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Unchartered Territory: Initial Adaptations by South Carolina's Drug-Free Community Coalitions During the Pandemic

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Introduction

The national trauma of the COVID-19 pandemic has created challenges and opportunities in the area of universal prevention programming to reduce and prevent substance use and related consequences. Existing systems built on reducing risk and enhancing protection have been negatively impacted in the midst of COVID-19. Whether it be school systems, health care facilities, faith-based institutions, or community-based support services, no sector has been untouched. The negative consequences of closing structured settings for youth and families are evident in increased rates of mental health conditions, suicides, and overdose deaths[1]. For coalitions whose methods of community change include collaboration, engagement, education, and dialogue, the way forward in the midst of a COVID-19 pandemic is certainly unchartered territory.

Since the early 1990s, considerable resources have been invested to support the development and implementation of community-based approaches to prevent substance use, misuse, and abuse. In 1992, the Community Anti-Drug Coalitions of America (CADCA) was established to expand the number of community anti-drug coalitions and to serve as a national resource for the development of public policy in this area. The Drug-Free Communities Act of 1997 demonstrates the investment of the federal government to support substance use prevention programming. Each funded coalition is eligible for $125,000.00 a year for up to a ten-year investment of $1,250,000.00[2].

Purpose of the Article

This article describes the results of a descriptive study designed to gather early evidence of how the DFC coalitions "pivoted" to adapt to changing circumstances emerging from COVID-19. Specifically, we present ways in which community coalitions have adapted their strategies, practices, and programs in light of the COVID-19 pandemic and uncertain future. Describing specific actions from a small group of coalitions in one state (i.e., South Carolina) allowed for documentation of initial efforts by coalitions to revise, update, and innovate on existing prevention strategies to promote effective community change.

This article also presents an adaptation framework for coalitions to consider as they move forward with their action planning. With over 700

DFC coalitions currently in various years of funding, the use of an adaptation framework to help promote systematic planning for challenging times seems wise. Because of the long-standing nature of the DFC coalitions, many coalitions have experience adapting to changing circumstances and events—although never during a global pandemic. Prior natural events (e.g., hurricanes, fires, flooding, etc.) affected the degree to which coalitions successfully implemented their action plans. While the COVID-19 pandemic created conditions where most coalitions likely stopped community activities for a period of time, all coalitions could benefit from considering types of adaptations for community change.

Overview of the Drug-Free Communities Support Program (DFC)

The main purpose of the Drug-Free Communities Support Program is to fund community coalitions to engage local partners to design and implement local strategies to prevent youth substance abuse. There are 12 required sectors for funded coalitions to include: schools, law enforcement, youth, business, religious or fraternal organizations, health care, youth-serving organizations, other organizations engaged in substance abuse, parents, civic or volunteer groups, media, and state, local, and tribal governments. Working together, community coalitions plan and implement prevention strategies to reduce the use of alcohol, tobacco, marijuana, and the illicit use of prescription drugs among youth in their communities. According to the 2020 national evaluation annual report, most coalitions focused on youth alcohol use (97%), 90% focused on marijuana, 84% on prescription drugs (opioids), and 72% on tobacco/nicotine[3].

Drug-free community coalitions are funded to implement a comprehensive action plan inclusive of individually-focused prevention strategies and environmental strategies to promote community-level change. An environmental strategy incorporates prevention efforts, aimed at changing or influencing community conditions, standards, institutions, structures, systems, and policies[4]. Brief descriptions and examples of the seven strategies for community-level change are in Table 1.

Table 1. Brief Descriptions of the Seven Strategies for Community-Level Change

Community-Level Change Strategies	**Description and Examples**

Provide Information	Disseminate information through methods such as educational presentations, workshops or seminars, and data or media presentations.
Enhance Skills	Enhance skills of staff, coalition members, and community residents through workshops, seminars, or activities designed to build skills and capacities.
Provide Support	Create opportunities for participation in activities that reduce risk or enhance protection.
Enhance Access/ Reduce Barriers	Improve systems/processes to increase the ease, ability, and opportunity to utilize those systems and services in prevention initiatives. **Reduce Access/Enhance Barriers:** Improve systems/processes to decrease the ease, ability, and opportunity for youth to access substances.
Change Consequences	Increase or decrease the probability of a behavior by altering the consequences for performing that behavior.
Physical Design	Change the physical design of the environment to reduce risk or enhance protection.
Modify Policies	Formal change in written procedures, by-laws, proclamations, rules, or laws.

Summary Evaluation Findings for the Drug-Free Communities (DFC) Support Program

The effectiveness of the DFC coalitions is assessed along several dimensions to include, a) sector engagement; b) coalition capacity; c) implementation of environmental strategies; and d) youth outcomes. Environmental strategies are selected based on the prioritized needs of the community and are designed to impact the "four core outcome measures" [5]. DFC coalitions are required to collect and submit youth data on the core measures every two years. The four core measures include:

- Self-reported alcohol/drug use in the past 30 days,
- Youth perceptions of the risk of harm from alcohol/drug use,
- Youth perception of parental disapproval of alcohol/drug use,
- Youth perception of peer disapproval of alcohol/drug use.

Summary results from the national cross-site evaluation showed that most middle school and high school youth in communities with a DFC coalition reported not using substances within the past 30 days. In fact, 30-day substance use/misuse for the 2018 grant recipients significantly decreased from the first report to the most recent report among middle

school students for alcohol (-22%), marijuana (-13%), and tobacco (-46%). Among high school students, the significant decreases were alcohol (-24%), marijuana (-5%), tobacco (-45%) and prescription drugs (-27%)[3]. Details of the evaluation findings reported in July 2020 is available at https://www.thenmi.org/wp-content/uploads/2020/07/2020-ONDCP-DFC-Evaluation-Report_Executive-Summary.pdf

Examining changes in the coalitions' strategies during the time of COVID-19 allows for new learnings and an opportunity to disseminate new and innovative ideas. The impact of COVID-19 on the work of the South Carolina DFC coalitions has been significant with many able to adapt their content into a delivery system to comply with COVID-19 restrictions (e.g., quarantine, social distancing, etc.). Documenting how coalitions pivoted to maintain a community presence during these unprecedented times provides a historical record of these efforts. It also describes adaptations to the seven community change strategies inclusive of the three individually-focused prevention strategies as well as the four environmental strategies designed for community-level change.

Methods

Participants. Leadership representing ten DFC coalitions in South Carolina were interviewed by the lead author using a semi-structured interview protocol. Of the 13 active coalitions, ten were selected because they were at least in their third year of funding. This allowed input from experienced coalitions to share how they adapted the seven community-level change strategies in their existing action plan. While the number of years that participating DFC coalitions were funded ranged from 3-10, the mode was six.

Measures. The interview protocol was developed to assess modifications in the coalitions' operations as well as adaptations to the community change strategies during the early months of the COVID-19 pandemic. The interview protocol included questions about coalition operations such as meeting structure, community participation/involvement, and workflow. Participants were asked how they adapted (or planned to adapt) each of the seven community change strategies listed in Table 1. Notes were taken during the interview and were used to determine the frequencies of changes in coalition operations as well as the categories of the adaptations reported.

Procedures. The interview protocol allowed for qualitative data collection from ten participants who volunteered to be interviewed by telephone or Zoom when requested by the lead author. Analytic procedures included

frequency counts as well as descriptions of planned or current adaptations by the coalitions. Data were collected from July 15, 2020 – August 11, 2020, with either the coalition's project director or project coordinator interviewed. The length of the interviews averaged 48 minutes (range: 22 minutes to 70 minutes).

Results

Results are presented according to the two main categories of the interview protocol: modifications to the coalition's operations and adaptations of the community change strategies. Using a frequency analyses metric, the authors present the numbers of coalitions that reported modifications to their meeting structure, community participation/involvement, and workflow. At least three coalitions had to report the modification for it to be included in the results. When describing the adaptations for the community change strategies, the authors highlight specific examples of adaptations provided by the coalition leaders for each of the seven strategies. Not every coalition described an adaptation for each strategy. Because each DFC had an approved action plan comprised of the community change strategies, adaptations of these strategies were defined by the interviewee.

Modifications to Coalition Operations

In South Carolina, the first documented case of COVID-19 was on March 6, 2020 and ten days later, the governor's initial Executive Order closed schools/universities through March 16, 2020. The remaining public-school year was cancelled on April 22, 2020. All coalitions reported that the initial impact of COVID-19 was an immediate halt or slowing down of coalition activities. No regularly scheduled coalition or subcommittee meeting occurred between March 13th – April 16th 2020. After that time, coalition meetings (including subcommittees) were held using a virtual platform. Six of the coalitions maintained their regular meeting schedule after mid-April 2020, with each reporting that late spring was used to consider potential adaptations to the action plans.

Because of the coalitions' significant community influence, eight were able to maintain a community presence even in the spring months of 2020. This included regular virtual events such as coalition meetings and training activities using innovative social media platforms. Seven of the coalition leaders reported virtual participation by partners who were not regularly in attendance at meetings and events. This was an unexpected positive outcome. In addition, four of these seven coalitions reported more participation from diverse and hard-to-reach populations than during pre-

pandemic times. Examples included school principals, politicians, parents, and youth/families representing different cultures. Half of the coalitions reported that the adaptation of their delivery methods (e.g., virtual) for online meetings and events was organized and/or led by youth or young adults.

As spring turned to summer, all coalitions were faced with news reports and "alerts" from state officials communicating increasing rates of alcohol and drug use. While increased overdoses involving fentanyl, heroin, cocaine, and methamphetamine occurred, the numbers of fatal and nonfatal overdose varied across South Carolina's 46 counties with statewide implications. Certainly, the needs for prevention, treatment and recovery support continued to be significant for individuals, families and communities. In hindsight, the COVID-19 pandemic began during a worsening drug epidemic in South Carolina which included increasing misuse of illicitly manufactured fentanyl and psychostimulants in late 2019.

Adaptions of the Community-Level Change Strategies

One major hurdle faced by all coalitions was that many of the proposed strategies in the coalitions' action plans were not feasible (as written) given the mandates for lockdown, quarantine, face masks, and social distancing. For example, 100% of the South Carolina coalitions immediately canceled all plans for alcohol and tobacco compliance checks because of quarantine and/or competing priorities of law enforcement partners. Results indicate that eight of the coalitions described at least one adaptation (completed or planned) to the three individual-oriented prevention strategies in Table 2.

The primary ways coalitions adapted the first three prevention strategies (e.g., provide information, enhance skills, provide support) included changes/updates to the content, changes to the delivery method for disseminating the content, or changes to both. One common way coalitions modified content was to provide new and/or updated information about COVID-19. For example, nine of the DFC coalitions added information about the virus to existing presentations, explained why alcohol or drug use may increase negative consequences from the virus, and updated existing branding of the coalition (e.g., visually creating a special logo with people physically distancing and wearing face masks). Four of the six DFC coalitions that had planned youth summits, conferences, and community events during pre-pandemic conditions eventually implemented these events using online platforms. However, challenges related to internet access as well as stable internet connection and user error were reported for those in rural locations.

Changes to the delivery methods of these prevention strategies also varied with Zoom, GoToMeeting, Microsoft Teams, and WebEx being the most common virtual platforms used. Half of the DFCs reported collaboratively planning innovative ways to deliver information such as: partnering with drive-in movie theaters to show prevention messaging, offering a merchant education program virtually, inserting messages about locations of drop boxes in water bill statements, and using on online platform to continue an annual candlelight vigil for victims of DUI. Table 2 includes sample adaptations in the delivery methods for the three individually-focus prevention strategies for the coalitions interviewed.

Table 2. Sample Adaptations for Delivery Methods for Three Individually-Focused Prevention Strategies

Prevention Strategy	Potential Adaptation
Provide Information	Virtual town halls including data walks
	Social media posts to parents and youth
	Sharing data for ongoing planning
	Educational presentation via virtual platforms
	PSAs, YouTube, Podcasts, Instagram to provide information
	Listservs, Facebook live events, apps
	Game-based learning platforms (e.g., Kahoot)
Enhance Skills	Virtual student prevention education via online platforms
	Health classes via online platforms
	Various educational and skill-building events (e.g., youth summit) via online platforms
	Virtual evidence-based programming for youth and/or parents
	YouTube videos for skill building (e.g., how to use a prescription drug disposal pouch)
Provide Support	Virtual youth clubs/ youth advisory council meetings
	Virtual awareness event to recognize those lost to overdose
	Web-based communication and support (e.g., COVID-19 pandemic hotline, recovery support hotline)
	Virtual “open house” event during recovery month

Detailed qualitative data were collected to document examples of adaptations for the four environmentally-oriented community change strategies. These adaptations are described below and organized by the change strategies, 1) enhance access to information or services and increase barriers to obtain substances; 2) change consequences of performing a behavior; 3) change in physical design of the environment, and 4) modify policies/laws. Each section provides possible examples the coalition might have planned in pre-pandemic conditions followed by details of the actual adaptation.

Enhance access/Increase barriers. Possible strategies planned in pre-pandemic conditions included changes in environmental conditions that enhance access to services, community resources, and life-saving products (e.g., Narcan). Strategies to enhance barriers to substances might include responsible beverage service or regular compliance checks. During the COVID-19 pandemic, DFC coalitions partnered to adapt typical distribution mechanisms and implemented “drive-thru” or “drive-to” health fairs that included distributing Narcan, drug disposal pouches, and other prevention information. These community events were marketed in a variety of ways through collaborative efforts. Community partners distributed food, back to school supplies, and other family necessities to those in vehicles. Frequently, rolling carts were used to bring products to the vehicles to reduce handling of the items. Similar events were organized as “parking lot appointments” where a much smaller number of partners and families met to receive information and/or products while in their parked car. In at least one community, the health sector advertised in the newspaper that free Narcan was available, and it was delivered to their home.

Coalitions also participated in newly planned events to ensure that prevention information was disseminated. Specifically, members of one coalition participated in a local “motor march” organized by schoolteachers and their advocacy groups to voice their opinions about returning to school. Coalition members joined the parade which featured prevention messaging on their cars, and they distributed information about the locations of drop boxes and how to access medication lock boxes, lock bags, and drug disposal products. Another strategy to enhance access to information and services included “piggy backing” on existing community events. Examples included providing “thank you bags” filled with prevention information for those participating in blood drives and making drug disposal pouches available to seniors receiving Meals on Wheels.

Increasing barriers for youth to obtain products from retail establishments suggests collaboration with law enforcement such as conducting alcohol or tobacco compliance checks. Certainly, successful implementation of compliance checks were impacted by COVID-19. No coalition resumed compliance checks with the same intensity of pre-pandemic conditions before Fall 2020. South Carolina had a bill filed in September 2019 to provide Narcan in conjunction with an opioid prescription which was presumably to pass in March 2020. Once the hearing was rescheduled to September 2020, the DFC coalitions educated their representatives about the importance of the bill to enhance access to the life-saving medication. This example is inclusive of at least two environmental strategies, namely enhanced access and modified policies. During this time, no additional strategies to increase barriers to substances were reported (e.g., increasing costs of products, etc.).

Change Consequences of a Behavior. Possible strategies planned in pre-pandemic conditions included increasing fines for minor in possession of alcohol or tobacco and increasing taxes on these products. The proper and timely disposal of opioid medication decreases the likelihood of negative consequences of drug use. In the early months of the COVID-19 pandemic, all South Carolina coalitions increased access to drug disposal pouches and most shared additional prevention information during their distribution. Half of the coalitions also participated in planning or attending events that promoted easier access to Narcan which could immediately change consequences of drug use. Two coalitions used technology to target internet advertising for locations of local drop boxes. By geofencing Facebook ads, customers leaving a pharmacy with an opioid prescription saw the locations of prescription drop boxes on their mobile devices.

Coalitions also educated the community about the consequences of substance use/misuse through online and platform messaging (e.g., YouTube, Instagram) as well as venues such as Gas TV and virtual game shows. One coalition reported that community leaders who had been hard to engage, such as politicians, logged into Zoom and participated on a team with youth to increase awareness of the consequences of drug use. As students return to in-person educational settings (e.g., high school, college), it is likely that new and innovative ways to educate communities about negative consequences of substance misuse will emerge.

Change Physical Design. Possible strategies planned in pre-pandemic conditions included changes in the physical design of

environments (e.g., settings) to reduce risk or enhance protection. Common examples would be safer settings through improved lighting, reduced signage advertising alcohol, and changes in alcohol outlet density in neighborhoods. Many of these strategies were halted given community lockdown and quarantine. During the COVID-19 pandemic, South Carolina saw many of its restaurants/bars change their design (and menu) to accommodate curbside pick-up when the governor allowed curbside alcohol sales with takeout food orders. Several months later when COVID-19 numbers rose precipitously, he mandated that no alcohol be served in restaurants or bars after 11:00 pm. This law was rescinded on March 1, 2021. It is noteworthy that two coalitions created signage to inform consumers of underage drinking laws and discouraged community members and tourists from supplying alcohol to minors. Others reached out to restaurants and bars through letters and telephone calls about the increased risk of curbside sales and providing alcohol to those riding or driving cars. Some coalitions made and delivered signage (including window clings) to the restaurants to create a visual image for the owners, managers, and servers. In another example of changing physical design, coalitions partnered with pharmacies to ensure prescription drug drop-off options using the drive through lane could occur.

Modify Policies/Laws. Possible strategies planned in pre-pandemic conditions included formal changes in written procedures, by-laws, or laws to prevent or reduce alcohol, tobacco, and drug use. Modifying policies or changing laws usually requires ongoing community involvement and significant planning. No coalition reported adapting any new or existing policy directly related to substance use. However, several coalitions described policy changes that helped facilitate the coalition's work during COVID-19. For example, one coalition reported a change in the lead agency's policies to allow certain people to drive an agency car to participate in a "drive to" event. Another coalition reported that it worked with a retail establishment to modify its policies to accept attendance at a merchant education program that was presented virtually. Finally, one school district modified its Open Community Use (OCU) policy, which allowed free access to outdoor recreational facilities to promote positive home, school, and community relations through healthy living opportunities.

Discussion

Initial adaptations by most coalitions included modifications to specific events being delivered (e.g., webinars, etc.) to integrate information about COVID-19. Subsequent changes included modifying the delivery methods to ensure that the revised content could be shared using virtual platforms. Although challenging, prioritizing the adaptation of content and the delivery system was fairly straightforward. This allowed for coalitions to take time to gather additional information to fully prepare for more complex adaptions, which could require in-depth planning and outside guidance. For example, in planning for the reinstatement of compliance checks, alternative transportation arrangements for the undercover informant (UCI) had to be made to adhere to local regulations such as social distancing. In addition, new information had to be considered such as the legal implications of a potential future case against a seller who sold alcohol to a UCI without a request to remove the mask and properly check for identification. When coalitions plan for future adaptations, starting with less complex adaptations and moving toward those with more complexity is a useful principle to consider. In addition, useful mechanisms from disaster planning and related research (e.g., response teams) may be an area for consideration.

Because COVID-19 quickly became the priority for the nation, DFC coalitions were faced with significant decisions about how to adapt and implement the funded community change strategies in their action plan. In early April 2020, ONDCP offered guidance for coalitions on administrative and financial issues necessary for continued functioning. In South Carolina, this allowed the coalitions to use subsequent months to update their planning and to better understand how COVID-19 was affecting the roles of key partners (law enforcement, schools, etc.). Many found new partners that were not existing coalition members (e.g., Red Cross, drive-in theater owners, etc.), while other partners had no recent involvement. The COVID-19 pandemic allowed for opportunities to re-engage members through joint planning and communication platforms (e.g., Facebook). For example, once treatment agencies began using telehealth for individual and group settings, coalition partners helped to publicize their reopening, share information about “virtual office tours”, and jointly plan community events. In addition, some coalitions worked with newly formed recovery community organizations (RCOs) to increase access to Narcan and establish more intentional collaborative opportunities.

A major change in workflow for leadership and coalition members was learning to work from home which included learning computer skills to navigate the virtual world. Half of the coalitions led by older and seasoned prevention professionals were challenged by technology which created

frustration and inefficiencies. In pre-pandemic conditions, providing an in-person training or facilitating a coalition event was within the expertise of most coalition leaders. Conducting a virtual event during the COVID-19 pandemic was unchartered territory to many. The involvement of youth and young adults was critical to the success of the adaptations regarding virtual platforms, online communication, and ongoing youth involvement.

Future adaptations of virtual events may continue to be completed with the assistance of youth and/or young adults given the changing nature of virtual options. Digital natives, a term coined by Mark Prensky in 2001, are described as the generation of people who grew up in the era of ubiquitous technology, including computers and the internet. Digital natives are comfortable with technology and computers at an early age and consider technology to be an integral and necessary part of their lives. Many teenagers and children today are generally considered to be digital natives as they mainly communicate and learn via computers and text[6]. Because maintaining an online presence is necessary for sustained youth involvement, many leaders believe that in-person events will not be the sole delivery method for education, training, and conferences involving youth.

While there were challenges to moving forward with community activities, South Carolina coalitions worked to enhance their online and social media presence as probably most coalitions did. In the ideal online world, connectivity is perfect and there are no dropped calls, computer glitches, or difficulty with sustained connectivity. As technology becomes more sophisticated and users feel more confident in their abilities, technology options in future years are limitless. The degree to which technology will be integrated into the future work of DFCs will be determined over time.

Additional challenges that DFCs face is the degree to which the coalition is “ready” to plan potential adaptations to their action plan. Readiness refers to organizations being willing (motivated) and able (capacity) to implement change[7]. The concept of organizational readiness for a new innovation is relevant to a variety of topic areas including coalitions[8,9]. Examples of how to assess and build readiness components (e.g., capacities, motivation for change, etc.,) currently exist in the literature (e.g.,[10,11,12,13]).

Proactive Model to Guide Adaptation

As the COVID-19 pandemic continues to unfold in the following months, coalitions are likely to further modify content and processes as priorities, needs, environmental conditions, and context shift. When adapting either

the content or delivery of existing strategies, it is important to approach adaptation systematically, iteratively, and with explicit attention to both the intended and unintended impacts that adaptations may have on the desired outcomes (e.g., core measures).

Adaptations allow implementers the flexibility and opportunity to tailor a strategy to the needs of a specific population or a community. At the broadest level, adaptations are changes to a strategy's *content* or *delivery.* The field of implementation science offers several frameworks (e.g., [14],[15]) for classifying adaptations based on their attributes (e.g., who made the adaptation, what was adapted, why was the adaptation made). These frameworks promote consistent descriptions of adaptations across research studies, allowing researchers to compare findings across studies. However, classification frameworks that promote consistent descriptions of adaptations are only the first step[16]. It is important to use systematic processes to guide the design of adaptations in order to improve the adaptations' positive effects on outcomes. One advantage of the Model for Adaptation Design and Impact (MADI) is the opportunity to use a systematic process in a prospective way.

The Model for Adaptation Design and Impact (MADI) helps implementers design adaptations in a way that prospectively considers their intended and unintended impact on outcomes[17]. For example, in the time of COVID, a coalition may identify a need for adaptation such as offering a parent training through a virtual platform if the in-person training event is no longer possible. The MADI guides implementers through several structured questions to anticipate the impact of the adaptation on outcomes, identify and weigh potential benefits and risks of adaptations, and ultimately decide whether to move forward with an adaptation, abandon it, or redesign it. The three decision points to inform the adaptation design are:

1. Is the adaptation systematic, designed with a goal in mind, and aligned with core functions of the strategy? (If yes, move on to decision point 2)
2. Are any negative impacts on outcomes predicted (intended or unintended)? (If negative impacts predicted, move on to decision point 3)
3. Can negative impacts be mitigated or offset with positive impacts on other outcomes?

Table 3 outlines an example adaptation for the prevention strategy of providing information and enhancing refusal skills through a youth

summit. The example shows how MADI can be used to guide the discussion about adaptation design.

Table 3. Applying MADI to the Adaptation Design of a Youth Summit

<table>
<tr><td colspan="3">Prevention Strategy: Community Youth Summit
Need for adaptation: Due to the social distancing requirements of COVID-19, the planned youth summit cannot be held in person. The DFC coalition identifies a need to adapt the youth summit for remote delivery with plans to maintain the reach and fidelity of the event.
Proposed adaptation: After discussing several options, the coalition decides to adapt the delivery of the youth summit by hosting it via Zoom. They selected Zoom after consulting data about reliability of virtual meeting platforms, and discussions with key coalition members including the youth subcommittee.</td></tr>
<tr><th>MADI Decision Point</th><th>Explanation</th><th>DFC Example</th></tr>
<tr><td>Is the adaptation systematic, designed with a goal in mind, and aligned with core functions of the strategy?</td><td>This question asks whether the adaptation is:
Systematic: the adaptation is systematic if it is designed using a formal process that includes consulting data, theory, best practice, and/or stakeholders, as well as considering the impact on outcomes.
Designed with a goal in mind: the adaptation is designed to improve some outcome.
Aligned with core functions: the adaptation is aligned with the</td><td>The coalition had discussions about whether the Zoom based adaptation meets the three criteria. They decided that the adaptation was systematic because the entire coalition was involved in designing it, and they consulted data and stakeholders in the design. The coalition also decided the adaptation was designed with a goal in mind – they adapted the delivery of the youth summit to maintain attendance at sessions (reach) and structured the event to have the same goals and desired outcomes</td></tr>
</table>

	core functions of the strategy in that the adaptation does not detract from core functions or risk compromising the efficacy of the strategy.	as the in-person event. The coalition was sure that the adaptation was aligned with its mission, objectives, and action plan. The youth subcommittee posits that the purpose of the youth summit is to provide information and enhance skills to become effective peer leaders. They decided that remote sessions would still maintain these core functions, so they decided to move onto decision point two.
Are any negative impacts on outcomes predicted (intended or unintended)?	MADI asks implementers to consider whether the adaptation could have intended or unintended impacts (either positive or negative) on the following outcomes: • Adoption • Acceptability • Appropriateness • Cost • Feasibility • Fidelity • Reach • Sustainability	The coalition discussed the potential switch to Zoom for the youth summit and identified some costs and benefits to virtual sessions. Although Zoom is more appropriate and feasible than in-person delivery methods and is an adaptation that can engage many youth (i.e., reach), a coalition member brings up that cost and feasibility may have unintended consequences. To host sessions on Zoom, the coalition should obtain a professional, HIPAA

		compliant account to effectivens host the sessions (vs. a free Zoom account). Prior youth summits were hosted in a school gymnasium at no cost to the coalition. They also considered whether Zoom is a feasible/acceptable platform for youth whose families may have parents who need their only computer to complete work tasks.
Can negative impacts be mitigated or offset with positive impacts on other outcomes?	For adaptations where potential negative impacts are identified, MADI asks implementers to consider whether negative impacts can be mitigated or offset with positive impacts on other outcomes?	Although the coalition identified some costs and benefits of using Zoom, they decided the benefits outweighed the costs (e.g., continued youth engagement). Coalition members identified unused supply funds that could be used to cover the cost of Zoom. In addition, the fact that Zoom offers a HIPAA compliant option made it a more appropriate platform for youth participation than other platforms. The coalition also discovered that Zoom could be used on a cellphone not just a laptop which alleviated concerns about using the family computer. A

		member of the youth subcommittee offered to create a “getting started with Zoom” YouTube video to help families learn to use Zoom and its key features including break out rooms. They decided that the benefits outweighed the costs and identified several strategies to mitigate potential barriers and decided to move forward with using Zoom.

Study Limitations

There are several limitations to this study including a descriptive study design with primary data collection limited to qualitative methods with a small sample size of coalitions. However, this allowed for follow-up questions and opportunities to probe the details about the adapted community change strategies. Participating coalitions were recruited because of their years of experience in the DFC program. This experience could have increased the likelihood that the adaptations described were more advanced or sophisticated that what less experienced coalitions would describe (or be able to do). It is also possible that the project leadership presented the coalition’s progress and adaptations in an overly favorable light. However, this study design relied on a single interviewer who had some knowledge of each coalition interviewed including the general scope of the action plans in pre-pandemic conditions.

The small sample size in one geographic location limits the ability to generalize to coalitions outside of South Carolina. It is noteworthy that the DFC program uses a specific model for community change strategies that is required for coalitions to document in their action plan. This suggests that many of the activities and strategies are common across all DFC coalitions throughout the US and that implementation details primarily vary according to setting and context.

This is the first descriptive study with documented examples of how DFC coalitions in one state modified their strategies in the early months of

the COVID-19 pandemic. Fortunately, many of the DFC coalitions successfully pivoted to a virtual format and continued to provide information, enhance skills, and provide support. While many recognize the benefits of virtual platforms (e.g., cost, convenience, etc.), the degree to which coalition activities will resume as primarily in-person events is unknown. While no follow-up data was formally collected from the coalitions, it is likely that the use of online platforms will play a larger role in implementation than they did prior to the COVID-19 pandemic.

Information gathered from the DFC coalitions suggests that many implemented innovative adaptations to keep prevention messages relevant at the community level. While leadership and project staff at ONDCP/SAMHSA/CDC responded to coalitions' questions regarding project management, financial options, and statutory requirements, little guidance about specific programming was available. For newly awarded DFC coalitions announced in December 2020, it is likely that new guidance and planning ideas will emerge as updated information is made available. Regardless, all DFC coalitions can benefit from a systematic planning process to facilitate adaptation in a prospective way (e.g., MADI). Documenting adaptations will be necessary to determine the extent to which meaningful adaptations actually occurred, which adaptations are effective, and how they possibly contribute to the desired outcomes of the overall DFC program (e.g., core measures).

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