anxiety drugs such as benzodiazepines such as Xanax or Valium or Klonopin? (2)	❍	❍
Painkillers such as oxycodone like OxyContin, Opana or Percocet; hydrocodone such as Vicodin or Lortab? (3)	❍	❍
Stimulants such as Ritalin, Adderall, or amphetamines? (4)	❍	❍
Marijuana including hashish, wax, or dab? (5)	❍	❍
Methamphetamine? (6)	❍	❍
Cocaine/Crack? (7)	❍	❍
Heroin? (8)	❍	❍
Other drugs such as Hallucinogens like LSD, PCP, MDMA, mushrooms; Synthetics like bath salts, spice or K2; Inhalants like spray paint or glue? (9)	❍	❍

Q22 On how many occasions, if any, have you used marijuana during the last 30 days? Enter a 2 digit number for # of days.

Q23 In the past year, have you used two or more drugs at the same time. Our definition of "drugs" includes alcohol and prescription medications, as well as illegal drugs.

- ❍ Yes (1)
- ❍ No (2)

Display This Question:
If In the past year, have you used two or more drugs at the same time. Our definition of "drugs" includes alcohol and prescription medications, as well as illegal drugs. Yes Is Selected

Q24 What combination of drugs did you take?

Q25 Have you ever, even once, taken any drugs by injection with a needle like heroin, cocaine, amphetamines, or steroids? Do not include anything you took under a doctor's orders.

- ❍ Yes (1)
- ❍ No (2)

Q25A Have you ever received a prescription for a drug to help with chronic pain?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't Know (3)

Q26 In your opinion, how much do people risk harming themselves physically and in other ways if they use prescription drugs that are not prescribed to them or that they took only for the experience or feeling they caused?

- ❍ No risk (1)
- ❍ Slight risk (2)
- ❍ Moderate risk (3)
- ❍ Great risk (4)

Q27 How do you think your close friends feel (or would feel) about you using prescription drugs that are not prescribed to you or that you took only to get high or have fun?

- ❍ Not at all concerned (1)
- ❍ Slightly concerned (2)
- ❍ Very concerned (3)

We're almost finished. Now we have a few last questions to help us understand our results.

QD12 What is your home zip code? Enter your 5 digit zip code.

QD13 Are you currently a high school student?

- ❍ Yes (1)
- ❍ No (2)

Display This Question:
If Are you currently a high school student? No Is Selected

QD13a Did you graduate or complete high school during the 2017-2018 academic year?

- ❍ Yes (1)
- ❍ No (2)

QD13b What is the last grade in school you completed?

- ❍ 8th Grade or Less (1)
- ❍ High School Incomplete (Grades 9, 10 and 11) (2)
- ❍ High School Complete (Grade 12 or high school equivalency) (3)
- ❍ Vocational/Technical School (Includes Cosmetology Schools, Welding Certificate Programs) (4)
- ❍ Some College (5)
- ❍ Junior College Graduate (2 Year, Associates Degree) (6)
- ❍ 4 Year College Graduate (Bachelor's Degree) (7)
- ❍ Graduate Work (Masters, Law/Medical School, Etc.) (8)
- ❍ Other [Please specify] (9) _____

Display This Question:
If Are you currently a high school student? No Is Selected
Q93 Are you currently enrolled in a post-secondary school (including vocational, college, or graduate school)?

- ❍ Yes (1)
- ❍ No (2)—Skip to Q97

Which of the following best describes where you are living now while attending college? (NSSE)

- Dormitory or other campus housing (not fraternity/sorority house)
- Residence (house, apartment, etc.) within walking distance of the institution
- Residence (house, apartment, etc.) within driving distance
- Fraternity or sorority house

Q97 Are you currently registered to vote in the county where you live?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Not sure (3)

QD2 What is your current living situation? Are you currently living with:

- ❍ Your spouse (1)
- ❍ A romantic partner (2)
- ❍ Parent(s) or other family member(s) (3)
- ❍ Roommate(s) (4)
- ❍ I live alone (5)
- ❍ Other (6)

QD3 Are you the parent, legal guardian or caretaker of any children under 18 now living in your home?

- ❍ Yes (1)
- ❍ No (2)

QD4 Do you currently have someone who depends on you for financial support or caretaking, such as a child or other family member?

- ❍ Yes (1)
- ❍ No (2)

QD6 Over the past 12 months, how often were you able to comfortably cover your monthly expenses?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Never (3)

QD8 Over the past 12 months, have you received financial assistance from a government program such as WIC, TANF or SNAP?

- ❍ Yes (1)
- ❍ No (2)

QD9 Over the past 12 months, how often did you receive financial support from someone else, like your parents for instance?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Never (3)

QD10 Are you currently serving, or have you ever served, in a branch of the United States military?

- ❍ Yes (1)
- ❍ No (2)

Display This Question:
If Are you currently serving, or have you ever served in a branch of the United States military? Yes Is Selected

QD11 Were you ever deployed to an active combat zone?

- ❍ Yes (1)
- ❍ No (2)

QD14 We are interested in learning about your health insurance coverage. Do you currently have health insurance?

- ❍ Yes (1)
- ❍ No (2)

QD15 What kind of health insurance do you have? Please just tell us "Yes" or "No" for each form of insurance you may be eligible.

	Yes (1)	No (2)
Your parent's insurance (1)	❍	❍
Insurance provided through your university (2)	❍	❍
Insurance you or your spouse purchased yourself (3)	❍	❍
Insurance you or your spouse received through an employer (4)	❍	❍
Veteran's Benefits or Tricare (5)	❍	❍
Government provided insurance (like Medicaid, Medicare or Healthy Indiana Plan (HIP)) (6)	❍	❍
Other [specify] (7)	❍	❍

QD16 Do you consider yourself to be of Latino or Hispanic origin?

- ❍ Yes (1)
- ❍ No (2)

QD17 What is your race? Please check all that apply.

- ❍ Black or African American (1)
- ❍ White (2)
- ❍ Asian (3)
- ❍ Alaska native (4)
- ❍ American Indian or Native American (5)
- ❍ Native Hawaiian or Other Pacific Islander (6)
- ❍ Other [specify] (8) _____

QD18 What sex were you assigned at birth, on your original birth certificate?

- ❍ Male (1)
- ❍ Female (2)

QD19 How do you describe your gender identity?

- ❍ Male (1)
- ❍ Female (2)
- ❍ Male-to-female transgender (MTF) (3)
- ❍ Female-to-male transgender (FTM) (4)
- ❍ Other gender identity (Please specify) (5) _____

QD20 Which of the following best represents how you think of yourself?

- ❍ Gay or lesbian (1)
- ❍ Straight, that is not gay or lesbian (2)
- ❍ Bisexual (3)
- ❍ Something else (Please Specify) (4) _____

What is your marital status? (ACS)

- Now Married
- Widowed
- Divorced
- Separated
- Never Married

During the last month, did you work for pay at a job (or business)? (ACS-modified from one week)

- Yes (Skip to end)
- No

During the last month, were you actively looking for work?

- Yes
- No

If you wish to go back to review or change your answers, please use the "BACK" button below. IF you click "SUBMIT", you will be unable to go back. Please click the "SUBMIT" button if you are ready to submit your survey responses.

Appendix B: Exit interview protocols

INTERVIEW PROTOCOL FOR PFS COMMUNITIES

Hello [*participant name*]. This is [*name of interviewer*] from the Indiana University Richard M. Fairbanks School of Public Health at IUPUI. I am calling to conduct an exit interview for the Partnerships for Success, or PFS, grant.

Thank you again for agreeing to be interviewed as part of this evaluation. As I mentioned, we are conducting exit interviews with each of the PFS-funded organizations to learn about your specific processes and experiences over the five-year PFS grant cycle. This contains the essential SPF [*pronounced "spif"*], or Strategic Prevention Framework, components including assessment; capacity building and community engagement; planning and implementation of programs; evaluation; and sustainability of the initiative moving forward.

The entire interview process should take approximately 45-60 minutes. I would like to record our interview so that we can get an accurate representation of what you said. Do I have your permission to record?

If 'Yes': Thank you, then let's begin:

Planning & Implementation

I'll begin by asking you about the program that your community chose to implement, why it was chosen, how it was adapted to fit your community, and how it compares to other programs in your community.

1. Can you describe to me the program(s) that your community chose to implement?

(Probe: target issue (alcohol, prescription drug misuse, both), target population, community organizations involved)

2. Can you describe how this program was chosen (these programs were chosen)?
    a. Who decided to implement this specific evidence-based strategy?
    a. How was the decision made to implement this specific evidence-based strategy? (Probe: List of strategies provided by DMHA, proposed new strategy)
    a. What characteristics of this specific strategy stood out as being appropriate for your community?

3. What did influential stakeholders think of the program(s)?

(Probe: Administrative leaders, Community Leaders)

4. How does this program compare to other existing programs in your community?
    a. Describe how this program differed from other programs in your community addressing these issues?
    a. Describe any advantages that this program had over other programs. Describe any disadvantages.

Now I am going to ask you a series of questions related to the planning and implementation process of this program.

5. Can you describe the process of planning this program(s)?
   (Probe: detailed written plan, role planning, hiring, capacity building, community readiness)
   a. Describe the process of creating a written implementation plan, if applicable.
   a. How did you decide who would fill certain roles? What was the hiring process like?
   a. Describe any steps you had to take to build community capacity (i.e. developing skills, knowledge, or tools) to prepare for the program(s).

6. Can you describe the process of implementing this program(s)?
   (Probe: Costs, resources, stakeholders, outreach efforts)
   a. Describe the process for obtaining the necessary resources.
   a. Did you experience any unexpected costs?
   a. Describe the process for engaging stakeholders during implementation.
   a. Describe any outreach efforts you utilized to engage the community.

7. Can you describe any difficulties, or barriers, you faced in implementing this program(s)?
   (Probe: Hiring, staff turnover, community or stakeholder engagement, costs)
   a. Did you utilize DMHA technical assistance? (Research, informational material, training, consultation)

8. Describe any modifications or adaptations you had to make to the program(s) after implementation began.
   a. If changes made, why were these modifications or adaptations necessary?

9. What was your strategy for getting the word out about the program(s)?

Capacity / Community Engagement

10. What community sectors are involved in your prevention coalition?

11. Are there any sectors that are currently not involved, but you believe they should be?
    If yes,
    a. What are the sectors?
    a. Why do you believe they are difficult to involve?

12. Who have been the key influential individuals in your coalition?
    (Probe: Internal, external, champions)
    a. Describe their level of engagement over the course of the PFS grant period.

Assessment

13. When the grant started, what was your community's level of readiness; i.e., the community's knowledge of the problem, existing prevention efforts, availability of resources, support of local leaders, and attitudes toward substance use in the community?

14. At the end of the PFS grant period, how has community readiness changed?
    a. How did you raise the level of readiness in your community?

Evaluation

15. Describe whether you feel the program(s) has met its goals? (Probe: Outcomes achieved)

16. What do you think are the biggest successes of the PFS initiative?

Sustainability

17. Describe any plans for the future of the program(s)?
    a. If the program(s) will continue, can you tell me a bit about your plan for sustaining the program efforts after the funding has ended?
    b. What do you perceive to be the major barriers to long term sustainability?
    c. What do you perceive to be the major facilitators to long term sustainability?

18. Anything else you would like to share?

We are now finished with the interview. Thank you again for your participation. Do you have any questions or additional comments for me before we conclude the conversation?

INTERVIEW PROTOCOL FOR DMHA PROJECT COORDINATOR

Hello [*Dr. Vera Mangrum*]. This is [*name of interviewer*] from the Indiana University Richard M. Fairbanks School of Public Health at IUPUI. I am calling to conduct an exit interview for the Partnerships for Success, or PFS, grant.

Thank you again for agreeing to be interviewed as part of this evaluation. As I mentioned, we are conducting exit interviews with each of the PFS-funded organizations as well as with you, the state-level grant coordinator at the Indiana Division of Mental Health and Addiction. The interview will address essential SPF [*pronounced "spif"*], or Strategic Prevention Framework, components including assessment; capacity building and community engagement; planning and implementation of programs; evaluation; and sustainability of the initiative moving forward. This will help us learn more about your experiences over the five-year PFS grant cycle.

The entire interview process should take approximately 45-60 minutes. I would like to record our interview so that we can get an accurate representation of what you said. Do I have your permission to record?

If 'Yes': Thank you, then let's begin:

Planning & Implementation
I'll begin by asking you a few questions about program planning and implementation, both at the state and the community level.

1. Can you describe to me how DMHA selected the 10 communities that were funded through the PFS grant?
   (Probe: based on target issue (alcohol, prescription drug misuse, both) or target populations; request for proposals send to communities?)

2. What were some of the programs the communities chose to implement?

3. How did DMHA assist the communities in choosing these programs?
   (Probe: Provided a list of evidence-based programs and strategies; encouraged specific programs)
   a. Can you provide one or more examples of how characteristics of a specific strategy stood out as being appropriate for a particular community or a particular population?

4. Can you describe any difficulties, or barriers, the communities faced in implementing their programs?
   (Probe: Hiring, staff turnover, community or stakeholder engagement, costs)
   a. Did any of the communities utilize DMHA technical assistance? (Research, informational material, training, consultation)

5. Can you describe one or more examples of modifications or adaptations a community had to make to their programs after implementation began?
   a. If changes made, why were these modifications or adaptations necessary?
   b. How many communities had to make modifications or adaptations after beginning implementation?

6. What were some of the strategies used for getting the word out about these prevention programs?
   a. At the state level (by DMHA)
   b. At the community level

Capacity / Community Engagement

7. How successful were the communities in coalition building and community engagement?
   (Probe: wide representation of sectors, key stakeholders, leaders, and champions)
   a. What were the challenges?
   a. How did the communities overcome these challenges?

Assessment

8. When the grant started, what was your perception of the overall level of readiness in the PFS communities; i.e., the community's knowledge of the problem, existing prevention efforts, availability of resources, support of local leaders, and attitudes toward substance use in the community?
   a. How do you feel the communities perceived their own readiness (i.e. did your and the communities' perceptions align?)

9. At the end of the PFS grant period, do you feel the level of community readiness has changed? (Probe: How so?)
    a. How did communities raise the level of readiness in their communities?

Evaluation

10. Describe whether you feel the PFS initiative has met its goals? (Probe: Outcomes achieved)
    a. At the state level
    b. At the PFS community level

11. What do you think are the biggest successes of the PFS initiative?
    a. At the state level
    b. At the PFS community level

Sustainability

12. Describe any plans for the future; i.e., after the PFS initiative ends (Probe: sustainability plan)
    a. Can you provide one or more examples of a community's plan for sustaining the program efforts after the funding has ended?
    b. What do you perceive to be the major barriers to long term sustainability for communities continuing their programming?
    c. What do you perceive to be the major facilitators to long term sustainability for communities continuing their programming?

13. Anything else you would like to share?

We are now finished with the interview. Thank you again for your participation. Do you have any questions or additional comments for me before we conclude the conversation?

The mission of the Center for Health Policy is to conduct research on critical health-related issues and translate data into evidence-based policy recommendations to improve community health. The CHP faculty and staff collaborate with public and private partners to conduct quality data driven program evaluation and applied research analysis on relevant public health issues. The Center serves as a bridge between academic health researchers and federal, state, and local government as well as healthcare and community organizations.

Author(s): Samantha Childress, BSPH; Tamara Leech, PhD; Dennis Watson, PhD; Lisa Robison, MPH; Marion Greene, PhD, MPH

Please direct all correspondence and questions to: Marion Greene, PhD, MPH, Center for Health Policy, IU Richard M. Fairbanks School of Public Health at IUPUI, 1050 Wishard Blvd, RG 5192, Indianapolis, IN 46202; Email: msgreene@iu.edu; Phone: (317)278-3247