

CALIFORNIA LEGISLATURE

SENATE COMMITTEE ON EDUCATION AND
SENATE COMMITTEE ON HEALTH

JOINT INFORMATIONAL HEARING

IMPLEMENTING AND FUNDING THE CONTROL,
REGULATE, AND TAX ADULT USE OF MARIJUANA ACT'S
(AUMA) YOUTH EDUCATION, PREVENTION, EARLY
INTERVENTION AND TREATMENT ACCOUNT (YEPEITA)



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FEBRUARY 13, 2019 ■ 1:30 PM

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California State Senate

SENATE EDUCATION AND SENATE HEALTH



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IMPLEMENTING AND FUNDING THE CONTROL, REGULATE, AND TAX ADULT USE OF MARIJUANA ACT'S (AUMA) YOUTH EDUCATION, PREVENTION, EARLY INTERVENTION AND TREATMENT ACCOUNT (YEPEITA)

Wednesday, February 13, 2019
1:30 p.m. -- John L. Burton Hearing Room (4203)

AGENDA

1. **Opening Remarks by Senator Pan and Senator Leyva**
2. **Overview of the Youth Education, Prevention, Early Intervention and Treatment Account**
 - Clint Kellum, Assistant Program Budget Manager, Department of Finance
 - Sonja Petek, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
3. **Stakeholders' Experiences and Recommendations for Implementation/Oversight of Funded Programs**
 - Juliet Sims, Associate Program Director, Prevention Institute
 - Dr. Jim Kooler, Administrator, California Friday Night Live Partnership, Tulare County Office of Education
 - Warren Daniels, MA, LAADC, CCJP, Chief Strategy Officer, Community Recovery Resources
4. **Departments' Plans for Implementation/Oversight of Funded Programs**
 - Jennifer Kent, Director, Department of Health Care Services
 - Karen Smith, MD, MPH, State Public Health Officer and Director, Department of Public Health
 - Stephanie Papas, Education Administrator, Department of Education
5. **Public Comment**

IMPLEMENTING AND FUNDING THE CONTROL, REGULATE, AND TAX ADULT USE OF MARIJUANA ACT'S (AUMA) YOUTH EDUCATION, PREVENTION, EARLY INTERVENTION AND TREATMENT ACCOUNT (YEPEITA)

BACKGROUND MATERIALS

1. **Proposition 64 Revenue and Taxation Code-RTC**
2. **Proposition 64 Stakeholder Group**
3. **Prevention, Intervention, & Treatment**
 - **Promoting Health Equity and Community Resilience Through Primary Prevention**
 - **Community Recovery Resources 2016-2017 Annual Report**
4. **Legislative Proposals Legislation Related to the Youth Education, Prevention, Early Intervention and Treatment Account (YEPEITA)**
5. **Resources & Programs**
 - **State Schools Chief Torlakson Announces School Resources Following Legalization of Recreational Marijuana.**
 - **California Department of Education Resources for Schools**
 - **Student Assistance Programs**
 - **CA Friday Night Live Partnership Overview**
 - **National Drug Control Strategy**
6. **Other States**
 - **Education Commission of the States**
 - **Marijuana Funding to Support School Behavioral Health, Colorado Department of Education**
 - **Colorado Framework for School Behavioral Health Services**
 - **Washington State Institute for Public Policy- Updated Inventory of Programs for the Prevention and Treatment of Youth Cannabis Use**
 - **Overview & Introduction to the Programs, University of Washington and Washington State University**

PROPOSITION 64



Close

Code Text**REVENUE AND TAXATION CODE - RTC**

DIVISION 2. OTHER TAXES [6001 - 60709] (*Heading of Division 2 amended by Stats. 1968, Ch. 279.*)

PART 14.5. Cannabis Tax [34010 - 34021.5] (*Heading of Part 14.5 amended by Stats. 2017, Ch. 27, Sec. 161.*)

34019. (a) Beginning with the 2017–18 fiscal year, the Department of Finance shall estimate revenues to be received pursuant to Sections 34011 and 34012 and provide those estimates to the Controller no later than June 15 of each year. The Controller shall use these estimates when disbursing funds pursuant to this section. Before any funds are disbursed pursuant to subdivisions (b), (c), (d), and (e) of this section, the Controller shall disburse from the Tax Fund to the appropriate account, without regard to fiscal year, the following:

- (1) Reasonable costs incurred by the board for administering and collecting the taxes imposed by this part; provided, however, such costs shall not exceed 4 percent of tax revenues received.
- (2) Reasonable costs incurred by the bureau, the Department of Consumer Affairs, the Department of Food and Agriculture, and the State Department of Public Health for implementing, administering, and enforcing Division 10 (commencing with Section 26000) of the Business and Professions Code to the extent those costs are not reimbursed pursuant to Section 26180 of the Business and Professions Code. This paragraph shall remain operative through the 2022–23 fiscal year.
- (3) Reasonable costs incurred by the Department of Fish and Wildlife, the State Water Resources Control Board, and the Department of Pesticide Regulation for carrying out their respective duties under Division 10 (commencing with Section 26000) of the Business and Professions Code to the extent those costs are not otherwise reimbursed.
- (4) Reasonable costs incurred by the Controller for performing duties imposed by the Control, Regulate and Tax Adult Use of Marijuana Act, including the audit required by Section 34020.
- (5) Reasonable costs incurred by the Department of Finance for conducting the performance audit pursuant to Section 26191 of the Business and Professions Code.
- (6) Reasonable costs incurred by the Legislative Analyst's Office for performing duties imposed by Section 34017.
- (7) Sufficient funds to reimburse the Division of Labor Standards Enforcement and the Division of Occupational Safety and Health within the Department of Industrial Relations and the Employment Development Department for the costs of applying and enforcing state labor laws to licensees under Division 10 (commencing with Section 26000) of the Business and Professions Code.

(b) The Controller shall next disburse the sum of ten million dollars (\$10,000,000) to a public university or universities in California annually beginning with the 2018–19 fiscal year until the 2028–29 fiscal year to research and evaluate the implementation and effect of the Control, Regulate and Tax Adult Use of Marijuana Act, and shall, if appropriate, make recommendations to the Legislature and Governor regarding possible amendments to the Control, Regulate and Tax Adult Use of Marijuana Act. The

recipients of these funds shall publish reports on their findings at a minimum of every two years and shall make the reports available to the public. The bureau shall select the universities to be funded. The research funded pursuant to this subdivision shall include but not necessarily be limited to:

- (1) Impacts on public health, including health costs associated with cannabis use, as well as whether cannabis use is associated with an increase or decrease in use of alcohol or other drugs.
 - (2) The impact of treatment for maladaptive cannabis use and the effectiveness of different treatment programs.
 - (3) Public safety issues related to cannabis use, including studying the effectiveness of the packaging and labeling requirements and advertising and marketing restrictions contained in the act at preventing underage access to and use of cannabis and cannabis products, and studying the health-related effects among users of varying potency levels of cannabis and cannabis products.
 - (4) Cannabis use rates, maladaptive use rates for adults and youth, and diagnosis rates of cannabis-related substance use disorders.
 - (5) Cannabis market prices, illicit market prices, tax structures and rates, including an evaluation of how to best tax cannabis based on potency, and the structure and function of licensed cannabis businesses.
 - (6) Whether additional protections are needed to prevent unlawful monopolies or anti-competitive behavior from occurring in the adult-use cannabis industry and, if so, recommendations as to the most effective measures for preventing such behavior.
 - (7) The economic impacts in the private and public sectors, including, but not necessarily limited to, job creation, workplace safety, revenues, taxes generated for state and local budgets, and criminal justice impacts, including, but not necessarily limited to, impacts on law enforcement and public resources, short and long term consequences of involvement in the criminal justice system, and state and local government agency administrative costs and revenue.
 - (8) Whether the regulatory agencies tasked with implementing and enforcing the Control, Regulate and Tax Adult Use of Marijuana Act are doing so consistent with the purposes of the act, and whether different agencies might do so more effectively.
 - (9) Environmental issues related to cannabis production and the criminal prohibition of cannabis production.
 - (10) The geographic location, structure, and function of licensed cannabis businesses, and demographic data, including race, ethnicity, and gender, of license holders.
 - (11) The outcomes achieved by the changes in criminal penalties made under the Control, Regulate and Tax Adult Use of Marijuana Act for cannabis-related offenses, and the outcomes of the juvenile justice system, in particular, probation-based treatments and the frequency of up-charging illegal possession of cannabis or cannabis products to a more serious offense.
- (c) The Controller shall next disburse the sum of three million dollars (\$3,000,000) annually to the Department of the California Highway Patrol beginning with the 2018–19 fiscal year until the 2022–23 fiscal year to establish and adopt protocols to determine whether a driver is operating a vehicle while impaired, including impairment by the use of cannabis or cannabis products, and to establish and adopt protocols setting forth best practices to assist law enforcement agencies. The department may hire personnel to establish the protocols specified in this subdivision. In addition, the department may make grants to public and private research institutions for the purpose

of developing technology for determining when a driver is operating a vehicle while impaired, including impairment by the use of cannabis or cannabis products.

(d) The Controller shall next disburse the sum of ten million dollars (\$10,000,000) beginning with the 2018–19 fiscal year and increasing ten million dollars (\$10,000,000) each fiscal year thereafter until the 2022–23 fiscal year, at which time the disbursement shall be fifty million dollars (\$50,000,000) each year thereafter, to the Governor's Office of Business and Economic Development, in consultation with the Labor and Workforce Development Agency and the State Department of Social Services, to administer a community reinvestments grants program to local health departments and at least 50 percent to qualified community-based nonprofit organizations to support job placement, mental health treatment, substance use disorder treatment, system navigation services, legal services to address barriers to reentry, and linkages to medical care for communities disproportionately affected by past federal and state drug policies. The office shall solicit input from community-based job skills, job placement, and legal service providers with relevant expertise as to the administration of the grants program. In addition, the office shall periodically evaluate the programs it is funding to determine the effectiveness of the programs, shall not spend more than 4 percent for administrative costs related to implementation, evaluation, and oversight of the programs, and shall award grants annually, beginning no later than January 1, 2020.

(e) The Controller shall next disburse the sum of two million dollars (\$2,000,000) annually to the University of California San Diego Center for Medicinal Cannabis Research to further the objectives of the center, including the enhanced understanding of the efficacy and adverse effects of cannabis as a pharmacological agent.

(f) By July 15 of each fiscal year beginning in the 2018–19 fiscal year, the Controller shall, after disbursing funds pursuant to subdivisions (a), (b), (c), (d), and (e), disburse funds deposited in the Tax Fund during the prior fiscal year into sub-trust accounts, which are hereby created, as follows:

(1) Sixty percent shall be deposited in the Youth Education, Prevention, Early Intervention and Treatment Account, and disbursed by the Controller to the State Department of Health Care Services for programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. The State Department of Health Care Services shall enter into interagency agreements with the State Department of Public Health and the State Department of Education to implement and administer these programs. The programs shall emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth, their families and caregivers. The programs may include, but are not limited to, the following components:

(A) Prevention and early intervention services including outreach, risk survey and education to youth, families, caregivers, schools, primary care health providers, behavioral health and substance use disorder service providers, community and faith-based organizations, fostercare providers, juvenile and family courts, and others to recognize and reduce risks related to substance use, and the early signs of problematic use and of substance use disorders.

(B) Grants to schools to develop and support student assistance programs, or other similar programs, designed to prevent and reduce substance use, and improve school retention and performance, by supporting students who are at risk of dropping out of school and promoting alternatives to suspension or expulsion that focus on school retention, remediation, and professional care. Schools with higher than average dropout rates should be prioritized for grants.

- (C) Grants to programs for outreach, education, and treatment for homeless youth and out-of-school youth with substance use disorders.
- (D) Access and linkage to care provided by county behavioral health programs for youth, and their families and caregivers, who have a substance use disorder or who are at risk for developing a substance use disorder.
- (E) Youth-focused substance use disorder treatment programs that are culturally and gender competent, trauma-informed, evidence-based and provide a continuum of care that includes screening and assessment (substance use disorder as well as mental health), early intervention, active treatment, family involvement, case management, overdose prevention, prevention of communicable diseases related to substance use, relapse management for substance use and other cooccurring behavioral health disorders, vocational services, literacy services, parenting classes, family therapy and counseling services, medication-assisted treatments, psychiatric medication and psychotherapy. When indicated, referrals must be made to other providers.
- (F) To the extent permitted by law and where indicated, interventions shall utilize a two-generation approach to addressing substance use disorders with the capacity to treat youth and adults together. This would include supporting the development of family-based interventions that address substance use disorders and related problems within the context of families, including parents, foster parents, caregivers and all their children.
- (G) Programs to assist individuals, as well as families and friends of drug using young people, to reduce the stigma associated with substance use including being diagnosed with a substance use disorder or seeking substance use disorder services. This includes peer-run outreach and education to reduce stigma, anti-stigma campaigns, and community recovery networks.
- (H) Workforce training and wage structures that increase the hiring pool of behavioral health staff with substance use disorder prevention and treatment expertise. Provide ongoing education and coaching that increases substance use treatment providers' core competencies and trains providers on promising and evidenced-based practices.
- (I) Construction of community-based youth treatment facilities.
- (J) The departments may contract with each county behavioral health program for the provision of services.
- (K) Funds shall be allocated to counties based on demonstrated need, including the number of youth in the county, the prevalence of substance use disorders among adults, and confirmed through statistical data, validated assessments, or submitted reports prepared by the applicable county to demonstrate and validate need.
- (L) The departments shall periodically evaluate the programs they are funding to determine the effectiveness of the programs.
- (M) The departments may use up to 4 percent of the moneys allocated to the Youth Education, Prevention, Early Intervention and Treatment Account for administrative costs related to implementation, evaluation, and oversight of the programs.
- (N) If the Department of Finance ever determines that funding pursuant to cannabis taxation exceeds demand for youth prevention and treatment services in the state, the departments shall provide a plan to the Department of Finance to provide treatment services to adults as well as youth using these funds.
- (O) The departments shall solicit input from volunteer health organizations, physicians who treat addiction, treatment researchers, family therapy and counseling providers, and professional education associations with relevant expertise as to the administration of any grants made pursuant to this paragraph.

(2) Twenty percent shall be deposited in the Environmental Restoration and Protection Account, and disbursed by the Controller as follows:

(A) To the Department of Fish and Wildlife and the Department of Parks and Recreation for the cleanup, remediation, and restoration of environmental damage in watersheds affected by cannabis cultivation and related activities including, but not limited to, damage that occurred prior to enactment of this part, and to support local partnerships for this purpose. The Department of Fish and Wildlife and the Department of Parks and Recreation may distribute a portion of the funds they receive from the Environmental Restoration and Protection Account through grants for purposes specified in this paragraph.

(B) To the Department of Fish and Wildlife and the Department of Parks and Recreation for the stewardship and operation of state-owned wildlife habitat areas and state park units in a manner that discourages and prevents the illegal cultivation, production, sale, and use of cannabis and cannabis products on public lands, and to facilitate the investigation, enforcement, and prosecution of illegal cultivation, production, sale, and use of cannabis or cannabis products on public lands.

(C) To the Department of Fish and Wildlife to assist in funding the watershed enforcement program and multiagency taskforce established pursuant to subdivisions (b) and (c) of Section 12029 of the Fish and Game Code to facilitate the investigation, enforcement, and prosecution of these offenses and to ensure the reduction of adverse impacts of cannabis cultivation, production, sale, and use on fish and wildlife habitats throughout the state.

(D) For purposes of this paragraph, the Secretary of the Natural Resources Agency shall determine the allocation of revenues between the departments. During the first five years of implementation, first consideration should be given to funding purposes specified in subparagraph (A).

(E) Funds allocated pursuant to this paragraph shall be used to increase and enhance activities described in subparagraphs (A), (B), and (C), and not replace allocation of other funding for these purposes. Accordingly, annual General Fund appropriations to the Department of Fish and Wildlife and the Department of Parks and Recreation shall not be reduced below the levels provided in the Budget Act of 2014 (Chapter 25 of the Statutes of 2014).

(3) Twenty percent shall be deposited into the State and Local Government Law Enforcement Account and disbursed by the Controller as follows:

(A) To the Department of the California Highway Patrol for conducting training programs for detecting, testing and enforcing laws against driving under the influence of alcohol and other drugs, including driving under the influence of cannabis. The department may hire personnel to conduct the training programs specified in this subparagraph.

(B) To the Department of the California Highway Patrol to fund internal California Highway Patrol programs and grants to qualified nonprofit organizations and local governments for education, prevention, and enforcement of laws related to driving under the influence of alcohol and other drugs, including cannabis; programs that help enforce traffic laws, educate the public in traffic safety, provide varied and effective means of reducing fatalities, injuries, and economic losses from collisions; and for the purchase of equipment related to enforcement of laws related to driving under the influence of alcohol and other drugs, including cannabis.

(C) To the Board of State and Community Corrections for making grants to local governments to assist with law enforcement, fire protection, or other local programs addressing public health and safety associated with the implementation of the Control,

Regulate and Tax Adult Use of Marijuana Act. The board shall not make any grants to local governments which have banned the cultivation, including personal cultivation under paragraph (3) of subdivision (b) of Section 11362.2 of the Health and Safety Code, or retail sale of cannabis or cannabis products pursuant to Section 26200 of the Business and Professions Code or as otherwise provided by law.

(D) For purposes of this paragraph, the Department of Finance shall determine the allocation of revenues between the agencies; provided, however, beginning in the 2022–23 fiscal year the amount allocated pursuant to subparagraph (A) shall not be less than ten million dollars (\$10,000,000) annually and the amount allocated pursuant to subparagraph (B) shall not be less than forty million dollars (\$40,000,000) annually. In determining the amount to be allocated before the 2022–23 fiscal year pursuant to this paragraph, the Department of Finance shall give initial priority to subparagraph (A).

(g) Funds allocated pursuant to subdivision (f) shall be used to increase the funding of programs and purposes identified and shall not be used to replace allocation of other funding for these purposes.

(h) Effective July 1, 2028, the Legislature may amend this section by majority vote to further the purposes of the Control, Regulate and Tax Adult Use of Marijuana Act, including allocating funds to programs other than those specified in subdivisions (d) and (f). Any revisions pursuant to this subdivision shall not result in a reduction of funds to accounts established pursuant to subdivisions (d) and (f) in any subsequent year from the amount allocated to each account in the 2027–28 fiscal year. Prior to July 1, 2028, the Legislature may not change the allocations to programs specified in subdivisions (d) and (f).

(Amended by Stats. 2017, Ch. 27, Sec. 171. (SB 94) Effective June 27, 2017. Note: This section was amended on Nov. 8, 2016, by initiative Prop. 64.)

PROPOSITION 64

STAKEHOLDER GROUP



PROPOSITION 64 STAKEHOLDER GROUP

Recommendations on the Use of Proposition 64 Adult Use of Marijuana Act Youth Funds

The new revenues generated by state taxes on marijuana represent a unique opportunity to invest in community-based public health education, prevention, early intervention, treatment, and recovery and to do so through the lens of racial and health equity, focusing those strategies on the underlying conditions that lead to substance abuse, such as toxic stress, trauma, multigenerational impacts, stigma and co-occurring mental illness.

The undersigned youth-serving organizations -- including a diverse coalition of stakeholders representing education, prevention, early intervention, treatment, and recovery -- propose the following recommendations to ensure a robust and transparent stakeholder process, that should begin no later than July 2018. All of these recommendations apply both to statewide processes and programs, as well as those at the local level.

Process

We recommend that the California Department of Health Care Services (DHCS), the California Department of Public Health (DPH), the California Department of Education (CDE) conducts a robust needs assessment and planning process in collaboration with community stakeholders and partners to determine the most effective investments in the areas of education, prevention, early intervention, treatment, recovery, and workforce development. Stakeholders should include those explicitly listed in Proposition 64, as well as community-based providers, youth development organizations, impacted youth, families, and communities disproportionately affected by the war on drugs. This planning process must be informed by the evidence about what works to prevent disease and addiction, and the perspectives and lived experiences of adults and young people impacted by past drug policies.

The Proposition 64 Youth Funds should not be used to supplant existing funding for services and supports; funds should be used to fill gaps in local program needs, in the absence of other

funding suitable streams such as the Medicaid 20/20 waiver, private insurance, the substance abuse prevention and treatment block grant (SAPT), Hub and Spoke, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or existing federal and state education funding dedicated to ongoing prevention activities.

- **Create a statewide needs assessment with common standards that will guide the work consistently across all three state agencies.** The needs assessment should: (1) Establish shared definitions of what public education, prevention, early intervention, treatment and recovery, with guidance on target ages and services for each element; (2) Include an assessment of disparities based on race, ethnicity, primary language, immigration status, gender identity, and sexual orientation; and (3) Examine the needs of children, youth, young adults, families/caregivers across different ages, from 0-26; with specific focus upon the needs of more vulnerable populations such as foster youth, youth experiencing homelessness, youth with disabilities, and transition aged youth.
- **Build capacity:** Leverage and strengthen existing infrastructure for delivering publicly funded substance use activities and services while maintaining and expanding existing community programs with demonstrated positive outcomes that have addressed the needs of the community, including those early intervention programs serving the very young and vulnerable, should be considered as important new programs addressing high need youth and their families.
- **Plan:** DHCS, DPH, and CDE should prioritize spending based on the findings of its needs assessment that creates clear short- and long-term goals related to reducing youth substance use and related health consequences. All funded activities, services, and programs should use science-based information and recommendations in non-judgmental and non-punitive settings. Programs should also prioritize safety, and recognize the importance of moderation, self-regulation, and harm reduction alongside encouraging abstinence in a way that is developmentally appropriate. In particular funds should address vital unmet needs in programs that have proven to be effective in preventing students from engaging in risky behaviors and provide alternatives to suspension and expulsion. Education, prevention, early intervention, treatment, and recovery programs should meet higher quality standards than those currently in place for substance use programs. These may include the use of evidence based or promising practices for preventing and treating substance use disorders (SUDs). State and local planning efforts should incorporate lessons learned from other states and nations on their marijuana, alcohol, and tobacco prevention efforts.
- **Implement:** Funding from DHCS, DPH, and CDE should focus on partnerships across the full spectrum of care including education, prevention, early intervention, treatment, and recovery based on local needs.
- **Evaluate:** DHCS, DPH, and CDE should assist in the evaluation of all funded programs on an ongoing basis and provide sufficient technical assistance to local efforts to ensure that measures are uniform across agencies, use a mixture of indicators and outcomes that

are appropriate to the setting, specific intervention and age of program participants, demonstrate successes and failures of programs designed to reduce substance use-related negative outcomes or consequences, and collect and report consistent demographic data, including sexual orientation and gender identity. Evaluation efforts should not become barriers to programs, organizations and smaller communities receiving funding, and the state should provide a broad range of technical assistance to small organizations and/or new grantees for implementing an effective evaluation plan.

- **Review:** DHCS, DPH, and CDE should review these plans on a periodic basis in order to adapt their planning and implementation activities to maximize impact.

Guidelines and Principles

In addition to above stakeholder process, the coalition also offers the following recommendations as principles that should be guide the work of all funded programs.

- **Integration:** Youth and their families generally interact with multiple public and non-profit entities, therefore their substance use education, prevention, early intervention, treatment, and recovery services should be linked, coordinated and/or integrated, to school programs, afterschool, child care, child welfare interactions, primary care, and mental health systems, when appropriate. The specific nature of the Proposition 64 funding should not serve to isolate activities and programs within separate disciplines or boundaries but should promote approaches that encourage communication between different delivery systems that compliment and integrate activities and services across the youth/family specific domains, ensuring that the funds are leveraged, and impacts of these efforts are maximized at the local level.
- **Meet youth where they are:** Education, prevention, early intervention, treatment, and recovery services should be provided in a variety of school and community settings to ensure access for youth and young adults with diverse needs. Programs should meet youth “where they are” and be widely accessible to all young people, including those not in contact with the public education system, those who are homeless or marginally housed, justice-involved youth, LGBTQ youth, and youth from other underserved and/or marginalized communities. Programs should prioritize health equity and cultural responsiveness.
- **Innovation:** Education and health agencies should be expected to create innovative investments and partnerships with community based organization across the spectrum of education, prevention, early intervention, treatment, and recovery. Funding for piloting and evaluating emerging practices, community-defined practices, and practices targeted at reducing substance use disparities, should be included within the statewide plan.
- **State leadership:** Though the majority of state and federal funds are now allocated to counties through state legislation, there remain important opportunities for addressing statewide needs and gaps. Efforts such as public education campaigns, work force

components and assistance in developing state of the art programs can be done effectively through coordinated state level implementation activities.

- **Equity:** Communities of color have been disproportionately impacted by marijuana policy and under legalization will be particularly at risk. For decades Black, Latino, immigrant and LGBTQ communities suffered disproportionate arrests and convictions for marijuana-related and other drug crimes. As a result, families were driven into poverty, children were separated from parents, and adults faced huge obstacles in gaining employment, housing and education as a result of felony convictions. In many communities marijuana businesses and marijuana ads are disproportionately located in low-income communities and communities of color. Certain vulnerable populations of young people suffer disproportionate rates of marijuana and substance abuse, including LGBTQ, foster youth and homeless youth
- **Positive youth development:** Any youth system of care should be designed from a positive youth development model that is developmentally appropriate, culturally and linguistically competent, takes a trauma-informed and harm reduction approach, and honors youth choice and voice. Youth development professionals should inform program design. Any programs funded needs to serve youth in accordance with their gender identity and must meet a basic level of LGBTQ cultural competency.
- **Trauma-informed:** Programs serving populations who have experienced trauma, funded by Proposition 64 will be trauma-informed. Proposition 64 funding should be provided to entities committed to engaging in trauma-informed approaches and interventions. These organizations should be committed to training all staff to be trauma-informed. These organizations should reflect Substance Abuse and Mental Health Services Administration (SAMHSA) six principles for a trauma-informed approach.

Workforce

As a part of the stakeholder process, the DHCS, DPH, and CDE should develop and implement a strategic plan for addressing the workforce shortage for substance use prevention, early intervention, treatment, and recovery. The plan should also include education, training, and standards for first responders, teachers, community members, youth workers, afterschool professionals; expanded treatment roles for primary care providers, nurse practitioners, peer support specialists, and other non-traditional providers; promoting efforts to recruit more people into the mental health substance use workforce through loan forgiveness and financial incentives; and advancing the use of technology to expand treatment options and access to care.

- Resources must be portable across the different systems of care while also encouraging a continuum that promotes communication between adequately trained and compensated substance use, mental health, and primary care providers serving underserved communities who provide education, prevention, and early intervention.
- Barriers to entry to the workforce treating youth should be reviewed to ensure that persons with lived experience are prioritized, encouraged, and not being excluded.

- All services, in all settings, need to be culturally competent and available in variety of languages. Training should be provided to ensure competency for special populations, including LGBTQ, trauma, criminal justice involvement, foster care and others.
- In developing a workforce for the provision of services and supports, DHCS, DPH, CDE, and stakeholders should work to include a pathway for a peer specialist, student assistance program professionals, and peer intervention specialist certification program for youth.

California AfterSchool Network

California Alliance of Child and Family Services

California Associations of Alcohol and Drug Program Executives, Inc

California Association for Alcohol/ Drug Educators

California Behavioral Health Planning Council

California Consortium of Addiction Programs and Professionals

California Council of Community Behavioral Health Agencies

California Health + Advocates

California LGBTQ Health and Human Services Network

California School-Based Health Alliance

Child and Adolescent Health Measurement Initiative, John Hopkins University

Children's Defense Fund – California

County Behavioral Health Directors Association

MILPA Collective

Steinberg Institute

Tarzana Treatment Center

Youth Forward

PROPOSITION 64 STAKEHOLDER GROUP
916-329-7409

PREVENTION, INTERVENTION, & TREATMENT



Promoting Health Equity and Community Resilience Through Primary Prevention

Juliet Sims, Associate Program Director
November 13, 2018
juliet@preventioninstitute.org

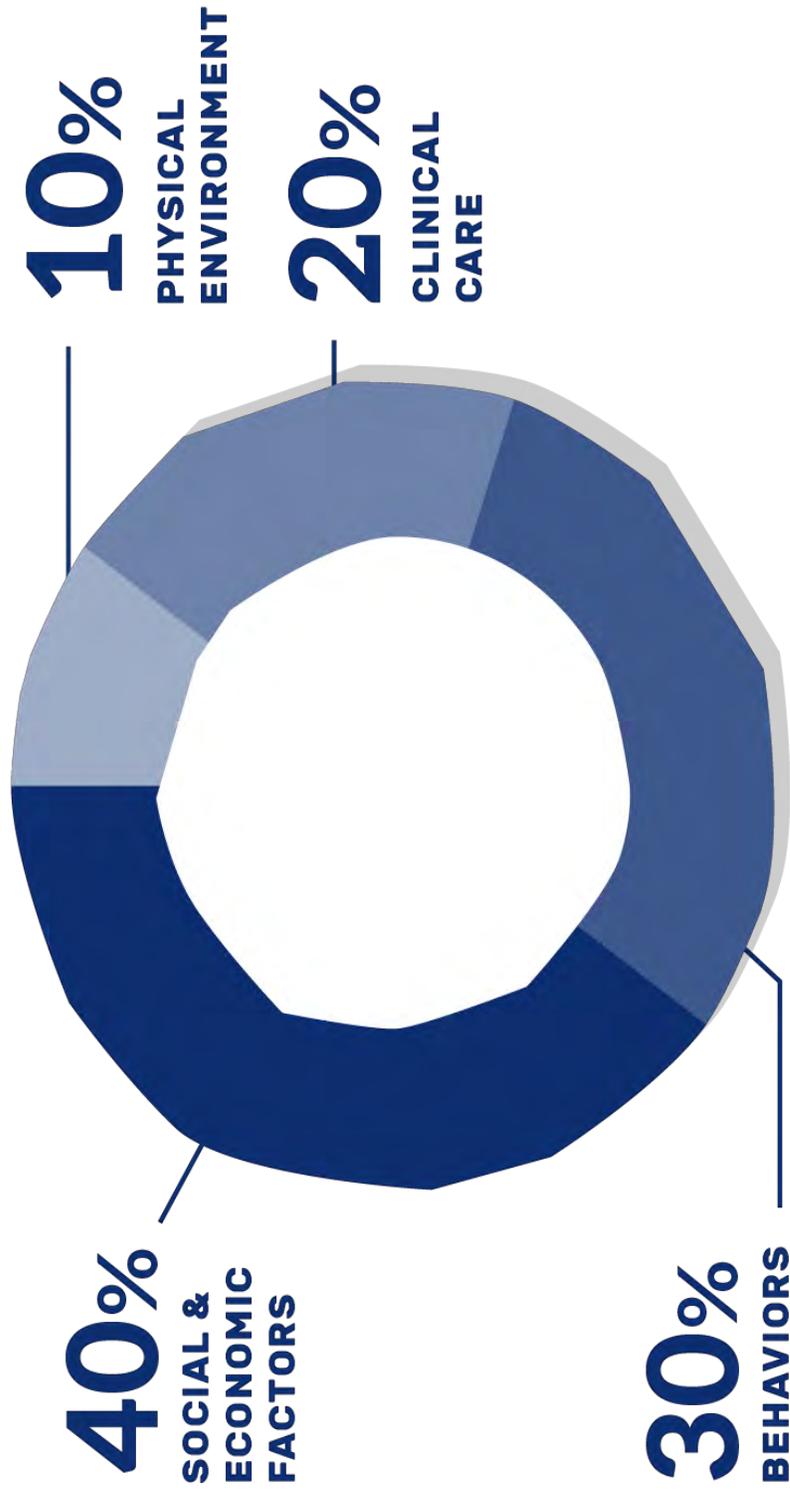
PREVENTION
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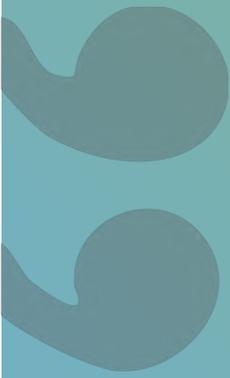




People’s health is strongly influenced by the overall life odds of the neighborhood where they live. Indeed, place matters. In many low-income urban and rural communities, whole populations are consigned to shortened, sicker lives.”

Factors that influence health





It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.

- Institute of Medicine



Prevention

A systematic process that reduces the frequency and/or severity of illness or injury.

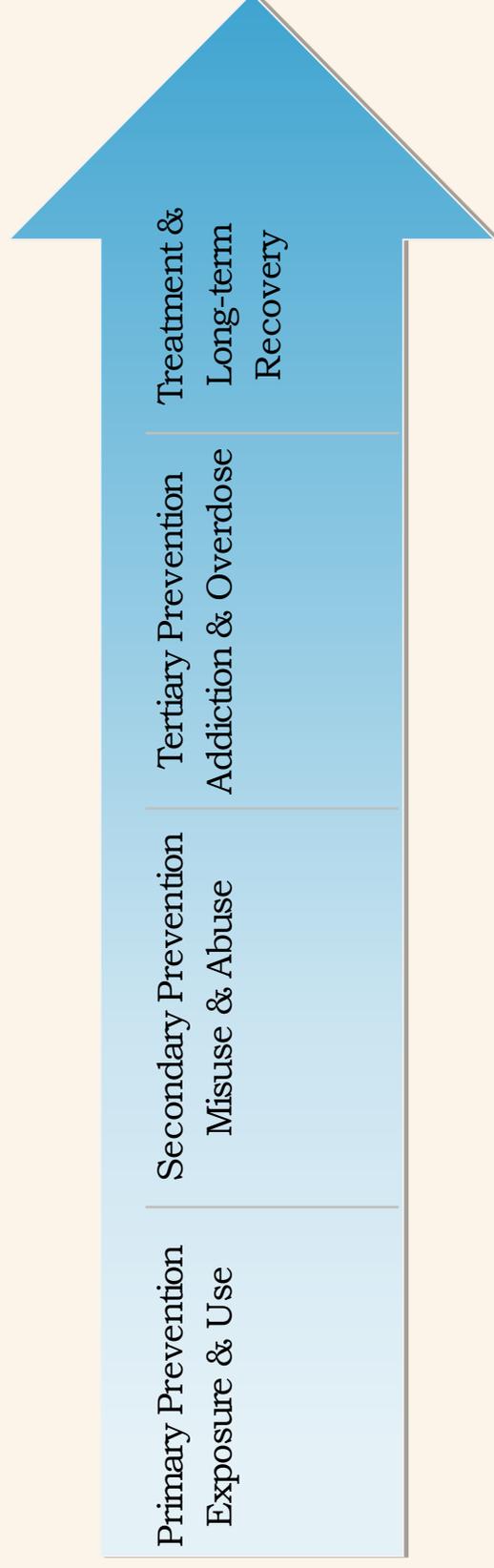
Primary Prevention

Promotes healthy environments and behaviors to prevent problems from occurring before the onset of symptoms.

Prevention Works

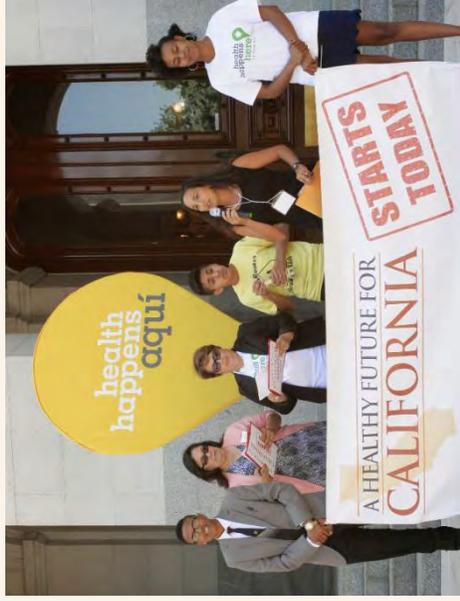
- Child Restraint and Safety Belt Use
- Smoking Prevention
- Bans on School Junk Food
- School-Based Wellness Policies for Physical Activity
- Childhood Immunizations
- Motorcycle and Bicycle Helmet Laws

Substance abuse trajectory of prevention

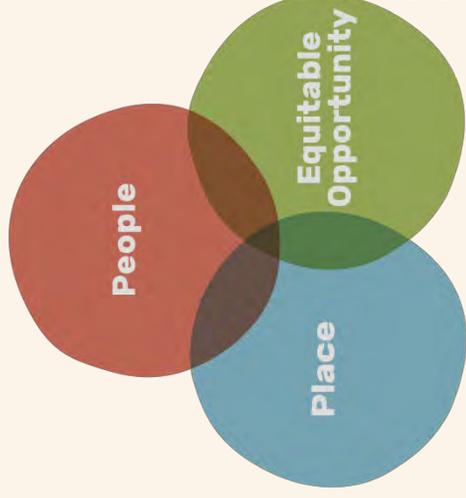


- *What are we trying to prevent?*
- *What message do we send to youth when we focus most on tertiary prevention?*

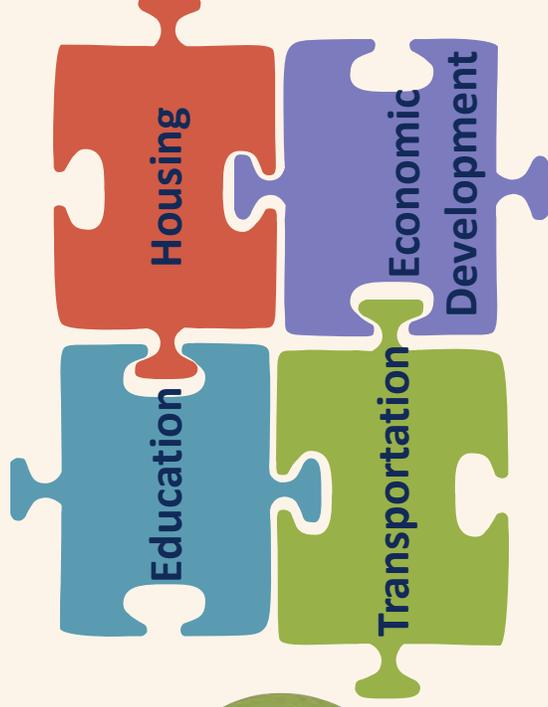
Core Elements of Community Initiatives to Advance Health, Safety, and Wellbeing



Youth & Community Leadership



Community Determinants



Multisector Support

Community Determinants

People



Social networks & trust



Participation & willingness to act for the common good



Norms & culture



Education



Living wages & local wealth/assets

Equitable Opportunity

Place



What's sold & how it's promoted



Look, feel, & safety



Housing



Parks & open space



Air, water & soil



Getting around



Arts & cultural expression

Youth & Community Leadership



Displacement isn't only about other people pushing me out of my community.

It's also in the messages that tell me that success is getting out.

And what I need to hear is that success is staying here and changing my community.

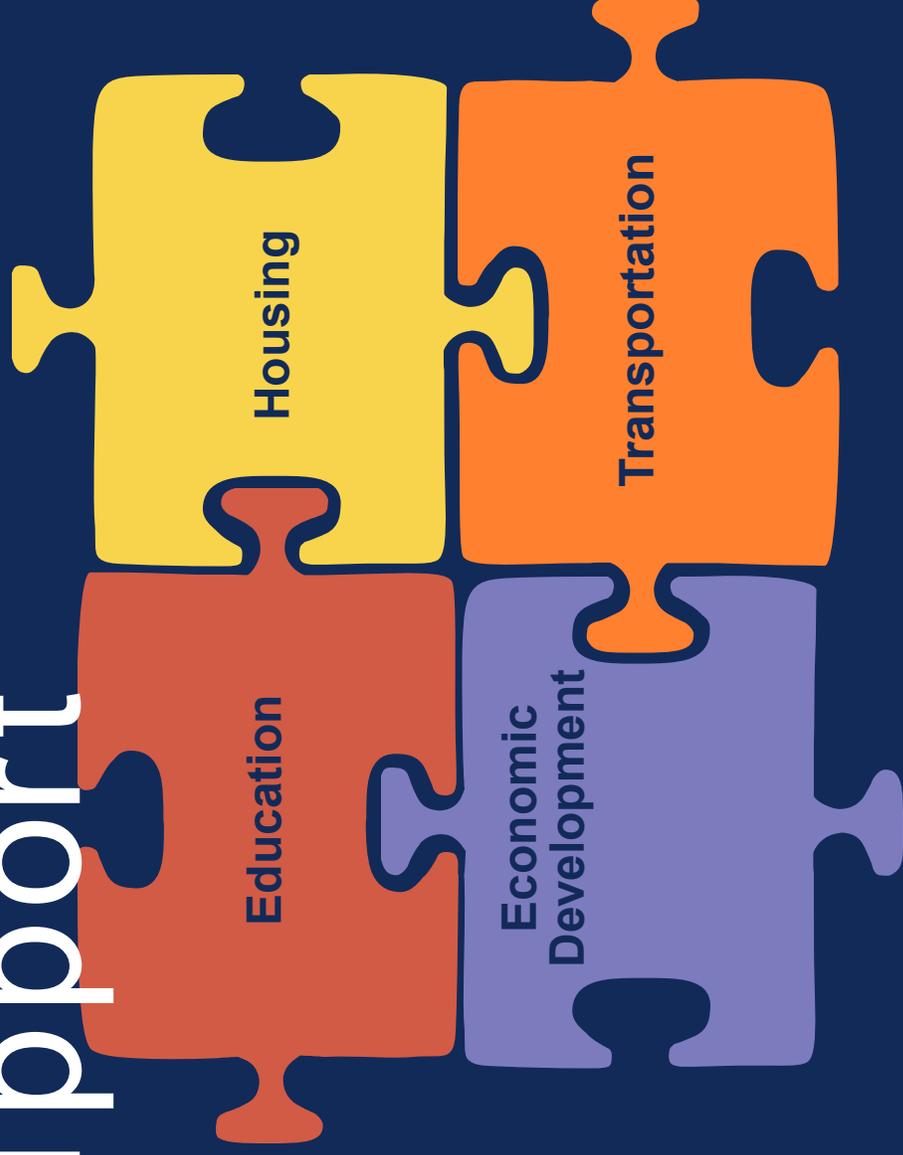
- Baruch Campos, Together for Brothers

Community participation, when it's real, is your main investment in accountability. It's your main investment in sustainability... community participation is when, truly, you involve people in creating a mechanism for themselves to define change.

- America Bracho, Executive Director
Latino Health Access



Multisector Support





We each have a role



We each have a role



Medical Care

Jobs

Clean Air

Neighborhoods

Policy Makers

Transportation

Childcare

We each have a role

Housing

Economics

Parks and Activities

Residents

Education

Healthy Food



COMMUNITY RECOVERY RESOURCES

*5 Years Of The Campus Model:
A Local Solution For Today
A National Model For Tomorrow*



GRASS VALLEY
AUBURN
LINCOLN
ROSEVILLE
KINGS BEACH
TRUCKEE

**2016-2017
Annual
Report**



MESSAGE FROM CoRR'S PRESIDENT, CEO & DEPUTY CEO

Dear Friends of CoRR,

We are grateful to be once again sharing an annual report with you that demonstrates tremendous service and outcomes as we provide life-changing, and life-saving, services. As we celebrate 5 years at the Campus, and over 40 years of service, we know we can be successful in treating and managing a disease that can cause immense suffering, and even death. We see that hope and success every day as babies and young children get their parents back, teens find strength in themselves, adults recover meaning and purpose as contributive citizens, and families are reunited. Our growth and evolution can be attributed to the dedication of our staff, the increasing effectiveness of our evidence-based care, and the support of our community.

But even as we can celebrate these successes, we face tremendous challenge. We are all painfully aware of the tragedy of the opiate epidemic, as we face the ultimate loss of loved ones—sons, daughters, parents, spouses. This public health catastrophe has left millions of Americans with a chronic life-threatening disease. Neighborhoods and communities are suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse.

As our Surgeon General noted, “most Americans know someone with a substance use disorder, and many know someone who has lost or nearly lost a family member as a consequence of substance misuse. Yet, at the same time...Substance use disorder treatment in the United States remains largely segregated from the rest of health care and serves only a fraction of those in need of treatment”.

We are here to change that. Because we believe in the value of all life. We believe in alleviating suffering, and that a healthy, joyous life of meaning is not only possible, but should be expected. **We know for sure that there is reason for hope.** Whatever challenges lie ahead, the individuals and families we serve remain at the heart of everything we do. It is their resilience and indomitable spirit that have inspired us for decades—and will energize us for years to come.

Please know that the important work of Community Recovery Resources would not be possible without you, our loyal donors. We couldn't be more grateful for your confidence and need your **continued** support.



Warren Daniels
CEO



Steve Martino
Board President



Ariel Lovett
Deputy CEO

FROM VISION TO REALITY: 5 YEARS AT THE CAMPUS

- | | | | |
|-------------|--|-------------|---|
| 2005 | Local leaders declare methamphetamine at crisis levels | 2011 | Local contractors break ground on the Campus, Capital Campaign is launched |
| 2007 | Purchase of homes on East Main, Brentwood | 2012 | Doors open at the Campus |
| 2008 | California Endowment funds business plan for Campus | 2017 | Successful capital campaign generates nearly \$2 million in donations to support the Campus, and the community celebrates 5 years of life saving services |
| 2009 | Submission of proposal to USDA Rural Development | | |
| 2010 | USDA Approves \$9.3 million loan | | |



CELEBRATING FIVE YEARS AT THE CAMPUS 2012-2017

The Campus offers hope to thousands each year as people of all ages find compassionate and quality services to heal from trauma, substance use disorders, mental health challenges, and related health issues.

Families are the motivation and heart of the Campus. About 100 children are reunified with their families each year through Mothers in Recovery and Hope House programs ... **an estimated annual savings of \$2,214,000 in placement costs. (Over 5 years, that's \$11,070,000).**

Between 110-150 children nurtured in CoRR's child development center each year, or over 625 children over five years. This is how we begin to end the cycle of substance use disorder, poverty, crime and family violence, and *begin a story of health, joy, and wellness.*



Courtesy of Sugar Pine Studios

The Campus Outpatient Center serves about 250 people monthly with outpatient drug treatment and education programs, including intensive outpatient, counseling, therapy, teen programs, Mothers in Recovery, parenting classes, anger management and DUI programs. In the five years, more than 700 women have been supported by Grass Valley Mothers in Recovery with parenting, counseling, therapy, and life-skills.

In addition, partnering with Western Sierra Medical Clinic, the Campus has served 342 people with 1,254 visits for primary care, with diabetes, hypertension, and hepatitis C as the top three primary health issues.

About 100 Nevada County teens are served each year, in schools or in outpatient programs at CoRR's Campus.

The Campus Residential programs have served more than 2,000 individuals in this critical phase of treatment.

Hope House residential treatment program has helped 1,087 women find recovery (plus helped about 200 little ones who lived with their moms).

Prior to the Campus, there was no residential program like it for men, and now *1,094 men have sought treatment at Serenity House.*

In an average year, about 440 individuals access residential treatment, with around 90 people accessing withdrawal management—a life saving resource that was previously unavailable in this community.

The Campus Supportive Housing Programs provide a safe environment, prevent homelessness, and encourage development of lifelong skills to achieve long-term recovery, wellness, and self-sufficiency.

■ CoRR's Grass Valley Campus offers 36 beds in supportive housing. That's about 12,000 bed nights each year that women, men and children are not homeless or in unsafe places: or *60,000 safe nights in 5 years.*



2016-2017 PROGRAMS OVERVIEWS & HIGHLIGHTS



CoRR's comprehensive offering provides support to our community members wherever they are in their illness, or wellness, to achieve optimal health, joy, and meaning.

OUTPATIENT TREATMENT & SUPPORT

CoRR has worked with approximately 4,000 people struggling with substance use disorders and changing the course of their lives — step-by-step, moment-by-moment, one day at a time.

Primary outpatient treatment programs in Truckee, Kings Beach, Grass Valley, Auburn, Lincoln and Roseville provide counseling, evidence-based curriculum and support to men, women and teens. Intensive outpatient supports a higher level of care, and Mothers in Recovery offers specialized support for pregnant and parenting women.



WEEKLY FAMILY RECOVERY EDUCATION NIGHTS

Located in Grass Valley, Truckee, Roseville and Auburn, these nights are open to all, offering no-cost sessions for families to learn about supporting relatives in recovery and caring for themselves in the process.

COMMUNITY OUTREACH & PREVENTION ACTIVITIES

Hundreds of presentations at schools, clubs, hospitals, service clubs, health fairs, and community events from Truckee to Roseville let people in our community know that help is there when they need it, and how to reduce the risk of substance use disorder for themselves, and their children.

RECOVERY & WELLNESS SERIES

The series has welcomed more than 600 participants this year in a no-cost series learning about topics related to health, like managing depression; addressing trauma in teens; supporting children who have experienced familial substance use disorders, or learning about the opiate epidemic.

CHILD CARE & FAMILY DEVELOPMENT

These services play an important role in connecting parents to programs that help them achieve longer term goals. Through services like therapy, case management, social work, education and quality child development programs, families have a greater ability to heal. CoRR's staff meets with parents to identify and ensure age-appropriate development, teach child development techniques, and support each child's achievement of developmental milestones. CoRR's Child Development Centers have nurtured 104 in Grass Valley, 44 in Roseville and 35 in Auburn.



2016-2017 PROGRAMS OVERVIEWS & HIGHLIGHTS

ADOLESCENT PROGRAMS

These help 615 teenagers regain health, focus, and prepare for a bright future.

■ Student Assistance Programs provide prevention support and education about substance use among students at 18 high schools in Placer and Nevada Counties. At-school support helps to discourage drug, alcohol, and tobacco use with at-risk teens and support kids to stay in school. With the support of the Nevada County and Placer County school districts, CoRR has impacted 449 adolescents this past year.

■ Outpatient treatment for teens in Roseville, Auburn, and Grass Valley, provides life-changing help to teens with substance use disorders and emerging mental health issues. CoRR provides tools and techniques to empower adolescents to handle challenging family and social situations, address trauma, understand themselves, and learn new ways to live free of alcohol and other drugs. 166 adolescents.

DUI & EDUCATION PROGRAM

CoRR is licensed by the DMV and State of California's Department of Alcohol and Drug Programs to provide DUI treatment services for first- and/or multiple-offender. With the goal of community safety, CoRR's DUI program is designed to encourage participants to change attitudes and behavior. CoRR has helped hundreds of participants at all six CoRR locations.



MOTHERS IN RECOVERY

Everyday CoRR staff stands together for the empowerment and dignity of women and families. Mothers in Recovery contributes to restoring confidence, strength and health as women learn practical living skills and overcome trauma. This past year CoRR has served 191 women in Grass Valley, 70 women in Auburn, and 66 women in Roseville getting support to be clean, strong, and healthy.

RESIDENTIAL/INPATIENT TREATMENT & WITHDRAWAL MANAGEMENT

A unique asset-based treatment and wellness plan is developed to create the greatest opportunity for success for each individual. Residential treatment and withdrawal management provide intensive support to begin the journey to recovery. CoRR supports 68 beds of residential treatment for adult men and women:

- Auburn Campus Residential: 28 beds for adult men and women
- Grass Valley Campus Hope House: 20 beds for women, and their children
- Grass Valley Campus Serenity House: 20 beds for men

TRANSITIONAL HOUSING

Many clients experience multiple complex issues simultaneously to include the imminent prospect of homelessness, unemployment, mental health struggles, food insecurity, and lack of education, transportation and other unmet needs. The impact on the community can be reduced community safety, and high costs to public systems. We continue to grow to meet this challenge, and CoRR now provides 80 beds of transitional supportive housing through Placer and Nevada County communities; *that's 29,200 bed nights per year.* 145 women and 168 men experienced targeted supportive services and addressed housing barriers which led them to self-sufficiency, and 50 children were safely housed with their parents.



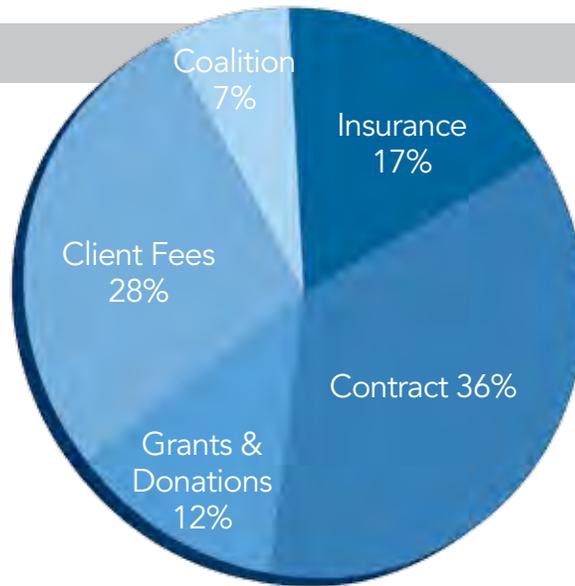
SUSTAINING THE MISSION

Our mission is to support the communities we serve with a full spectrum of wellness-focused programs to reduce the social, health and economic impact on families and children from all types of substance abuse and behavioral health issues.

CoRR leverages public and private funding through contracts, insurance revenue, fees, grants, and donations to maximize our outcomes for families and communities.

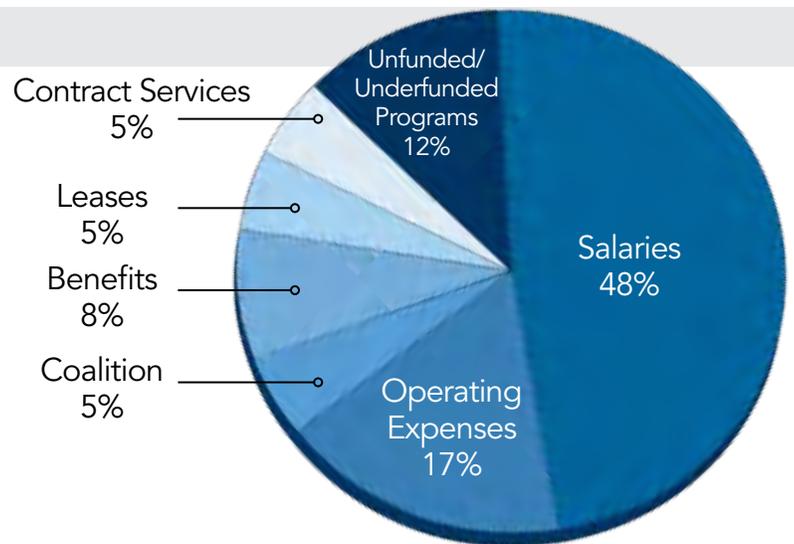
REVENUE

Contract	\$2,785,004.28
Grants & Donations	\$937,295.62
Client Fees	\$2,148,565.16
Coalition	\$531,227.76
Insurance	\$1,356,644.39
Total	\$7,758,737.21



EXPENSES

Salaries	\$3,715,963.69
Operating Expenses	\$1,306,991.06
Coalition	\$382,343.17
Benefits	\$657,409.55
Leases	\$362,395.00
Contract Services	\$378,954.73
Unfunded/Underfunded Programs	\$954,680.01
Total	\$7,758,737.21



We thank our donors for demonstrating corporate responsibility and individual generosity. With their gifts, our donors are giving for change, as they:

- Prevent homelessness
- Reduce out-of-home placement for children
- Prevent child abuse
- Prevent domestic violence
- Make our community safer--reducing crime
- Keep families together
- Reduce unemployment, promote economically vibrant communities



THE CoRR FOUNDATION LEVERAGING POWERFUL OUTCOMES



The CoRR Foundation is established with the mission to ensure resources to support CoRR's recovery and wellness programs to support individuals and families and build safe, strong communities. An independent nonprofit, The CoRR Foundation raises funds for CoRR with the belief that there is perhaps no better investment than in recovery and wellness services that reduce homelessness; alleviate child abuse and neglect, and domestic violence; reduce healthcare and criminal justice costs; increase community safety, and support local economies through a revived workforce.

This work needs your help. Becoming a monthly donor is an easy way to support CoRR programs and services through secure, recurring donations from your credit/debit card or bank account.

The CoRR Foundation sponsors the Bill Schultz Golf Classic, the Ed Bonner Golf Classic, and the upcoming Winter Gala, February 24th, at Morgan Creek Country Club.

To learn more, please visit our website at www.CoRR.us, call the office at 530-273-9541 or send this form to our office at 180 Sierra College Drive, Grass Valley CA, 95945

PLEASE CONSIDER A MONTHLY DONATION! OVER A YEAR, WHAT AN IMPACT THESE SMALL GIFTS HAVE!

- \$10 each month can help **provide healthy snacks for babies and children** in our care
- \$25 monthly allows counselors to provide interventions to **help families in crises**
- \$50 per month equals **six months of supportive housing** for a woman and child

Or, choose a one-time donation in the envelope included.

Donate online: www.corr.us click on DONATE button. Call: 530-273-9541 x 217 or send in a donation in the envelope included.



WHY THIS IS SO IMPORTANT

LEAVE YOUR LEGACY WITH CoRR

Include CoRR in your estate plans and leave a legacy of hope. When you make a gift, you've made an everlasting investment in your values, your hopes and your dreams.

BECAUSE OF YOU

Everything we do is made possible by our devoted and generous supporters. We are honored to recognize those who contribute. Please visit our website at www.corr.us/connect to learn more about ways to give, and our donors.

WHAT YOUR GIFT DOES FOR THE COMMUNITY

Look what you've done! With one gift to CoRR, your investment works to prevent homelessness; reduce out-of-home placement for children; prevent child abuse; prevent domestic violence; reduce crime and make our community safer; keep families together; reduce unemployment, and promote economically vibrant communities; and reduce addiction within all sectors of our society.

Only 10% of the 23 million Americans with a substance use disorder get the treatment they need. Addiction is treatable. People can and do recover to lead healthy productive lives. That's why, with your support, we provide treatment and in doing so inspire hope, grow health, heal families, and strengthen communities.

CoRR is honored to carry your aspirations forward in helping more individuals, families and communities find freedom from addiction.



Community Recovery Resources
180 Sierra College Drive
Grass Valley, CA 95945
www.CoRR.us



PLEASE REMEMBER US IN YOUR WILLS AND TRUSTS

Your gift changes lives



LEGISLATIVE PROPOSALS

Legislation Related to the Youth Education, Prevention, Early Intervention and Treatment Account (YEPEITA)

2019-20

AB 258 (Jones-Sawyer) requires the Department of Health Care Services (DHCS) to establish an interagency agreement with the California Department of Education (CDE) to award YEPEITA funds to local educational agencies (LEAs) in which 55 percent or more of the pupils enrolled are unduplicated pupils for programs that provide support services that will include programs designed to educate pupils and prevent substance use disorders from affecting pupils and their families at or near the school. AB 258 is pending referral in the Assembly.

AB 307 (Reyes) requires the Homeless Coordinating and Financing Council to develop and administer a grant program to support young people experiencing homelessness and prevent and end homelessness among California's youth, including addressing substance use disorders or the risk of substance abuse and ensuring that participating youth receive services that provide education, prevention, early intervention, and timely treatment services. This bill provides that the grant program is to be funded in part from available funds from the YEPEITA. AB 307 is pending referral in the Assembly.

2017-18

AB 1744 (McCarty) would have required DHCS to enter into an interagency agreement with CDE to implement and administer after school programs with an educational enrichment element that is designed to educate about and prevent substance use disorders and to prevent harm from substance abuse, and to allocate to schools funding from the YEPEITA. AB 1744 was held in the Senate Appropriations Committee.

AB 2328 (Nazarian) would have required the development of regulations for treatment and recovery programs for youth under 21 years of age, and the development of criteria for participation (including consideration of indicators of drug and alcohol use among youth), programmatic requirements, treatment standards, and terms and conditions for funding. AB 2328 stated intent that DHCS seek funding for this bill through Medi-Cal, federal financial participation, and through funds in the YEPEITA. AB 2328 was held in the Assembly Appropriations Committee.

AB 2471 (Thurmond) would have required DHCS to establish an interagency agreement with CDE to award YEPEITA funds to LEAs with high concentrations of disadvantaged students to increase in-school support services designed to prevent substance use disorders. AB 2471 was held in the Assembly Appropriations Committee.

SB 191 (Beall) would have authorized a LEA to enter into a contract with a county or qualified mental health service provider to create a partnership for providing mental health services to students. SB 191 would have requires the Mental Health Services Oversight and Accountability Commission, in consultation with CDE and DHCS, to develop guidelines for the use of funds from the Mental Health Services Fund, including provisions for integration with funds and services supplemented with funds from YEPEITA. SB was held in the Senate Appropriations Committee.

RESOURCES & PROGRAMS



Home / Newsroom / News Releases / Year 2018

CALIFORNIA DEPARTMENT OF EDUCATION
NEWS RELEASE

TOM TORLAKSON
State Superintendent
of Public Instruction

Release: #18-11
February 7, 2018

Contact: Bill Ainsworth
E-mail: communications@cde.ca.gov
Phone: 916-319-0818

State Schools Chief Torlakson Announces School Resources Following Legalization of Recreational Marijuana

SACRAMENTO – State Superintendent of Public Instruction Tom Torlakson announced today that the California Department of Education (CDE) is offering resources aimed at preventing those under 21 from using marijuana, something even more important now that Proposition 64 has taken effect.

Proposition 64, besides legalizing the recreational use of cannabis for adults 21 and older, creates a tax on cannabis for wholesalers, retailers, and purchasers of cannabis and cannabis products. Eventually, some of these tax funds will be directed by the CDE to promote health, education, and drug prevention.

“This is an excellent time to remind parents, students, educators, administrators, and the public about the detrimental effects of marijuana, especially to the developing brains of children,” Torlakson said. “In this new environment we need to be even more vigilant in making certain school-aged children understand the importance of making healthy decisions. We are committed to making sure that new resources will effectively support schools, families, and communities in this charge.”

Torlakson said the new CDE [Adult Use of Marijuana](#) Web page provides information to assist students, parents, educators, and local education agencies in the prevention and intervention of cannabis use.

“We look forward to working with our partners at the California Department of Health Care Services who have been leading the effort to share science-based facts about the effects of cannabis use,” Torlakson said.

Proposition 64 does not change regulations regarding use of marijuana by preschool through grade 12 students. The California Education Code continues to prohibit use, possession, possession for sale, and being under the influence of a controlled substance.

Proposition 64 contains a number of safeguards against the use of marijuana by those under 21 years

of age.

- It prohibits advertising aimed at children and bars any marijuana ads from within 1,000 feet of a school, day care center, or youth center.
- It prohibits marijuana businesses from being located within 600 feet of a school, day care center, or youth center unless allowed by local government.
- It bars anyone under the age of 21 from working for a marijuana business or being on the premises of a recreational marijuana retailer.

Torlakson said CDE will seek to use funds from Proposition 64 taxes to help students counter the negative effects of marijuana and address vital unmet needs in programs that have proven to be effective in preventing students from engaging in risky behaviors, as intended by Proposition 64.

Additionally, CDE will identify critical needs in drug use education and prevention, school mental health, child development, parent and early education programs, career technical education, after school programs, and school facilities.

###

Tom Torlakson — State Superintendent of Public Instruction
Communications Division, Room 5602, 916-319-0818, Fax 916-319-0100

Last Reviewed: Wednesday, February 7, 2018



Home / Learning Support / Health / Adult Use of Marijuana Act

Adult Use of Marijuana Act

The Adult Use of Marijuana Act legalizes recreational use of marijuana for adults and imposes taxes that can be used for health and education.

The Control, Regulate and Tax Adult Use of Marijuana Act, also known as Proposition 64, legalizes recreational cannabis use for adults 21 and older, but does not change laws banning the use of marijuana by Preschool -12 students or on school campuses.

The California Department of Education (CDE) has assembled resources below to help parents, students, educators, and the public understand the effects of marijuana on the brains of developing children and teenagers, and to provide information about prevention education as well as data.

The California Education Code continues to prohibit use, possession, possession for sale and being under the influence of a controlled substance, including marijuana.

Proposition 64 designates CDE as a recipient of some future revenue generated by new marijuana taxes, which are to be used on education, prevention and early intervention services for youth as well as other educational needs.

Data

[California Healthy Kids Survey \(CHKS\)](#)

An anonymous, confidential survey of school climate and safety, student wellness, and youth resiliency. Administered to students at grades five, seven, nine, and eleven, it enables schools and communities to collect and analyze data regarding local youth health risks and behaviors, school connectedness, school climate, protective factors, and school violence.

[Youth Risk Behavior Survey](#)

Provides data on health-risk behaviors among ninth through twelfth grade students, including behaviors that contribute to injuries and violence; alcohol or other drug use; tobacco use; sexual risk behaviors; unhealthy dietary behaviors; and physical inactivity.

Prevention Education

[Health Education Standards and Frameworks](#)

Information and resources related to health education for students in grades k – 12, including content standards, curriculum frameworks and state-adopted instructional materials.

[SAMHSA – Prevention of Substance Abuse and Mental Illness](#)

Resources from the Substance Abuse and Mental Health Services Agency (SAMHSA) regarding prevention and early intervention strategies to reduce the impact of mental and substance use disorders in America's communities.

[SAMHSA's National Registry of Evidence-based Programs and Practices](#)

A searchable online registry from SAMHSA of more than 400 substance use and mental health interventions developed to help the public learn more about prevention and intervention resources available for implementation.

Resources

[Let's Talk Cannabis](#)

California Department of Public Health (CDPH) website sharing science-based information and facts you need to know to make safe and informed choices about cannabis use.

[Partnership for Drug-Free Kids](#)

A non-profit supporting families struggling with substance abuse. They offer confidential one-on-one counseling as well as a library of resources to connect with your teen about drug use.

[The National Center on Addiction and Substance Abuse](#)

A non-profit research and policy organization with resources focused on improving understanding, prevention and treatment of substance use and addiction.

[Student Assistance Programs](#)

Student Assistance Programs (SAPs) are designed to intervene with students who are displaying behaviors of concern. Bulletins on various topics describe supports school administrators, teachers, counselors and other school district personnel, non-profit organizations, and agencies deliver through SAPs.

[Marijuana Facts for Teens](#)

National Institute on Drug Abuse (NIDA) publication discussing the often confusing themes of health consequences of cannabis use in this age group, its effect on the developing brain, its addiction risk, and what we know about its potential as a medicine.

[Marijuana Tips for Teens](#) (PDF)

Brochure for teens from SAMHSA provides facts about cannabis. It describes short and long-term effects and lists signs of cannabis use. The brochure also helps to dispel common myths about cannabis.

[California Education Code – 48900](#)

Establishes unlawfulness of possession, use, sale and being under the influence of a controlled substance while on school grounds or attending a school-sponsored activity.

Questions: Executive Office | 916-319-0800

Last Reviewed: Friday, February 2, 2018



Home / Learning Support / Health / Alcohol, Tobacco & Other Drug Prevention

Student Assistance Programs

Provides information for implementing new Student Assistance Programs (SAPs) along with resources for strengthening existing SAPs.

Student Assistance Programs (SAPs) evolved from the Employee Assistance Program (EAP) model of the 1960s-1970s. Recognition of the importance of removing all barriers to work performance translated to school policy in the 1980s when SAPs developed in the vein of EAPs. SAPs at first only addressed substance abuse in students, but soon expanded to help address a wide range of issues that impede adolescent academic achievement. These non-academic barriers to learning include, but are not limited to the following:

- school adjustment problems
- trauma generated at school or at home
- attendance and dropout problems
- mental health issues including depression or suicide issues, self-injury, stress and anxiety related issues, grief
- physical and sexual abuse, violence
- substance abuse
- gender issues
- teen pregnancy and parenting
- family issues including dissolution, homelessness or displacement, family member mental health and substance use disorders, and relationship difficulties
- parent or other family member incarceration
- military deployment
- delinquency and involvement with the juvenile justice system

As Gary Anderson writes in the first published model for Student Assistance Programs, “Any student assistance program effort demonstrates that a school system recognizes, first, that such problems do plague students and, second, that a responsible system of adults must respond and help.” (Hipsley, 2001)

What is a SAP?

SAP is a comprehensive school-based approach that coordinates support services and some direct services for students. Through the referral and facilitation of appropriate services, SAPs have been successful in reducing students’ behavioral and disciplinary violations including substance use, helping students get through schools safely and successfully, and improving school attendance and academic

performance. Although the approach is titled Student Assistance Program, it directly benefits and supports the staff, family, and the community when students use the supportive services when they need it.

SAP is a flexible model that can be customized to fit the infrastructure and staffing available at a school-site or district. It could be used as a portal to allow the students and families to access the county or community based services. Referrals to the SAP are usually open to any school staff, family, or students. There are a lot of variations of how a SAP is structured, run, and funded. Services provided under a SAP also vary, but may include interventions such as Brief Intervention or utilize the Brief Risk Reduction Interview and Intervention Model. Some form of counseling is usually offered or coordinated by the SAP staff.

Most SAPscan be initiated by the school/district and are often supported by county behavioral health or community based agencies. Districts interested in starting a SAP may check with the following county programs to explore collaboration opportunities:

- Substance Abuse Prevention and Treatment (SAPT) Prevention Coordinators facilitate federal funding for alcohol and other drug prevention. See a list of County Prevention Coordinators [here](#) .
- [California Friday Night Live](#)  Partnership offers youth development opportunities and training.
- Mental Health Services Act dedicates 20% of the funding to Prevention and Early Intervention (PEI).A list of funding is available at [PEI Coordinators](#) .

Some currently active SAPs can be found in these school districts:

[Conejo Valley Unified School District](#) 

[Desert Sands Unified School District](#) 

[Murrieta Valley Unified School District](#) 

Some sample school-based prevention programs:

SAP Approaches to Prevention	California County
Athletes Committed and Life of an Athlete	Butte, Stanislaus
Project Success	Amador, Contra Costa, Napa, Nevada Sonoma
Seven Challenges	Santa Cruz, Santa Clara
Brief Intervention	Butte, Contra Costa, Riverside, Stanislaus, Ventura
Brief Risk Reduction Interview and Intervention Model	Riverside, Stanislaus, Ventura

Bulletins

[Student Assistance Program \(SAP\) Bulletins](#)

These bulletins have been designed to support school administrators, teachers, counselors and other school district personnel, non-profit organizations, and agencies who are involved with SAPs.

Intervention Registry

[California Evidence-Based Clearinghouse for Child Welfare \(CEBC\)](#)

The CEBC is a searchable online registry of evidence-based practices for children and families involved with the child welfare system.

[SAMHSA's National Registry of Evidence-based Programs and Practices](#)

A searchable online registry from the Substance Abuse and Mental Health Services Administration (SAMHSA) of more than 400 substance use and mental health interventions developed to help the public learn more about prevention and intervention resources available for implementation.

Resources

[Connecticut Governor's Prevention Partnership](#)

The Student Assistance Program is a school-based prevention and early intervention program for students in kindergarten through twelfth grade.

[National Center on Addiction and Substance Abuse](#)

A non-profit research and policy organization with resources focused on improving understanding, prevention and treatment of substance use and addiction.

[National Child Traumatic Stress Network \(NCTSN\)](#)

NCTSN works to increase access to services and raise the standard of care through public education, workforce development, improved access to quality treatment, policy analysis and education, development of effective trauma-informed evidence-based practices, and initiatives to address gaps in services for underserved children and special populations.

[Pennsylvania Network for Student Assistance Services](#)

Supporting the Pennsylvania state SAP model. The PA Network assists school personnel in identifying issues such as alcohol, tobacco, other drugs, and mental health issues that pose a barrier to a student's success.

[Partnership for Drug-Free Kids](#)

A non-profit supporting families struggling with substance abuse. They offer confidential one-on-one counseling as well as a library of resources to connect with teens about drug use.

[Prevention First](#)

The Student Assistance Center offers resources to develop capacity in schools to implement a systems approach to delivering non-academic services to students and improving school climate.

[Substance Abuse and Mental Health Services Administration](#)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

[Student Assistance Program Guidebook](#)

This Student Assistance Program Guidebook offers processes, strategies, tools, websites and other resources for schools implementing or looking to implement evidence-based Student Assistance Programs as a strong system to support those struggling students.

Training

[Center for Applied Research Solutions \(CARS\)](#)

Provides professional development and technical assistance for substance abuse and mentoring professionals.

[Masonic Model Foundation for Children](#)

The Masonic Model Student Assistance Program provides training to educators to identify the barriers preventing students from achieving academic success and provide intervention to help the youth lead productive, useful, and healthy lives.

Questions: Coordinated School Health and Safety Office | 916-319-0914

Last Reviewed: Wednesday, December 19, 2018



PARTNERSHIP

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Friday Night Live
★
Club Live

Friday Night Live
Kids

★
Friday Night Live
Mentoring

California Youth
★
Council

Tulare County
Office of Education
Jim Vidak,
Superintendent

★
California Friday Night Live
Collaborative

Youth Leadership
Institute



Friday Night Live
builds partnerships for
positive and healthy
youth development
which engage youth
as active leaders
and resources in
their communities.



fridaynightlive.org

CA Friday Night Live Partnership Overview

The Friday Night Live (FNL) program was established in 1984 as a high school program to reduce underage drinking and driving and to promote a teenage lifestyle free of alcohol and other drugs. The mission of FNL is to build partnerships for positive and healthy youth development that engage youth as active leaders and resources in their communities. Youth involved in FNL have the opportunity to develop skills and plan activities in concert with their peers and adult advisors. FNL programs are youth-driven; therefore, providing meaningful roles for youth in the program. FNL builds community partnerships that support youth, helping to foster a sense of autonomy and power, and promote the belief in a young person's capacity to contribute. In supporting the holistic development of youth, FNL has gone above and beyond the message of prevention.

Today the FNL program operates in 50 of the 58 counties on more than 600 sites including schools, community centers, juvenile halls and housing projects. With age appropriate programs in elementary school, Friday Night Live Kids (FNL Kids/FNLK), in middle school (Club Live/CL), in high school, Friday Night Live (FNL), cross-age mentoring, Friday Night Live Mentoring (FNLM), and the California Youth Council (CYC). The cumulative budget of the local programs is \$7.4 million with approximately 150 staff.

FNL is driven by youth-adult partnerships that create essential and powerful community activities that enhance and improve their environments. Some activities include educating policy-making officials, first responders, providing safe social outlets for youth, and hosting training and conferences on varying issues from leadership to social factors that contribute to substance abuse. FNL chapters offer participants the opportunity to connect to their school and/or community through skill-building activities and caring relationships in environments free of alcohol, tobacco, other drugs and violence.

In 1998 FNL began the process of applying the best practices and research to transition to a "youth development" model. Youth development is the ongoing process that engages young people in building skills, attitudes, knowledge and experiences that prepare them for the present and the future. It also facilitates their efforts to become fully prepared, capable and competent individuals. The goal is to promote developmental outcomes, not just problem prevention or achievement outcomes.

Friday Night Live programs have a long history of tackling youth related traffic safety issues, such as bicycle/helmet safety, seat belt safety,

distracted driving and impaired driver awareness. Youth driven traffic safety campaigns and projects are an important component of FNL, CL, FNL Kids, and Mentoring programs and a positive approach to increasing the safety and well-being of youth.

The California Youth Council (CYC) is a group of approximately twelve youth, high school and college age. They are reflective of California's youth population, who work together to bring youth voice to important issues affecting young people. They bring their prevention experiences from geographically diverse counties together to inform and support state level issues and the efforts of the California Friday Night Live Partnership. They host the annual FNL Youth Summit.

In March 1996, the California Department of Alcohol and Drug Programs began contracting out the statewide coordination of the FNL programs to the Tulare County Office of Education, which resulted in the formation of the California Friday Night Live Partnership (CFNLP). Services provided to county FNL/CL/FNL Kids/FNL Mentoring programs include:

- Program design and development assistance;
- Technical assistance and training to incorporate the youth development and FNL Mentor models;
- Development and distribution of research materials on innovative youth programs;
- Support for the involvement of youth in all phases of program planning and implementation;
- Identification of new and existing cultural and geographically diverse youth organizations to work with the CFNLP in the design of new programs;
- Conducting routine evaluations to assess progress, and to refine, improve and strengthen program effectiveness;
- Use of web technology to serve as a forum for youth, provide resources on prevention information, and function as a network for FNL county coordinators to access programmatic information

The CFNLP is the intermediary that provides the leadership and support to the FNL statewide network as it continually evolves to meet the needs of young people. FNL was designed in California for California!



Friday Night Live/Club Live Youth Development Standards of Practice

Youth in FNL/Club Live programs will experience the following:

- **A Safe Environment**
 - Physical safety – to feel safe physically, free from the risk of harm.
 - Emotional Safety – to feel safe emotionally, to feel like they can be who they are.
- **Opportunities for Community Engagement**
 - Knowledge of Community – to learn about their community and its resources.
 - Interaction/Interface with the Community – to interact and work with community members.
 - Communication with the Community – to communicate about the program or youth issues.
 - Contribution to the Community – to give back and serve the community.
- **Opportunities for Leadership and Advocacy**
 - Decision-Making and Governance – to participate in decision-making and occupy leadership roles, such as staff or board roles.
 - Youth Voice – to learn to express their opinions constructively and to hear those of others.
 - Action – to take action on issues or projects they care about outside of the program – in the community, at school.
- **Opportunities to Build Caring and Meaningful Relationships with Peers and Adults**
 - Peer Knowledge – to learn about their peers and build relationships with them.
 - Adult Knowledge/Guidance – to learn about the adult staff and build relationships with them.
 - Emotional Support – to feel supported emotionally by others in the program.
 - Practical Support – to feel like their practical needs are met by adult staff.
 - Sense of Belonging – to feel like they belong, like they matter to the group and its success.
- **Opportunities to Engage in Interesting and Relevant Skill Building Activities**
 - Specific Skills – to develop and build specific skills through program activities.
 - Challenging and Interesting Activities – to engage in interesting and challenging activities.



While confronting today's drug crisis to arrest its growth and reduce its effects, we must also further develop the capability, knowledge, and infrastructure to respond to the evolving nature of the drug threat as we move deeper into the twenty-first century. Drug traffickers will continue to attempt to secure ever-greater profits by expanding their customer base, reducing overhead, and mitigating risks to their supply chains. The exponential growth in the availability and use of synthetic drugs in the United States, especially synthetic opioids like fentanyl and its analogues, provides a window into the likely future of drug use and trafficking. Drug trafficking organizations can avoid the costly process of harvesting illicit crops and producing plant-based drugs by the much cheaper and faster process of chemical synthesis. Potent synthetic drugs can be smuggled across our borders in small quantities that can be more easily concealed than bulkier plant-based drugs. They can also be purchased cheaply on the dark web using cryptocurrencies that provide anonymity, and shipped into the United States through international mail or as express consignment shipments. The combination of low production cost, the anonymity of the darkweb and cryptocurrencies, and drugs with higher potency than plant-based drugs, creates a favorable risk-reward structure that drug traffickers will embrace to an even greater degree in the years to come.

Along with the emergence of the greater availability and trafficking of synthetic drugs, we must also confront an emerging crisis of cocaine availability and use in the United States. The increased cultivation of coca and production of cocaine in Colombia, the source of more than 90 percent of the cocaine in the U.S. market, has once again reached record levels. Moreover, the suspension of aerial eradication programs in Colombia during its peace process, from 2015 until today, has led to even greater yield from coca plants, resulting in increased production and purity levels. Cocaine use in the United States started rising again after many years of decline. From 2016 to 2017, overdose deaths in which cocaine was the primary contributing drug increased 34 percent according to the CDC, and the National Survey of Drug Use and Health (NSDUH) shows that in 2017 past-month users of cocaine aged 12 and above increased from 1.9 million Americans to 2.1 million and new initiates to cocaine use increased to 1 million, averaging approximately 2,800 per day.

Given the current drug crisis facing America, and the President's priorities, this *Strategy* adopts a strong bias toward *action*. It focuses on leveraging our understanding of the complex interplay between the availability of drugs in the U.S. market and their use, anticipating changes in the drug environment in both the public health and law enforcement domains, and adapting our actions to seize the initiative to make lasting progress against this historic challenge. The global drug trafficking enterprise is vast, dynamic, and adaptable, but it is not without vulnerabilities. It is only through a unified effort in which the Federal government works with, and in support of, creative and resourceful individuals and organizations across the country, that can we address this complex national security, law enforcement, and public health problem.

STRATEGIC OBJECTIVE AND ASSUMPTIONS

This *Strategy* is focused on achieving one overarching strategic objective:

Building a stronger, healthier, drug free society today and in the years to come by drastically reducing the number of Americans losing their lives to drug addiction in today's crisis, and preparing now to dominate the drug environment of the

future. This will be done by preventing initiates to drug use, providing treatment services leading to long-term recovery for those suffering from addiction, and aggressively reducing the availability of illicit drugs in America's communities.

This *Strategy* consists of three interrelated elements designed to achieve the President's goal of building and fostering a stronger, healthier, and drug free society: prevention, treatment and recovery, and reducing the availability of drugs in America. The single and most important criterion of success is saving American lives, and achieving that objective requires the Federal government to work with partners at the state, local, and tribal levels; the healthcare sector; industry; foreign partners; and every concerned American citizen to advance our Nation's efforts to promote and maintain healthy lifestyles, and help build and grow safe communities free from the scourge of drug use and addiction.

This *Strategy* makes several key assumptions:

- Deliberate, sustained, and well-coordinated education and prevention efforts will, over time, reduce the number of Americans who initiate illicit drug use.
- Better prescribing practices and the expansion of alternatives to prescription drugs that hold a high potential for addiction and abuse will have a positive effect on reducing the number of initiates to illicit drug use.
- Increasing the availability of treatment services for substance use disorder will lead to a greater number of Americans achieving sustained recovery and reduce the size of the illicit drug market and demand in the United States.
- Reducing the availability of illicit drugs in the United States will enable public health efforts to take hold, increasing the potential for successful prevention and treatment efforts.
- Aggressive and versatile drug trafficking organizations will respond to sustained pressure placed upon them by disruption, dismantlement, interdiction efforts and judicial/prosecutorial efforts, and will adapt their production and trafficking methods to minimize risk and maximize profit.

STRATEGY IMPLEMENTATION

The three fundamental elements that form the heart of this *Strategy*—prevention, treatment and recovery, and reducing availability—are complementary and mutually supporting. Reducing the size of the illicit drug using population involves **preventing** initiates to illicit drug use through education and evidence-based prevention programs. Providing **treatment services leading to long-term recovery** for those suffering from substance use disorder, often using medication-assisted treatment (MAT) combined with therapy, moves people out of the active user population and on the path to recovery. By reducing the number of individuals who use illicit drugs through prevention and treatment, we can diminish the market forces pulling illicit drugs across our borders and into our communities. Simultaneously, we must drastically reduce the **availability** of these drugs in the United States. Increased availability increases the opportunity for individuals to initiate drug use, and the path from first use to chronic use can be brutally short, particularly for potent and highly addictive drugs like opioids. By reducing availability we not only lessen the negative ancillary effects of drug trafficking that impact the safety of

our communities and the well-being of our citizens, we also relieve the pressure on the public health domain in its prevention and treatment efforts. Reducing the size of the illicit drug-using population through prevention and treatment, together with reducing the availability of drugs in the United States through law enforcement and cooperation with international partners, are complementary efforts that inform and support one other, and will set the Nation on the path to being strong, healthy, and drug-free.

This *Strategy* is not intended to enumerate every activity the Federal government and key stakeholders must execute in order to achieve the President's strategic objective. Rather, it articulates the President's drug control priorities and sets the strategic direction for the Administration to take measures to prevent Americans, especially our future generations, from falling into the cycle of drug use and addiction; to provide Americans who suffer from substance use disorders with world class treatment and recovery services; and to protect America's citizens from the negative effects of drug trafficking and use. It also provides Federal drug control departments and agencies the strategic guidance they need for developing their own drug control plans and strategies, and it ensures programming and resource decisions about Federal drug control budget dollars are allocated in a manner consistent with the Administration's priorities.

PREVENTION

Preventing drug use before it starts is a fundamental tenet of a comprehensive approach to drug control. The science of prevention has evolved and significantly improved, and decades of research show that prevention works when implemented through evidence-based programs focused on specific audiences. Early intervention through informational media campaigns and community support mechanisms can alter the trajectory of young people in a positive direction and increase protective factors while reducing risk factors. Studies show that addiction is a disease that can be prevented and treated through sound public health interventions. Evidence-based prevention is most effective when it is carried out over the long-term with repeated interventions to reinforce original prevention goals.

Combining two or more evidence-based elements in a comprehensive prevention program is more effective than a single activity alone. Moreover, these early investments pay large dividends in substantially reduced treatment and criminal justice costs, saving taxpayer dollars while reducing the number of young people whose lives are tragically affected by early substance abuse.

As the Commission noted, "substance abuse prevention is a process which requires a shift in the behavior, culture, and community norms." The Commission emphasized the three categories of prevention intervention that target risk factors and increase protective measures: universal interventions that attempt to reduce specific health problems across all people in a particular population by reducing a variety of risk factors and promoting a broad range of protective measures; selective interventions delivered to particular communities, families, and children who, due to their exposure to certain environmental considerations, are at increased risk of substance misuse; and appropriate interventions directed to those already involved in a risky behavior such as substance misuse, or are beginning to demonstrate problems but have not yet developed a substance use disorder.

Implementing a Nationwide Media Campaign

Mass media campaigns are most effective when developed with coherent, credible, evidence-based messages grounded in behavioral science research. The Administration is already addressing the unmet need of a compelling and universal information campaign to educate our Nation on the drug-related vulnerabilities of our youth and other at-risk populations. The Administration implemented the *RxAwareness* campaign as a first step to address this problem, and augmented that initiative by launching a national substance abuse prevention media campaign, *The Truth About Opioids*. This major effort will reach audiences not targeted by *RxAwareness* by addressing topics related to the speed at which chronic substance use can develop, the drastic measures those suffering from substance use disorder will take to feed their addiction, and the need to reduce the stigma associated with addiction and treatment for substance abuse.

The media campaign is principally focused on opioids that are killing so many of our citizens. Prevention messages targeting youth are being disseminated through social media and other popular platforms utilized by young people. As the campaign moves forward, its messaging will use data analytics to determine appropriate messaging based on target population and substance, and will employ communication and marketing methods such as market segmentation, demographic data on users, and multiple formats and languages for individuals with disabilities and individuals with limited English proficiency. The campaign will be augmented by science-based primary prevention across multiple sectors using approaches that effectively engage students, parents, schools, health care systems, faith communities, social service organizations, and other sectors, in the development and implementation of community and school-based prevention initiatives.

Addressing Safe Prescribing Practices

There is a compelling need for additional research on, and the implementation of, evidence-based guidelines for the dosages and duration of prescription opioid treatment for injuries and post-surgical pain management. This is particularly important for patients with a history of substance abuse or at elevated risk for drug misuse. Additionally, information on viable alternatives for particular surgeries and pain-related conditions, along with an examination of health care coverage for alternative treatment, will advance efforts to reduce overall opioid prescribing in the United States. Government experts, the healthcare sector, the research community, and stakeholder organizations all play key roles in addressing these needs to build evidence on effective treatment and periodically updating prescriber guidelines. Moreover, clinical guidelines and best practices should be standardized in provider training programs and continuing medical education programs for those who prescribe and administer opioids such as surgeons, emergency medicine providers, and emergency medical technicians.

In 2016, CDC published the *CDC Guideline for Prescribing Opioids for Chronic Pain* for using opioids to treat chronic pain intended to improve communication between the primary care provider and the patient regarding the risk and benefits of these treatments and to improve the effectiveness of pain management treatment in general. The *Guideline* focus on three areas: determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinua-

OTHER STATES

October 5, 2018

Tom Keily and Jill Mullen

tkeily@ecs.org and jmullen@ecs.org

Your Question:

You asked about how K-12 schools handle the administration of medical marijuana and if there are any safety concerns schools should consider. Additionally, you asked how states are using marijuana tax revenue for K-12 education.

Our Response:

Marijuana legalization has been a growing trend across the U.S. According to the [National Conference of State Legislatures](#), nine states and D.C. have legalized the use of recreational marijuana, and [31 states](#) allow marijuana for medical purposes. The legalization and sale of marijuana have raised education policy issues, including student use of medical marijuana on K-12 campuses and related safety and health concerns, as well as the use of tax revenue from marijuana sales for K-12 education.

Medical Marijuana on K-12 Campuses

As states have legalized medical marijuana and students have been prescribed the substance, states have grappled with ways to ensure student have access to medical marijuana on school grounds. ECS has identified six states that have policies providing for administration of medical marijuana to students on school grounds. More states may have such a policy but have not been identified.

Common elements have emerged in these states. In particular, Colorado, New Jersey, and Maine have adopted similar standards for the administration of medical marijuana at schools. In these states, common provisions include:

- Students using medicinal marijuana products must have a valid medical recommendation.
- Only non-smokable marijuana products may be administered on school grounds.
- Only parents, legal guardians or primary caregivers may administer the substance.
- Students cannot be punished for marijuana use on school grounds.

State Policy Examples: Administration of Medical Marijuana on School Grounds

Colorado

In April 2016, Colorado passed [House Bill 1373](#) amending [Colorado Revised Statutes 22-1-119.3](#) to set guidelines for district policies on the use and possession of marijuana in schools for medical purposes. The rules establish the following provisions for the use of medical marijuana in schools:

- **Administration:** A primary caregiver may possess and administer medical marijuana to a student who has a valid recommendation. Local school boards or charter schools may adopt policies regarding who may act as a primary caregiver and the reasonable parameters of the administration and use of medical marijuana. The administration of medical marijuana should not disrupt the educational environment or be exposed to other students.
- **Location:** District policy must include a process through which schools may restrict student possession and self-administration on school grounds, school buses, or at any school-sponsored event.
- **Method:** Nonsmokable medical marijuana only.

In addition to addressing the issue of the use of medical marijuana in schools, Colorado set provisions for when school districts or charter schools do not have to comply with the rules above. Compliance is not required if a school district or charter school can demonstrate all of the following:

- It will lose federal funding as a result of implementing the rules;
- It can reasonably demonstrate that it lost federal funding as a result of implementing the rules; and
- It posts on its website in a conspicuous place a statement regarding its decision not to comply with the rules.

Additional information on Colorado's marijuana policy can be found in this [fact sheet](#) provided by the Colorado Department of Education.

New Jersey

The statutes governing the use of medical marijuana in New Jersey are [similar](#) to those outlined in Colorado. In November 2015, New Jersey passed [Assembly Bill 4587](#), which established the following provisions for the administration of medical marijuana at schools:

- **Administration:** Parents, guardians, and primary caregivers are allowed to administer medical marijuana to students on school grounds, aboard school buses, or at school events. Criteria for qualification as a primary caregiver who may administer marijuana to a student can be found in [New Jersey Public Law 2009, c.307](#).
- **Location:** Schools must designate locations on school grounds where medical marijuana may be administered.
- **Method:** Smoking or inhalation of marijuana while on school grounds, school buses, or at school events is prohibited.

Illinois

In February 2018, Illinois passed [HB 4870](#) that requires a school district, public school, charter school, or nonpublic school to authorize the use and possession of medical marijuana on school grounds.

- **Administration:** A parent or guardian of a student who is a qualified patient may administer a medical cannabis infused product to the student on school grounds or a school bus if both the student and the parent or guardian have been issued registry identification cards under the Compassionate Use of Medical Cannabis Pilot Program Act. The administration of medical marijuana should not disrupt the educational environment or be exposed to other students.
- **Location:** The product may be administered by the designated caregiver on school grounds or school buses.
- **Method:** The law specifies that a "medical cannabis infused product" may be administered.

The Illinois law notes that "a school district, public school, charter school, or nonpublic school may not authorize the use of medical marijuana if the school district would lose federal funding as a result."

Maine

In June 2015 Maine passed [H.P. 381](#) amending [22 MRSA §2426](#) and [20-A MRSA §6306](#), which establish rules for the use of medical marijuana while attending school. The following provisions are in place for the administration of medical marijuana in schools in Maine:

- **Administration:** Marijuana must be administered by a [caregiver](#). A child who holds written certification for medical marijuana should not be denied eligibility to attend school because they require non-smokable marijuana to perform their daily activities.
- **Location:** An eligible caregiver may possess marijuana for administration on school grounds or a school bus.
- **Method:** Medical marijuana must be in nonsmokable form.

Washington

To date, Washington has taken a slightly different approach to the administration of medical marijuana in schools. In 2015 Washington passed [Senate Bill 5052](#), which permits students to consume medical marijuana on school grounds in accordance with school policy but does not require schools to make accommodations for the consumption of medical marijuana. The student and the guardian administering the marijuana must hold a recognition card.

Florida

Florida statute, [Fla. Stat. Ann. § 1006.062 \(8\)](#), establishes that district school boards must adopt a policy and procedure for allowing those students who [qualify as a patient](#) to access medical marijuana. The statute requires that district policies:

- Ensure access for qualified patients;
- Identify how the marijuana will be received, accounted for, and stored; and
- Establish processes to prevent unauthorized students and school personnel from accessing the marijuana.

Additional information can be found in ECS's 2016 [blog](#) on administering medical marijuana to students while at school.

Marijuana and Safety Concerns for Schools

The legalization of recreational marijuana is still a relatively new area of policy. States are still navigating the complex regulatory landscape in response to new safety concerns. At the [federal level](#), marijuana is still classified as a controlled substance.

Some states that have legalized recreational marijuana have released guidance for parents on how to prevent underage use of marijuana. For example, the Oregon Health Authority Public Health Division's [guidance document](#) includes information on how marijuana use can affect youths' health, the different types of marijuana products, and strategies for talking with kids about marijuana.

In Colorado, the Department of Public Safety has a [resource center](#) with many guidance documents, fact sheets, and studies on youth marijuana use prevention. Additionally, in 2015, Colorado passed legislation, [HB 1273](#), adding the unlawful use, possession, or sale of marijuana on school property to the list of items that must be included in each school's annual written report to the board of education concerning the school's learning environment-- ensuring marijuana offenses are noted separately from other drug offenses.

Marijuana Funding for K-12

While every state is different, many have imposed some type of tax on [medical](#) and recreational marijuana sales, according to a marijuana policy advocacy group. Our general sense is that revenue from recreational marijuana exceeds revenues collected from medical sales. For example, Nevada allowed medical marijuana before recreational was legalized. In [fiscal year 2015-16](#), \$761,848 was collected in tax revenue from medical marijuana sales. By contrast, [roughly \\$62 million](#) has been collected in Nevada since the state legalized recreational marijuana and began sales in 2017.

The chart below provides the year states legalized recreational marijuana and whether any of the revenue collected has gone toward funding public education. Colorado and Washington were the first states to allow recreational marijuana. While Washington has used most of the recreational marijuana revenues for public health programs and administration, Colorado has used a substantial amount of its collected marijuana revenues for K-12 education grants and programs. Oregon, also, has appropriated a significant amount of marijuana revenues collected to education.

Legalization of Recreational Marijuana

State	Date sales started	Legalizing Document	What is known about where the revenue goes?
Alaska	Late 2016	Measure 2 (2014) – Measure 2 left it up to the legislature to determine how the marijuana revenue is spent.	In 2017 , Alaska collected \$1.7 million in marijuana cultivator tax revenue. As of June 2018, \$11 million has been collected. Marijuana is only taxed when it is sold or transferred from a marijuana cultivation facility to a retail store. Half of the revenue goes to a Recidivism Reduction Fund; the other half goes to the state’s General Fund.
California	Jan. 2018	Proposition 64 (2016) – Proposition 64 specifies a portion of the tax funds collected shall go to into the Youth Prevention, Early Intervention, and Treatment Account and may be used to address substance abuse and improve school retention and performance.	Governor Brown estimates the cannabis excise tax will generate \$630 million in 2018-19 (page 131). But, it is unclear how much, if any, will go towards education.
Colorado	2014	Amendment 64 (2012) – A64 specifically included language that taxes from the sale of marijuana would be used to fund school construction. That has been expanded with subsequent legislation .	In 2017-18 , the Colorado Department of Education (CDE) received \$90.3 million in marijuana revenue. In 2016-17, CDE received \$48.5 million. CDE uses the money to fund school construction projects, early literacy grants, school health professional grants, school bullying prevention grants, and drop-out prevention programs.
District of Columbia	Not yet in effect.	Initiative 71 (2014) – The Initiative legalizes personal use and not commercial sale. As a result, the Initiative does not contain language on taxation.	
Maine	Not yet in effect.	Question 1 (2016) – Q1 specifies all sales tax revenue collected must be deposited in the General Fund.	
Massachusetts	Not yet in effect.	Question 4 (2016) – Q4 specifies all money collected from the sale of marijuana shall be deposited in the Marijuana Regulation Fund. The Fund is subject to appropriation but can be deposited in the General Fund.	

Nevada	July 2017	Question 2 (2016) – Proceeds from the excise tax will first fund the costs of administration by the Department of Taxation; the excess revenue will be deposited in the Distributive School Account to provide K-12 funding.	In May 2018 , marijuana tax revenues totaled \$62.64 million. It is unclear how much will go toward education.
Oregon	Jan 2016	Measure 91 (2014) – Marijuana revenue collected is deposited in the Oregon Marijuana Account. Measure 91 specifies 40% of the money available for distribution in the account must go to the Common School Fund.	In 2017 , \$34 million (40% total eligible revenue for distribution) was provided to the State School Fund.
Vermont	Not yet in effect.	H. 511 (2018) – The bill does not include language on taxation.	
Washington	2014	Initiative 502 (2012) – The Initiative outlines how the tax revenue should be distributed (page 41).	In 2017 , Washington collected \$319 million in marijuana revenue. The money is used for public health programs, substance abuse prevention, research and given to local governments.

[Additional Resources](#)

[ECS Historical Policy Database on Health Issues](#): In this ECS database additional information can be found on past legislation relating to school-related marijuana policy and other topics dating back to 1996.

[ECS Policy Tracking](#): This database can provide additional information on the current session enacted or vetoed legislation across all fifty states.

[National Council of State Legislature Deep Dive on Medical Marijuana](#): While this resource does not deal directly with the administration of medical marijuana in schools, it does provide a comprehensive list of state policy on medical marijuana as well as an abundance of resources on the topic.



Marijuana Funding to Support School Behavioral Health

Sarah Mathew, Colorado Department of Education

Behavioral Health 101



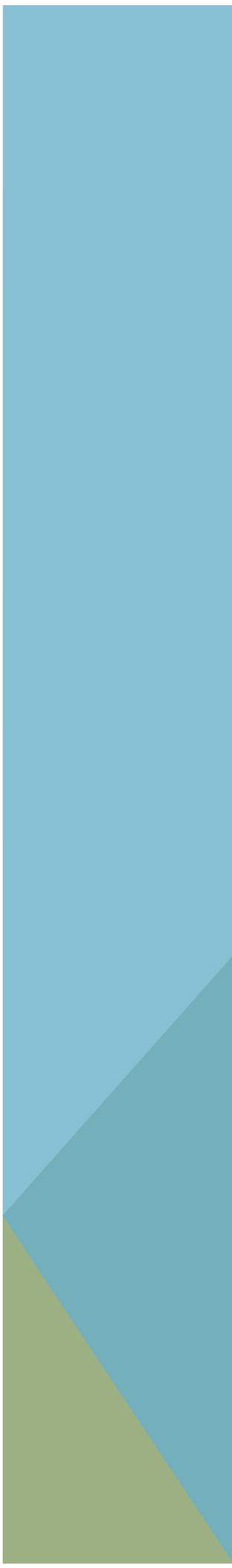
**HEALTHY SCHOOLS
CAMPAIGN**

COLORADO MARIJUANA TAX FUNDS

The table below shows medical and retail marijuana tax and fee collections totals by calendar year starting in 2014. Although sales of medical marijuana began prior to 2014, the Department of Revenue did not report tax collection data until February of 2014, after retail marijuana sales began.

Marijuana Taxes, License, and Fees Revenue

2014	\$67,594,323
2015	\$130,411,173
2016	\$193,604,810
2017	\$247,368,473
2018 (Jan- April)	\$63,688,122



Building Excellent Schools Today

MARIJUANA TAX FUNDS

To date, Building Excellent Schools Today (BEST) grant program has received \$807 Million in revenue. Marijuana Excess tax accounts for 18% of those funds.

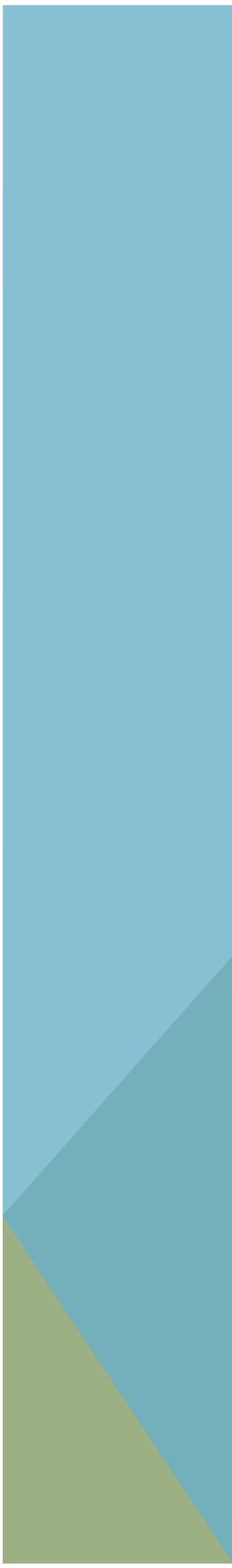


COLORADO DEPARTMENT OF EDUCATION

Building the infrastructure to support School Mental Health including substance use prevention and education. Previous to the Marijuana Cash Tax Fund (MJCTF) there was no state funding to support this work. Since 2014 funding has increased from 3 million to 12 million statewide.

COLORADO SCHOOL HEALTH PROFESSIONAL GRANT

- Funding the Marijuana Cash Tax Fund (MJCTF) that supports behavioral health including substance use prevention in schools.
- School Health Professionals are defined as: CO State Licensed School Psychologists, School Social Workers, School Counselors, and School Nurses.
- School Districts can apply for FTE, Professional Development and Training, resources to develop and implement high quality behavioral health programming including evidence programs that address substance use prevention and universal screening.
- Funding began in 2014-2016, \$2.28 million dollars yearly, funding to 66 schools, 44 FTE, and 22 grantees.
- 2017-18 appropriation increase of \$9.4 million, (11.98 million total) and now open to elementary schools



School Behavioral Health Services Framework

Linking with Systems of Care
Adequate Information Sharing
Strong Communication Loop
Warm Hand-Off
Wraparound Services
Youth-Driven and Family-Guided Services



Tier 3 FEW
Crisis Response
Re-entry Plan
Individual/Group
Counseling/Therapy

Tier 2 SOME
Progress Monitoring
Evidence-Based Interventions

Tier 1 ALL
Referral Process
Behavioral Health Screening
Social, Emotional Learning Opportunities
Positive Behavior Supports

FOUNDATION

Family-School-Community Partnerships
Mental Health Stigma Reduction
Positive School Climate and Culture
Data-Based Decision Making
Staff Professional Development
Accountability Systems

**District and School Teams
Drive the Work**

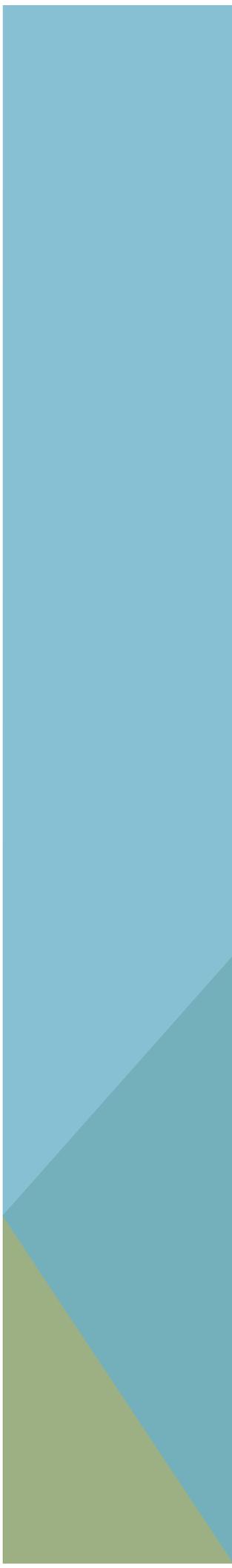
SCHOOL BULLYING PREVENTION GRANT

The Colorado School Bullying Prevention and Education Grant

Program is authorized in statute to provide funding to reduce the frequency of bullying incidents. This includes:

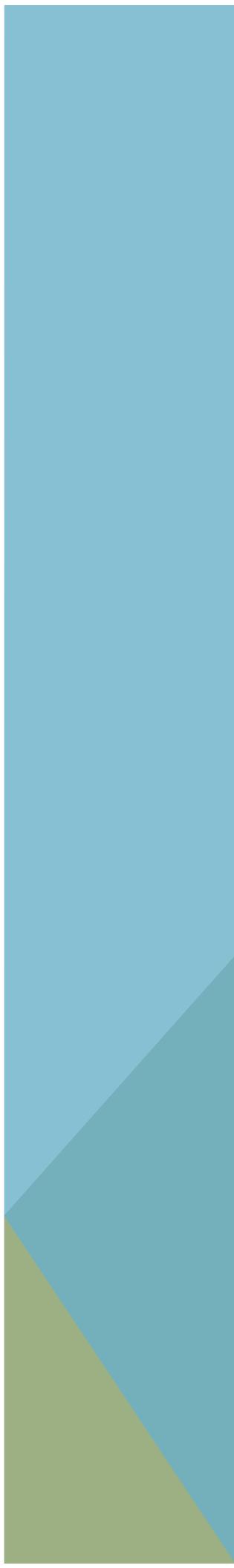
- Implementing evidence-based bullying prevention practices with fidelity;
- Family and community involvement in school bullying prevention strategies; and
- Adopting specific policies concerning bullying education and prevention.

In 2016-17, 14 districts have received awards to distribute funds to 73 schools (\$2.9 million dollars in state appropriated funds through MJCTF)



STUDENT REENGAGEMENT GRANT

State appropriation of 2 million dollars for this new grant program began in January 2016. The grant program is authorized by C.R.S. 22-14-109 to assist local education providers in providing educational services and supports to students to maintain student engagement and support student re-engagement at the secondary level. Competitive grants under this statute were awarded for the first time in March 2016. It is anticipated that a new RFA (Request for Applications) for this 3-year grant will be released in Fiscal Year 2018-19.



COMPREHENSIVE HEALTH EDUCATION STANDARDS

Colorado's Emotional and Social Wellness Standard (ESW) is located within the Comprehensive Health & Physical Education content area.

- The ESW standard provides a developmental framework regarding social-emotional skills that are expected at each grade level.

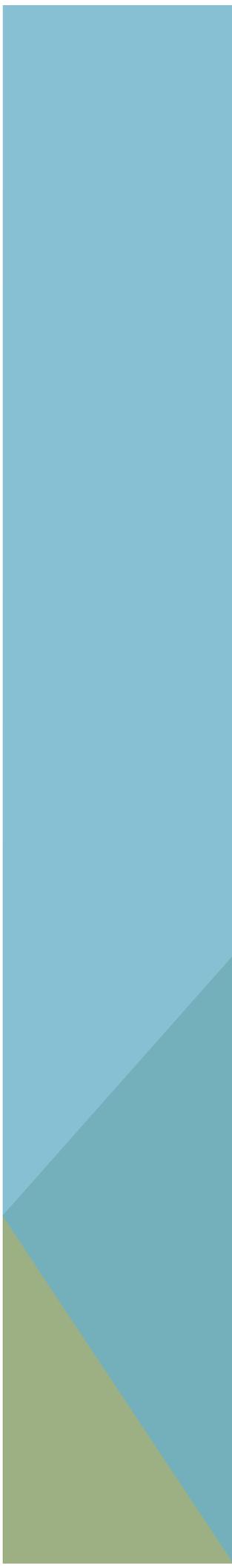
The ESW Standard includes mental, emotional, and social health skills that enable a student to:

- recognize and manage emotions
- develop care and concern for others
- establish positive relationships
- make responsible decisions,
- handle challenging situations constructively,
- resolve conflicts respectfully,
- manage stress,
- make ethical and safe choices; examine internal and external influences on mental and social health;
- identify common mental and emotional health problems and their effect on physical health.



COMPREHENSIVE HEALTH EDUCATION STANDARDS

- Prevention and Risk Management, as well as the two other standards under Comprehensive Health & PE, is also highly connected to ESW, articulating healthy relationships and violence and bullying prevention.
- Successful post secondary workforce readiness depends on an array of social and emotional competencies.
- Furthermore, social skills are critical for negotiating life's challenges and developing satisfying relationships.
- By providing a progression of grade level expectations of the skills necessary for students to engage in healthy and productive relationships, the ESW Standard promotes 21st century learning and workforce readiness.



COLORADO RESOURCES

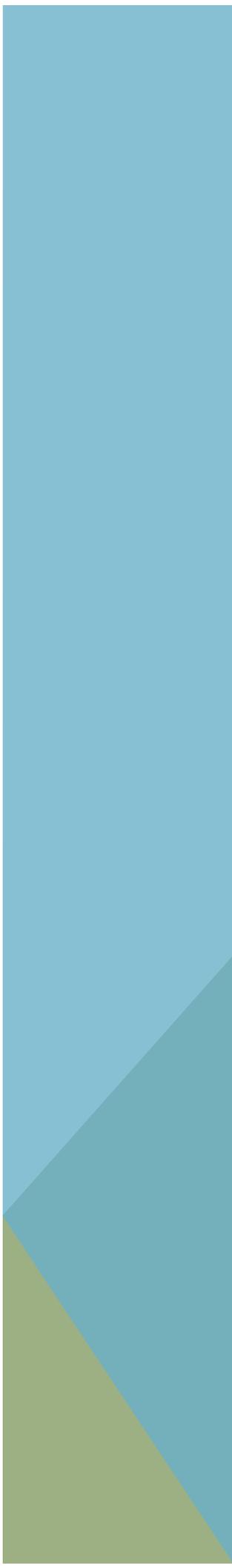
<https://www.colorado.gov/pacific/revenue/disposition-marijuana-tax-revenue>

https://www.cde.state.co.us/sites/default/files/documents/pbis/bullying/downloads/pdf/briefoverview_coloradoemotionalwellnessstandards.pdf

<http://www.coloradoinitiative.org/resources/schoolbehavioralhealth/>

<https://www.cde.state.co.us/offices/healthwellnessoffice>

<https://www.cde.state.co.us/dropoutprevention/studentreengagement>



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Colorado Framework

for School Behavioral Health Services



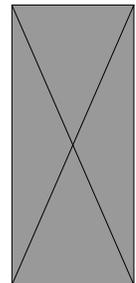
A Guide to K-12 Student Behavioral Health Supports with a
Focus on Prevention, Early Intervention, and Intervention
for Students' Social, Emotional, and Behavioral Health Needs



THE
COLORADO
EDUCATION
INITIATIVE

Colorado Framework for School Behavioral Health Services

Acknowledgements	4
Executive Summary	5
Introduction	7
Comprehensive School Behavioral Health Systems Overview	8
School Behavioral Health Services Framework.....	9
Best Practices Guide.....	10-17
Foundation.....	10
Tier 1	13
Universal Screening: Spotlight on Aurora Public Schools and Boston Public Schools	14
Tier 2.....	16
Tier 3.....	16
System of Care	17
Three Models for Specialized Service Delivery: Model 1: Co-Located School-Based Health Center Services, Model 2: School-Based Services, and Model 3: Community-Based Services.....	18
Spotlight on a Community of Excellence.....	24
Linking to Early Childhood.....	27
In Summary	28
Tools and Resources	29
References	30





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- **Hope Wisneski**—Gill Foundation, Program Officer
- **Claudia Zundel**—Colorado Department of Human Services, Child, Adolescent and Family Services Director





Executive Summary

A Guide to K-12 Student Behavioral Health Supports with a Focus on Prevention, Early Intervention, and Intervention for Students' Social, Emotional, and Behavioral Health Needs

Comprehensive School Behavioral Health Systems Defined

K-12 comprehensive school behavioral health systems include district- and school-level educational and local behavioral health professionals working in concert with families to improve prevention, early intervention, and intervention strategies within the school and community to meet students' social, emotional, and behavioral health needs.

Why School Behavioral Health Systems

Research increasingly points to the link between students' academic success and social, emotional, and behavioral health. However, schools are generally not measured and evaluated on social, emotional, and behavioral health outcomes for students. As a result, they are often unable to justify and provide the attention, data infrastructure, and funding necessary to embed social, emotional, and behavioral health initiatives into school culture. Additionally, many schools do not have the necessary resources and support to address the misconceptions and lack of understanding about behavioral health, which contributes to its stigma.

The Colorado Opportunity

While multiple barriers persist in regard to implementing comprehensive school behavioral health systems, recent state and federal legislation and various state-wide behavioral health initiatives are now affording Colorado schools more opportunities to improve student behavioral health. With this improvement, the state will be positioned to realize greater academic achievement, enhanced student and staff wellbeing, and improved school climate and culture.



Framework Snapshot

Includes:

- ▶ Best Practices Guide
- ▶ Tools and Resources
- ▶ Implementation Spotlights From Districts and Schools



“Given schools’ unique ability to access large numbers of children, they are most commonly identified as the best place to provide supports to promote the universal mental health of children” (CASEL 2008, p. 1).¹



The Framework

To reduce barriers to learning, schools need comprehensive systems that integrate behavioral health supports into the daily academic life of the school. With this understanding and with support from Rose Community Foundation, The Colorado Education Initiative (CEI) created a statewide *Framework* for school behavioral health services. Additionally, CEI identified challenges to and opportunities for improving school behavioral health systems in Colorado. Along with a state-wide gaps and barriers analysis, CEI has investigated the scalability of the Colorado Department of Education's Building Bridges for Children's Mental Health. Building Bridges was piloted in Mesa County and integrated two complementary approaches: 1). Positive Behavioral Interventions and Supports (PBIS), "an implementation *Framework* that is designed to enhance academic and social behavior outcomes for all students" (Sugai and Simonsen, 2012, p. 1)² and 2). System of Care (SOC) from the behavioral health system (see definition below). Other research that informed the development of this *Framework* includes: a review of appropriate literature and state policy documents, interviews and focus groups throughout Colorado with district and school personnel and behavioral health and education experts, a scan of national models, and interviews with school district leaders throughout the nation engaging in this work. The development of the *Framework* was guided by a leadership advisory committee comprised of education and behavioral health professionals.

Based on the aforementioned methods, the *Colorado Framework for School Behavioral Health Services* blends a Multi-Tiered System of Supports (MTSS) from the education realm with a System of Care (SOC) more commonly used in the public health arena. Along with state and federal movements toward MTSS, CDE is using a MTSS system, which combines Positive Behavioral Interventions and Supports (PBIS) with Response to Intervention (RTI) so that all students receive a layered continuum of supports.

Definitions

MTSS combines Positive Behavioral Interventions and Supports (PBIS) with Response to Intervention (RTI). MTSS is a whole school, data-driven, prevention-based framework for improving learning outcomes for every student through a layered continuum of evidence-based practices and systems. MTSS includes: shared leadership; a layered continuum of supports; universal screening and progress monitoring; evidence-based instruction, intervention, and assessment practices; data-based problem solving and decision-making; and family, school, and community partnering (Colorado Department of Education 2013).

A System of Care is a "spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated school network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul, et.al, 2010, p. 3).³



Introduction

According to the American Psychological Association, less than half of children with mental health problems get treatment, services, or support.⁴ Yet, research increasingly reveals the connection between social, emotional, and behavioral health and academic achievement.⁵ Because students are much more likely to seek behavioral health support when school-based services are available (Slade, 2002),⁶ schools need comprehensive behavioral health systems to create positive learning environments where all students can flourish.

Historically, school policies and procedures have separated behavior and academics; as a consequence, classroom management has been largely addressed in a superficial manner. Students who have *externalizing* behavioral health problems have traditionally received behavioral health services because they have been referred through a disciplinary approach—for example, an office referral, suspension, or expulsion. Conversely, students with behavioral health issues that are often *internalized* – for example, anxiety and depression – have largely been under-identified. In addition, educators have long noted that the unmet social, emotional, and behavioral health needs of children challenge their capacity to effectively teach their students (Atkins, et al., 2010, p. 2).⁷ However, research reveals that when schools focus on district- and school-wide systemic improvements to prevention and early intervention for student’s social, emotional, and behavioral health needs, both externalizing and internalizing students not only improve their social outcomes, but they also have increased academic outcomes.

What is *externalizing* behavior?

Externalizing behavior is the undercontrol of emotions, which could include difficulties with attention, aggression, and conduct.⁸

What is *internalizing* behavior?

Internalizing behavior is the overcontrol of emotions, which could include withdrawal, anxiety, fearfulness, and depression.⁹ Internalizing behaviors may not be apparent to others and may manifest themselves as frequent worrying, self-denigrating comments, and low self-confidence.¹⁰



“A study estimating the relative influence of 30 different categories of educational, psychological, and social variables on learning revealed that social and emotional variables exerted the most powerful influence on academic performance”

(CASEL, 2003, p. 7).¹¹



It is the shared responsibilities of a given district, school, and the people they serve to gauge their local needs and ensure they are building the best system for all stakeholders.

Comprehensive School Behavioral Health Systems Overview

The *Colorado Framework for School Behavioral Health Services* melds a System of Care within a Multi-Tiered System of Supports. *The Framework* includes three models of service delivery for students with high behavioral health needs: 1). Co-located services, where a district or school has a school-based health center that includes behavioral health and primary care; 2). A school-based therapist, where a therapist from the community comes to the district or school to deliver group and individual based therapy; and 3). A referral to a community based therapist, where a district or school has a strong relationship with a Community Mental Health Center (CMHC) and has a streamlined referral process with the center to create a seamless service delivery model for children, adolescents, and their families. Given the Colorado context, the service delivery model should be determined based on each community's location, needs, and resources. While the specific model may vary between communities, there are critical foundational elements both within and outside of the school that must be in place to foster and sustain comprehensive school behavioral health systems. In addition, it is the shared responsibilities of a given district, school, and the people they serve to gauge their local needs and ensure they are building the best system for all stakeholders.

The following *Framework* and best practices guide provide the key elements required to implement comprehensive school behavioral health systems in districts and schools across Colorado. As part of a tiered system of supports, school staff must realize that individual students' needs are not fixed at one of the tiered levels; instead, students may move fluidly between tiers—up or down—at any time, depending on circumstances. While the pyramid is fixed, students' needs are not.

Definitions

Who are local behavioral health professionals?

Local behavioral health professionals are therapists from the Community Mental Health Center (CMHC), School-Based Health Center (SBHC), or other children- and adolescent-serving behavioral health practice.

Who are school behavioral health professionals?

School behavioral health professionals include school psychologists, school social workers, and school counselors.

What is student behavioral health?

Student behavioral health includes the social, emotional, and mental health needs as well as the substance abuse behaviors of students. All students require social and emotional skill-building opportunities while some students may have more complex needs as suggested by the three-tiered pyramid in this guide (see p. 9).

School Behavioral Health Services Framework

Linking with Systems of Care

- Adequate Information Sharing
- Strong Communication Loop
- Warm Hand-Off
- Wraparound Services
- Youth-Driven and Family-Guided Services



Tier 3 FEW

- Crisis Response
- Re-entry Plan
- Individual/Group Counseling/Therapy

Tier 2 SOME

- Progress Monitoring
- Evidence-Based Interventions

Tier 1 ALL

- Referral Process
- Behavioral Health Screening
- Social, Emotional Learning Opportunities
- Positive Behavior Supports

FOUNDATION

- Family-School-Community Partnerships
- Mental Health Stigma Reduction
- Staff Professional Development
- Positive School Climate and Culture
- Accountability Systems
- Data-Based Decision Making



**District and School Teams
Drive the Work**



“The Surgeon General identified the stigma surrounding mental illness as one of the primary reasons that individuals and families don’t seek help.”¹³



Best Practices Guide

for Implementing Comprehensive School Behavioral Health Systems

District and school teams guide the behavioral health work.

District- and school-based teams must be the drivers of the work, and these teams must garner buy-in from administration and school staff. For many districts and schools, the teams could be the pre-existing RtI/PBIS/MTSS, health and wellness, school climate and culture, or leadership team. It is important the teams are comprehensive with representation from various stakeholders, including family representation, to create buy-in. The teams should gauge their local needs to inform next steps and to create sustainable school behavioral health policies. Teams can use the readiness assessment in the  tools and resources section of this *Framework* to do so.

The foundational elements that support the tiered levels of support students receive are critical to the success of prevention, early intervention, and intervention for the positive development of students’ social, emotional, and behavioral health. The foundational elements drive districts’ and schools’ abilities to engage in comprehensive school behavioral health efforts.

Foundation Best Practices

Districts and schools have strong family-school-community partnerships.

The district and school teams engage families, community members, and community organizations to advance student behavioral health and learning. Families are aware of their individual student’s social and emotional development and know how to support behavioral learning at home, and families are included in intervention and counseling efforts. Family-school-community partnerships provide a foundation to leverage resources for students’ behavioral health needs. Research explains that “mental health resides not only within the child but also within the influential web of interactions surrounding the child, including the family, the school, and the neighborhood and community in which the child lives” (Kellam, Ensmiger, & Branch, 1975, from SAMHSA, 2011, p. 5).¹² One of the critical success elements of creating comprehensive systems of care in education is the stakeholder relationship, especially among school leadership, the behavioral health provider, community members, and families. In Colorado, evidence of family and community involvement is required to renew accreditation. Learn about Colorado’s new family-school-community partnership legislation in the  tools and resources section.

District, school, and community leaders ensure pointed efforts to reduce the stigma around mental health.

Over the past decade, state-wide and national campaigns have helped reduce the stigma of mental health; yet, there is still a major need for school systems to address the stigma. “The Surgeon General identified the stigma surrounding mental illness as one of the primary reasons that individuals and families don’t seek help” (U.S. Public Health Service, 1999 from SAMHSA, 2011, p. 8).¹³ Along with staff professional development, the school, community, families, and students should engage in mental health stigma reduction efforts. Students can do this through project-based learning assignments (see the 🇺🇸 tools and resources section for examples), and school personnel can work closely with the community to engage in joint efforts to reduce the stigma around mental health by providing Youth Mental Health First Aid Trainings (MHFA) and creating a culture of care. Youth MHFA trainings are discussed on page 19.

Staff professional development opportunities address social, emotional, and behavioral health systems.

Staff must acquire the knowledge, tools, and resources to promote the positive development of students’ social, emotional, and behavioral health. Because social, emotional, and behavioral health interrelate to academic success and school climate and culture, school leaders should schedule staff professional development for behavioral health throughout the entirety of the year. Professional development should include:

- **Working within a comprehensive school behavioral health system:** The staff should be trained on who will refer and how to refer students for services, how to speak with families about their concerns, how to promote mental health stigma reduction and mental health awareness, and how to universally screen and progress monitor students. These elements of a comprehensive school behavioral health system will be discussed further in the guide, and there are tips in the 🇺🇸 tools and resources section that address these professional development needs.

- **Creating trauma-sensitive and culturally-responsive schools:** “A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being” (Lesley University and Massachusetts Advocates for Children 2012).¹⁴ Research increasingly reveals that students who have experienced trauma or adverse childhood experiences¹⁵ struggle to regulate emotions, attend to classroom activities, and/or achieve normal developmental milestones (Wisconsin Department of Public Instruction).¹⁶ Culturally responsive classrooms acknowledge the lived experiences of all students in a classroom, including those in poverty, LGBT students, and students who are culturally and linguistically diverse. School leaders must provide opportunities for teachers to learn about creating trauma-sensitive and culturally-responsive classrooms. For tips on how to help teachers create trauma-sensitive and culturally responsive classrooms see 🇺🇸 the tools and resources section.
- **Understanding child and adolescent development:** Through the Building Bridges for Children’s Mental Health pilot in Mesa County, school staff developed rubrics to help school and community agency staff as well as families and teachers “talk the same language” and understand social/emotional stages in a student’s development. The rubrics were developed from the national Counseling Standards and cross walked with Colorado’s Emotional Social Wellness Standards. The rubrics are included in the 🇺🇸 tools and resources section.



“A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being.”¹⁴

- **Promoting staff self-care:** Many educators and behavioral health practitioners burnout, and as a result, negatively impact students, suffer health consequences, and leave their profession. Now, research is pointing to vicarious trauma and compassion fatigue that can result from burnout. Vicarious trauma and compassion fatigue can lead to changes in one's psychological, physical and spiritual well-being (Headington Institute).¹⁷ Staff self-care is not only part of the coordinated school health model, it is a necessary ingredient to the success of students. School leaders must provide their staff the knowledge, tools, and resources about being self-aware and maintaining one's own care; a healthy staff is necessary to create a positive learning environment for all students. For tips on improving staff self-care see the 🧩 tools and resources section.

District and school leaders prioritize a positive school climate and culture. The interplay of environment and pathology is unquestionable. School climate refers to patterns of people's experiences of school life; it reflects the norms, goals, values, interpersonal relationships, teaching, learning and leadership practices, as well as the organizational structure that comprise school life.¹⁸ School culture is a critical factor in school success. For nearly two decades, a growing body of research has described the link between positive school climate and student absenteeism, suspension, feeling connected and attached to school, student self-esteem, positive self-concept and motivation to learn. A school's culture, in short, either promotes or undermines student learning (CEI, Transforming School Climate Toolkit, 2013). To learn more about improving school climate and culture see: CEI's school climate toolkit at <http://coloradoedinitiative.org/resource/transforming-school-climate/>.

As part of building a positive school climate, behavioral health professionals, both within and outside of the school, should be embedded into the culture of the school. These professionals should work closely with educators to create a collaborative support system for students. They should also play a meaningful role on the school team tasked with guiding this work. The school behavioral health professionals should have clear roles, which are now clarified as a result of Colorado's Great Teachers and Leaders Act of 2010 (SB 10-191).

It is also critical that school efforts focus on creating trauma-informed and culturally responsive classrooms as discussed on

page 11. There should be district- and school-wide efforts to implement PBIS, Positive Behavior Interventions and Supports. CDE has trained over 900 schools across Colorado in PBIS. For more information about PBIS, visit <http://www.cde.state.co.us/pbis/>.

Social, emotional, and behavioral health efforts are included in accountability systems. Schools focus on current accountability measures regarding academic achievement, which often means that students' social, emotional, and behavioral health do not receive the priority they deserve. Yet, research reveals that behavioral health interrelates to academic outcomes¹⁹ and school climate and culture. Therefore, schools must include comprehensive behavioral health strategies in their school improvement plans to ensure behavioral health initiatives are prioritized and evaluated. But simply including them in a plan will not suffice. School leaders must create a supportive context²⁰ for this work, include social, emotional, and behavioral health in policies, and hold themselves and their staff accountable to effectively implement behavioral health systems.

Schools use data-based decision making to guide their behavioral health efforts. Schools need to begin assessing their behavioral health needs through multiple measures. To do so, The Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that schools:

1. Conduct a comprehensive assessment of mental health problems and concerns in the school and community and the existing policies and resources to meet these needs.
2. Use the public health approach; focus on the larger school population to maximize the program's effectiveness.
3. Use existing data to identify problems, analyze related risk and protective factors in the school and community, and determine the gaps between the current situation and the coalition's vision for a whole-school approach.
4. Share results with the community, proposing recommendations that build on community strengths and resources (SAMHSA, 2011, p. 22).²¹

Once districts and schools have begun implementing behavioral health systems by assessing their local needs, they should create systems to examine the interplay between behavioral health outcomes and school outcomes, such as suspension rates, academic achievement, and discipline referrals.



Tier 1-Universal Supports for ALL STUDENTS

Tier 1 includes the supports that all students should receive within a district and school to build their social and emotional skills.

Positive behavior supports are implemented across the district. Rather than focus on control and punishment, schools should focus on creating positive classroom environments that focus on social, emotional, and behavioral health skill building with clear and consistent expectations.²² As part of PBIS, positive behavior supports for all students is emphasized.

Evidence-based/practice based social, emotional learning opportunities are included across classes and curriculum. Districts and schools should include evidence-based or practice-based social and emotional learning throughout the curriculum, across content, and across grade levels. Research reveals that when schools integrate skills-based social and emotional learning opportunities throughout the school day, across classes, and across grade levels, the impacts are greater than if schools simply set aside twenty minutes a week for social and emotional learning.²³ However, even if full integration of SEL is not feasible, any opportunity for social and emotional learning can be impactful for students. Also, with Colorado's new Emotional and Social Wellness Standards (ESW), which are embedded in the Comprehensive Health and Physical Education Standards, schools now have more guidance about how to implement social and emotional learning across grade levels so that students build the necessary skills, such as resiliency, advocacy, and knowing one's self, to succeed in school, in the community, and in life. Research supports partnering with families to support these skills at home, helping to generalize and expand learning. To learn more about SEL and the Colorado Department of Education's ESW Standards, see the  tools and resources section.

CEI also promotes practice-based work in schools. These practices are created within a district or school, based on local need and show positive results.

Schools include universal behavioral health screening.

Currently, very few schools in Colorado use formal measures to screen students for behavioral health needs. Instead, too often, students' behavioral health needs are addressed only from a reactionary and punitive approach rather than a preventative one, and internalizing students' needs are overwhelmingly not addressed. Districts and schools must be very thoughtful in their approach to universal screening and ensure that appropriate tiered interventions are in place and that students are not over-pathologized or labeled (Adelman and Taylor, 2010, p. 34-43).²⁴ Read more about how to approach universal screening in the  tools and resources section and in the spotlight stories on Aurora Public Schools and Boston Public Schools on pages 14 and 15.



Districts and schools have a formal referral process in place. School leaders must work with all school staff and behavioral health experts outside of the school to create a streamlined referral system for students with Tier 2 and Tier 3 needs. Additionally, schools must ensure they have adequate systems in place so that students who are referred for Tier 2 and 3 interventions have the support they need. All school staff members need training to know how to and who should refer students for more specialized services, and families need to know how to access the referral system and support services. Each school may vary in its referral process, but all schools must include appropriate documentation and ensure student and family confidentiality. For an example of a referral form see the  tools and resources section.

Universal Screening

When it comes to data sharing and universal screening for school behavioral health systems, Aurora Public Schools (APS) and Boston Public Schools (BPS) have worked tirelessly to create systems change with existing practitioners and resources.



After only 10-15 weeks of intervention, around 50% of students showed significant behavioral improvement based on pre- and post-assessments.



Aurora Public Schools, 2012-2013 School Year

Jessica O'Muireadhaigh, a Board Certified Behavior Analyst and Special Education Consultant of APS, took an idea to the superintendent to conduct a social, emotional learning pilot at APS elementary schools. That idea has taken off and shown positive early outcomes. Jessica recognized a need to scale up prevention, early intervention, and intervention efforts at elementary schools in the district, so she brought on Shannon Kishel, a school psychologist, and Adria Young, a school social worker, to begin helping schools implement the evidence-based social and emotional learning curriculum for all students called *Caring School Communities*. In addition to using a school-wide social and emotional curriculum, they helped teachers use a universal screener to determine the top three externalizing and top three internalizing students. Those students were then screened using the BASC-2, a behavior assessment, in order to identify the elevation status of each of the identified students. Students screened extremely elevated were the focus of the pilot. To improve students' social, emotional, and behavioral health, the Tier 2 evidence-based curriculums they used are *I Can Problem Solve* and *Social Skills Improvement System*. Tier 3 curriculum that was used included *Skill Streaming*. After only 10 to 15 weeks of intervention, around 50% of students showed significant behavioral improvement based on pre- and post-assessments. Hoping to grow their work across APS, staff members involved in the pilot remain reflective about how to improve their practices and translate those across the district. Overall, school staff members have seen initial improvements as a result of the pilot and hope to increase the program to more schools in the future.



Boston Public Schools, 2012-2013 School Year

Massachusetts comprehensive health care legislation has existed since 2006, which has helped bridge the gap between schools and behavioral health service providers. However, while legislation can play an important role in driving district level work, the Student Services Department for Boston Public Schools (BPS) has found another impetus for its behavioral health systems change. According to Andria Amador, Acting Director of Special Education and Student Services, the pressing unmet need for comprehensive behavioral health services in schools drove the creation of its comprehensive behavioral health model (CBHM), called the Lighthouse Model in 2012. Between an executive planning committee and strong partnerships with Boston Children’s Hospital and the University of Massachusetts, Boston is finding much success with its model in its 10 pilot schools and plans to expand its work over the next couple of years until all schools throughout BPS have comprehensive behavioral health systems.

After piloting various universal screeners, BPS selected the BIMAS,²⁵ a screener created here in Colorado, to screen every student for both externalizing and internalizing behaviors. Because teachers were highly engaged in the piloting process, there has been instrumental buy-in from the teaching staff to help create the systems change. BPS staff members have found the BIMAS to have very few false positives and false negatives (i.e. the incorrect results of a universal screener), and they have also explained that the screener is user friendly.

Along with deciding to use the BIMAS, BPS had to figure out many logistics, including: acquiring parental consent, figuring out when to do the screening, finding the right space for screening, deciding which grade levels to screen, and providing alternative activities for youth who did not have parental permission for screening. Each school in the pilot made these decisions according to their own needs.

Once students were screened, in the fall and once in the spring, BPS had to ensure supports were in place for students who needed supplemental services. Because the BIMAS has substantial progress monitoring built into its system, which includes an online data collection system, the district has been working on integrating the BIMAS data with other school outcome measures to create transformational school climate and culture change.

Along with the universal screening and the interventions at Tier 2 and Tier 3 levels, all schools in the pilot engaged in 30 minutes of social and emotional learning using the evidence-based Second Step or *Open Circle* programs.



The school psychologists in the district are leading the pilot, and they attend monthly Professional Learning Communities (PLCs) to learn from each other about what is working and what is not at each of the pilot schools. Pre-service school psychologists from local universities are being trained in the CBHM to leverage their practicum hours and to ensure they are prepared to work within a school comprehensive behavioral health system. In addition, monthly principal breakfasts ensure the principals participating in the pilot program are receiving the support they need to implement comprehensive school behavioral health systems. BPS staff are very excited about integrating a comprehensive school behavioral health system into the district, and because of the positive early outcomes, they have the energy to keep moving forward with the pilot.

To learn more about how your district/school can implement universal screening, see the universal screening toolkit in the  tools and resources section.



Tier 2-Secondary or Targeted Interventions for SOME STUDENTS

For too long, students needing early intervention services go unnoticed because they may not exhibit externalizing behaviors. At the same time, those who do externalize a behavioral health issue are often dealt with through a disciplinary and reactionary approach. Truly, without comprehensive behavioral health systems in place that link Systems of Care with Tier 2 students, schools often fail to intervene early. The unfortunate result is that Tier 2 students do not receive the support they need and either continue to go unnoticed or spiral downward. These students experience increasing challenges during youth and adolescent years, and likely, increased challenges in their adult life.

Schools offer evidence-based group and/or individual interventions. School behavioral health professionals and local behavioral health experts should work together with the school and the team guiding the behavioral health work to ensure the interventions they are using are effective. Interventions should (a) be sustained, flexible, positive, collaborative, culturally appropriate, and regularly evaluated; (b) build on the strengths of the students and their families; and (c) address academic as well as social behavioral deficits (Bullock and Gable, 2006).²⁶ It is important to strategically plan for how students will receive interventions throughout the school day.

Progress monitoring is integrated into the school day.

Progress monitoring is most effective when it occurs in natural settings throughout the school day and when it includes multiple measures, including those from the home and community. Behavioral health professionals should work closely with the school to share adequate information with educators to ensure students are transferring their behavioral health skills in multiple environments, and they are receiving the interventions they need.



Tier 3-Tertiary or Intensive Interventions for FEW STUDENTS

When Tier 1 and Tier 2 interventions do not meet students' needs, other interventions should be used. Tier 3 interventions should be linked with the System of Care principles discussed further on in the guide.

Schools offer opportunities for individual and group counseling/therapy during the school day.

Students who have tertiary needs will struggle to learn without the proper support in place. Schools need to include opportunities throughout the school day for students to receive the therapy and counseling services they need.

Schools have a re-entry program for students transitioning back from hospitalization or residential treatment.

Districts and schools should have a thorough plan in place that supports students and their families transitioning back to school from hospitalization or residential treatment. Colorado HB 10-1274 highlights that schools should help ensure a successful transition for students back into the public school system after receiving care in day treatment facilities, facility schools, or hospitals. For

an example of a school program for students transitioning back to school from residential or hospital treatment see the 🧩 tools and resources section.

Schools have a crisis response plan in place.

Schools must establish a crisis response protocol and have a plan in place for events that affect multiple students and that address the need for grieving and coping. Some districts and schools in Colorado have used Psychological First Aid, which is designed to reduce the initial distress caused by traumatic events and help students cope with disaster. In addition to district- and school-wide crisis plans, with the recent passage of Colorado SB 13-266, Colorado is developing a coordinated behavioral health crisis response system as discussed in the 🧩 tools and resources section.



System of Care

A System of Care (SOC) requires multiple agencies working together to improve students' outcomes. SOCs should be youth guided and family driven and promote the SOC concept and philosophy. For information about the SOC Concept and Philosophy, see the  tools and resources section.

Schools ensure adequate information sharing between the behavioral health professional, other youth-serving agencies, families, and necessary school staff. For many districts and schools, the lack of adequate information sharing has kept students from receiving the services they need in school and has made progress monitoring of school's behavioral health efforts difficult. Yet, districts and schools have many options to address this barrier through tiered consent forms from families and children and adolescents about what information should and can be shared with the schools. This consent form is fluid and allows students and families the ability to change how much information they want shared. Plus, with the new State of Colorado Authorization-Consent to Release Information Form, schools can now use a streamlined information sharing form between all agencies. At the same time, district, school, and behavioral health professionals must comply with the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA). Without adequate information, schools cannot collect and analyze the data that is necessary to track and improve their behavioral health efforts to meet students' needs. For more information on this topic see the  tools and resources section.

Constant and effective communication loops exist between the behavioral health professionals and the team leading the behavioral health work. As part of a comprehensive school behavioral health system, schools need a strong communication loop with the behavioral health professional(s) serving the school and other youth-serving systems. The team guiding this work should ensure constant and effective communication among staff who interact with the students, so the students' needs are met, and students transfer the skills they have gained in their social, emotional, or behavioral health interventions across multiple settings.

Schools ensure opportunities exist for “warm hand-offs” between school staff and behavioral health professionals. A warm hand-off is an empathetic process where an educator, school social worker, school psychologist, school counselor, or school nurse introduces a student to the local behavioral health specialist and helps that student navigate the process of care coordination between

the behavioral health professionals within and outside of the school. Before a warm hand-off is initiated, schools must ensure families have provided consent for services. However, per Colorado statute, youth who are fifteen years or older can consent to their own behavioral health treatment.

Wraparound services are available for students with Tier 3 needs. Wraparound services are individualized, community-based services that bring multiple systems together with the child or adolescent and their families to provide a highly individualized plan to meet the unique needs of the student. A team, consisting of a teacher, other school staff, a service provider, family member, and student, should work closely together to develop an individualized-care plan that includes intervention, culturally and linguistically relevant services, and progress monitoring. Wraparound services are often provided in the community, home, or school setting.²⁷

School leaders ensure youth-guided services and family partnerships for students with Tier 2 and Tier 3 needs. As part of the System of Care principles, youth-guided services and family partnering are integral to the success of student interventions. Family partnering is a critical piece to help families navigate the complex behavioral health system. Family members should help develop local policies and serve on committees in relationship to this work, and families should partner with teachers and school staff throughout the 3 Tiers. In Colorado, there are family navigators throughout the state who help families learn how to better access services. Through the Colorado Department of Human Services Trauma-Informed System of Care, which are county- or area-wide initiatives to build Systems of Care, each selected Community of Excellence throughout Colorado must have a family advocate in place. A family advocate must have experience caring for youth with mental health issues while family navigators do not require this qualification.

School behavioral health services best practices must be youth-guided and should link to one of three models for specialized behavioral health service delivery.

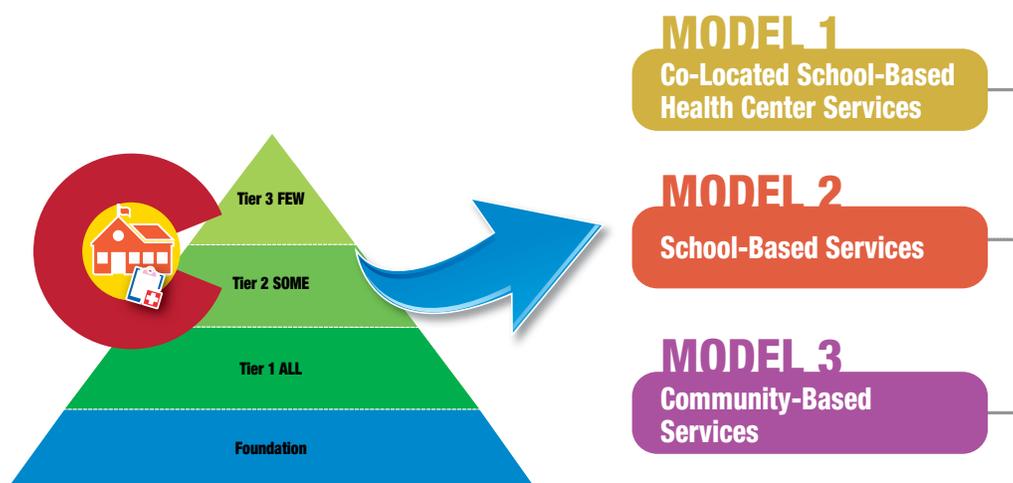


Three Models for Specialized Service Delivery

There are three models that Colorado districts and schools use for specialized services within a comprehensive school behavioral health system. Depending on location, resources, and need, the three models include delivering early intervention and intervention evidence-based services through: 1. co-located services within a school-based health center; 2. a school-based therapist who comes to the school to deliver services; and 3. a community-based therapist who delivers services in a Community Mental Health Center. In the following section, there are best practices and spotlight stories about each model in Colorado. While the three models vary in setting, they have common best practices.

Common Best Practices for Specialized Service Delivery Models

1. A memorandum of understanding (MOU) exists between the CMHC or local behavioral health professional and the district and school.
2. Culturally and linguistically appropriate (CLAS) services are delivered.²⁸ “More than 5.5 million students in U.S. schools are English-language learners (ELLs)...ELLs are expected to comprise more than 40 percent of elementary and secondary school students by 2030” (Thomas & Collier, 2002 from SAMHSA, 2011, p. 8).²⁹ For information on the CLAS Standards, see the  tools and resources section.
3. Local and school behavioral health professionals are integrated into the school culture, and a common language between the school staff and behavioral health professionals exists.
4. Local and school behavioral health professionals have a strong working relationship with clear boundaries and specific role differentiation.
5. School staff, leaders, and local and school behavioral health professionals agree about when to provide student services during the school day based on student need and thoughtful collaboration between educators, families, and behavioral health professionals.
6. School staff and school behavioral health professionals have a clear understanding of how they communicate with and work with local behavioral health professionals.
7. Appropriate physical space is allocated within the school for behavioral health care service delivery. Rooms include adequate space and privacy.
8. Local and school behavioral health professionals help schools implement effective progress monitoring within the school setting.



9. Local and school behavioral health professionals help bridge the gap in communication between the school staff, families, and students.
10. Local and school behavioral health professionals help school staff build capacity to identify and refer students in need of behavioral health services.
11. The district and school leaders and the behavioral health professionals have a common understanding of legal responsibility.
12. A local and school behavioral health professional sit on the school team that leads the behavioral health work for the district and school.
13. Local behavioral health professionals work directly with school staff members to train them in mental health stigma reduction and help them better understand how to identify students who may be struggling by educating them about expected measurable behaviors a child might exhibit at certain stages of development. Various educators, bus drivers, and other school staff in Colorado have found the Mental Health First Aid Youth Curriculum Training to be very helpful.
14. Local and school behavioral health professionals work closely with other youth serving agencies to improve student behavioral health. This is happening throughout many Communities of Excellence, which are county- or area-wide initiatives to build Systems of Care through a Grant from the Colorado Department of Human Services. Current Communities of Excellence are: Adams, Arapahoe, Boulder, Chaffee, Eagle, El Paso, Garfield, Gunnison/Hinsdale, Jefferson, Lake, Larimer, Montezuma/Dolores, Montrose, Pueblo, and Weld counties and the San Luis Valley.
15. Local and school behavioral health professionals ensure that prevention and early intervention are emphasized and, if needed, ensure coordination of existing intervention and service plans, such as RtI, IEP, and 504 plans, with behavioral health interventions.



“More than 5.5 million students in U.S. schools are English-language learners (ELLs)...ELLs are expected to comprise more than 40 percent of elementary and secondary school students by 2030”²⁹



“Youth Mental Health First Aid (MHFA) is a public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and most importantly – teaches individuals how to help a youth in crisis or experiencing a mental health or substance use challenge. Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care” (Mentalhealthfirstaid.org).³⁰ For more information about MHFA in Colorado visit www.mhfacolorado.org.

MODEL 1

Co-Located School-Based Health Center Services Model

A School-Based Health Center “is a health care facility located within or on school grounds. It is staffed by a multi-disciplinary team of medical and behavioral health specialists. . . School-Based Health Centers serve students whose access to care is limited. Services are designed to identify problems early, provide continuity of care, and improve academic participation” (Colorado Association of School Based Health Centers).³¹

There are 54 SBHCs in Colorado, and the need for them continues to grow.

Because students are much more likely to seek services when school-based services are available, SBHCs are ideal for students with behavioral health needs. To learn more about Colorado SBHCs, visit <http://www.casbhc.org/>.



Referral to Co-Located Services

Spotlight on Pueblo City Schools—

As part of the Safe Schools/Healthy Students federal grant, Pueblo City Schools (PCS) created a System of Care by partnering with the CMHC, the police department, justice systems, community organizations, and families.

Through its efforts, PCS bolstered its behavioral health services by placing school-based mental health therapists at four co-located wellness centers, two at middle schools and two at high schools throughout the district. School leaders trained staff, including support staff, to implement Positive Behavioral Interventions and Supports (PBIS) and a bully prevention program with fidelity.

To complement the work in the schools, Pueblo police continues to train officers in de-escalation techniques, and School Resource Officers participated in bully prevention and crisis response trainings. Police trainers have also provided the de-escalation training for district and building administrators, counselors, school psychologists, community advocates, and nurses. There is now trust building between the police and students, resulting in less punitive approaches to discipline for youth.

By blending the System of Care principles with the co-located services in the schools, over 600 students per year received services (approximately 3,000 encounters). Interestingly, the number of youth clients at the same mental health organization’s other community-based

outpatient facilities did not decrease, indicating that the services in the school reached a population of youth who were not previously accessing services. Through the PBIS efforts, schools reduced office discipline referrals significantly and therefore increased classroom time for students and reduced administrative time for discipline issues. Not only do Multi-Tiered Systems of Support blended with Systems of Care help students, but also they create cost savings. The system they designed saved the community an estimated \$239,000 because of decreased student Emergency Room visits.

While PCS found much success and learned invaluable lessons, PCS leaders said that data continues to be a barrier because currently, there are not a lot of data collection efforts for behavioral health in schools. However, PCS has attempted to address that gap by generating a data system that ties office referrals, suspension rates, and absences to the behavioral health system data. Another challenge that PCS leaders have noted is the need to tie comprehensive behavioral health practices, not programs, to Unified Improvement Plans (UIPs) and accountability measures. Without a planning and accountability piece, PCS found that schools will not implement comprehensive behavioral health supports to standard.

SBHCs should have fully integrated care—the coordination of services between the primary and behavioral health care provider—where the primary and behavioral health providers should have a formal process for sharing student information.

MODEL 2

School-Based Services Model

A district and school may have a community behavioral health therapist or private behavioral health therapist come to the school to deliver group and/or individual based therapy during the school day.

- The district and school should ensure that, if private therapists are used, they can bill Medicaid.
- There are 17 Community Mental Health Centers (CMHC) across the state in addition to other non-profit CMHCs.
- Less stigma is associated with seeing a behavioral health professional at school.
- When a local behavioral health professional is integrated into the school climate and culture, the stigma of mental health is greatly reduced.



Referral to a School-Based Therapist

Spotlight on Metro Denver – Community Reach Center and Jewish Family Service

Community Reach Center

Community Reach Center, a CMHC in north metro Denver, operates one of the largest school-based service programs in Colorado by providing therapy and case management services to students and families within Adams County School Districts 1, 12, 14, and 27J. Community Reach Center hires, screens, and trains the school-based therapists. While the therapists practice in schools, Community Reach Center is their employer and collaborates with the schools to create an integrated care approach. At the start of the school year, school-based therapists from Community Reach Center visit the schools to help students and families learn about their services and inform them about resources to meet students' social, emotional, and behavioral health needs.

The school is an ideal environment for providing students services because it is a collaborative environment where students can feel supported by various professionals. Even more noticeable, by having school-based therapists present in schools, the mental health stigma is greatly decreased, as the school-based therapist is there to support the entire school. The school-based therapist can be beneficial for students who may move quickly between Tiers 1, 2, and 3 as well as for some students who may

simply need one session to access the right resources. School-based therapists can also be integrated into the school community by serving as a member of a restorative justice circle at the school, and they can be a beneficial resource for helping students acquire practical skills to improve their behavior.

School-based therapists from Community Reach Center also host family dinners and family game nights at the schools for their consumers because they realize the importance of family and peer support in overcoming behavioral health challenges.

As students' behavioral health needs are on the rise, it is now more important than ever for communities of professionals to work together to create healthy environments where all students feel safe to learn. To meet this need, Community Reach Center plans to offer the Mental Health First Aid Youth Curriculum, a public education program that helps participants better understand how to help adolescents who may be struggling with a mental health challenge or crisis, free of charge to schools in Adams County. Providing the MHFA Youth Curriculum is an effective strategy for supporting the *Colorado Framework for School Behavioral Health Services*.



🔗 See the tools and resources section for an informational one-pager about HIPAA/ FERPA.

Jewish Family Service

Jewish Family Service (JFS) has played a leading role in helping to create school environments that support positive academic performance and developmental success by addressing the mental health challenges that often compromise student performance in school. In 1995, JFS's Counseling Center began providing school-based intervention services when a local Denver Public Schools (DPS) middle school asked the agency to address bullying and anger management among a small group of girls. The counseling was so successful that not only did the middle school ask JFS to continue its bully-proofing services for the following school year, but it also asked the agency to provide services for a wider range of students and include consultation with families and staff. Upon learning of JFS's impact, another DPS school also engaged JFS to provide mental health services for their students. Within a few years, the program now known as *KidSuccess* was formalized, and today it operates in 12 Denver Public Schools.

The goal of *KidSuccess* is to provide a safety net for the entire school community by removing barriers to learning and, in turn, giving low-income, underinsured, and/or uninsured students the tools they need to succeed in school and in life. *KidSuccess* services include individual, group, and family counseling; family case management; family psychoeducational presentations; staff consultation and training; psychiatric services and intervention and prevention services as indicated.

Highlights from JFS survey results from the 2012- 2013 school year

- **83% of students** surveyed report that they are much more able to cope with problems.
- **75% of students** surveyed report they have greatly improved their ability to deal with others.
- **100%** of students surveyed report their counselor was very responsive to their personal issues.
- **100%** of parents surveyed report the counselor was very responsive to the needs of their child.
- **75%** of parents surveyed report there was a significant improvement in their child's behavior.
- **100%** of school staff surveyed report very adequate collaboration between the JFS counselor and school personnel.
- **82%** of school staff surveyed report there significant improvement in the desired behaviors of students.

Having therapists placed in schools helps the students they work with feel more connected to school. In addition, school-based therapists can provide teacher consultation through one-on-one support, which has increased various educators' abilities to help students with behavioral health challenges. In the 2012-2013 school year, JFS conducted a mental health intervention at a school to help school staff members learn how to respond to students with behavioral health needs.

Overall, *KidSuccess* Program at JFS provides access to mental health services that would typically be much more costly and difficult for students and families to access. Through *KidSuccess*' collaboration, students and their families have found many positive outcomes.

MODEL 3

Community-Based Services Model

When districts and schools do not have a SBHC and do not have access to school-based therapists, they may create a strong relationship with a CMHC to ensure there are streamlined referral processes and communication loops with the center to create a seamless service delivery model for children and adolescents.

- District and school leaders should establish a strong relationship with the CMHC.
- District and school leaders should ensure there is a way to embed the community behavioral health professional into the culture of the school.
- Local behavioral health professionals should help school staff build the capacity to identify and refer students with behavioral health challenges.



Referral to a Community-Based Therapist

Spotlight on Mesa County

In 2009, CDE selected Mesa County to pilot Building Bridges for Children's Mental Health—a system that integrated a System of Care within a Positive Behavioral Interventions and Supports (PBIS) model. Building Bridges helped the school district make a much stronger connection to its community partners, particularly the mental health provider, Colorado West (now Mind Springs Health), by emphasizing school-community collaboration to improve behavioral health supports. As a result of Building Bridges, teachers and school staff—including bus drivers—were trained on how to identify and refer students while supporting those students in the classroom through a PBIS model. This allowed students to receive the services they needed as well as the school community—teachers, administrators, counselors, and social workers—the collaboration necessary to provide wraparound services (see wraparound services defined on page 17) to Mesa County students.

According to student services leaders in Mesa County, the first step to create an effective system of supports is to build strong relationships with the community provider and the schools. This involves communicating frequently with the community provider; including the community provider as a member of the school and/or district student services team; and partnering with the community provider to deliver professional development to school staff.

While many districts/schools have expressed that HIPAA and FERPA regulations are difficult to navigate, preventing necessary information sharing between the service provider and school, those involved in the Mesa County project have not found these regulations to be a barrier. In fact, they said, through the Building Bridges project they have found that integrating a member from

the CMHC onto the school student services' team has helped streamline information sharing efforts.

Along with CDE, Mesa County student services professionals created tip sheets for teachers about how to call families whose students were exhibiting behavioral health problems; this helped teachers feel more comfortable with calling families to express their concerns about students' behavioral health. A common referral form and informational one-pagers about various mental health issues were developed, and school staff members were trained on how to refer students to services. The Building Bridges resources are included in the  tools and resources section of the *Framework*.

The largest project that resulted from the work of Building Bridges is a Social/Emotional Standards rubric outlining the expected measureable behaviors a child might exhibit at certain stages of development. These rubrics help school and community agency staff as well as families and teachers “talk the same language” and understand social/emotional stages in a student's development. The rubrics were developed from the national Counseling Standards and cross walked with the state's Emotional Social Wellness Standards, and the rubrics are included in the  tools and resources section.

Despite multiple successes, there are barriers that Grand Junction continues to face, and those include: sustaining systems due to lack of funding; ensuring that schools have effectively implemented PBIS/MTSS; and providing the data to show the direct link of the services provided to students' academic growth. While Mesa County continues to address these challenges by being more proactive about implementing PBIS and using data to guide their decisions, Mesa County continues to face some of the aforementioned key systemic barriers for all districts and schools in Colorado working to sustain comprehensive school behavioral health systems.



Spotlight on a Community of Excellence

Chaffee County is one of Colorado’s System of Care Communities of Excellence.

Chaffee County has been delivering high fidelity wraparound services for the past six years to provide integrated services. In its approach to school-based therapy, various schools throughout the area partner with West Central Mental Health Center (WCMHC) so that students can receive therapeutic services at the school. The counselors in the schools serve as the link between the teachers and the WCMHC behavioral health therapists to ensure a streamlined referral process. In addition to the therapeutic services offered, WCMHC has conducted various Mental Health First Aid Youth Trainings to help community members better identify and refer children and adolescents who may be in need of behavioral health services. Teachers and bus drivers have attended these trainings, and they have reported that the trainings have been very beneficial.



See definitions
on page
17 about
Colorado’s
Communities of
Excellence and
Youth Mental
Health First Aid.

Chaffee County High School

As part of Chaffee County’s Communities of Excellence initiatives, students at a local alternative school took part in many social and emotional skill building opportunities, including youth-guided work, a powerful instrument for change. Teachers and school counselors serve as supporters for the youth to empower students’ social and emotional health. Some students formed a youth advisory council to ensure youth voice and support for LGBTQ youth. The youth-led initiative was successful, as other community members helped support students in this effort. Now, students will connect with a member from Southwest Conservation Corps to work collaboratively on the LGBTQ initiative, and a business in Buena Vista will host events and have speakers to support the students’ efforts. Another youth-guided project in Chaffee County includes training youth at the alternative high school in restorative justice, a mediation approach that focuses on rehabilitation of offenders through the restoration of relationships with the victims and community. A student leading the restorative justice work at the school facilitated this initiative as a truly peer-guided opportunity and will continue the work with the project in the 2013-2014 school year.

In addition to youth-guided social and emotional efforts, at the beginning of the school year, students at the alternative school take part in intensive social and emotional skill building for half a day for an entire month and again at the beginning of the new semester. Erin Dziura, a former school counselor at the alternative high school and now a counselor at Salida Middle School, would provide students an emotional intelligence assessment, and based on the assessment, students selected two social and emotional goals for the school year. Students showed growth data of 67% in one or more of the target goals. Also, WCMHC conducted Mental Health First Aid Youth training with students over the course of several days. While it was emotionally challenging for many of the students, the students positively evaluated the training, explaining they really liked it and thought it was culturally empowering. To build relationships with students, a therapist from the CMHC conducted a yoga class at the alternative high school every Thursday afternoon, emphasizing life skills for breathing, centering, and finding space for one’s self. The yoga class helped students become familiar with the WCMHC therapist, which decreased the stigma associated with seeing a behavioral health professional. Finally, alternative school staff also took part in a trauma-informed training to improve their skill and knowledge base about creating a trauma-informed school.

Salida Middle School

Another key to the work that Chaffee County is currently doing as a Community of Excellence is to build systemic support systems for the appropriate identification of children and adolescents in need of social, emotional, or behavioral health support. Now, school counselors in Chaffee County are working to create systems-level change by examining data to develop specific tiered interventions to intentionally identify students earlier and build a school behavioral health system through a preventative lens. As part of holistic change to school climate and culture, restorative justice will be implemented at Salida Middle School in the 2013-2014 school year with alternative and elementary schools in the area showing interest in developing similar systems.

Buena Vista School District

In addition to partnering with the CMHC, Buena Vista School District has partnered with a private therapist to provide school-based services. When Karla Carroll came to the Buena Vista community in 2011, she quickly learned of the unmet behavioral health needs of many students, so she approached the district about a potential partnership to deliver her services within the school. Because she is a private practitioner, and she can bill Medicaid, the district was very excited to enter into an agreement with her for her therapeutic services.

The district/school leaders recognized the pressing need for students' behavioral health and, specifically, the continued unmet needs of Medicaid and CHP+ students and were very pleased that services would now be accessible for students who traditionally did not access them. Therefore, in September of 2011, Karla began delivering child and adolescent therapy in a counselor's office at an elementary school.

A flier was given to families, so they could learn about Karla's services, and the response to Karla quickly took off as more and more families contacted her about their children's needs. In addition, teachers continue to ask for the flier to speak with a family about a student concern. Realizing the extent of need, Karla has expanded her services across elementary, middle, and high schools in the district. Now, every week, Karla sees approximately 22 children and adolescents, and she has a case load capped between 35 and 40 students.

To help students, Karla met with each of the families to determine which children/adolescents needed to be seen at the school and which ones could be seen during her private practice hours. Working collaboratively with the school staff, times were decided upon for when Karla should see each student. The teachers were just as excited as the administrators and families to have this type of support, and Karla spent a lot of time in teacher and IEP meetings.

While many positive outcomes have been realized, Chaffee County has learned a lot. For one, Karla had to be clear that the liability with regard to the service delivery lies solely with her, not the school district. When students are referred for services in the school, the school is not legally liable for the actual service delivery. Also, there must be strong communication among Karla, families, and teachers to share the right amount of information to positively support students in a school setting; this often entails Karla meeting with families and children/adolescents to discuss how best information can be shared to support the student. Finally, due to a high case load, sometimes Karla must deliver *pro bono* services, and she has performed some threat assessments for which she cannot get reimbursed, which can lead to an overbearing workload and practitioner burnout. This, again, reveals the pressing need for more streamlined partnerships with schools and behavioral health professionals.





Because of the success, principals and administrators have been huge supporters of her work, and teachers are now implementing classroom strategies to create classroom environments that are responsive to students' behavioral health needs. Also, a health teacher at the middle school has invited Karla to the girls' 8th grade health class to speak on mental health issues that may come up at that age. This has been useful for the students, as students like to self-diagnose on the Internet without professional support, often misdiagnosing and self-medicating themselves. Overall, by coming to the health classes, Karla has built a strong rapport with the students.

For other schools/districts looking for a similar partnership with a private practice therapist, Karla suggests they find a therapist with strong child/adolescent experience and one who is highly passionate about working with schools to help students succeed in school, in the community, and in life.

Overall, through the Community of Excellence initiative in Chaffee County, school counselors and other behavioral health professionals hope to build the cultural foundation, knowledge, and language to embed positive school climate and culture and behavioral health practices throughout the county schools.

While many local and national schools are finding success with school behavioral health systems, districts and schools are faced with common gaps.

Based on an analysis from academic literature, state policy documents, and interviews and focus groups with educational and behavioral health professionals in Colorado and across the nation, CEI has recognized the top systemic barriers that provide substantial challenges to implementing comprehensive behavioral health systems. To see the complete gaps and barriers analysis, see the  tools and resources section.

What is needed for success:

- Collaboration and information sharing between agencies and schools for youth, especially youth involved in multiple systems
- The ability to tie student-level and school-level behavioral health data with other student-level and school-level outcome measures
- The acquisition of knowledge and skills for school staff to support the positive development of students' social, emotional, and behavioral health
- A common understanding that schools are not legally or financially liable when they refer students for services
- An increased capacity of—including number, culturally and linguistically appropriate, and quality of—youth- and adolescent-serving behavioral health professionals, especially in rural areas
- Adequate funding and resources to support comprehensive services, especially in rural areas



Linking to Early Childhood

“Beginning in the fall of 2013, local education providers are required to ensure all children in publicly-funded preschool or kindergarten receive an individual school readiness plan” (Colorado Department of Education Office of Early Learning and School Readiness, 2013). To help schools implement school readiness plans, CDE has assembled a School Readiness Assessment Guidance for Kindergarten. As part of Colorado’s Achievement Plan for Kids (CAP4K), local education providers must administer the school readiness assessment to each student in kindergarten. See the  tools and resources section for CDE’s School Readiness Assessment Guidance for Kindergarten.

As leaders in Colorado in the field of early childhood mental health, Sarah Hoover and Lorraine Kubicek with JFK Partners, an interdepartmental program of the departments of Pediatrics and Psychiatry of the University of Colorado School of Medicine, developed an environmental scan of challenges, progress, and recommendations for the social and emotional health of Colorado’s children. A condensed version of the report can be found here: <http://www.rcfdenver.org/reports/EarlyChildhoodMentalHealthinColoradoExecutiveSummary2013.pdf>.

As part of the Early Childhood Colorado Initiative, social, emotional, and mental health are emphasized. The Early Childhood Colorado *Framework* emphasizes: increased availability and use of high quality social, emotional, and mental health training and support; increased number of supportive and nurturing environments that promote children’s healthy social and emotional development; increased number of environments, including early learning settings, providing early identification and mental health consultation; improved knowledge and practice of nurturing behaviors among families and early childhood professionals; increased number of mental health services for children with persistent, serious challenging behaviors; and decreased number of out-of home placements of children.

As early childhood mental health initiatives have stressed relationship building and social and emotional learning, children moving from an early childhood system to kindergarten and first grade may struggle because of the lack of emphasis on relationship building and social and emotional learning in the education system. Therefore, it is important to create a system of social and emotional supports from early childhood through and beyond K-12 education so that students receive a consistent continuum of care to enhance their social and academic outcomes.



Communities will reap many positive outcomes when they integrate comprehensive behavioral health systems change from early childhood through and beyond k-12 education.



Students should not be labeled Tier 1, Tier 2, or Tier 3; many students will move in between tiers in one area while others may move in between the tiers based on another area. Remember, while the pyramid is fixed; students' needs are not.



In Summary

Along with the best practices, districts and schools need a person in-district who can champion creating comprehensive school behavioral health systems and work to integrate local and school behavioral health services into a continuum of care. While planning to implement a comprehensive school behavioral health system, it is important to remember that an individual student can fall anywhere on the three-tiered pyramid depending on individual circumstances. Therefore, students should not be labeled Tier 1, Tier 2, or Tier 3; many students will move in between tiers in one area while others may move in between the tiers based on another area. Remember, while the pyramid is fixed; students' needs are not.

Once districts and schools have worked through the phases of thoughtfully planning and implementing comprehensive behavioral health systems, they should identify how they will sustain the most effective practices they have implemented.

Overall, district and school leaders must prioritize behavioral health efforts for any systemic change to be found.

To help district and school leaders get started, the accompanying tools and resources section includes a needs assessment along with the tools and resources listed on the following page.

Getting Started

- Identify a champion to lead the school behavioral health work.
- Garner buy-in from various stakeholders, including school- and district-level staff, community agencies, and families.
- Create—or embed in an existing team—a school behavioral health services team.
- Assess your local systems and need (see the needs assessment in the tools and resources to help get you started).
- Create an action plan that includes goals, objectives, methods, and a timeline; identifies responsible people; and pinpoints resources required to implement the plan.
- Begin implementing your plan and continually assess progress toward your goals.



Tools and Resources on the CD

* = CEI-Created Resources

Additional Resources – *Additional Resources Compendium

Building Bridges Resources – Behavioral health facts and classroom tip-sheets for parents and teachers about: Attention Deficit Hyperactivity Disorder, Anxiety Disorder, Bipolar Disorder, Conduct Disorder, Depression, Oppositional Defiant Disorder, Substance Use Disorder, and Post Traumatic Stress Disorder

Flip-chart script for calling parents, Managing Challenging Behaviors for Parents and Teachers tip-sheet, Mandated Reporting for School Professionals tip-sheet, Daily Transition Support in School tip-sheet, Building School Teams tip-sheet, Family-Driven Care informational one-pager, An Introduction to Colorado's Emotional and Social Wellness (ESW) Standards one-pager, National Assembly on School-Based Health Care Assessment Tools for School Mental Health Capacity Building, and Spark Policy Institute's legal memo regarding referrals

***District- and School-Level Needs Assessments**

Family-School-Community Partnerships – See Building Bridges Resource on family-driven care and script for calling parents, “On the Team and At the Table” family partnering toolkit and Colorado's State Advisory Council for Parent Involvement in Education (SACPIE) resource

***Gaps and Barriers Analysis**

Information Sharing and Consent – Information Sharing tip-sheet, State of Colorado Consent to Share Information Form, Colorado Association for School-Based Health Care's Understanding Minor Consent and Confidentiality in Colorado, An Adolescent Provider Toolkit, and West Virginia Sample-Parental Consent form

Mental Health Stigma Reduction – *Mental health stigma reduction tip-sheet for school leaders, school board members, school staff, students, families, and community members

Memorandum of Understanding (MOU) – MOU example between Pueblo City Schools and Spanish Peaks and School-Based Mental Health Services Contract

Programs for Transitioning Back to School from Residential or Hospitalization Treatment – PACE and BRYT example programs

Referral Form – Colorado West school referral form and West Virginia sample referral form

School Readiness for Kindergarten – CDE School Readiness Assessment Guidance

Social and Emotional Learning (SEL) – *SEL guide and Mesa County Social and Emotional Continuum for preK-12th grade

***Staff Self-Care Tip Sheet**

System of Care Concept and Philosophy One-Pager

***The Colorado Context**

***The National Context**

Trauma-Sensitive and Culturally-Responsive Schools – *Tip-sheet for creating trauma-sensitive and culturally-responsive classrooms and Responding to traumatic events tip sheet

***Universal Screening Toolkit**



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Learn more at www.coloradoedinitiative.org/schoolbehavioralhealth

December 2018

Updated Inventory of Programs for the Prevention and Treatment of Youth Cannabis Use

Initiative 502 (I-502) legalized recreational marijuana for adults in Washington State. The law directs the Washington State Institute for Public Policy (WSIPP) to conduct a benefit-cost evaluation of the implementation of I-502.¹ State law also requires the Health Care Authority's Division of Behavioral Health and Recovery (DBHR)² to expend substance abuse prevention funding derived from cannabis revenues on programs demonstrated to be effective. Specifically, the law requires at least 85% of programs funded by cannabis revenues to be evidence-based or research-based and up to 15% to be promising practices.³

In this report, we summarize the research evidence for a set of programs intended for the prevention or treatment of youth substance use. The programs reviewed include those nominated by DBHR as well as similar programs from WSIPP's current set of inventories that have been evaluated for cannabis outcomes.⁴ We rate the level of evidence for each program using the same methods used in other WSIPP inventories, as described below.

This inventory is not limited to effective programs; we report on all programs reviewed, whether or not we find evidence of effectiveness. It is important to note that a wide variety of outcomes may be examined for a given program. Our evidence ratings are based on all relevant outcomes reported in the research, so it is possible that a given program is effective in preventing or treating the use of some substances but not others. It is also possible that a program is effective for related outcomes such as crime or risky sexual behavior but not for substance use. In addition to the overall evidence rating for each program, we also denote which programs have demonstrated evidence of effectiveness for preventing or treating cannabis use. Complete detailed results with specific outcome effects for each program can be found on WSIPP's website.⁵

This inventory is a snapshot of the evidence at a point in time.⁶ Ratings for a program may change as new research becomes available and refinements are made to the WSIPP benefit-cost model.

¹ [RCW 69.50.550](#).

² Recently re-located from the Department of Social and Health Services to the Health Care Authority.

³ [RCW 69.50.540](#).

⁴ Miller, M., Goodvin, R., Grice, J., Hoagland, C., & Westley, E. (2016). *Updated Inventory of evidence-based and research-based practices: Prevention and intervention services for adult behavioral health*. (Doc. No. 16-09-4101). Olympia: Washington State Institute for Public Policy; Cramer, J., Bitney, K., & Wanner, P. (2018). *Updated inventory of evidence- and research-based practices: Washington's K-12 Learning Assistance Program*. (Doc. No. 18-06-2201). Olympia: Washington State Institute for Public Policy; and EBPI & WSIPP. (2018). *Updated inventory of evidence-based, research-based, and promising practices: For prevention and intervention services for children and juveniles in the child welfare, juvenile justice, and mental health systems*. (Doc. No. E2SHB2536-9). Olympia: Washington State Institute for Public Policy.

⁵ Washington State Institute for Public Policy. *Benefit-cost results*. Olympia, WA: Author.

⁶ This inventory is an update of a previous inventory; the most recent prior version is Darnell, A., Goodvin, R., Lemon, M. & Miller, M. (2016). *Preventing and treating youth marijuana use: An updated review of the evidence*. (Doc. No. 16-12-3201). Olympia: Washington State Institute for Public Policy.

Creating the Youth Cannabis Inventory

WSIPP’s approach to creating the inventory is the same approach we use for legislatively directed inventories in other policy areas.⁷ We first use a rigorous, three-step research approach to assess the evidence, economics, and risk for each program. Then, using information derived from the three-step approach, we classify all programs according to standard definitions. WSIPP’s three-step approach is as follows:

- 1) **Identify what works (and what does not).** For each program under consideration, we systematically review all rigorous research evidence and estimate the program’s effect on all relevant outcomes. The evidence may indicate that a program worked (i.e., had a desirable effect on outcomes), caused harm (i.e., had an undesirable effect on outcomes), or had no detectable effect one way or the other.
- 2) **Assess the return on investment.** Given the estimated effect of a program from Step 1, we estimate—in dollars and cents—how much the program would benefit people in Washington were it implemented and how much it would cost the taxpayers to achieve this result. We use WSIPP’s benefit-cost model to develop standardized, comparable results for all programs that illustrate the expected return on investment. We present these results as net present values on a per-participant basis. We also consider how monetary benefits are distributed across program participants, taxpayers, and other people in society.
- 3) **Determine the risk of investment.** We allow for uncertainty in our estimates by calculating the probability that a program will at least “break even” if critical factors—like the actual cost to implement the program and the precise effect on the program—are lower or higher than our estimates.

We follow a set of standardized procedures (see [Exhibit 1](#)) for each of these steps. These standardized procedures support the rigor of our analyses and allow programs to be compared on an “apples-to-apples” basis. For full detail on WSIPP’s methods, see WSIPP’s Technical Documentation.⁸

⁷ EBPI, & WSIPP. (2018).

⁸ Washington State Institute for Public Policy. (December 2018). *Benefit-cost technical documentation*. Olympia, WA: Author.

Exhibit 1

WSIPP's Three-Step Approach

Step 1: Identify what works (and what does not)

We conduct a meta-analysis—a quantitative review of the research literature—to determine if the weight of the research evidence indicates whether desired outcomes are achieved, on average.

WSIPP follows several key protocols to ensure a rigorous analysis for each program examined. We:

- **Search for all studies on a topic**—We systematically review the national and international research literature and consider all available studies on a program, regardless of their findings. That is, we do not “cherry pick” studies to include in our analysis.
- **Screen studies for quality**—We only include rigorous studies in our analysis. We require that a study reasonably attempt to demonstrate causality using appropriate statistical techniques. For example, studies must include both treatment and comparison groups with an intent-to-treat analysis. Studies that do not meet our minimum standards are excluded from analysis.
- **Determine the average effect size**—We use a formal set of statistical procedures to calculate an average effect size for each outcome, which indicates the expected magnitude of change caused by the program (e.g., tutoring by adults) for each outcome of interest (e.g., standardized test scores).

Step 2: Assess the return on investment

WSIPP has developed, and continues to refine, an economic model to provide internally consistent monetary valuations of the benefits and costs of each program on a per-participant basis.

Benefits to individuals and society may stem from multiple sources. For example, a program that reduces the need for publicly funded substance use treatment services decreases taxpayer costs. If that program also improves participants' educational outcomes, it will increase their expected labor market earnings. Finally, if a program reduces crime, it will reduce expected costs to crime victims.

We also estimate the cost required to implement an intervention. If the program is operating in Washington State, our preferred method is to obtain the service delivery and administrative costs from state or local agencies. When this approach is not possible, we estimate costs using the research literature, using estimates provided by program developers, or using a variety of sources to construct our own cost estimate.

Step 3: Determine the risk of investment

Any tabulation of benefits and costs involves a degree of uncertainty about the inputs used in the analysis, as well as the bottom-line estimates. An assessment of risk is expected in any investment analysis, whether in the private or public sector.

To assess the riskiness of our conclusions, we look at thousands of different scenarios through a Monte Carlo simulation. In each scenario, we vary a number of key factors in our calculations (e.g., expected effect sizes, program costs) using estimates of error around each factor. The purpose of this analysis is to determine the probability that a particular program or policy will produce benefits that are equal to or greater than costs if the real-world conditions are different than our baseline assumptions.

Classifying Practices as Evidence-Based, Research-Based, or Promising

Results from meta-analyses and benefit-cost modeling are then used to classify programs as evidence-based, research-based, or promising, based on the definitions in state law shown below.

Legislative Definitions of Evidence-Based, Research-Based, and Promising Practices

Evidence-based practice

A program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

Research-based practice

A program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection (14) of this section but does not meet the full criteria for evidence-based.

Promising practice

A practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection (14) of this section (defining "evidence-based").

RCW 71.24.025.

To classify programs, the criteria in the statutory definitions are operationalized as follows:

- 1) [Weight of evidence](#). To meet the evidence-based definition, results from at least one random-effects meta-analysis of multiple evaluations or one large multiple-site evaluation must indicate the practice achieves the desired outcome(s) (p-value < 0.20). To meet the research-based definition, at least one single-site evaluation must indicate the practice achieves desired outcomes (p-value < 0.20).
- 2) [Benefit-cost](#). The statute defining evidence-based practices requires that, when possible, a benefit-cost analysis be conducted. Programs that achieve at least a 75% chance of a positive net present value meet the "cost beneficial" criterion.⁹

⁹ To operationalize the benefit-cost criterion, net benefits must exceed costs at least 75% of the time. After considerable analysis, we found that a typical program that WSIPP has analyzed may produce benefits that exceed costs roughly 75% of the time with a p-value cut off of up to 0.20. Thus, we determined that programs with p-values < 0.20 on desired outcomes should be considered research-based to avoid classifying programs with desirable benefit-cost results as promising.

3) [Heterogeneity](#). To be designated as evidence-based, a program must have been tested on a “heterogeneous” population. We operationalize heterogeneity in two ways. First, the proportion of program participants belonging to racial/ethnic minority groups must be greater than or equal to the proportion of minority children in Washington. From the 2010 Census, for children age 0-17 in Washington, 68% were White and 32% belonged to racial/ethnic minority groups.¹⁰ Thus, if the weighted average of program participants in the outcome evaluations of the program was at least 32% racial/ethnic minority, then the program was considered to have been tested in a heterogeneous population.

Second, the heterogeneity criterion can also be achieved if at least one of a program’s outcome evaluations has been conducted on children in Washington and a subgroup analysis demonstrates the program is effective for racial/ethnic minorities (p-value < 0.20).

To summarize, we begin with the pool of programs defined at the outset and review the research literature for studies meeting WSIPP’s criteria for methodological rigor. Programs that have no studies are not analyzed further, and these programs are noted in the report. Programs are deemed to be promising if some research on the program suggests effectiveness even though the studies do not meet WSIPP’s methodological criteria or if the program has a well-defined theory of change. For programs that do have studies that meet WSIPP’s methodological criteria, we conduct a meta-analysis. If the meta-analysis indicates at least one effect on an outcome of interest according to the weight of evidence criterion, the program is eligible to be either research-based or evidence-based. To reach the top tier, a program must also meet heterogeneity and benefit-cost criteria. Many interventions produce effects on more than one type of outcome. In our evidence ratings and benefit-cost results, we include all relevant outcomes, not just those related to substance use or marijuana.

WSIPP has clarified classifications for programs that produce null or poor results since the last inventory update. In prior inventories, there was a single category for programs producing “null or poor outcomes.” Programs with null effects on outcomes (p-value > 0.20) were inconsistently categorized as either “null or poor” or as “promising.” For the current inventory, WSIPP has defined two separate categories to distinguish between programs producing null results (no significant effect on desired outcomes) and those producing poor (undesirable) outcomes. If results from a random-effects meta-analysis of multiple evaluations or one large multiple-site evaluation are not statistically significant (p-value > 0.20) for relevant outcomes, the practice may be classified as “null.” If results from a random-effects meta-analysis of multiple evaluations or one large multiple-site evaluation indicate that a practice produces undesirable effects (p-value < 0.20), the practice may be classified as producing “poor” outcomes. If there is sufficient evidence of desirable effects on some outcomes but undesirable effects on other outcomes, we note the mixed results next to the program rating.

Results of our classifications are displayed at the end of this report and are also available on our website.¹¹ Further information on the individual programs contained in the inventory can also be found on our website.¹²

¹⁰ [United States Census Bureau, 2010](#).

¹¹ Darnell, A., Goodvin, R., del Moral, S., Hicks, C., Wanner, P., & Westley, E. (2018). *Updated inventory of programs for the prevention and treatment of youth cannabis use*. (Document Number 18-12-3201). Olympia: Washington State Institute for Public Policy.

¹² WSIPP. *Benefit-cost results*.

Updates to the Inventory as of December 2018

Since the previous publication of this inventory, WSIPP has updated the benefit-cost results for all programs¹³ and has updated the literature reviews and meta-analyses for ten topics. [Exhibit 3](#) provides an overview of programs for which we changed classifications and the reasons for classification changes.

There are a variety of reasons the classification for a program may change in an inventory update. These reasons include new research evidence, removing studies from the set of included studies, updating statistical calculations, and/or updating program costs. In this update of the cannabis inventory, the introduction of the null classification of programs also resulted in classification changes for some programs. In other cases, classifications changed because we based the rating on a broader set of outcomes than previously. Results have also changed due to updates to WSIPP's benefit-cost model and analyses. In November 2018 WSIPP completed an update to its benefit-cost model that reflects ongoing improvements to inputs and calculations across a variety of policy areas. We revised benefit-cost analyses using WSIPP's updated model for all eligible programs on the inventory.

¹³ WSIPP's meta-analytic and benefit-cost methods are described in detail in our [Technical Documentation](#).

December 2018 Updated Inventory of Programs for the Prevention and Treatment of Youth Cannabis Use

Definitions and Notes:

Level of Evidence:

Evidence-based:

A program or practice that has been tested in heterogeneous or intended populations with multiple randomized and/or statistically controlled evaluations, or one large multiple-site randomized and/or statistically-controlled evaluation, where the weight of the evidence from a systematic review demonstrates sustained improvements in at least one outcome. Further, "evidence-based" means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, has been determined to be cost-beneficial.

Research-based:

A program or practice that has been tested with a single randomized and/or statistically-controlled evaluation demonstrating sustained desirable outcomes; or where the weight of the evidence from a systematic review supports sustained outcomes as identified in the term "evidence-based" in RCW (the above definition) but does not meet the full criteria for "evidence-based."

Promising practice:

A program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the alternative use.

Null outcome(s):

If results from multiple evaluations or one large multiple-site evaluation indicate that a program has no significant effect on outcomes of interest (p-value > 0.20), a program is classified as producing "null outcomes."

Reasons Programs May Not Meet Suggested Evidence-Based Criteria:

Benefit-cost:

The proposed definition of evidence-based practices requires that, when possible, a benefit-cost analysis be conducted. We use WSIPP's benefit-cost model to determine whether a program meets this criterion. Programs that do not have at least a 75% chance of a positive net present value do not meet the benefit-cost test. The WSIPP model uses Monte Carlo simulation to test the probability that benefits exceed costs. The 75% standard was deemed an appropriate measure of risk aversion.

Heterogeneity:

To be designated as evidence-based under current law or the proposed definition, a program must have been tested on a "heterogeneous" population. We operationalized heterogeneity in two ways. First, the proportion of minority program participants must be greater than or equal to the minority proportion of children under 18 in Washington State. From the 2010 Census, of all children in Washington, 68% were White and 32% minority. Thus, if the weighted average of program participants had at least 32% minorities then the program was considered to have been tested on a heterogeneous population.

Second, the heterogeneity criterion can also be achieved if at least one of the studies has been conducted on children in Washington, and a subgroup analysis demonstrates the program is effective for minorities (p-value < 0.20). Programs passing the second test are marked with a \wedge . Programs that do not meet either of these two criteria do not meet the heterogeneity definition. Programs whose evaluations do not meet either of these two criteria do not meet the heterogeneity definition.

No rigorous evaluation measuring outcome of interest: The program has not yet been tested with a rigorous outcome evaluation.

Single evaluation: The program does not meet the minimum standard of multiple evaluations or one large multiple-site evaluation contained in the current or proposed definitions.

Weight of evidence: To meet the evidence-based definition, results from a random-effects meta-analysis (p-value < 0.20) of multiple evaluations or one large multiple-site evaluation must indicate the practice achieves the desired outcome(s). To meet the research-based definition, one single-site evaluation must indicate the practice achieves the desired outcomes (p-value < 0.20).

Other Definitions:

Benefit-cost percentage:

Benefit-cost estimation is repeated many times to account for uncertainty in the model. This represents the percentage of repetitions producing overall benefits that exceed costs. Programs with a benefit-cost percentage of at least 75% are considered to meet the "cost-beneficial" criterion in the "evidence-based" definition above.

Suggested citation: Darnell, A., Goodvin, R., del Moral, S., Hicks, C., Wanner, P., & Westley, E. (2018). *Updated inventory of programs for the prevention and treatment of youth cannabis use*. (Document Number 18-12-3201). Olympia: Washington State Institute for Public Policy.

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Washington State Institute for Public Policy

The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs WSIPP and guides the development of all activities. WSIPP's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.

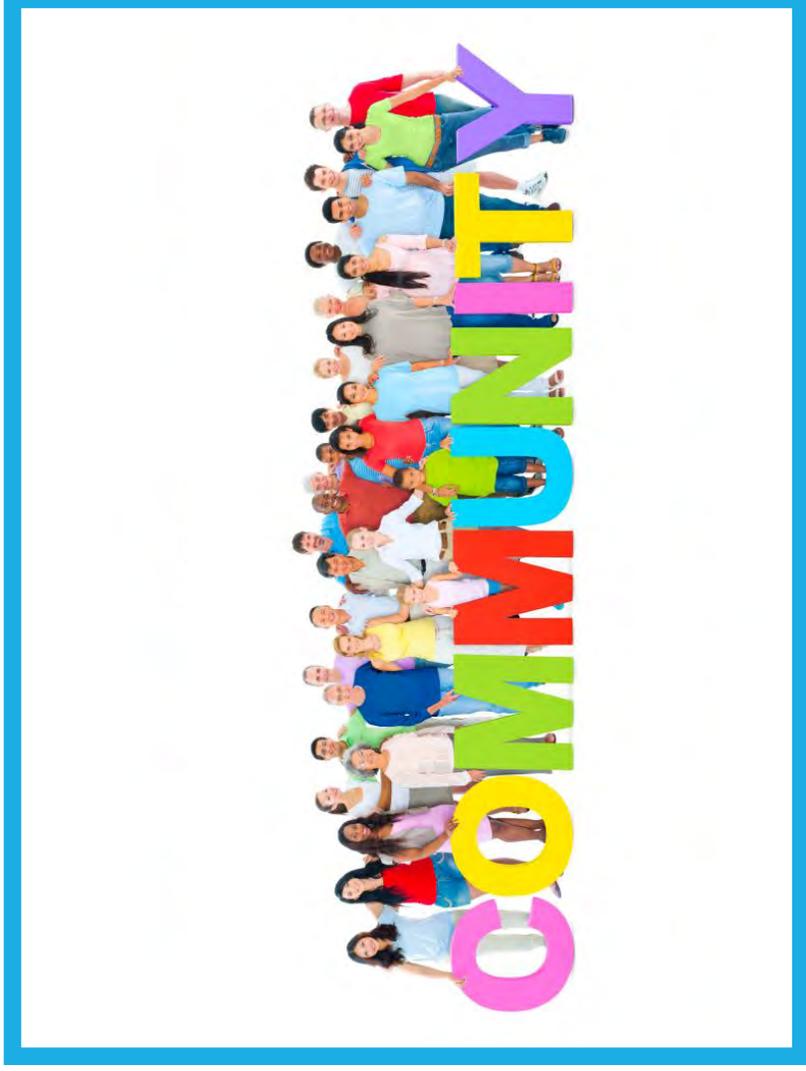
Overview & Introduction to the Programs

Kevin Haggerty, Ph.D., University of Washington
Brittany Rhoades Cooper, Ph.D., Washington State University

Presentation Overview

- Brief introduction to 24 programs on the DBHR list, organized by program type
 - Community-based (4)
 - School-based: Elementary (3), Middle School (7), High School (2)
 - Family-based (8)
 - Following each program type group, there will be an opportunity for discussion and questions related the programs in that group.
-
-

Community-based Programs



What is an Evidence Based program?

Attain strong evidence of positive program outcomes

- Conduct evaluation with random assignment (experimental design)
- Carry out multiple evaluations with strong comparison group (quasi-experimental design)

Obtain evidence of positive program outcomes

- Carry out evaluation with a comparison group
- Conduct regression analysis (quasi-experimental design)
- Perform multiple pre- and post = evaluations
- Meta-analysis

Produce indicators of positive outcomes

- Conduct pre- and post- intervention evaluation

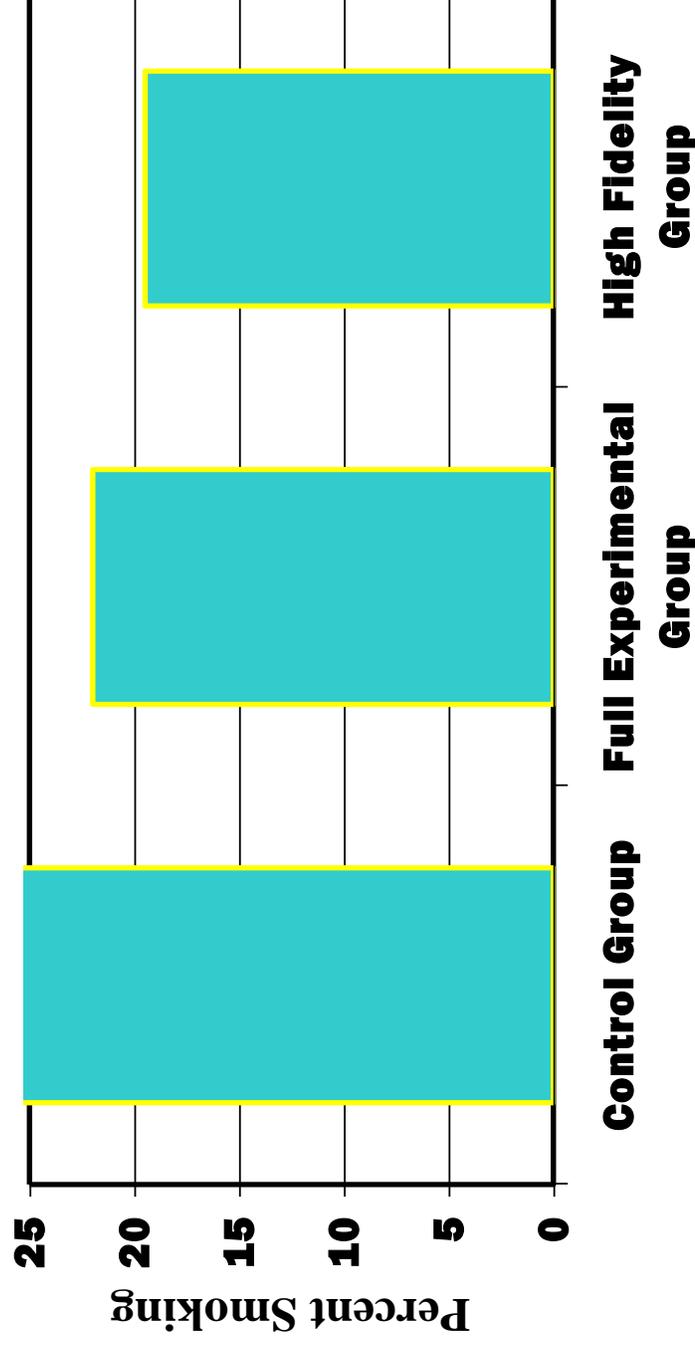
Ensure fidelity of implementation

- Evaluate program quality and process
- Establish continuous improvement system

Develop a strong program design

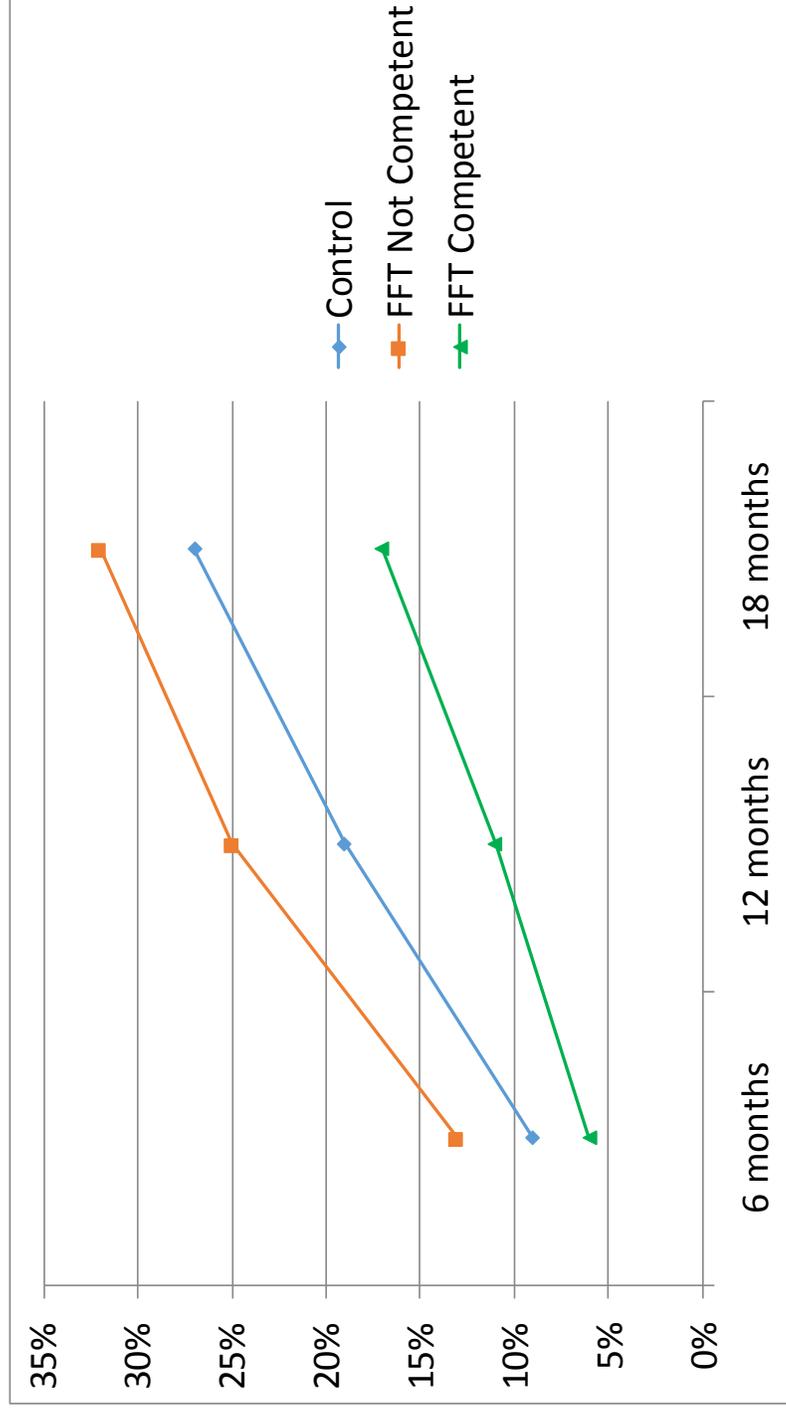
- Create logic model and replication materials

Effects of program fidelity on past month smoking reported by middle school students



Source: Botvin, Baker, Dusenbury, Botvin, & Diaz. (1995). JAMA, 273, 1106-1112.

Felony recidivism rates over time, by therapist competency



WSIPP: 2004

Project STAR (Midwest Prevention Project)

- **Target Audience:** young adolescents (aged 10-15)
- **Program Focus:** Community (e.g., religious, recreation) and School
- **Targeted Risk/Protective Factor(s):** Early initiation of drug use, Peer substance use, Parental attitudes favorable to drug use, Community disorganization, Laws and norms favorable to drug use/crime, Perceived availability of drugs, Clear standards for behavior, Perceived risk of drug use, Problem solving skills, Refusal skills, Skills for social interaction, Parent social support, Parental involvement in education
- **Proven Outcomes:**
 - Alcohol
 - Illicit Drug Use
 - Tobacco

For more information, please visit: www.blueprintsprograms.com

Project STAR

What are the program components?

- Five year comprehensive community-based, multifaceted program for adolescent drug abuse prevention that includes five components:
 1. *mass media*
 2. *school*,
 3. *parent*,
 4. *community*,
 5. *health policy*

What do participants learn?

- *mass media* about 31 television, radio, and print broadcasts per year.
- *school* initiated in grades 6 or 7, 10-session of youth educational program on skills training for resistance of drug use. Booster sessions the second year (grades 7 or 8).
- *parent* program, year 2, strives to develop family support and modeling for a non-drug use norm
- *community* plan and implement drug abuse prevention services and activities
- *health policy* actively implement policy change initiatives to reduce demand and limit supply of drugs.

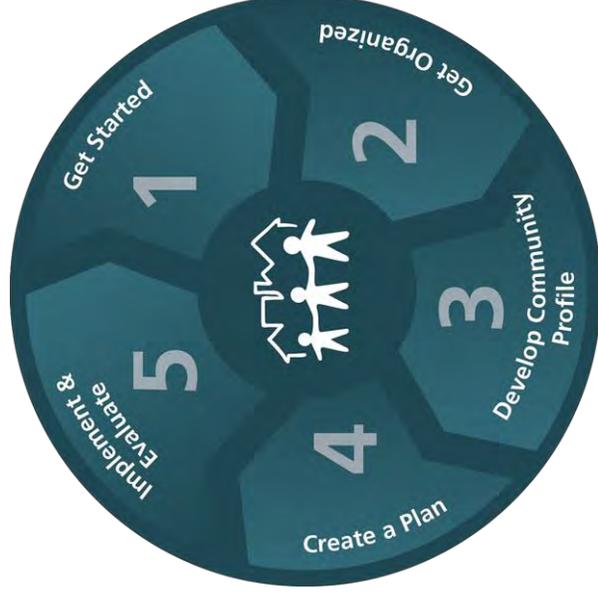


- **Target Audience:** Communities of 50,000-70,000 population
- **Program Focus:** Community Action to promote healthy development and prevent adolescent problem behaviors.
- **Targeted Risk/Protective Factor(s):** Community determines priority risk and protective factors based on CTC youth survey data.
- **Proven Outcomes:**
 - 33% less likely to initiate alcohol initiation three years later
 - 32% less likely to initiate tobacco initiation three years later
 - 25% less likely to initiate delinquent behavior three years later than 8th graders in control communities

For more information, please visit: www.wommunitiesthatcare.net

Communities that Care

What are the program components?



What do participants learn?

- Provides web based capacity building for communities to use prevention science to address their community needs with evidence based programs with strong implementation fidelity.

PROSPER

- **Target Audience:** Community—10-15 year olds
- **Program Focus:** A delivery system of Evidence Based Programs rather than a program
- **Targeted Risk/Protective Factor(s):** Favorable attitudes towards drug use* Interaction with antisocial peers, Poor family management, Perceived risk of drug use, Peer: Interaction with prosocial peers, Attachment to parents, Opportunities for prosocial involvement with parents, Parent social support
- **Proven Outcomes:**
 - Alcohol
 - Close Relationships with Parents
 - Delinquency and Criminal Behavior
 - Illicit Drug Use
 - Tobacco

For more information, please visit: www.blueprintsprograms.com

PROSPER

What are the program components?

- The program is best characterized by a school, community, and university partnership.

What do participants learn?

- Once formed, the local team is tasked to select evidenced-based, universal-level family-focused and school-based programs to implement with middle school youth and their families in the local school district.
-
-

Community-based Mentoring (based on Big Brothers/Big Sisters)

- **Target Audience:** 5-18 years old
- **Program Focus:** Mentoring
- **Targeted Risk/Protective Factor(s): Risk Factors:** Early initiation of antisocial behavior, Early initiation of drug use, Low school commitment and attachment, Poor academic performance, Academic self-efficacy, Prosocial behavior, Prosocial involvement, Family: Attachment to parents
- **Proven Outcomes:**
 - Alcohol
 - Antisocial-aggressive Behavior
 - Close Relationships with Parents
 - Close Relationships with Peers
 - Illicit Drug Use
 - Positive Social/Prosocial Behavior
 - Truancy - School Attendance

For more information, please visit: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=227>

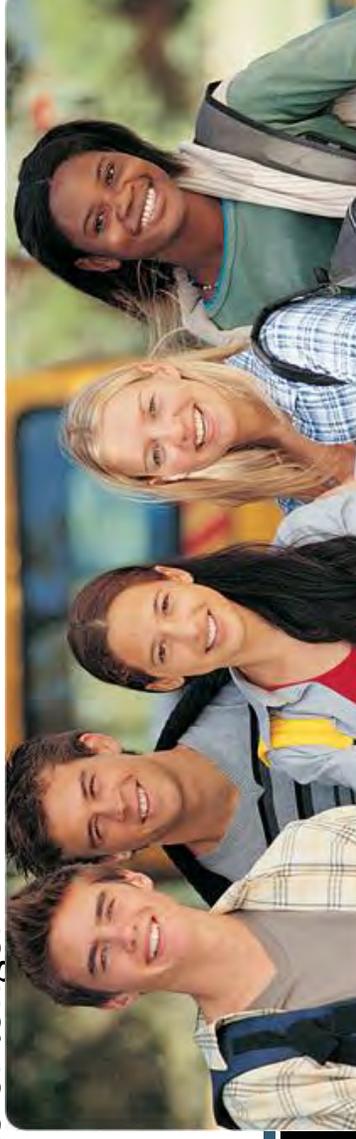
Community-based Mentoring

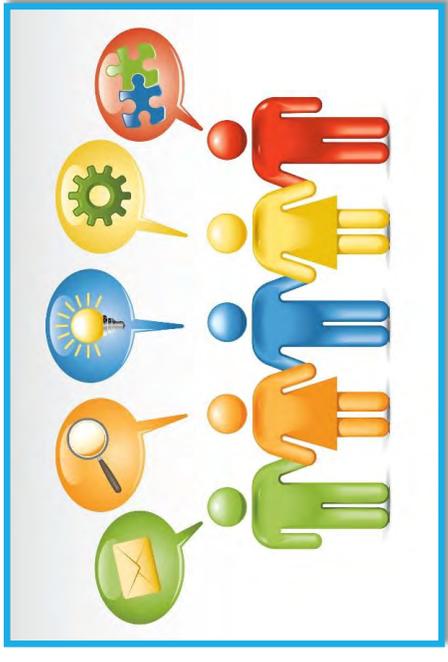
What are the program components?

- 1) recruitment; 2) screening; 3) training; 4) matching; 5) monitoring and support; and 6) closure.
- Mentors are expected to meet with the child at least 3-5 hours per week for a period of 12 months or longer

What do participants learn?

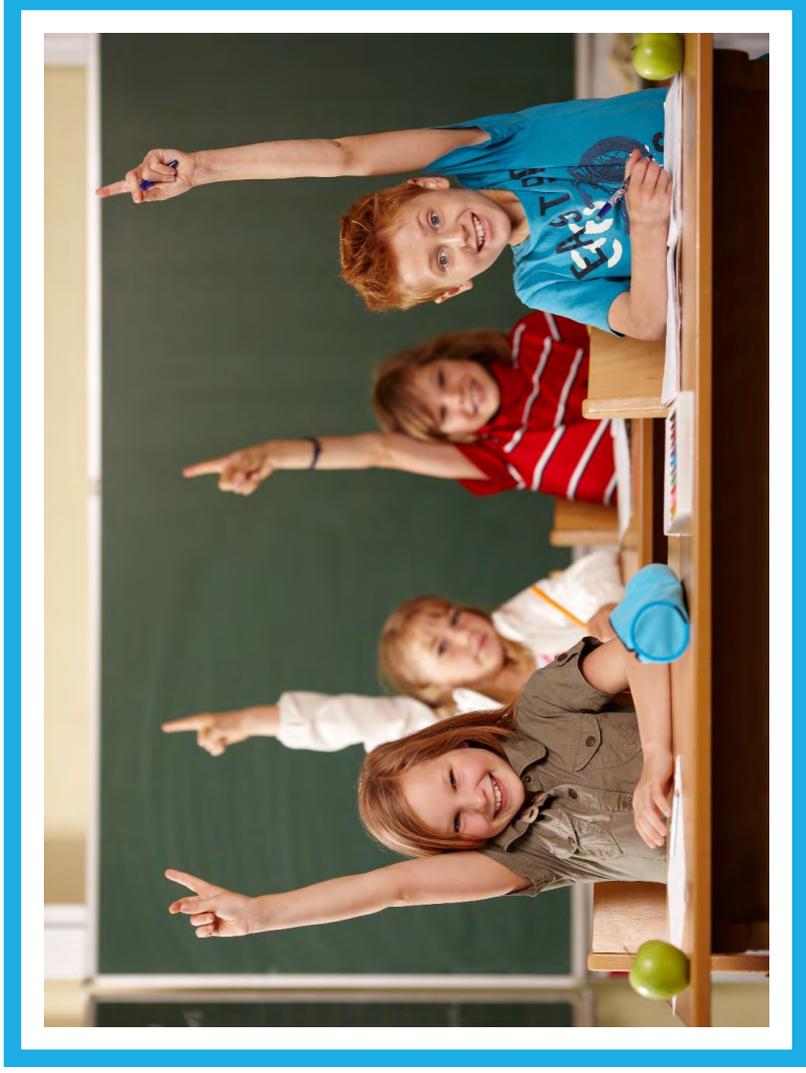
- Relationship development
- Goal setting
- Practice toward goals





Community-based Programs: Group Discussion

School-based Programs Elementary School



Good Behavior Game (GBG)

- **Target Audience:** Elementary school children (ages 5-11)
- **Program Focus:** Classroom-based behavioral management
- **Targeted Risk/Protective Factor(s):** early initiation of antisocial behavior, opportunities for prosocial involvement
- **Proven Outcomes (at 14-year follow-up):**
 - Reduced lifetime alcohol abuse/dependence and antisocial behavior
 - For males, reduced smoking and lifetime illicit drug use

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=201>

Good Behavior Game (GBG)

What are the program components?

- Classroom-wide game format with teams and rewards
- GBG is played 3x/week for 10 minutes
- Game periods are increased in length and frequency over time

What do participants learn?

- Classroom rules, team membership, self and team behavior monitoring, positive reinforcement
-
-

Case Management in Schools

(Communities in Schools, City Connects, Comer School Development Program)

- **Target Audience:** K-12th grade
- **Program Focus:** School-wide system for student support
- **Targeted Risk/Protective Factor(s):** School engagement, school climate
- **Proven Outcomes:**
 - Increased academic success
 - Decreased school drop-out

For more information, please visit the individual program websites.

Communities in Schools:

<http://www.communitiesinschools.org/>

City Connects:

<http://www.bc.edu/schools/lsoe/cityconnects/>

Comer School Development Program:

<http://medicine.yale.edu/childstudy/comer/>

Case Management in Schools

(Communities in Schools, City Connects, Comer School Development Program)

What are the program components?

- Case management involves placing a full-time social worker or counselor in a school to help identify at-risk students' needs and connect them and their families with relevant school and community services.
- Each model includes other services, but the program evaluations focus on the impact of the case management component.

What do participants learn?

- Students benefit from a community of support.
 - Services are tailored to their needs.
 - They are connected to needed services within and outside the school system.
-

Curriculum-Based Support Group Program

- **Target Audience:** Children, adolescents
- **Program Focus:** Group support intervention for at-risk youth
- **Targeted Risk/Protective Factor(s):** Attitudes favorable towards drug use*, intentions to use drugs*, antisocial attitudes
- **Proven Outcomes:**
 - Decreases in antisocial attitudes and self-reported rebellious behavior
 - Increases in anti-substance use attitudes and intentions

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=185>

*Youth marijuana use-related risk/protective factor

Curriculum-Based Support Group Program

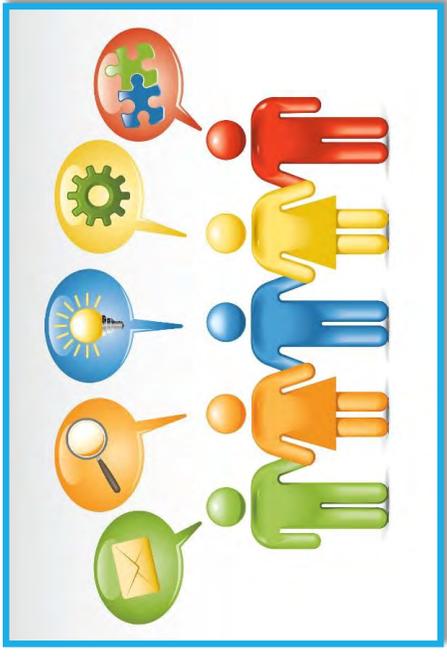
What are the program components?

- 1-hour support group sessions (6-10 participants) delivered over 10-12 weeks
- Lesson content and objectives are tailored for age and developmental status
- Trained adult facilitators and co-facilitators

What do participants learn?

- Essential life skills to cope with difficult family situations, resist peer pressure, set and achieve goals, refuse ATOD, reduce antisocial attitudes and rebellious behavior





Elementary School-based Programs: Group Discussion

- 1) Of the programs reviewed, which one would be a good fit for your community?
- 2) What implementation challenges do you anticipate with this program?

School-based Programs Middle School



LifeSkills Training

- **Target Audience:** Early adolescence (11-14 year olds)
- **Program Focus:** Universal, classroom-based, social competence promotion & drug abuse prevention curriculum
- **Targeted Risk/Protective Factor(s):** early initiation, student favorable attitudes toward use*, peer use*, laws and norms, refusal and coping skills
- **Proven Outcomes:**
 - Reductions in student tobacco, alcohol and marijuana use (50-75%)
 - Effects maintained through 12th grade

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=109>

*Youth marijuana use-related risk/protective factor

LifeSkills Training

What are the program components?

- 30 lessons taught over 3 years
- 6th or 7th grade: 15 class lessons
- 7th or 8th grade: 10 class lessons
- 8th or 9th grade: 5 class lessons

What do participants learn?

- Through instruction, demonstration, feedback, reinforcement and practice, they learn:
 - Drug resistance skills
 - Self-management skills
 - Social skills
-

Lions Quest Skills for Adolescence

- **Target Audience:** ages 10-14, grades 6th-8th
- **Program Focus:** Universal, classroom-based, substance use prevention curriculum
- **Targeted Risk/Protective Factor(s):** Student favorable attitudes toward use*
- **Proven Outcomes:**
 - Increased school success (e.g., higher GPA)
 - Reductions in youth marijuana use (lifetime and 30-day)

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=24>

Lions Quest Skills for Adolescence

What are the program components?

- 80, 45-minute sessions
- Integrated into existing subject areas or taught as stand alone
- Executed as 9-week mini course or over entire school year

What do participants learn?

- Through inquiry, presentation, discussion, group work, guided practice, service-learning, and reflection, they learn:
 - Accepting responsibility
 - Communicating effectively
 - Setting goals
 - Making health decisions
 - Resisting pressure to use substances
-

Keepin' It REAL

- **Target Audience:** Children, adolescents (multicultural)
- **Program Focus:** Universal, classroom-based, substance use prevention curriculum
- **Targeted Risk/Protective Factor(s):** Anti-substance use attitudes*, normative beliefs about substance use, substance use resistance
- **Proven Outcomes:**
 - Self-reported reductions in alcohol, marijuana, and cigarette use
 - Greater use of strategies to resist marijuana and cigarette use

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=133>

*Youth marijuana use-related risk/protective factor

Keepin' It REAL

What are the program components?

- 10-lesson curriculum taught by trained classroom teachers
- 45-minute sessions over 10 weeks
- Booster sessions delivered in the following school year
- 5 videos developed by kids for kids

What do participants learn?

- Students learn to think critically and communicate effectively
 - Lessons address risk assessment, decision making, conflict resolution and drug refusal
-
-

SPORT Prevention Plus Wellness

- **Target Audience:** Adolescents
- **Program Focus:** Universal, integrated health promotion and substance abuse prevention program
- **Targeted Risk/Protective Factor(s):** exercise, perceived risk of use*
- **Proven Outcomes:**
 - Drug-using students showed significant positive effects on alcohol consumption, and current and past drug use (cigarette smoking, mj use)
 - Positive effects for past cigarette and marijuana use at 12-month follow-up

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=342>

*Youth marijuana use-related risk/protective factor

SPORT Prevention Plus Wellness

What are the program components?

- In-person health behavior screen
- One-on-one consultation (e.g., teacher, coach etc.)
- Take-home fitness prescription targeting health promoting behaviors
- Flyers addressing key content are provided to parents/caregivers for 4 weeks after the intervention

What do participants learn?

- Promotes the benefits of an active lifestyle
- Emphasizes substance abuse as counterproductive to achieving positive image and behavior goals

Athletes Training and Learning to Avoid Steroids (ATLAS)

- **Target Audience:** High school athletes
- **Program Focus:** School-based program to promote nutrition and exercise as an alternative to drug use
- **Targeted Risk/Protective Factor(s):** Favorable attitudes toward use*, substance use*, peer use*, perceived risk of use*, refusal skills
- **Proven Outcomes:**
 - Reduced use of alcohol and illicit drugs
 - Decreased intent to use anabolic steroids

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=77>

*Youth marijuana use-related risk/protective factor

Athletes Training and Learning to Avoid Steroids (ATLAS)

What are the program components?

- 10, 45-minute interactive classroom sessions
- 3 exercise training sessions facilitated by peer educators, coaches, and strength trainers

What do participants learn?

- Sports nutrition
 - Exercise alternatives to steroids and supplements
 - Effects of substance abuse in sports
 - Drug refusal role-playing
 - Health promotion messages
-

Positive Action

- **Target Audience:** Pre K-12th grade
- **Program Focus:** Universal, school-based social emotional learning curriculum
- **Targeted Risk/Protective Factor(s):** Early initiation of drug use*, favorable attitudes towards drug use*, peer use*, perceived risk for use*, school commitment, attachment, and achievement
- **Proven Outcomes:**
 - Less substance use at grade 8 (mediated by social emotional development)
 - Increased social emotional and character development

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=400>

*Youth marijuana use-related risk/protective factor

Positive Action

What are the program components?

- 6 units, grade-specific toolkits for PreK through 12th grade
- 15-minute scripted lessons, 2-4 times a week
- Drug education, conflict resolution, sitewide climate development kits
- Counselor's, family, and community kit

What do participants learn?

- Positive actions and skills needed to achieve academically and in life (physical, intellectual, social, emotional)
 - Social Emotional skills
 - Family bonding
 - Conflict resolution
-
-

Project Northland

- **Target Audience:** Adolescents, parents, and communities
- **Program Focus:** Universal, multi-level substance use prevention
- **Targeted Risk/Protective Factor(s):** Student & parent favorable attitudes toward use*, peer use*, laws and norms, perceived availability, refusal skills, opportunities for prosocial involvement
- **Proven Outcomes:**
 - Adolescents were less likely to drink, smoke, use marijuana
 - Parents were more likely to communicate alcohol-related rules and expectations

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=25>

*Youth marijuana use-related risk/protective factor

Project Northland

What are the program components?

- Classroom curricula, peer leadership, parent involvement, community activism
- 6th grade: Student-parent homework, in-class discussions, community-wide task force
- 7th grade: peer and teacher-led discussion, games, role-plays
- 8th grade: peer-led small group work, community-based projects, mock town meeting

What do participants learn?

- Students learn to negotiate social influences related to alcohol use.
 - Parents learn how to communicate their alcohol use-related concerns to their adolescents.
 - Communities learn how to make alcohol more difficult for students to obtain.
-

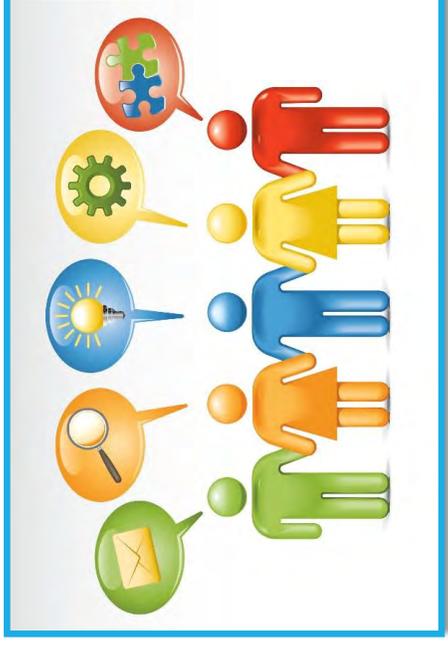
Project Northland (plus [Class Action](#))

What are the program components?

- High school component
- Teens divided into Class Action legal teams to prepare and present hypothetical cases in which someone has been harmed as a result of underage drinking

What do participants learn?

- Real-world social and legal consequences involving teens and alcohol
 - Drinking & Driving
 - Fetal Alcohol Syndrome
 - Drinking & Violence
 - Drinking & Rape
 - Drinking & Vandalism
 - School Alcohol Policies
 - Drinking & Hazing
 - Binge Drinking



Middle School-based Programs: Group Discussion

- 1) Of the programs reviewed, which one would be a good fit for your community?
- 2) What implementation challenges do you anticipate with this program?

School-based Programs High School



Project Towards No Drug Abuse

- **Target Audience:** High school youth (ages 14-19)
- **Program Focus:** Classroom-based drug prevention curriculum
- **Targeted Risk/Protective Factor(s):** Favorable attitudes toward use*, peer use*, health beliefs and standards, social competencies and problem solving skills
- **Proven Outcomes:**
 - Reduction in alcohol and tobacco use
 - Reduction in marijuana and “hard drug” use

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=21>

*Youth marijuana use-related risk/protective factor

Project Towards No Drug Abuse

What are the program components?

- 12 interactive 40-minute sessions
- Implemented over 4 weeks
- Topics include:
 - Active listening
 - Effective communication skills
 - Stress management
 - Coping skills
 - Tobacco cessation techniques
 - Self-control

What do participants learn?

- Motivation to not use drugs
 - Information about social and health consequences of drug use
 - Self-control and communication skills
-

Teen Intervene

- **Target Audience:** Adolescents (12-19 year olds) and parents
- **Program Focus:** Brief, targeted early substance use intervention
- **Targeted Risk/Protective Factor(s):** Substance use*, negative consequences associated with use
- **Proven Outcomes:**
 - Reduction in the frequency of alcohol and marijuana use (at 6 months)
 - Higher rate of participants abstaining in the last 90 days

For more information, please visit: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=287>

*Youth marijuana use-related risk/protective factor

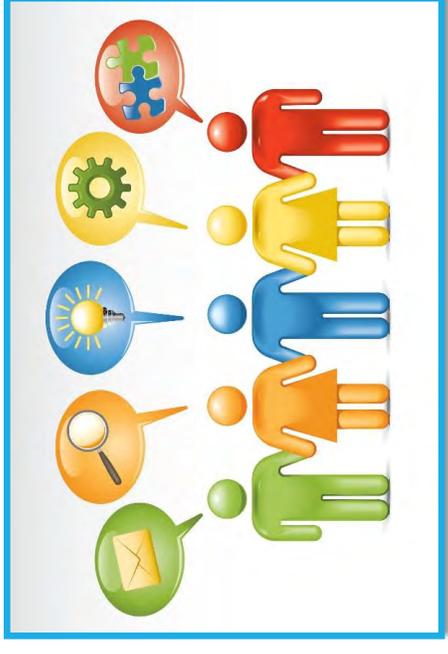
Teen Intervene

What are the program components?

- Three, 1-hour sessions conducted 10 days apart
 - Session 1 examines costs and benefits of substance use with teen
 - Session 2 assess progress and discusses strategies to overcome barriers
 - Session 3 works with parents to discuss parent-child communication and discipline strategies
- Typically administered in an outpatient, school, or juvenile detention setting by a trained professional

What do participants learn?

- Setting goals for behavior change
 - Strategies to overcome barriers
 - Parent-child communication and discipline strategies
-
-



High School-based Programs: Group Discussion

- 1) Of the programs reviewed, which one would be a good fit for your community?
- 2) What implementation challenges do you anticipate with this program?

Family-based Programs





- **Target Audience:** 0-2 year olds
- **Program Focus:** Single, first time, low income mothers
- **Targeted Risk/Protective Factor(s):** Family: Family conflict/violence, Family history of problem behavior, Low socioeconomic status, Parental attitudes favorable to antisocial behavior, Parental attitudes favorable to drug use, Poor family management,
- **Proven Outcomes:**
 - Child Maltreatment
 - Delinquency and Criminal Behavior
 - Early Cognitive Development
 - Internalizing
 - Mental Health –
 - Physical Health and Well-Being
 - Preschool Communication/Language Development
 - Reciprocal Parent-Child Warmth

For more information, please visit: www.blueprintsprograms.com

Nurse Family Partnership

What are the program components?

- Begins during pregnancy as early as is possible and continues through the child's second birthday.
- Nurses work with low-income pregnant mothers bearing their first child to improve the outcomes of pregnancy, improve infant health and development, and improve the mother's own personal life-course development through instruction and observation during home visits.
- Visits generally occur every other week and last 60-90 minutes.

What do participants learn?

- improving women's diets;
- helping women monitor their weight gain and eliminate the use of cigarettes, alcohol, and drugs;
- teaching parents to identify the signs of pregnancy complication;
- encouraging regular rest, appropriate exercise, and good personal hygiene related to obstetrical health;
- preparing parents for labor, delivery, and early care of the newborn.

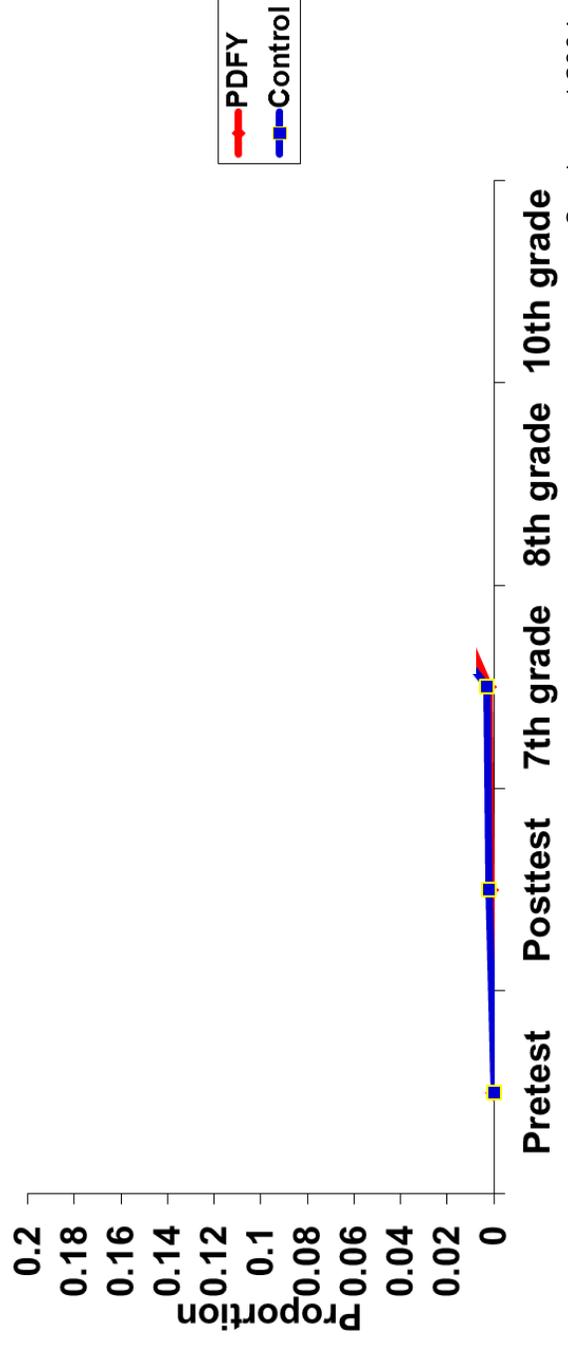


Program Name

- **Target Audience:** Guiding Good Choices
- **Program Focus:** Parents of 4th-8th grade students
- **Targeted Risk/Protective Factor(s):** Early initiation, favorable attitudes toward antisocial behavior, Parental attitudes favorable toward use, Family Management Problems.,
- **Proven Outcomes:**
 - 4 years later increased the likelihood that non-users would remain drug free by 28%
 - **Reduced alcohol and marijuana use by 40.6%.**
 - Reduced progression to more serious substance abuse by 54% six years later.

For more information, please visit: www.blueprintsprograms.com

New User Proportions for Marijuana Use by Experiment Conditions



Spoth, et al. 2004.

Guiding Good Choices

What are the program components?

- Five two hour interactive sessions,
- Children attend the third session on Refusal skills
- Conducted by certified workshop leaders

How do participants learn?

Strengthens parents' skills to:

- build family bonding,
 - establish and reinforce clear and consistent guidelines for children's behavior,
 - teach children skills to resist peer influence,
 - improve family management practices, and
 - reduce family conflict.
-
-



- **Target Audience:** Parents
- **Program Focus:** Children 3-8 years old
- **Targeted Risk/Protective Factor(s):** Early initiation of antisocial behavior, Hyperactivity, Family: Family history of problem behavior, Neglectful parenting, Parent aggravation, Parent stress, Poor family management, Psychological aggression/discipline, Violent discipline, Clear Standards for Behavior, Problem Solving Skills

Outcomes

- Antisocial-aggressive Behavior
- Close Relationships with Parents
- Conduct Problems
- Depression
- Externalizing
- Internalizing
- Positive Social/Prosocial Behavior

For more information, please visit: www.blueprintsprograms.com

What are the program components?

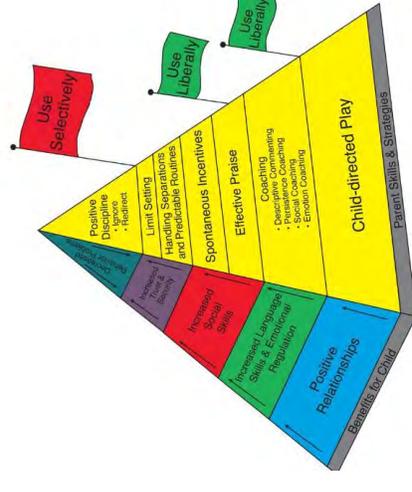
- Baby and Toddler Program (0-2 ½ years),
- Preschool Program (3-5 years) and
- School Age Program (6-12 years).
- Delivered in weekly group sessions for 3-5 months

ADVANCE Program

- Incredible Years—Teachers
- Incredible Years—Child Treatment

What do participants learn?

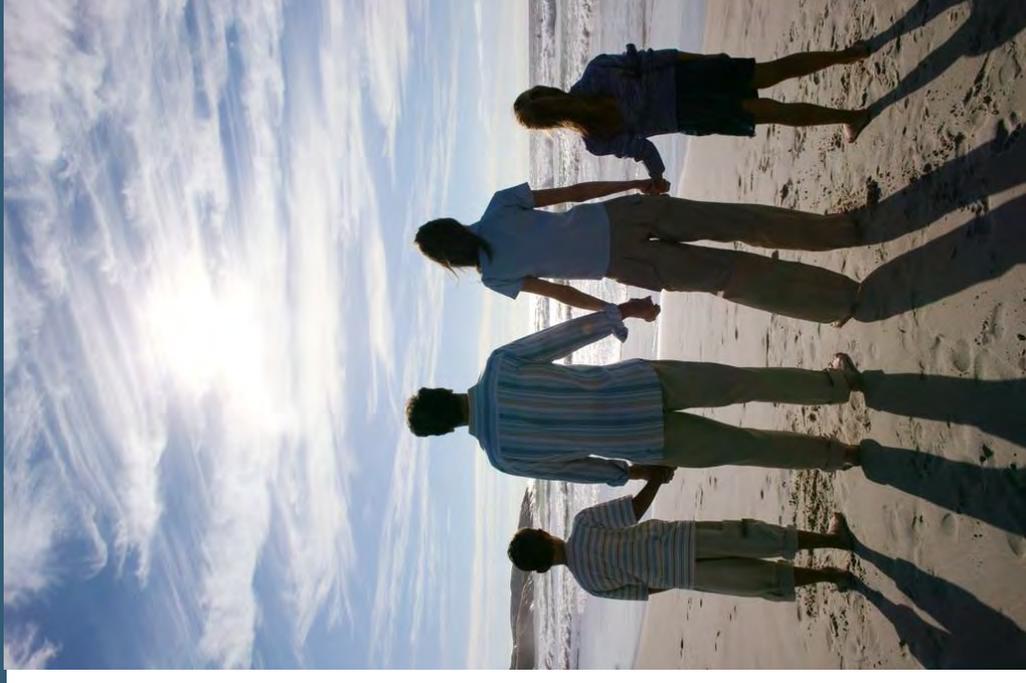
- child directed play with children; academic,
- persistence,
- social and emotional coaching methods;
- using effective praise and incentives
- setting up predictable routines and effective limit-setting;
- handling misbehavior with proactive discipline
- teaching children to problem solve.



Parenting Pyramid
 Toddlers (1 - 3 years)



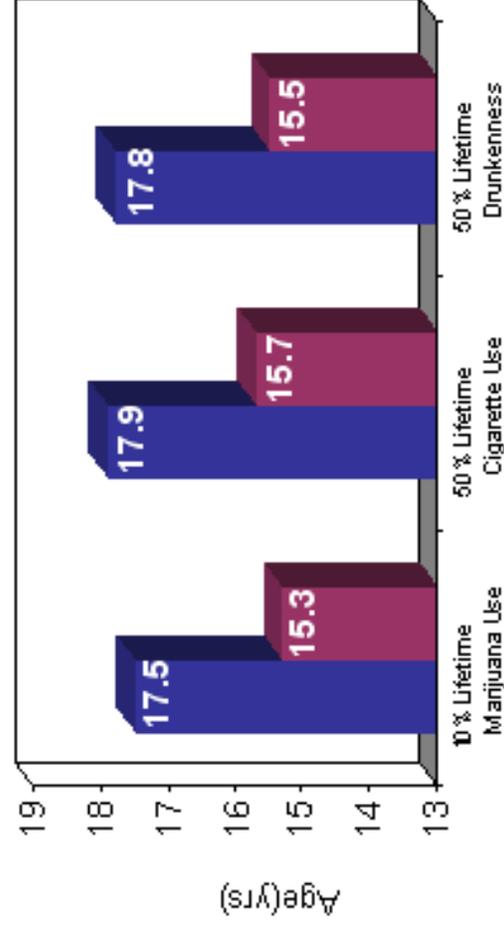
- **Target Audience:** Parent and children 10-14
- **Program Focus:** Strengthening Families
- **Targeted Risk/Protective Factor(s):** Early initiation, favorable attitudes toward antisocial behavior, Parental attitudes favorable toward use, Family Management Problems.,
- **Proven Outcomes:**
 - Alcohol
 - Antisocial-aggressive Behavior
 - Close Relationships with Parents
 - Illicit Drug Use (marijuana specific)
 - Internalizing
 - Tobacco



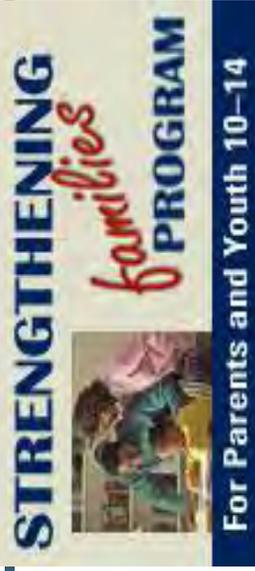
For more information, please visit: www.blueprintsprograms.com

Iowa Strengthening Families Effects on age of first use of Marijuana, Cigarettes, and Drunkenness

Age of Substance Initiation



■ Partnership-based Iowa Strengthening Families Program Youth ■ Control Group Youth



What are the program components?

- Seven weekly, two-hour sessions
- Separate parent and child skills-building followed by a family session where parents and children practice skills just learned work on
 - conflict resolution
 - communication,
 - engage in activities to increase family cohesiveness,
 - positive involvement of the child in the family.
- Sessions are led by three-person teams and average eight families per session.

What do participants learn?

- Parents learn to clarify expectations, use appropriate discipline, managing strong emotions, and effective communication.
- Children learn refusal skills and other social skills.



Familias Unidas

- **Target Audience:** 12-18 year olds
- **Program Focus:** multilevel family-based intervention designed to prevent problem behaviors in Hispanic adolescence
- **Targeted Risk/Protective Factor(s):** Early initiation of antisocial behavior, substance use, low socioeconomic status, Poor family management, low school commitment and attachment,

Proven Outcomes:

- Externalizing
- Illicit Drug Use
- Sexual Risk Behaviors

For more information, please visit: www.blueprintsprograms.com

Familias Unidas

What are the program components?

- The multi-parent groups, led by a trained facilitator,
- 8 to 9 weekly 2-hour sessions for the duration of the intervention.
- Each group has 10 to 15 parents, with at least 1 parent from each participating family.
- The program also includes 4 to 10 1-hour family visits

What do participants learn?

- Hispanic immigrant parents are empowered to first build a strong parent-support network and then use the network to increase
 - knowledge of culturally relevant parenting,
 - strengthen parenting skills,
 - apply these new skills in a series of activities





Coping Power

- **Target Audience:** Parents and Youth
- **Program Focus:** Youth 5-11 years old
- **Targeted Risk/Protective Factor(s):** Early initiation, favorable attitudes, poor family management, peer substance abuse, academic failure, low commitment to school
- **Proven Outcomes:**
 - Alcohol use
 - Antisocial-aggressive Behavior
 - Delinquency and Criminal Behavior
 - Illicit Drug Use

For more information, please visit: www.blueprintsprograms.com

Coping Power

What are the program components?

16-month program delivered during the 5th and 6th grade school years.

Children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade.

Groups are led by a school-family program specialist and a guidance counselor. Children also receive half hour individual sessions once every two months.

Parents attend 11 group sessions during their children's 5th grade year and 5 sessions during the 6th grade year.

What do participants learn?

Child component emphasizes

- problem-solving and
- conflict management techniques,
- coping mechanisms,
- positive social supports, and
- social skill development.

Raising Healthy Children (SSDP model)

- **Target Audience:** 1st-6th grade students
- **Program Focus:** Teachers, Parents, Students
- **Targeted Risk/Protective Factor(s):** Early initiation of antisocial behavior, Favorable attitudes towards antisocial behavior, drug use, Interaction with antisocial peers, Family conflict/violence, Parental attitudes favorable to antisocial behavior, drug use, Poor family management, Low school commitment and attachment, Poor academic performance
- **Proven Outcomes:**
 - Academic Performance
 - Alcohol
 - Antisocial-aggressive Behavior
 - Illicit Drug Use
 - Prosocial with Peers

For more information, please visit: www.blueprintsprograms.com

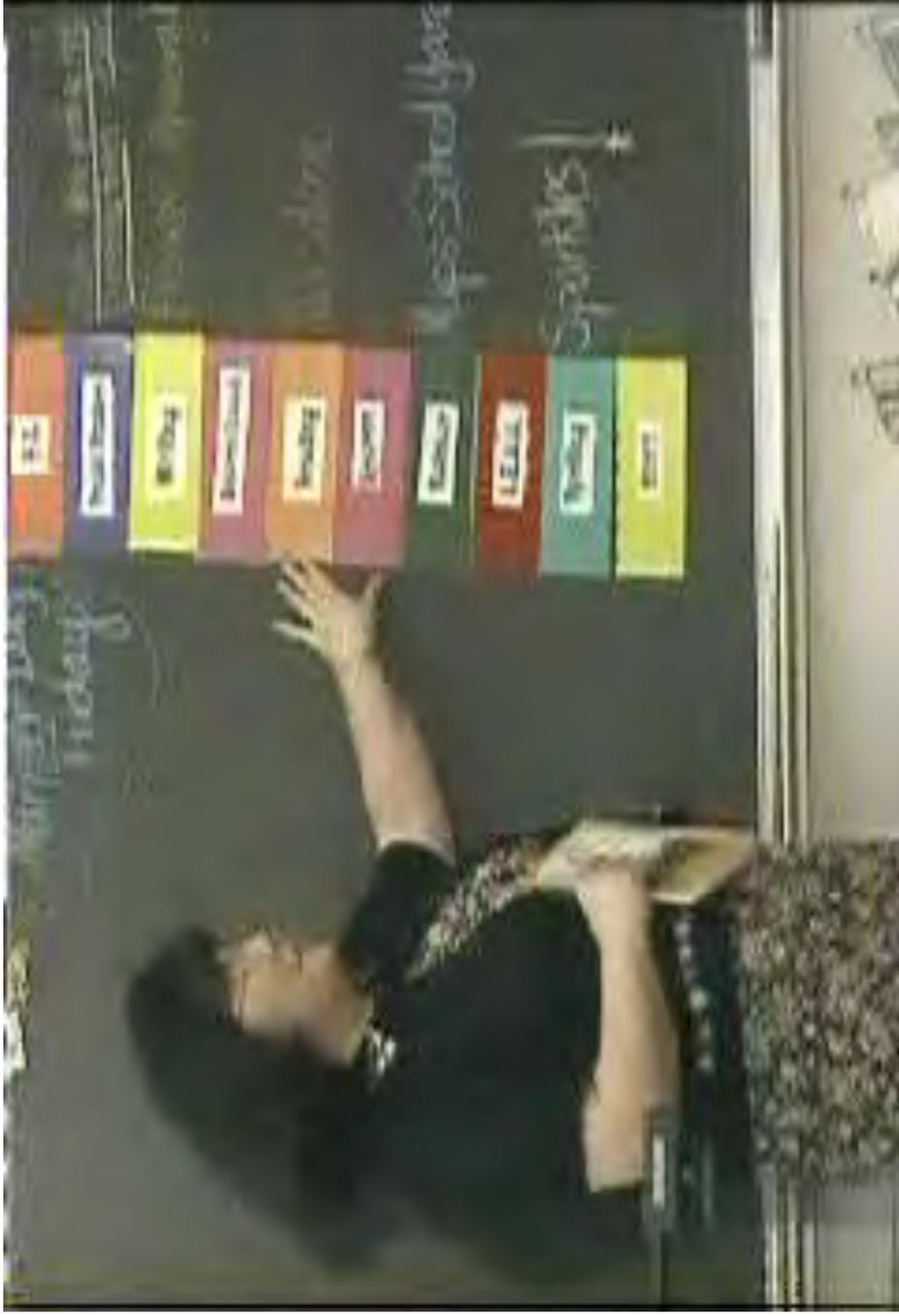
Raising Healthy Children (SSDP model)

What are the program components?

- Teacher training over three years:
 - Proactive management,
 - Cooperative Learning
 - Social/Emotional Skills,
 - Motivation,
 - Instructional Strategies
- Parent Trainings
 - Raising Healthy Children
 - Supporting School Success
 - Guiding Good Choices
- Student
 - Social Emotional Learning

What do participants learn?

A preventive intervention with teacher, parent, and child components, designed to promote positive youth development by enhancing protective factors, reducing identified risk factors, and preventing problem behaviors and academic failure.



Strong African American Families

- **Target Audience:** 11-13 years
- **Program Focus:** Black, rural, families
- **Targeted Risk/Protective Factor(s):** Favorable attitudes towards drug use, Family conflict/violence, Parental attitudes favorable to antisocial behavior, Parental attitudes favorable to drug use, Poor family management, Clear standards for behavior, Refusal skills, Attachment to parents
- **Proven Outcomes:**
 - Alcohol
 - Close Relationships with Parents
 - Delinquency and Criminal Behavior
 - Truancy - School Attendance

For more information, please visit: www.blueprintsprograms.com

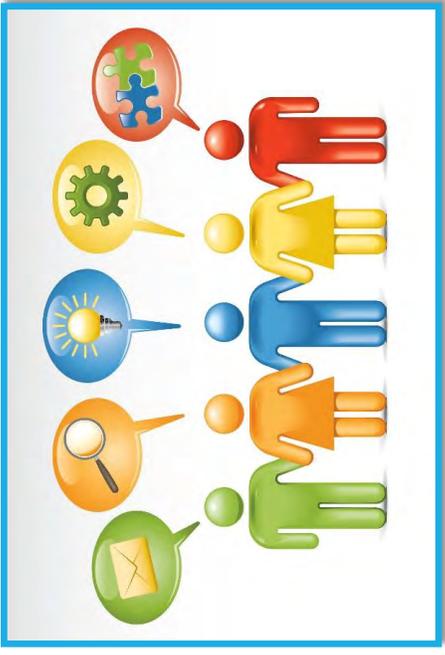
Strong African American Families

What are the program components?

- 7-week interactive educational program for African American parents and their early adolescent children.
- Each session includes three modules - Caregiver, Youth, and Family. SAAF modules are an hour each.
- One facilitator leads the Parent/Caregiver Sessions, while two facilitators share the responsibility of leading the Youth Sessions. All three facilitators lead Family Sessions

What do participants learn?

- (1) the development of a supportive and structured family environment that promotes positive parent-child relationships,
- (2) enhancing parental engagement in parenting that involves high levels of monitoring and support, strong communication about risk behavior such as substance use and sex, and racial socialization,
- (3) preparing youth to resist substance use and other risk behavior by maintaining a future orientation, enhancing risk behavior resistance skills, and accepting parental influences.



Family-based Programs: Group Discussion