Appendix

Supportive Mental Health for Students Funding Committee

DOUGLAS COUNTY
COLORADO

Report to the Board of Douglas County Commissioners

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Supportive Mental Health for Students Funding Committee
Member Biographies

Keith Sousa is a licensed school psychologist who has served in DCSD for over 15 years. He has been a member of the Behavior Support Team since 2007 and the Lead Behavior Specialist since 2010. Additionally, Keith is a Master Level CPI instructor and helps instruct numerous professional development classes. As part of his lead role, Keith supervises numerous Registered Behavior Technicians, including a Lead Technician and 8 Coaches. He also works with the other eight Behavior Specialists and serves several schools in the Douglas County High School feeder area. Keith has bachelor's degrees in Elementary Education and Psychology from Southern Connecticut State University and a master's degree and Certificate of Advanced Study from Fairfield University.

Julie Felske has been a School Psychologist for 10 years, working in Illinois and Colorado. For the past six years she has worked in this position at Platte River Academy, a kindergarten through eighth grade charter school in Highlands Ranch. Julie received her undergraduate degree in Sociology, with a minor in Psychology, at Trinity University in San Antonio, TX. She earned her master's in School Psychology from Governors State University in University Park, IL. She currently resides in Douglas County with her husband. They have two children who graduated from Mountain Vista High School.

Sarah Ericson is the Director of Diversion in the 18th Judicial District Attorney's Office. She oversees a staff of 16 providing therapeutically based diversion programming for over 600 juveniles and adults a year. Sarah has been a prosecutor with the DA's office since 2002 and has spent 12 years focused on juvenile justice. She participates in collaborative efforts to improve the juvenile justice system at the state, county and community level. Sarah is a Colorado native and alumni of the University of Colorado-Boulder. She earned her JD at Emory University School of Law.

Shelly Sack attended and graduated from the University of Northern Colorado in 1988 where she received a Bachelor of Science in Human Rehabilitative Service with an emphasis in juvenile and adult corrections, along with a minor in psychology. She began her professional career in 1988 with Arapahoe County Judicial Services. In 1990, she began her career with the 18th Judicial District Probation Department as an alcohol evaluator. Then in 1992, she was assigned a juvenile supervision caseload. Beginning in 1997, she was afforded the opportunity to create and supervise the 18th Judicial District's SB-94 Pre-Trial Release program. In 2007, she returned to probation and was promoted to a supervisor position. In 2009, she was promoted to Deputy Chief Probation Officer in the 18th Judicial District and currently remains in this position working closely with the Chief Probation Officer regarding day to day operations of the probation department. She is responsible for the department's juvenile programming and oversight. She has 29 years of experience working in the criminal justice field and serves on several committees, both at the state and local level, focused on best practices and improved outcomes for both our juvenile and adult population. She is a native of Colorado and has been a resident of Douglas County for 15 years with her two sons graduating from Mountain Vista High School.

Supportive Mental Health for Students Funding Committee Member Biographies

Dr. Stephanie Crawford-Goetz is a school psychologist and licensed psychologist working in schools for over 15 years. She serves as the Director of Mental Health, a role she began in March 2018. She joined DCSD in July 2012 and had previously served as a mental health provider at Plum Creek Academy and the district's autism program, an autism specialist, the autism team lead, and mental health coordinator. Dr. Crawford is a proud graduate of Oklahoma State University with a Bachelor of Science in Psychology, a Master of Science in Applied Behavioral Studies, and a PhD in Educational Psychology with a Specialization in School Psychology. She also has a principal certification from Lamar University in Texas. Dr. Crawford provides oversight for all school based mental health services. She oversees the autism and behavior team. She works closely with district leads, coordinators and directors to ensure best practices district-wide regarding mental health services, crisis prevention and intervention. She also serves as a liaison to district stakeholders, community agencies and universities.

Jason Hopcus is a motivator and catalyst for cultural change within current mental health systems as president/CEO of NAMI, the National Alliance of Mental Illness, Arapahoe/ Douglas Counties. Through lived and professional experience, he believes that connection to one's self, one's work and one's passion allows individuals to live a wholly authentic and full life. He creates systems of people working to deepen their relationships to work, play and ultimately our world. This vision shifts the way an organization leads, which effectively increases efficiency, and improves productivity, while having a positive impact on overall culture. As a catalyst for this cultural shift, Jason has helped leaders, health care organizations, nonprofits, mental health advocacy groups and private businesses alike. Through connection and growth, an organization can improve its culture to create a better working world – not only for the organization, but the community surrounding it. Through singular focus on the individual, he creates expansion and a system of 'next level' social responsibility.

Dr. Sarah Davidon joined Mental Health Colorado as the Research Director in 2017 and additionally leads the organization's child and adolescent mental health strategy. She also is an assistant professor at the University of Colorado School of Medicine. Dr. Davidon is a graduate of Bryn Mawr College, holds a master's degree from the Harvard University Graduate School of Education, and received her doctorate from the University of Colorado School of Education and Human Development in educational equity. Dr. Davidon is recognized for her work in both early childhood and school-age mental health system design and strategy, working with organizations in Colorado and across the country to improve how children's mental health is understood and addressed. She currently has a Governor's appointment to the Children's Mental Health Subcommittee of the Colorado Behavioral Health Task Force, has held a Governor's appointment to Colorado's Behavioral Health Transformation Council, served on the advisory board of Family Voices Colorado, and is past president of the Colorado Federation of Families for Children's Mental Health.

Supportive Mental Health for Students Funding Committee Member Biographies

Erin White serves as the site director for Manna Connect. Since 2009, she has worked in the field of social work, focused on the areas of poverty, homelessness, foster care and adoption. Erin feels called to serve her neighbors and work to help them break down barriers in order to reach wholeness in their lives. She was the inaugural recipient of the Laura Barnes Social Worker of the Year award by the Rockdale County School District. In 2014 she was presented with a proclamation by the Georgia General Assembly recognizing her efforts in combating family homelessness. When not working, Erin enjoys time with her family, reading, and cheering on her favorite sports teams. Erin is the parent of three children attending Douglas County schools.

Mia Hayden is a rising senior at ThunderRidge High School. She currently serves as the Co-Founder of Oasis Mental Health and TRHS Student Body Vice President. In school, Mia has a strong passion for business which she has applied to Oasis. In her future, she wants to continue using these skills to deliver a strong social impact in the community through Oasis and as a defense attorney.

Melanie Zhou is a rising senior at ThunderRidge High School. She currently serves as the Co-Founder of Oasis Mental Health and Colorado FBLA State Vice President of Education. In her free time, she enjoys hiking, watching movies and listening to music. Due to her passion for Oasis, mental health and business, Melanie hopes to become a neuroscience entrepreneur illuminating the unknowns of the brain.

COLORADO
Department of Public Health & Environment

HSR 3

HEALTHY KIDS COLORADO SURVEY 2017

Sponsored by:

Colorado Department of Public Health and Environment

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INTRODUCTION

2017 Communities That Care Report (High School Questionnaire Results)

HSR 3

This report summarizes the findings from the 2017 data pertinent to the Communities That Care (CTC) model from the Healthy Kids Colorado Survey (HKCS). The report includes data on the health outcomes and behaviors related to substance use, violence, and mental well-being, as well as scientifically-validated risk and protective factors that have been shown to influence the likelihood of these outcomes. The local results are presented along with comparisons to national data sources such as the Youth Risk Behavior Surveillance System (YRBSS) and the Bach Harrison Norm (BH Norm) when comparisons are available. In addition, the report contains important information about the risk and protective factor framework and guidelines on how to interpret and use the data.

What is the Healthy Kids Colorado Survey?

The Healthy Kids Colorado Survey (HKCS) is an essential tool that state and local communities use to better understand the health and choices of middle and high school students. The HKCS collects anonymous, self-reported information from Colorado middle and high school students every other year. The State launched the survey in 2013 as a unified effort to meet the needs of multiple agencies and organizations for youth health data and state and regional results.

The HKCS is separated into two similar yet separate survey instruments, one administered to grades 6-8 (referred to as the middle school survey) and one administered to grades 9-12 (the high school survey). Each survey has some questions that are identical, some that are similar but vary in the detail of the response sets, and some questions that are unique to that survey instrument.

The Colorado Department of Public Health and Environment (CDPHE), Colorado Department of Education (CDE) and Colorado Department of Human Services (CDHS) support the HKCS. The Community, Epidemiology & Program Evaluation Group at the University of Colorado Anschutz Medical Campus administers the survey. The survey incorporates the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (YRBSS) modules and questions. HKCS results represent Colorado's middle and high school populations statewide as well as regional estimates for each of the twenty-one health statistics regions for high schools. School and district level results are provided to the respective school or district. State and regional estimates (in the form of health statistics regions) are available as well.

Public and private organizations including schools, parents and youth across Colorado use this survey's state and regional health data to identify trends and enhance school and community based programs that improve the health and well-being of young people.

What Does the Survey Measure?

The HKCS measures students' health outcomes and behaviors and identifies the underlying causes, i.e. risk and protective factors, which influence young people's development, health, and education. This report provides specific information on health outcomes and behaviors, and risk and protective factors.

Risk and protective factors are a scientifically validated model for measuring and understanding the underlying causes that affect youth health. These scales measure specific aspects of a youth's life experience that predict whether youth will have adverse behaviors or outcomes.

The HKCS has incorporated 11 risk and protective factors from the Communities That Care Youth Survey to provide a clearer picture of these important sources of influence on youth outcomes.

These scales belong to four primary domains that influence youth well-being.

- Community (e.g., laws & norms favorable to substance use, perceived availability of substances)
- School (e.g., commitment to school, academic failure)
- Family (e.g., poor family management, opportunities for prosocial involvement)
- Peer-individual (e.g., early initiation of substance use, favorable attitudes toward substance use)

Health behaviors and outcomes are consequences that occur as a result of decisions, circumstances, and environments. The HKCS measures behavior and outcome data on youth substance use, violence, and mental well-being.

Survey Validity

In this local administration, 2,841 students in HSR 3 completed the survey, including 817 ninth grade, 697 tenth grade, 749 eleventh grade, and 552 twelfth grade students. This represents approximately 15.0% of the eligible students.

When the response rate is 80% or greater, we are confident that the data reflect, with reasonable accuracy, the experiences of the population being assessed. As response rates decline, we are less confident.

Because student anonymity was stressed during administration, most of the reasons for students to exaggerate or deny behaviors and choices were eliminated. In addition, CU Anschutz built several checks into the data analysis to minimize the impact of students who were either not truthful in their responses or who did not take the survey seriously. Each paper survey is inspected to look for indications the survey was not taken seriously. Individual responses or entire surveys were eliminated from the final data reported in this report for meeting one or more of predetermined indicators, including: 1) the student indicated past-month use rates that are higher than lifetime use rates; 2) the student reported an age that was inconsistent with their grade, their school, or inconsistent with the reported age of first substance use; and 3) the student provided the same response to a number of consecutive questions.

HOW TO READ THE CHARTS AND TABLES

Data in this report are segmented into relevant topic clusters – providing overall data in chart format with the specific data points and relevant national comparisons (when available) provided below the chart in table format. For Risk and Protective Factor chart/table combinations, data for the scaled risk or protective factor score is provided in the chart, with data provided in the table below for the items that make up the scale.

Understanding the Format of the Charts

There are two types of charts in this report: Risk and Protective Factors and Health Behaviors and Outcomes. There are several graphical elements common to each. Understanding the format of the charts and what these elements represent is essential in interpreting the results of the CTC survey.

The bars on health behavior and outcome charts represent the percentage of students in that grade who reported a given behavior. The bars on the risk and protective factor charts represent the percentage of students whose answers reflect significant risk or protection in that category.

Dots and diamonds provide points of comparison to larger samples - the state of Colorado, the Youth Risk Behavior Surveillance (YRBS) System or the Bach Harrison Norm (BH Norm).

The dots on the charts represent the percentage of all Colorado youth surveyed who reported substance use, problem behavior, elevated risk, or elevated protection. (Please note that the dot represents the aggregate results of all participating students rather than a random sample of students.)

Diamonds represent national data on levels of risk and protection (BH Norm) or health behaviors and outcomes (YRBS).

Scanning across the charts, it is important to observe the factors that differ the most from national samples. This is the first step in identifying the levels of risk and protection (BH Norm) and behaviors and outcomes (YRBS) that are higher or lower than those in other communities.

1. DEMOGRAPHICS

49.7% of participants were female, and 50.3% were male. 9th grade graders were the best represented, with an estimated 16.6% participation rate based on most recent enrollment.

Overall, 74.1% of students surveyed in HSR 3 were white or Caucasian, 8.5% of students were multi-racial, and the remainder were a combination of the remaining categories. 9.6% of students identified as being of Hispanic, Latino, or Spanish origin.

Grade-level data are only displayed in this report when there were a minimum of 25 valid participants. "All grades" represents the combined responses of all participating students from grades 9, 10, 11, and 12 ***as well as ungraded respondents****. Due to the possibility of skipped questions, the total number of respondents by gender, and/or race and ethnicity will not necessarily match the "All grades" total.*

Please note the distribution of participants in "All grades" data for HSR 3 and keep this in mind when comparing local data to state data. "All grades" data are most useful when they are available for all four grades, meet the minimum cutoff for the total number of participants, and have a similar distribution of participants to the state.

	HSR 2017		State 2017	
	Number	Percent	Number	Percent
Survey respondents				
All grades	2,841	100.0	47,146	100.0
Survey respondents by grade				
9	817	29.0	13,523	29.0
10	697	24.8	12,221	26.2
11	749	26.6	11,513	24.7
12	552	19.6	9,417	20.2
Survey respondents by gender				
Male	1,415	50.3	23,273	49.8
Female	1,400	49.7	23,454	50.2
Survey respondents by race and ethnicity				
American Indian or Alaska Native	23	0.8	626	1.3
Asian	145	5.2	1,374	2.9
Black or African American	38	1.4	1,101	2.4
Hispanic or Latino	271	9.6	12,854	27.6
Native Hawaiian or Other Pacific Islander	12	0.4	183	0.4
White	2,083	74.1	24,024	51.6
Two or more of the above	239	8.5	6,415	13.8

2. RISK AND PROTECTIVE FACTORS

Prevention is a science. The risk and protective factor model of prevention is a proven effective way of reducing substance abuse and its related consequences.

This model is based on the simple premise that to prevent a problem from happening, we need to identify the factors that increase the risk of that problem developing and then find ways to reduce the risks. Just as medical researchers have found risk factors for heart disease such as diets high in fat, lack of exercise, and smoking, a team of researchers at the University of Washington have defined a set of risk factors for youth problem behaviors.

Known to predict increased likelihood of substance use, delinquency, school dropout, and violent behaviors among youth, risk factors are characteristics of community, family, and school environments, and of students and their peer groups. For example, children who live in families with high levels of conflict are more likely to become involved in delinquency and substance use than children who live in families characterized by lower levels of conflict.

Protective factors, also known as "assets," are conditions that buffer

Risk factors are conditions that increase the likelihood of a young person becoming involved in substance use, delinquency, school dropout, and/or violence

		Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Depression & Anxiety
Community	Low Neighborhood Attachment	✓	✓			✓	
	Perceived Availability of Drugs	✓				✓	
	Perceived Availability of Handguns		✓			✓	
	Community Laws and Norms Favorable Toward Drug Use, Firearms and Crime	✓	✓			✓	
Family	Family History of Antisocial Behavior	✓	✓	✓	✓	✓	✓
	Poor Family Management	✓	✓	✓	✓	✓	✓
	Family Conflict	✓	✓	✓	✓	✓	✓
	Parental Attitudes Favorable Toward Drugs and Antisocial Behavior	✓	✓			✓	
School	Academic Failure	✓	✓	✓	✓	✓	✓
	Low Commitment to School	✓	✓	✓	✓	✓	
Peer / Individual	Rebelliousness	✓	✓	✓	✓	✓	
	Gang Involvement	✓	✓			✓	
	Perceived Risk of Drug Use	✓	✓	✓	✓	✓	
	Attitudes Favorable Toward Antisocial Behavior and Drug Use	✓	✓	✓	✓	✓	
	Friend's Use of Drugs	✓	✓	✓	✓	✓	
	Interaction with Antisocial Peers	✓	✓	✓	✓	✓	
	Depressive Symptoms	✓			✓		✓

youth from risk by reducing the impact of the risks or changing the way they respond to risks. Protective factors exert a positive influence against the negative influence of risk, thus reducing the likelihood that adolescents will engage in problem behaviors. Protective factors identified through research include strong bonding to community, family, school, and peers, and healthy beliefs and clear standards for behavior.

Protective bonding depends on three conditions:

- Opportunities for young people to actively contribute
- Skills to be able to successfully contribute
- Consistent recognition or reinforcement for their efforts and accomplishments

Bonding confers a protective influence only when there is a positive climate in the bonded community. Peers and adults in these neighborhoods, families, and schools must communicate healthy values and set clear standards for behavior in order to ensure a protective effect. For example, strong bonds to antisocial peers would not be likely to reinforce positive behavior.

Research on risk and protective factors has important implications for children's academic success, positive youth development, and prevention of health and behavior problems. In order to promote academic success and positive youth development and prevent problem behaviors, it is necessary to address the factors that predict these outcomes. By measuring risk and protective factors in a population, specific risk factors that are elevated and widespread can be identified and targeted by policies, programs, and actions shown to reduce those risk factors and to promote protective factors.

Each risk and protective factor can be linked to specific types of interventions that have been shown to be effective in either reducing risk(s) or enhancing protection(s). The steps outlined here will help your school make key decisions regarding allocation of resources, how and when to address specific needs, and which strategies are most effective and known to produce results.

In addition to helping assess current conditions and prioritize areas of greatest need, data from the Healthy Kids Colorado Survey can be a powerful tool in applying for and complying with several federal programs, such as Drug Free Communities grants, outlined later in this report. The survey also gathers valuable data which allows state and local agencies to address other prevention issues related to academic achievement, mental health, and gang involvement.

UNDERSTANDING CUT-POINTS

It is important that the reader gain an understanding of the cut-points that are used to create the risk and protective factor scale scores presented in this section, and to understand how to interpret and analyze these results.

What are Cut-Points?

A cut-point helps to define the level of responses that are at or above a standard/normal level of risk, or conversely at or below a standard/normal level of protection. Rather than randomly determining whether a youth may be at risk or protected, a statistical analysis is completed that helps to determine at what point on any particular scale that the risk or protective factor is outside the normal range. In this way, when you are provided a percentage for a particular scale, you will know that this percentage represents the population of your youth that are either at greater risk or lower protection than the national cut-point level. Cut-points also provide a standard for comparisons of risk and protection over time.

The HKCS questionnaire was designed to assess adolescent substance use, antisocial behavior, violence, mental health and the risk and protective factors that predict these outcomes. However, before the percentage of youth at risk or with protection on a given scale could be calculated, a scale value or cut-point needed to be determined that would separate the at-risk group from the group that was not at-risk. Because surveys measuring the risk and protective factors had been given to thousands of youth across the United States through federally funded research projects, it was possible to select two groups of youth, one that was more at-risk for problem behaviors and another group that was less at-risk. A cut-point score was then determined for each risk and protective factor scale that best divided the youth into their appropriate group, more at-risk or less at-risk. The criteria for selecting the more at-risk and the less at-risk groups included academic grades (the more at-risk group received "D" and "F" grades, the less at-risk group received "A" and "B" grades); alcohol, tobacco, and other substance use (the more at-risk group had more regular use, the less at-risk group had no substance use and use of alcohol or tobacco on only a few occasions); and anti-social behavior (the more at-risk group had two or more serious delinquent acts in the past year, the less at-risk group had no serious delinquent acts).

How to use Cut-Points

The scale cut-points that were determined to best classify youth into the more at-risk and less at-risk groups have remained constant and are used to produce the profiles in this report. Because the cut-points for each scale will remain fixed, the percentage of youth above the cut-point on each of the risk and protective factor scales provides a method for evaluating the progress of prevention programs over time. For example, if the percentage of youth at risk for family conflict in a community prior to implementing a community-wide family/parenting program was 60% and then decreased to 50% one year after the program was implemented, the program could be viewed as helping to reduce family conflict.

How does using Cut-Points affect my data?

Risk and protective factor data presented in this report use the scale cut-points discussed above, resulting in the percentage of *youth at-risk* and *youth with protection*. For example:

- If the *Community laws and norms favorable toward substance use* risk factor scale for 9th graders is at 35%, this means that 35% of 9th graders are at risk for engaging in problem behaviors due to community standards that to contribute to the normalization of substance use.
- If the *Family opportunities for prosocial involvement* protective factor scale is at 60% for 10th graders, the interpretation of this is that 60% of your 10th graders are protected against engaging in problem behaviors due to the positive effects of meaningful participation in the family unit.

What is the Bach Harrison Norm and how do I use it?

The BH Norm was developed by Bach Harrison L.L.C. to provide states and communities with the ability to compare their results on risk and protection measures with national data. Survey participants from eight statewide surveys and five large regional surveys across the nation were combined into a database of approximately 460,000 students. The results were weighted to make the contribution of each state and region proportional to its share of the national population. Bach Harrison analysts then calculated rates for behaviors and outcomes, and for students at risk and with protection for any particular scale. The results appear on the charts as the BH Norm. In order to keep the BH Norm relevant, it is updated approximately every two years as new data become available. The most recent iteration was completed using 2017 data.

Information about other students in the state and the nation can be helpful in determining the seriousness of a given level of problem behavior in your school. Scanning across the charts, it is important to observe the factors that differ the most from the Bach Harrison Norm. This is the first step in identifying the levels of risk and protection that are higher or lower than the national sample.

The risk factors that are higher than the Bach Harrison Norm and the protective factors that are lower than the Bach Harrison Norm are probably the factors that your school should consider including in prevention planning programs. The Bach Harrison Norm is especially helpful when reviewing scales with a small percentage of youth at-risk. For example, even though a small percentage of youth are at-risk within the Early Initiation of Drug Use scale, if you notice that the percentage at risk on your Early Initiation scale is higher than the Bach Harrison Norm, then that is probably an issue that should be considered for an intervention in your school. As you look through your data, we would encourage you to circle or mark risk scales that are higher than the BH Norm and protective factor scales that are lower than the BH Norm and add these items to your list of possible areas to tackle with prevention efforts.

OVERALL RISK AND PROTECTIVE SCORES

Overall risk and protective factor scales are a good way to review the health of HSR 3. Scales are grouped into four domains: community, family, school, and peer/individual. The charts show the overall percentage of students at risk and with protection for each of the scales.

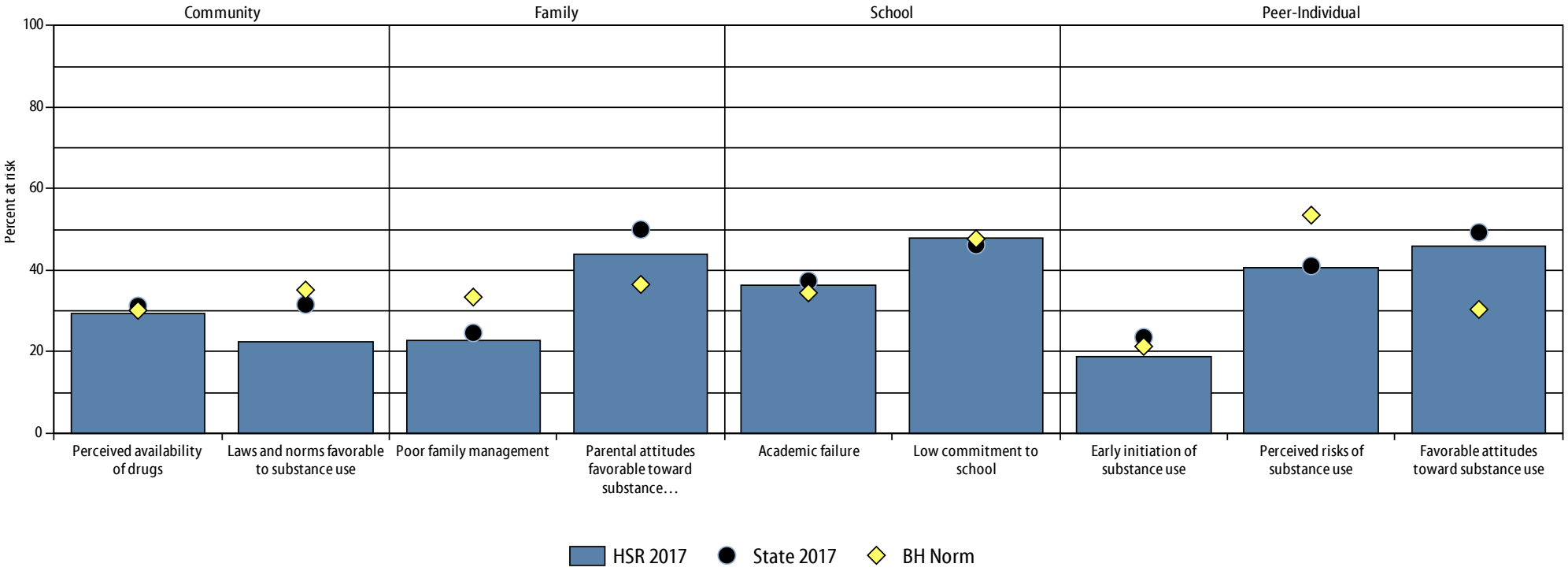
Students in HSR 3 reported the highest overall (all grades combined) risk factor scores for *Low commitment to school* (47.9% of students at risk) and *Favorable attitudes toward substance use* (45.9% at risk).

The two lowest overall risk scale scores were *Early initiation of substance use* (18.7% at risk) and *Laws and norms favorable to substance use* (22.4% at risk).

The highest protective factor scale in the overall sample of students was *Opportunities for prosocial involvement* (69.2% of students with protection). The lowest protective factor scale was *Rewards for prosocial involvement* (56.7% with protection).

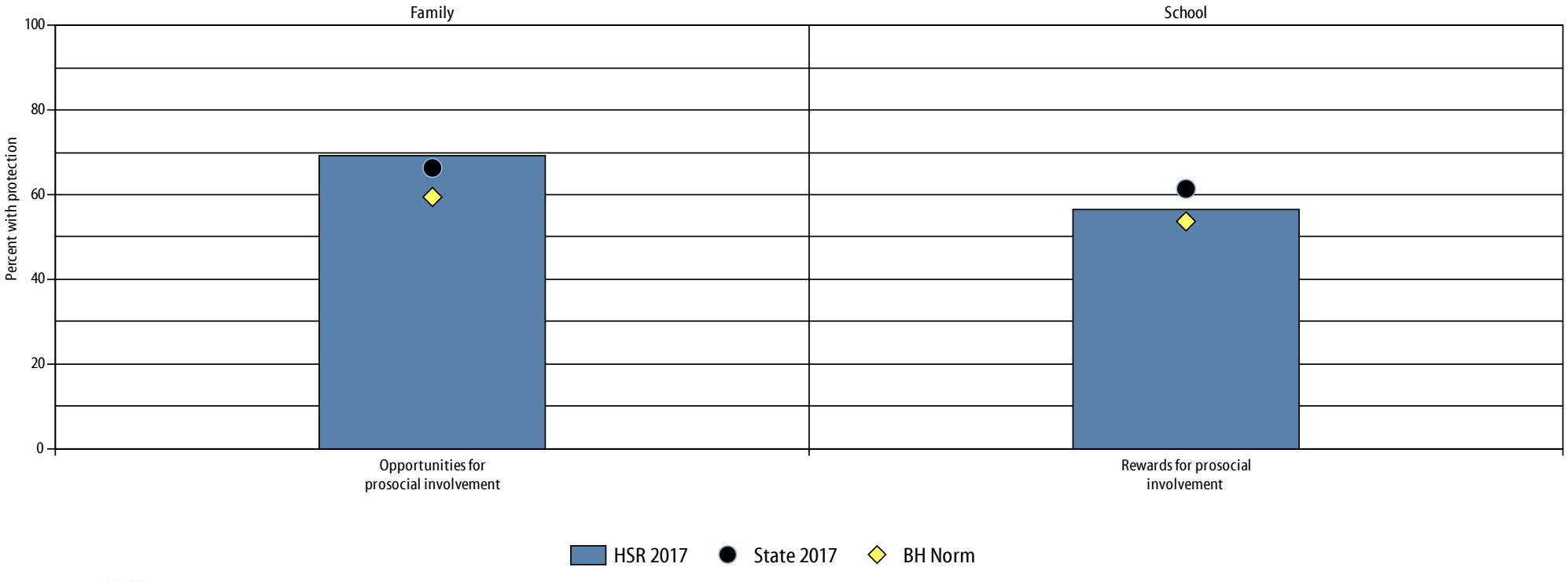
While policies that target any risk or protective factor could potentially be an important resource for students, focusing prevention planning in high risk and low protection areas could be especially beneficial. Similarly, factors with *low* risk or *high* protection represent strengths that can be built upon. In conjunction with a review of community-specific issues and resources, this information can help direct prevention efforts for HSR 3.

Risk Factor Profile
HSR 3 2017 Healthy Kids Colorado Youth Survey



		HSR 2017	State 2017	BH Norm 2017
Community	Perceived availability of drugs	29.4	31.2	30.1
	Laws and norms favorable to substance use	22.4	31.6	35.1
Family	Poor family management	22.9	24.6	33.4
	Parental attitudes favorable toward substance use	43.9	50.0	36.5
School	Academic failure	36.4	37.4	34.4
	Low commitment to school	47.9	46.2	47.7
Peer-Individual	Early initiation of substance use	18.7	23.5	21.3
	Perceived risks of substance use	40.6	41.0	53.5
	Favorable attitudes toward substance use	45.9	49.3	30.4

Protective Factor Profile
HSR 3 2017 Healthy Kids Colorado Youth Survey



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		HSR 2017	State 2017	BH Norm 2017
Family	Opportunities for prosocial involvement	69.2	66.3	59.4
School	Rewards for prosocial involvement	56.7	61.4	53.7

3. INDIVIDUAL RISK FACTORS

Risk factors are known to increase the likelihood of negative outcomes for children. The following charts and tables show the percentage of youth who are considered "higher risk" across a variety of risk factor scales, and explore the questions and answers used to make this determination.

For example, children who perceive that drugs are readily available in their community are more likely to use drugs themselves than children who live in communities where there are lower perceived access.

Scales related to ATOD use concentrate on four primary substances: regular use of alcohol, tobacco, and marijuana, and the use of prescription drugs not prescribed to the user.

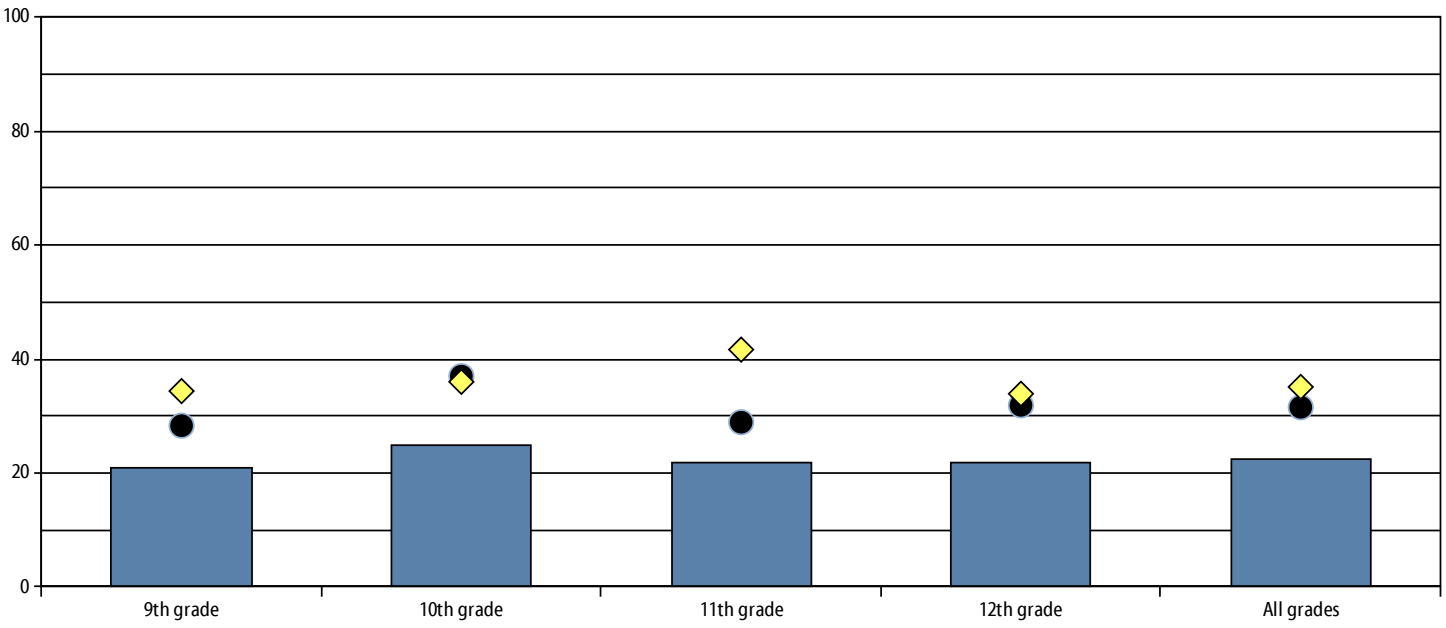
The scales discussed in this section are:

- Perceived availability of substances
- Laws and norms favorable to substance use
- Poor family management
- Parental attitudes favorable toward substance use
- Academic failure
- Low commitment to school
- Early initiation of substance use
- Perceived risks of substance use
- Favorable attitudes toward substance use.

LAWS AND NORMS FAVORABLE TO SUBSTANCE USE

Students' perceptions of the rules and regulations in their community related to alcohol and other substance use are related to the extent of problem behaviors during adolescence.

HSR 3 2017 Healthy Kids Colorado Youth Survey

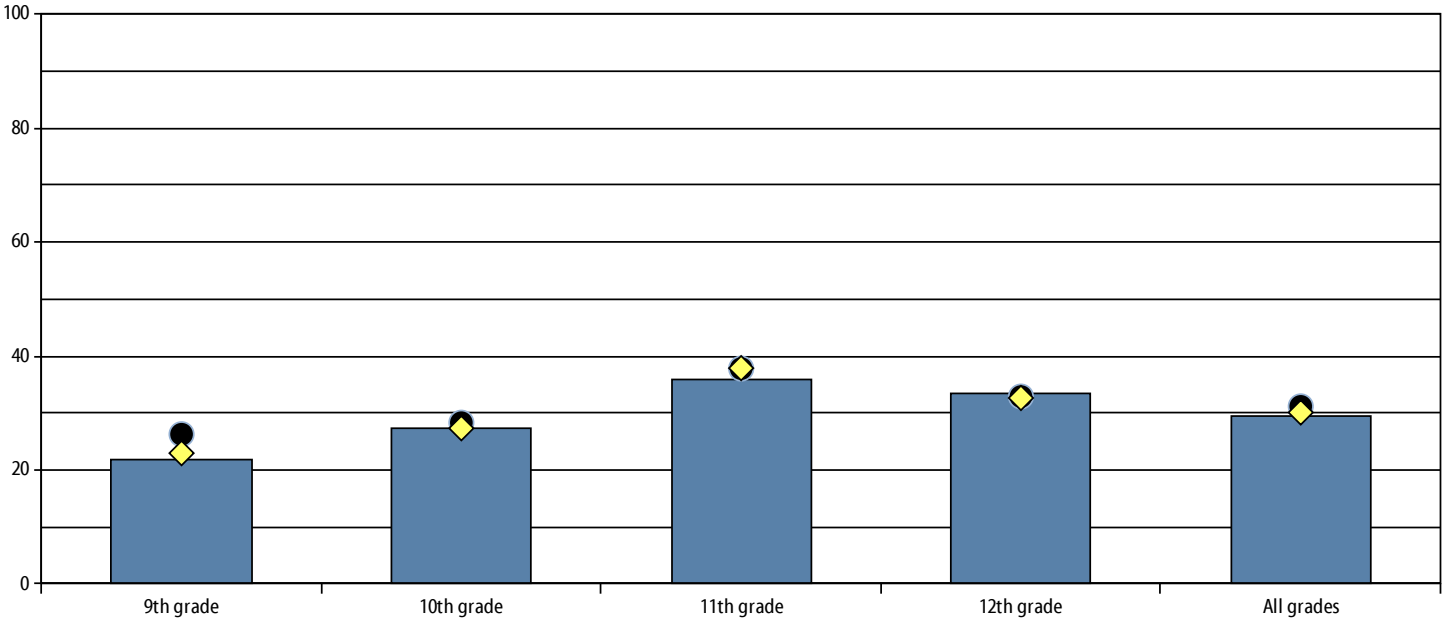


		HSR 2017	State 2017	BH Norm 2017
Laws and norms favorable to substance use		22.4	31.6	35.1
If a kid drank alcohol in your neighborhood, or the area around where you live, would he or she be caught by the police?	*(% of students who marked "no" or "NO!")*	70.6	72.0	-
If a kid used marijuana in your neighborhood, or the area around where you live, would he or she be caught by the police?	*(% of students who marked "no" or "NO!")*	57.8	66.1	-
How wrong would most adults (over 21) in your neighborhood think it is for kids your age to use marijuana?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	11.8	21.8	-
How wrong would most adults (over 21) in your neighborhood think it is for kids your age to drink alcohol?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	17.8	20.4	-
How wrong would most adults (over 21) in your neighborhood think it is for kids to smoke cigarettes?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	8.6	12.3	-

PERCEIVED AVAILABILITY OF SUBSTANCES

The availability of cigarettes, alcohol, marijuana, and other illegal drugs has been related to the use of these substances by adolescents.

HSR 3 2017 Healthy Kids Colorado Youth Survey

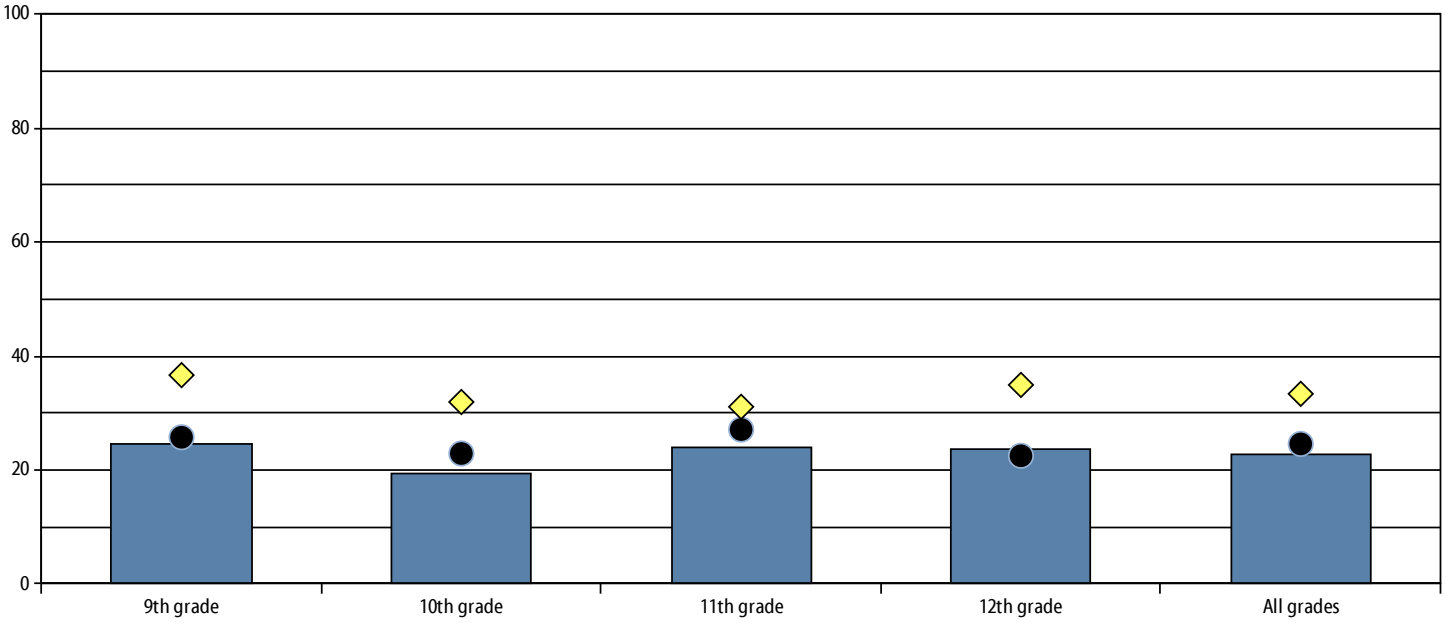


		HSR 2017	State 2017	BH Norm 2017
Perceived availability of drugs		29.4	31.2	30.1
If you wanted to get some cigarettes, how easy would it be for you to get some?	*(% of students who feel it would be "Sort of easy" or "Very easy")*	53.6	55.5	-
If you wanted to get some beer, wine, or hard liquor, how easy would it be for you to get some?	*(% of students who feel it would be "Sort of easy" or "Very easy")*	59.0	57.5	-
If you wanted to get some marijuana, how easy would it be for you to get some?	*(% of students who feel it would be "Sort of easy" or "Very easy")*	47.1	53.5	-
If you wanted to get a drug like cocaine, LSD, amphetamines, or any other illegal drug, how easy would it be for you to get some?	*(% of students who feel it would be "Sort of easy" or "Very easy")*	16.2	18.2	-
If you wanted to get prescription drugs not prescribed to you, how easy would it be for you to get some?	*(% of students who feel it would be "Sort of easy" or "Very easy")*	29.0	25.3	-

POOR FAMILY MANAGEMENT

Failure to provide clear expectations and to monitor children's behavior makes it more likely that they will engage in drug abuse, regardless if the family has a history of drug problems.

HSR 3 2017 Healthy Kids Colorado Youth Survey

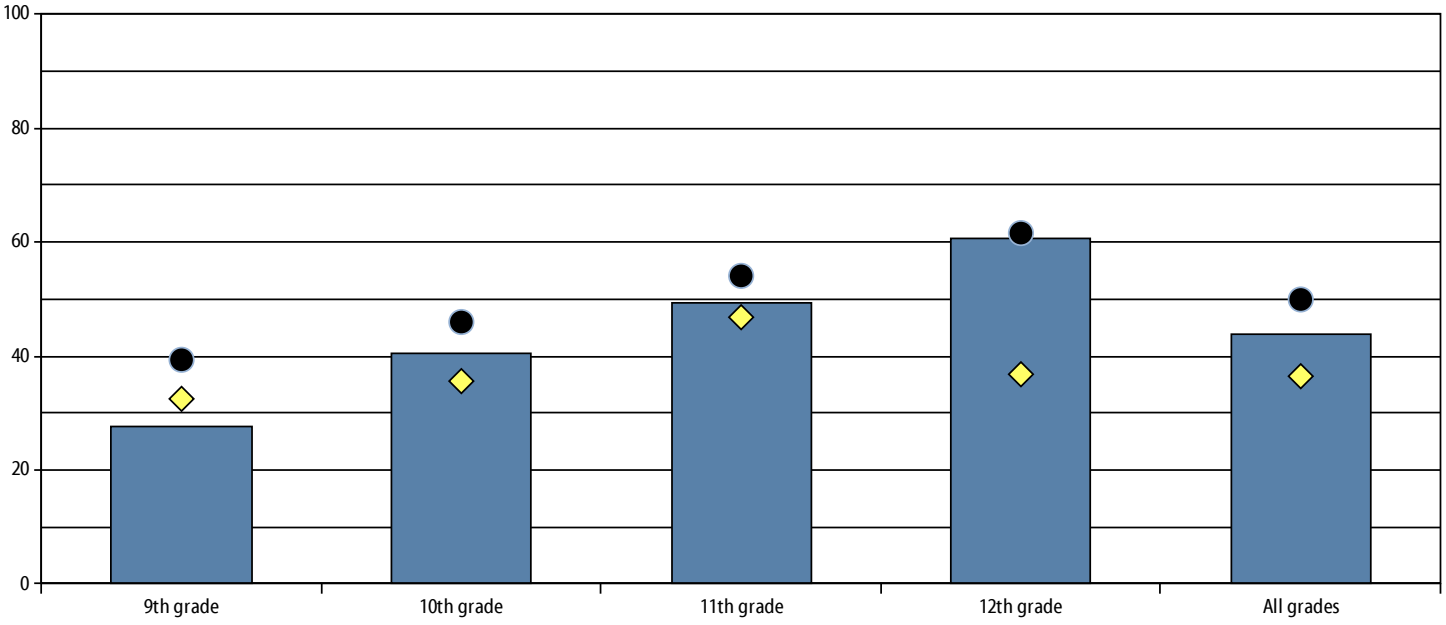


		HSR 2017	State 2017	BH Norm 2017
Poor family management		22.9	24.6	33.4
The rules in my family are clear.	*(% of students who marked "no" or "NO!")*	8.7	7.4	-
My parents or guardians ask if I've gotten my homework done.	*(% of students who marked "no" or "NO!")*	19.4	19.5	-
When I am not at home, one of my parents or guardians knows where I am and who I am with.	*(% of students who marked "no" or "NO!")*	9.6	8.7	-
Would your parents or guardians know if you did not come home on time?	*(% of students who marked "no" or "NO!")*	13.1	12.9	-
My family has clear rules about alcohol and substance use.	*(% of students who marked "no" or "NO!")*	8.8	9.4	-
If you drank some beer or wine or hard liquor without your parents' permission, would you be caught by your parents?	*(% of students who marked "no" or "NO!")*	44.8	49.7	-
If you skipped school, would you be caught by your parents or guardians?	*(% of students who marked "no" or "NO!")*	11.1	11.5	-

PARENTAL ATTITUDES FAVORABLE TOWARD SUBSTANCE USE

Youth in families where parents use illegal drugs, are heavy users of alcohol, or are tolerant of their children's use are at a higher risk for becoming substance users during adolescence.

HSR 3 2017 Healthy Kids Colorado Youth Survey

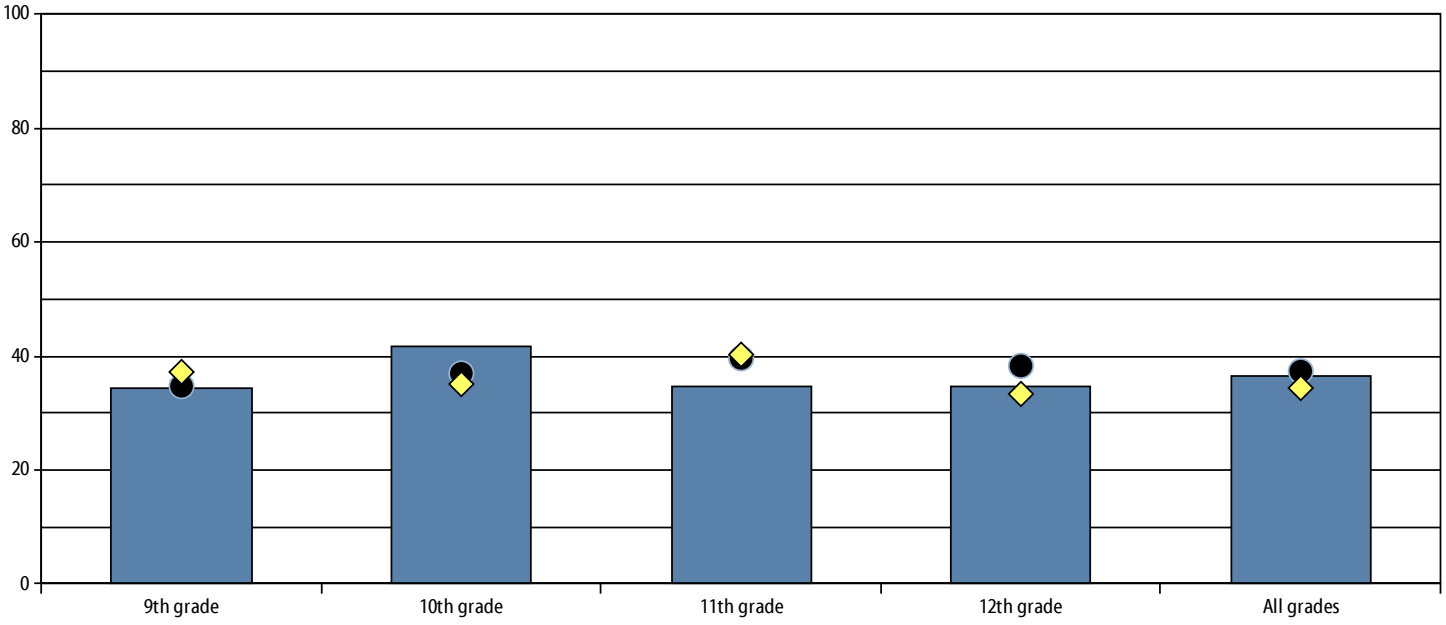


		HSR 2017	State 2017	BH Norm 2017
Parental attitudes favorable toward substance use		43.9	50.0	36.5
How wrong do your parents or guardians feel it would be for you to drink alcohol regularly (at least once or twice a month)?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	15.0	16.0	-
How wrong do your parents or guardians feel it would be for you to use marijuana?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	10.1	13.4	-

ACADEMIC FAILURE

Academic failure that occurs between the late elementary school (grades 4-6) and high school increases the risk of both drug abuse and delinquency. It appears that the experience of failure itself, for whatever reasons, increases the risk of problem behaviors.

HSR 3 2017 Healthy Kids Colorado Youth Survey



		HSR 2017	State 2017	BH Norm 2017
Academic failure		36.4	37.4	34.4
During the past 12 months, how would you describe your grades in school?	*(% of students who described their grades as mostly C's, D's or F's)*	15.1	18.9	-
Are your school grades better than the grades of most students in your class?	*(% of students who marked "no" or "NO!")*	35.2	36.0	-

LOW COMMITMENT TO SCHOOL

Surveys of students have shown that the use of substances is significantly lower among students who expect to attend college than among those who do not.

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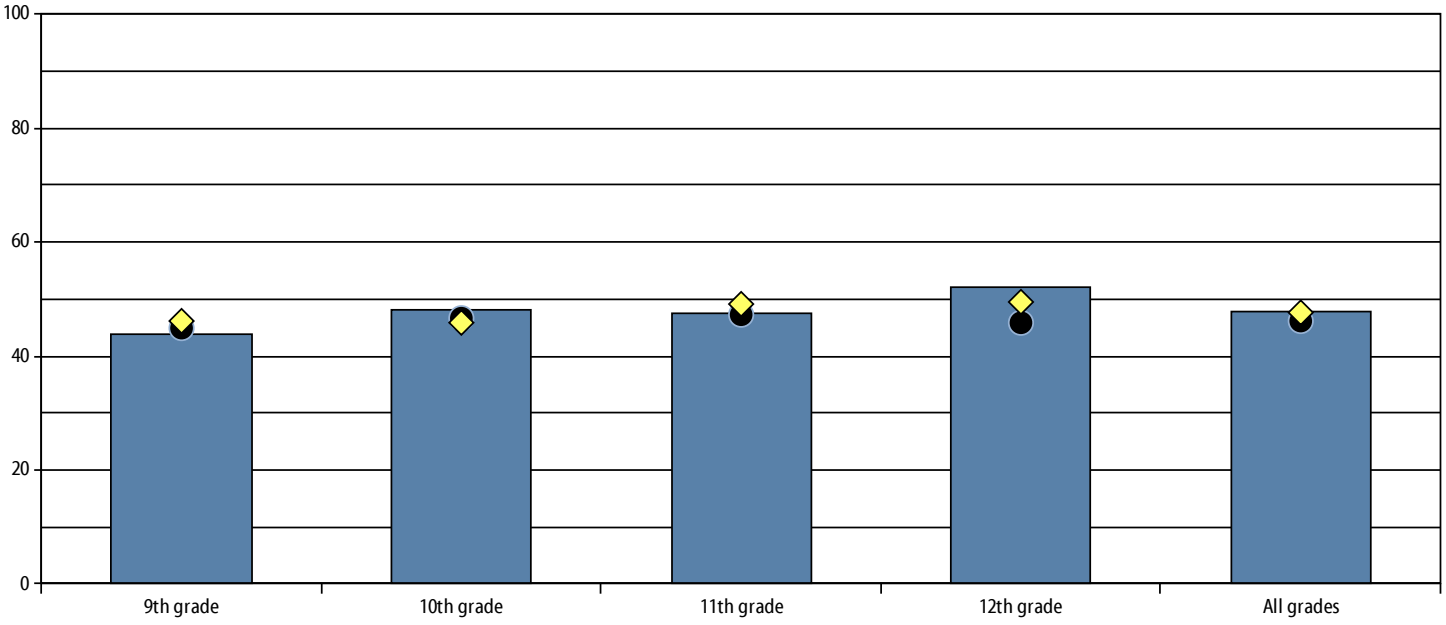
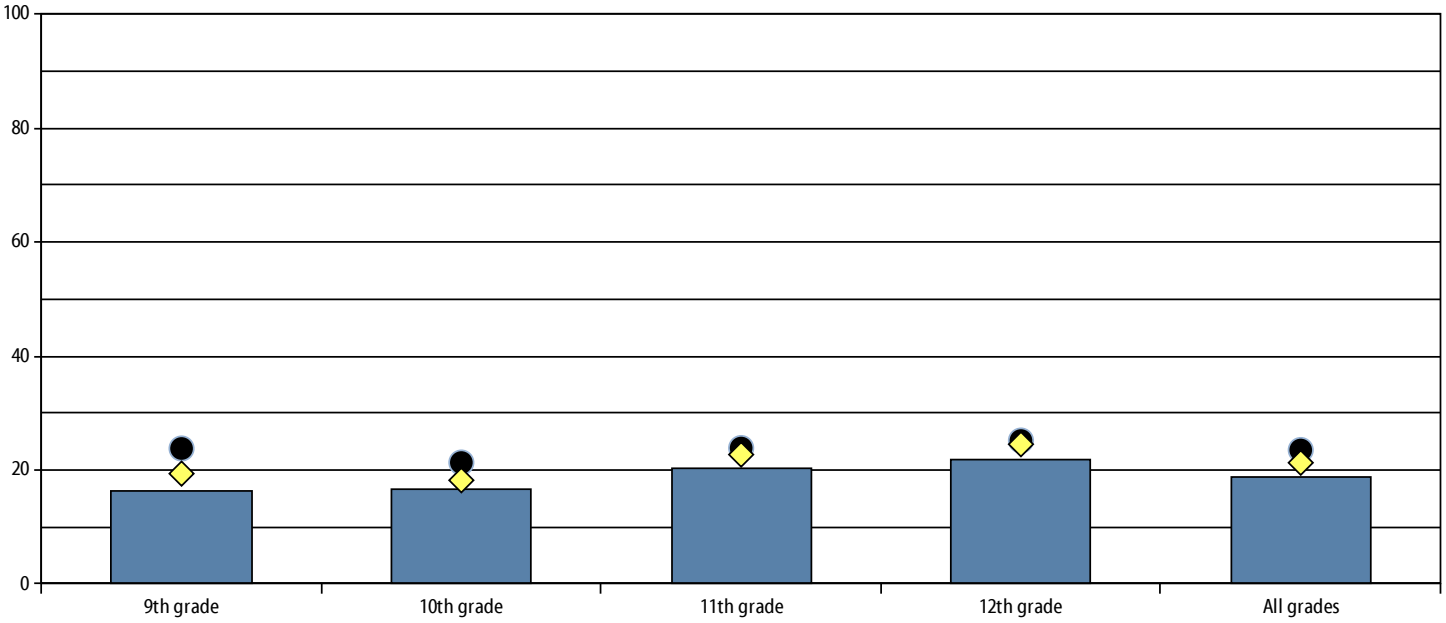


		HSR 2017	State 2017	BH Norm 2017
Low commitment to school		47.9	46.2	47.7
During the LAST FOUR WEEKS how many whole days of school have you missed because you skipped or cut?	*(% of students who marked 1 or more days)*	22.3	22.8	-
How often do you feel that the school work you are assigned is meaningful and important?	*(% of students who marked "Never" or "Seldom")*	36.2	30.8	-
How interesting are most of your courses to you?	*(% of students who marked "Slightly boring" or "Very boring")*	28.5	29.5	-
How important do you think the things you are learning in school are going to be for your later life?	*(% of students who marked "Not very important" or "Not at all important")*	44.4	40.2	-
Now, thinking back over the past year in school, how often did you enjoy being in school?	*(% of students who marked "Never" or "Seldom")*	31.7	30.2	-
Now, thinking back over the past year in school, how often did you hate being in school?	*(% of students who marked "Often" or "Almost always")*	38.9	40.2	-
Now, thinking back over the past year in school, how often did you try to do your best work in school?	*(% of students who marked "Never" or "Seldom")*	11.5	8.2	-

EARLY INITIATION OF SUBSTANCE USE

Early onset of substance use predicts misuse of substances. The earlier the onset of any substance use, the greater the involvement in other substance use and the greater frequency of use.

HSR 3 2017 Healthy Kids Colorado Youth Survey

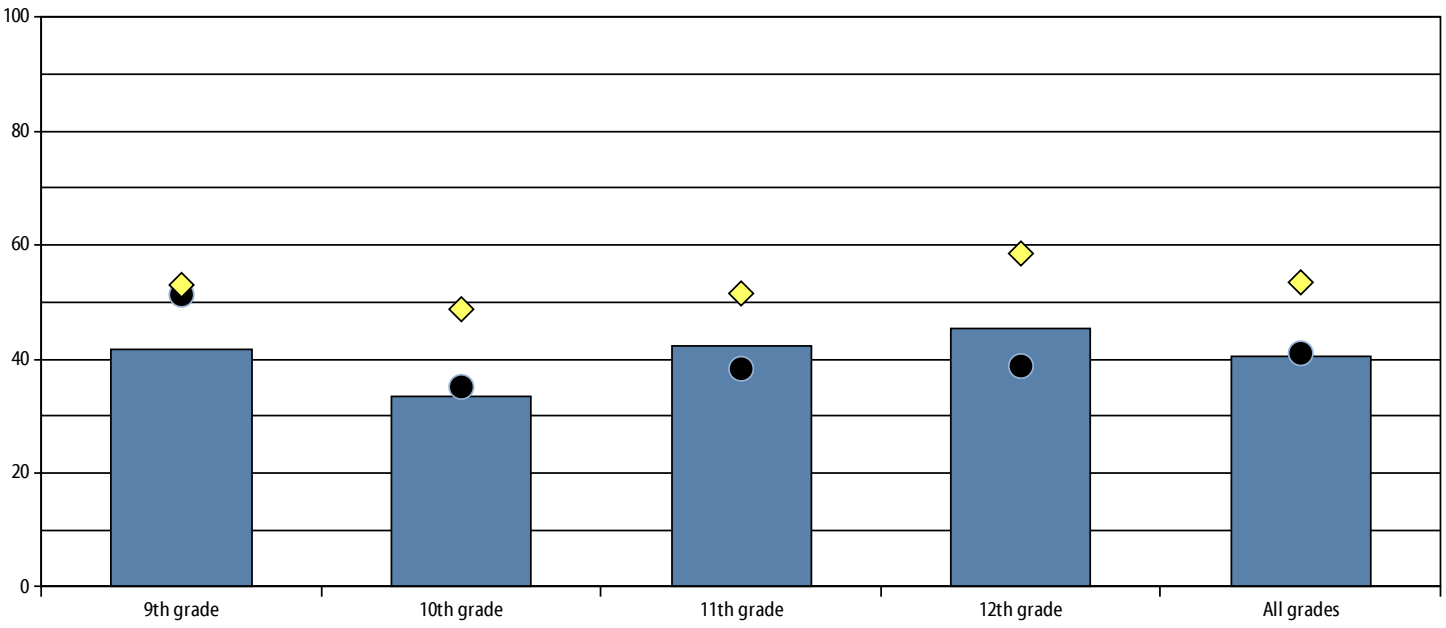


		HSR 2017	State 2017	BH Norm 2017
Early initiation of substance use		18.7	23.5	21.3
How old were you when you smoked a whole cigarette for the first time?	*(% of students who marked an age before 13 years old)*	3.0	4.8	-
How old were you when you had your first drink of alcohol other than a few sips?	*(% of students who marked an age before 13 years old)*	10.9	15.0	-
How old were you when you tried marijuana for the first time?	*(% of students who marked an age before 13 years old)*	3.3	6.5	-

PERCEIVED RISKS OF SUBSTANCE USE

Perception of risk is an important determinant in the decision-making process young people go through when deciding whether or not to use alcohol, tobacco, or other drugs.

HSR 3 2017 Healthy Kids Colorado Youth Survey

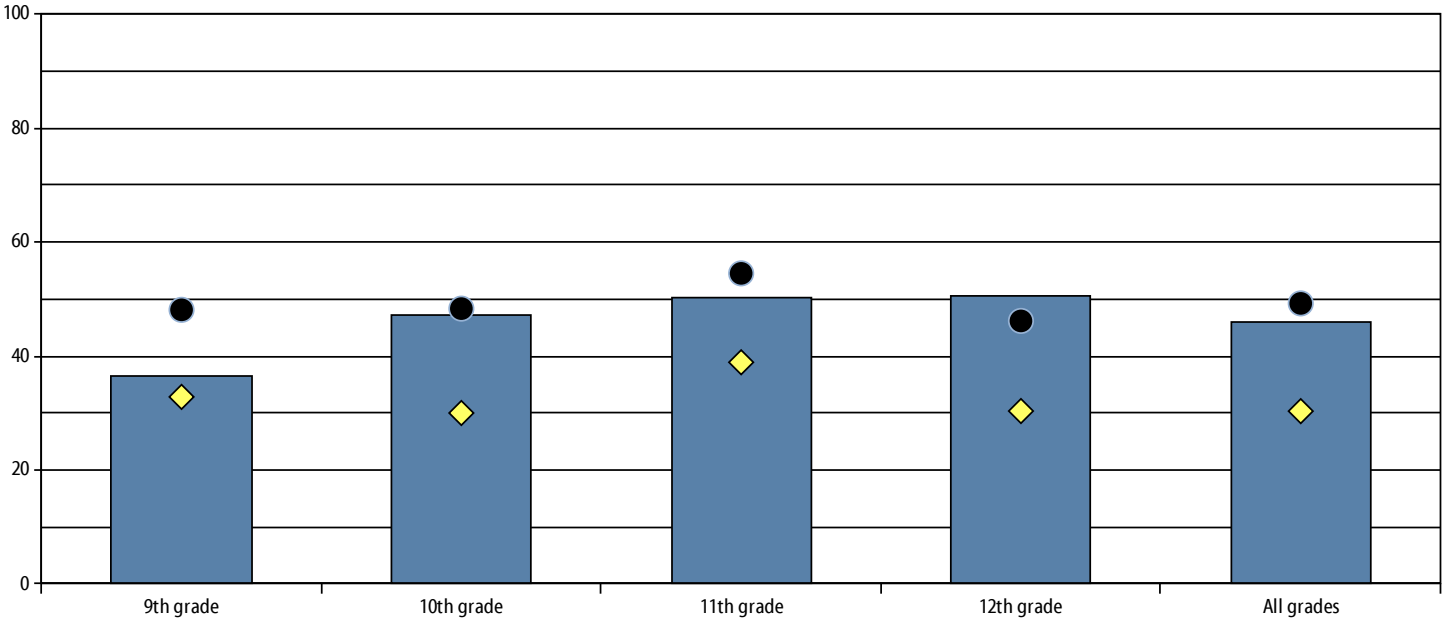


		HSR 2017	State 2017	BH Norm 2017
Perceived risks of substance use		40.6	41.0	53.5
How much do you think people risk harming themselves (physically or in other ways) if they smoke one or more packs of cigarettes per day?	*(% of students who marked "No risk" or "Slight risk")*	14.5	12.6	-
How much do you think people risk harming themselves (physically or in other ways), if they use marijuana regularly?	*(% of students who marked "No risk" or "Slight risk")*	43.9	48.2	-
How much do you think people risk harming themselves (physically or in other ways) if they have one or two drinks of alcohol nearly every day?	*(% of students who marked "No risk" or "Slight risk")*	30.1	27.8	-

FAVORABLE ATTITUDES TOWARD SUBSTANCE USE

Favorable attitudes toward substance use are positively correlated with the level of reported ATOD use across a range of Communities That Care Youth Survey communities.

HSR 3 2017 Healthy Kids Colorado Youth Survey



		HSR 2017	State 2017	BH Norm 2017
Favorable attitudes toward substance use		45.9	49.3	30.4
How wrong do you think it is for someone your age to drink alcohol regularly (at least once or twice a month)?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	38.0	37.7	-
How wrong do you think it is for someone your age to smoke cigarettes?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	19.1	18.3	-
How wrong do you think it is for someone your age to use marijuana?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	36.7	42.6	-
How wrong do you think it is for someone your age to use prescription drugs (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?	*(% of students who marked "Not wrong at all" or "A little bit wrong")*	12.2	11.3	-

4. INDIVIDUAL PROTECTIVE FACTORS

Protective factors help shield children from the negative influence of risk, thus reducing the likelihood that children and youth will experience negative outcomes. The following charts and tables show the percentage of youth who are considered "high in protection" across two protective factor scales, and explore the questions and answers used to make this determination.

For example, parents, friends and education professionals can model positive behaviors, uphold clear standards for behavior and provide opportunities, skills and recognition for meaningful involvement to protect a child living in that same struggling neighborhood.

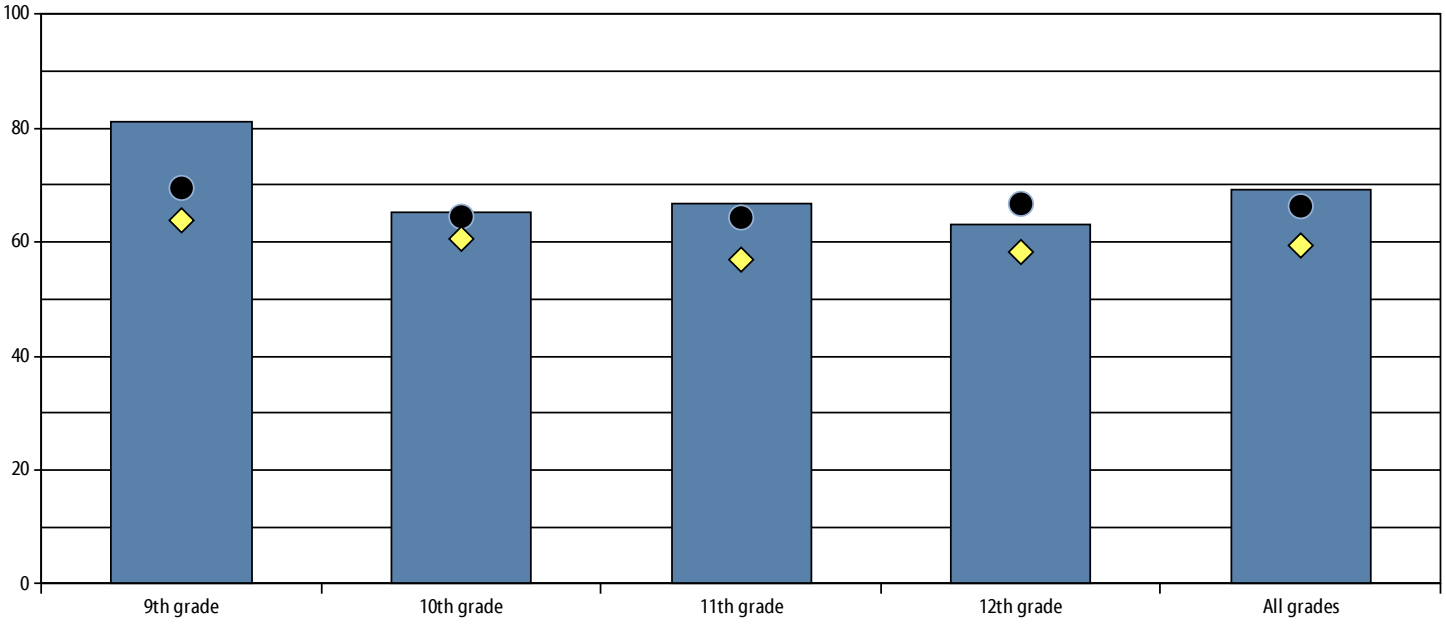
The scales discussed in this section are:

- Family opportunities for prosocial involvement
- School rewards for prosocial involvement

OPPORTUNITIES FOR PROSOCIAL INVOLVEMENT

Young people who are exposed to more opportunities to participate meaningfully in the responsibilities and activities of the family are less likely to engage in substance use and other problem behaviors.

HSR 3 2017 Healthy Kids Colorado Youth Survey

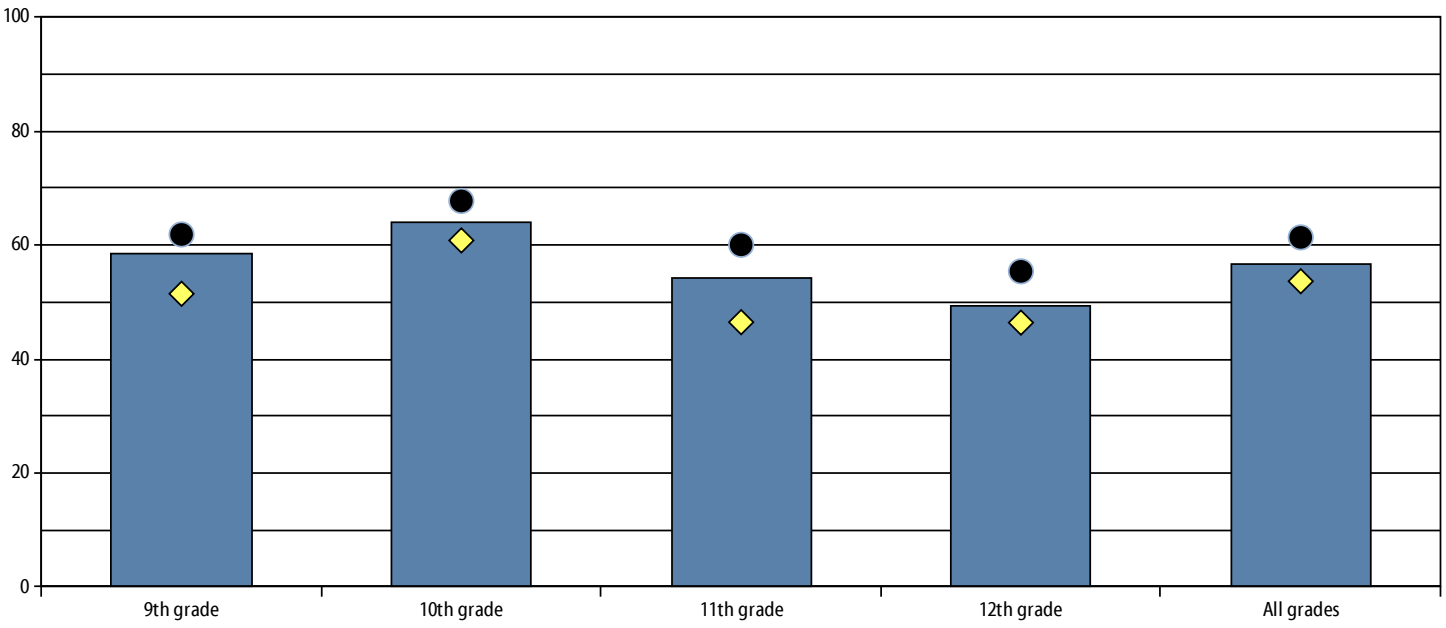


		HSR 2017	State 2017	BH Norm 2017
Opportunities for prosocial involvement		69.2	66.3	59.4
If I had a personal problem, I could ask my parents or guardians for help.	*(% of students who marked "yes" or "YES!")*	84.3	83.5	-
My parents or guardians give me lots of chances to do fun things with them.	*(% of students who marked "yes" or "YES!")*	79.2	78.6	-
My parents or guardians ask me what I think before most family decisions affecting me are made.	*(% of students who marked "yes" or "YES!")*	69.4	67.5	-

REWARDS FOR PROSOCIAL INVOLVEMENT

When young people are recognized and rewarded for their contributions at school, they are less likely to be involved in substance use and other problem behaviors.

HSR 3 2017 Healthy Kids Colorado Youth Survey



		HSR 2017	State 2017	BH Norm 2017
Rewards for prosocial involvement		56.7	61.4	53.7
My teacher(s) notices when I am doing a good job and lets me know about it.	*(% of students who marked "yes" or "YES!")*	54.4	62.0	-
I feel safe at my school.	*(% of students who marked "yes" or "YES!")*	90.7	90.0	-
The school lets my parents or guardians know when I have done something well.	*(% of students who marked "yes" or "YES!")*	38.5	42.3	-
My teachers praise me when I work hard in school.	*(% of students who marked "yes" or "YES!")*	44.4	49.7	-

5. HEALTH BEHAVIORS AND OUTCOMES

Monitoring Alcohol, Tobacco, and Other Drug (ATOD) Trends In Colorado Youth

Health Behaviors and Outcome charts

These charts are divided into three groups: youth substance use, violence, and mental well-being.

Youth substance use charts track use three ways: *Ever-used* (or lifetime use) is a measure of the percentage of students who tried the particular substance at least once in their lifetime and is used to show the percentage of students who have had experience with a particular substance. *30-day use* is a measure of the percentage of students who used the substance at least once in the 30 days prior to taking the survey and is a more sensitive indicator of the level of current use of the substance. *Heavy use* is measured by alcohol use, specifically binge drinking: *During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row (if you are female) or 5 or more drinks of alcohol in a row (if you are male)?*

The charts are organized by substance type and then usage type: lifetime, 30-day, and then heavy use (where available).

Violence charts are divided into three sections. *Physical violence* looks at student perception of threats and safety as well as the frequency of physical altercations and weapons on school property. *Dating or sexual violence* asks about incidence of physical abuse in the context of dating, as well as sexual coercion through physical means. Finally, *bullying* tracks the frequency of bullying on school property as well as bullying through social media and other electronic means.

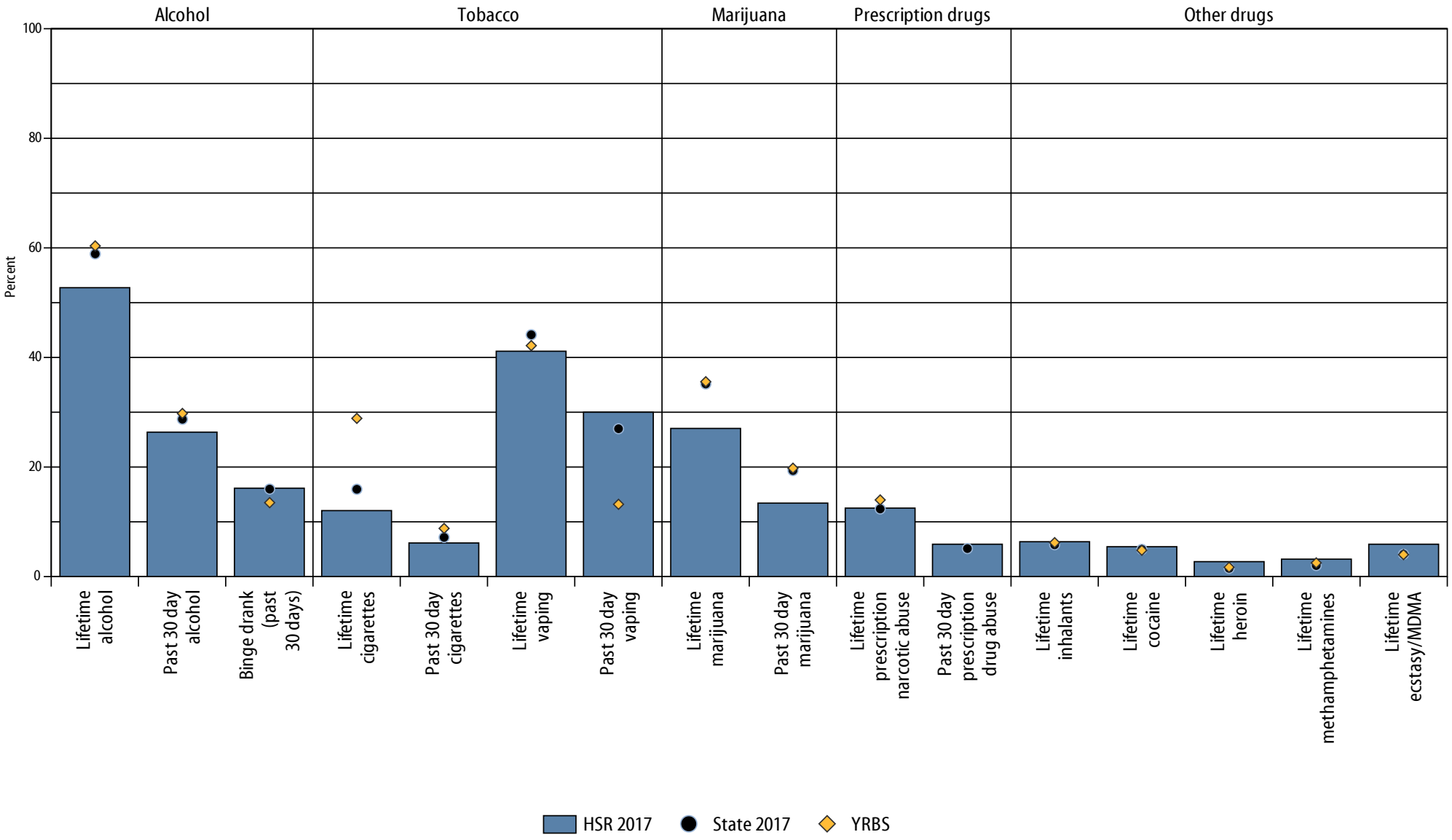
Mental well-being charts are also divided into three sections. *Depression* tracks episodes of feeling "sad and hopeless" that have lasted two or more weeks, as well as admissions of self-harm. *Suicide risk* looks at three suicidal behaviors: suicidal ideation, active planning of suicide, and actual suicide attempts. The final section, *availability of trusted adults* examines whether students feel like they have someone to turn to in the case of a serious problem or feelings of sadness, hopelessness or anger.

YOUTH SUBSTANCE USE

This section covers substances including alcohol, tobacco (traditional methods as well as vaping), marijuana, prescription and other drugs.

		HSR 2017	State 2017	YRBS 2017
Alcohol				
During your life, on how many days have you had at least one drink of alcohol?	*(% of students who marked 1 or more days)*	52.9	59.0	60.4
During the past 30 days, on how many days did you have at least one drink of alcohol?	*(% of students who marked 1 or more days)*	26.3	28.7	29.8
During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row (if you are female) or 5 or more drinks of alcohol in a row (if you are male)?	*(% of students who marked 1 or more days)*	16.1	16.0	13.5
Tobacco				
How old were you when you smoked a whole cigarette for the first time?	*(% of students who marked any answer other than "never")*	12.0	15.9	28.9
During the past 30 days, on how many days did you smoke cigarettes?	*(% of students who marked 1 or more days)*	6.0	7.2	8.8
Have you ever used a vapor product?	*(% of students who marked "Yes")*	41.1	44.2	42.2
During the past 30 days, on how many days did you use an electronic vapor product?	*(% of students who marked 1 or more days)*	30.0	27.0	13.2
Marijuana				
During your life, how many times have you used marijuana?	*(% of students who marked 1 or more times)*	27.0	35.2	35.6
During the past 30 days, how many times did you use marijuana?	*(% of students who marked 1 or more times)*	13.5	19.4	19.8
Prescription drugs				
During your life, how many times have you taken prescription pain medicine without a doctor's prescription or differently than how a doctor told you to use it? (Count drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet.)	*(% of students who marked 1 or more times)*	12.5	12.4	14.0
During the past 30 days, how many times did you take a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?	*(% of students who marked 1 or more times)*	5.9	5.1	-
Other drugs				
During your life, how many times have you sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high?	*(% of students who marked 1 or more times)*	6.5	5.8	6.2
During you life, how many times have you used any form of cocaine, including powder, crack, or freebase?	*(% of students who marked 1 or more times)*	5.4	5.0	4.8
During your life, how many times have you used heroin (also called smack, junk, or China White)?	*(% of students who marked 1 or more times)*	2.7	1.5	1.7
During your life, how many times have you used methamphetamines (also called speed, crystal, crank, or ice)?	*(% of students who marked 1 or more times)*	3.1	2.0	2.5
During your life, how many times have you used ecstasy (also called MDMA)?	*(% of students who marked 1 or more times)*	5.9	4.1	4.0

HSR 3 2017 Healthy Kids Colorado Youth Survey, All grades

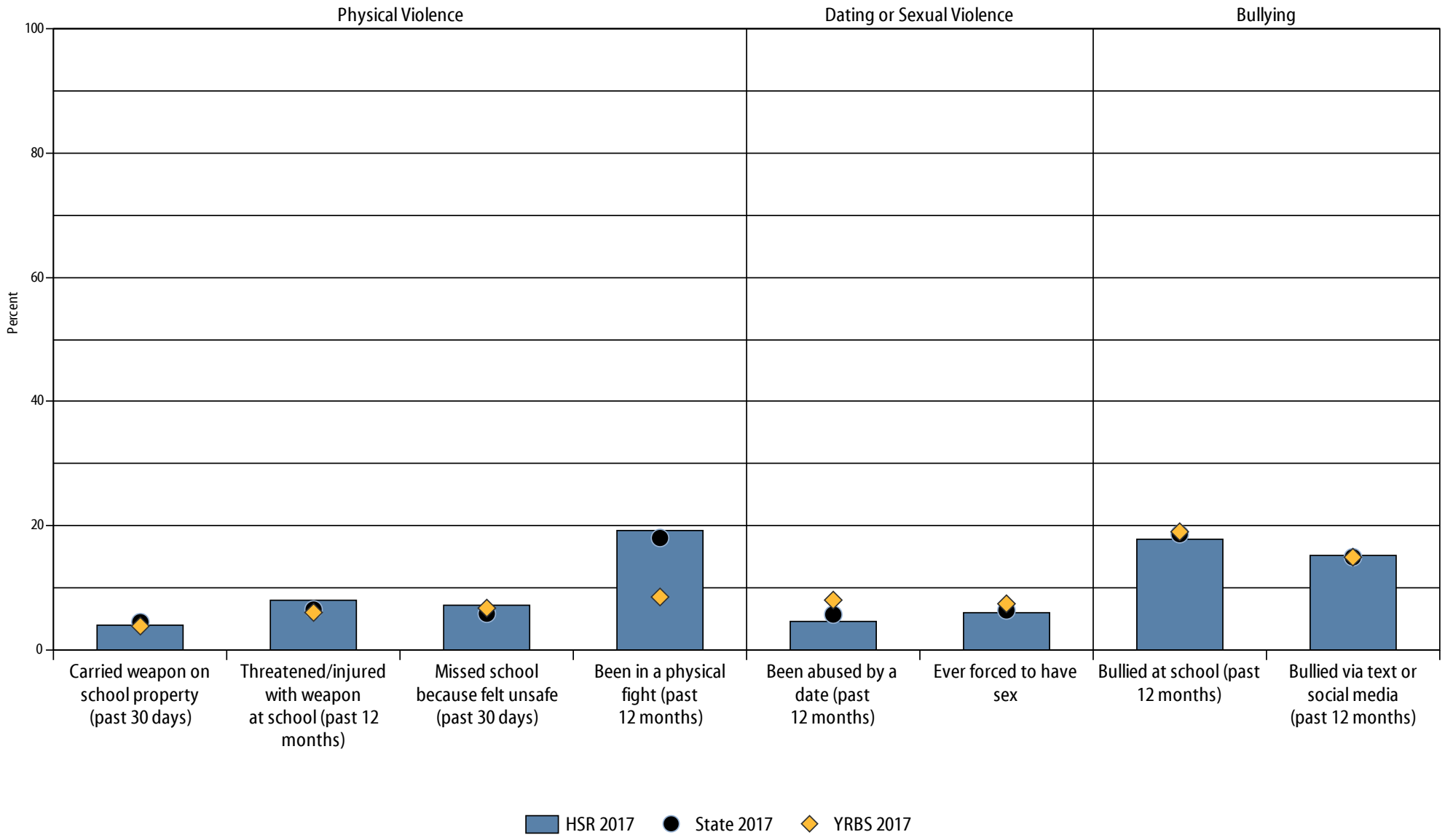


VIOLENCE

Violence and bullying are widely held to have become a serious problem in recent decades, especially where weapons such as guns or knives are involved.

		HSR 2017	State 2017	YRBS 2017
Physical Violence				
During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?	*0 days*	96.1	95.6	96.2
	1 day	1.3	1.2	0.9
	2 or 3 days	0.8	0.9	0.7
	4 or 5 days	0.2	0.3	0.2
	6 or more days	1.6	2.1	1.9
During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?	*0 days*	92.9	94.2	93.3
	1 day	4.0	3.1	3.6
	2 or 3 days	1.5	1.5	2.0
	4 or 5 days	0.4	0.4	0.4
	6 or more days	1.2	0.9	0.8
During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on school property?	*0 times*	92.1	93.5	94.0
	1 time	4.0	3.2	2.7
	2 or 3 times	1.6	1.7	1.5
	4 or 5 times	0.7	0.4	0.5
	6 or 7 times	0.3	0.1	0.3
	8 or 9 times	0.1	0.1	0.2
	10 or 11 times	0.2	0.1	0.1
	12 or more times	1.0	0.7	0.8
During the past 12 months, how many times were you in a physical fight?	*0 times*	80.8	82.0	76.4
	1 time	9.5	8.8	10.3
	2 or 3 times	6.4	5.8	7.8
	4 or 5 times	0.8	1.4	2.2
	6 or 7 times	0.3	0.4	0.9
	8 or 9 times	0.5	0.4	0.5
	10 or 11 times	0.1	0.1	0.3
	12 or more times	1.5	1.2	1.6
Dating or Sexual Violence				
During the past 12 months, how many times did someone you were dating or going out with physically hurt you on purpose? (Count such things as being hit, slammed into something, or injured with an object or weapon.)	*I did not date or go out with anyone during the past 12 months*	43.8	38.6	31.0
	0 times	51.6	55.7	63.5
	1 time	1.6	2.3	2.1
	2 or 3 times	1.5	1.8	1.7
	4 or 5 times	0.4	0.4	0.6
	6 or more times	1.0	1.1	1.1
Have you ever been physically forced to have sexual intercourse when you did not want to?	*Yes*	6.0	6.3	7.4
	No	94.0	93.7	92.6
Bullying				
During the past 12 months, have you ever been bullied on school property?	*Yes*	17.8	18.6	19.0
	No	82.2	81.4	81.0
During the past 12 months, have you ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)	*Yes*	15.2	14.9	14.9
	No	84.8	85.1	85.1

HSR 3 2017 Healthy Kids Colorado Youth Survey, All grades

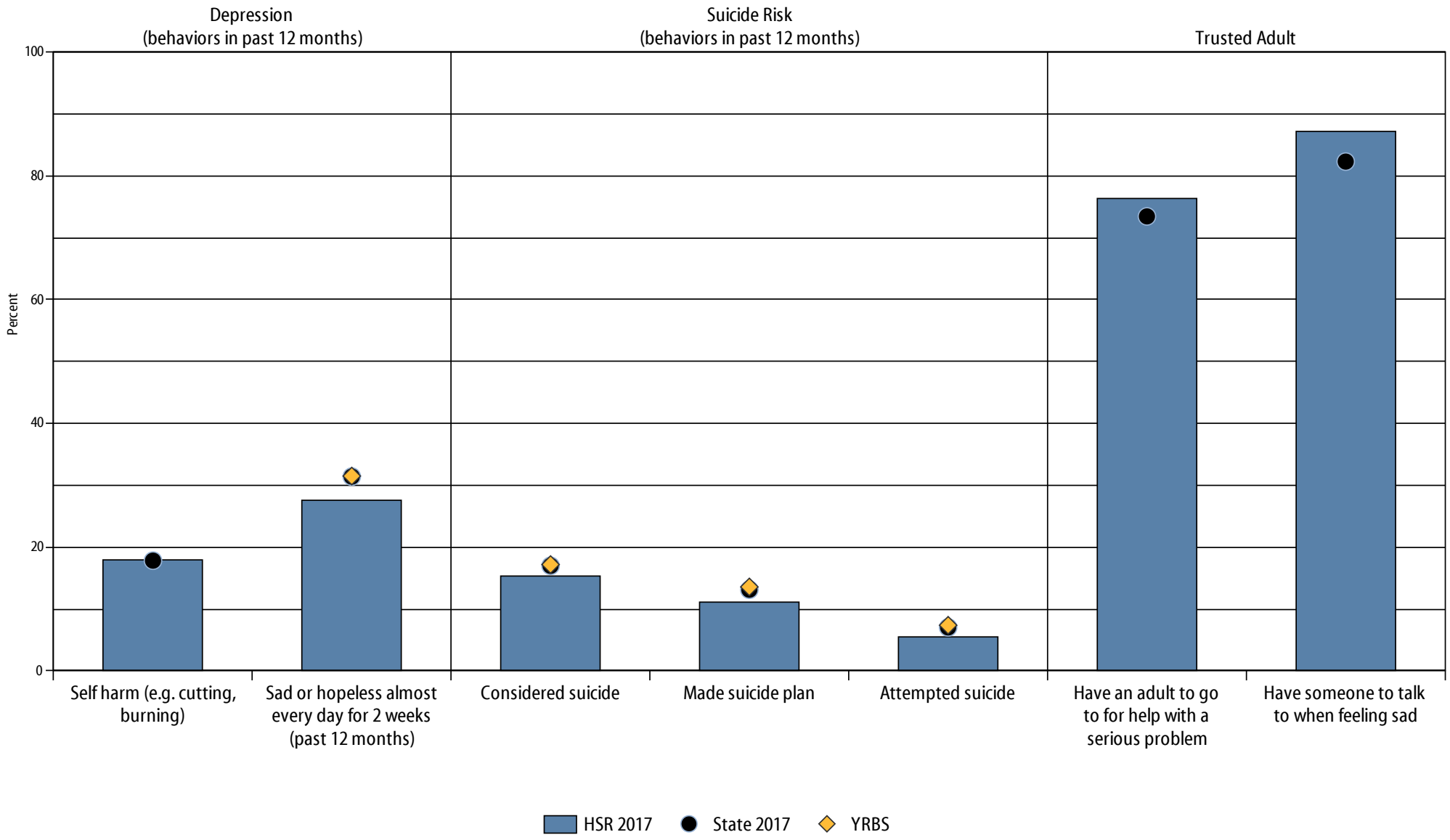


MENTAL HEALTH

A number of scientific studies have identified a link between mental health problems, such as depression, and the use of ATODs during adolescence. Depression is the number one risk factor for suicide by teens, the third leading cause of death in youth between the ages of 10 and 24.

		HSR 2017	State 2017	YRBS 2017
Depression				
During the past 12 months, how many times did you do something to purposefully hurt yourself without wanting to die, such as cutting or burning yourself on purpose?	*0 times*	82.1	82.2	-
	1 time	4.9	5.5	-
	2 or 3 times	6.3	5.5	-
	4 or 5 times	2.6	2.4	-
	6 or more times	4.1	4.4	-
During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?	*Yes*	27.6	31.4	31.5
	No	72.4	68.6	68.5
Suicide Risk				
During the past 12 months, did you ever seriously consider attempting suicide?	*Yes*	15.4	17.0	17.2
	No	84.6	83.0	82.8
During the past 12 months, did you make a plan about how you would attempt suicide?	*Yes*	11.1	13.1	13.6
	No	88.9	86.9	86.4
During the past 12 months, how many times did you actually attempt suicide?	*0 times*	94.5	93.0	92.6
	1 time	2.7	3.7	3.6
	2 or 3 times	1.6	2.2	2.4
	4 or 5 times	0.4	0.4	0.5
	6 or more times	0.9	0.7	0.8
Availability of Trusted Adults				
If you had a serious problem, do you know an adult in or out of school whom you could talk to or go to for help?	*Yes*	76.3	73.5	-
	No	11.4	12.1	-
	Not sure	12.3	14.4	-
When you feel sad, empty, hopeless, angry, or anxious, with whom would you most likely talk about it?	*I do not feel sad, empty, hopeless, angry, or anxious*	19.7	17.6	-
	Parent or other adult family member	22.9	20.1	-
	Teacher or other adult in this school	1.9	3.4	-
	Other adult	2.9	2.5	-
	Friend	33.1	32.8	-
	Sibling	4.8	4.8	-
	Not sure	9.6	13.7	-
	Checked 2 or more B-F	5.1	5.2	-

HSR 3 2017 Healthy Kids Colorado Youth Survey, All grades



APPENDIX A. HKCS FAQ

Who was eligible for the survey?

All students who were enrolled and who could take the survey unassisted in English or Spanish (with extra time if needed) were eligible for the survey.

How was the survey administered?

The survey was administered by the classroom teachers during regular class periods. Administration occurred on a specified day throughout the school in the fall of 2017 through January 2018.

Did the students have to participate?

No. Participation in the HKCS is always voluntary. Parents were notified of the survey ahead of time, asked to give consent for their children to participate, and given the opportunity to refuse their student's participation. Students were also informed of their right to refuse. Proctors and teachers were provided with training and materials to ensure that students' participation in the survey was voluntary and that all responses were anonymous and confidential. In addition, students were reminded several times that they could skip any question(s) they did not wish to answer, and that they could stop at any time.

Are these data representative of our student population?

The more students who participate from a certain grade, school, or district, the more representative the data will be of the population in that grade, school, or district. When the response rate is 80% or greater, we are confident that the data reflect, with reasonable accuracy, the experiences of the population being assessed. As response rates decline, we are less confident that they accurately represent the experiences of the student population.

How do we know the students were honest?

Research on student self-report of substance use and antisocial behavior indicates that students tend to be honest about their behavior and experience on anonymous, confidential surveys such as the HKCS. Furthermore, there are strategies built into the analysis of this survey to screen for dishonest or exaggerated responses. If a survey does not meet the criteria for honesty, it is eliminated from the data set.

How were the survey questions selected?

The survey questions are derived from extensive research over the past 20 years in the field of prevention science and related fields. They have been tested on large diverse samples of youth to ensure that they accurately and consistently measure each behavior or factor.

How does this report compare to the frequency report?

This report is intended for communities that are using the Communities that Care model, and it highlights youth behaviors and risk and protective factors that are related to those efforts. This report overlaps with the frequency report by reporting on substance use, violence, mental health, and risk and protective factors. This report goes beyond the frequency report by including indicators that combine several questions and providing national comparison estimates. On the other hand, the frequency report provides estimates in domains not included in this report such as physical activity, nutrition and other survey questions that are not presented in this report.

What is the Bach Harrison Norm?

The comparison points for the risk and protective profiles are based on a large-scale survey of youth in nine states (the "BH Norm") compiled by Bach Harrison, L.L.C., a survey research firm with expertise in mental health and substance abuse prevention and treatment services.

APPENDIX B. CONTACTS FOR PREVENTION

National Resources

Center for Substance Abuse Prevention (CSAP)
195 1 Choke Cherry Rd., Ste 4-1057
Rockville, Maryland 20857
240-276-2420
info@samhsa.hhs.org
http://prevention.samhsa.gov/

CSAP's Centers for the Advancement of Prevention Technologies
(all five CSAP Centers can be accessed through this website)
http://captus.samhsa.gov/home.cfm

National Institutes of Health (NIH)
National Institute on Drug Abuse (NIDA)
6001 Executive Blvd., Rm. 5213
Bethesda, Maryland 20892-9561
301-443-1124
information@lists.nida.nih.gov
http://www.nida.nih.gov/

National Registry of Evidence-based Programs and Practices (NREPP)
5600 Fishers Ln
Rockville, MD 20857
1-877-SAMHSA-7 (1-877-726-4727)
https://www.samhsa.gov/nrepp

Youth Risk Behavior Surveillance System (YRBSS)
https://www.cdc.gov/healthyyouth/data/yrbs/

State Resources

Colorado Dept. of Public Health and Environment: Communities That Care
https://www.colorado.gov/cdphe/ctc

Technical Assistance Provider for Communities That Care Center for the Study and Prevention of Violence:
University of Colorado Boulder
https://www.colorado.edu/cspv/

Healthy Kids Colorado Survey
https://www.colorado.gov/cdphe/hkcs

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University of Colorado Boulder
Center for the Study and Prevention of Violence

TOP 10 RECOMMENDATIONS FOR SCHOOL SAFETY

June 2018

In an effort to provide parents, schools and districts with information on steps for promoting school safety, we strongly recommend that all schools and districts have the following programs, policies, and procedures in place to prevent violence and promote safety in schools:

1. **Apply the U.S. Secret Service's seven major components and tasks for creating a safe/connected school climate (https://www2.ed.gov/admins/lead/safety/threatassessmentguide.pdf, Page 13):**
    1) Assessment of the school's emotional climate;
    2) Emphasis on the importance of listening in schools;
    3) Adoption of a strong, but caring stance against the code of silence;
    4) Prevention of, and intervention in, bullying;
    5) Involvement of all of the members of the school community in planning, creating, and sustaining a culture of safety and respect;
    6) Development of trusting relationships between each student and at least one adult at school;
    7) Creation of mechanisms for developing and sustaining safe school climates.
2. **Adopt a Safe Communities Safe Schools planning process which relies on adaptive leadership strategies (www.colorado.edu/cspv) or the equivalent, and includes:**
    a. Building a foundation and identifying goals for school and community safety;
    b. Collecting data on school climate, as well as student and staff needs;
    c. Developing an individualized school action plan to address data-identified gaps and needs;
    d. Implementing the plan, using evidence-based programs and practices; and
    e. Evaluating the impact of the plan, using data.
3. **Train staff on the red flags and warning signs for violence (e.g., social isolation, weapons fascination, anger problems, violent writings or drawings, disciplinary problems and non-compliance).**
4. **Implement hands-on training for students and staff on using an anonymous bystander reporting system to encourage the sharing of information and prevention of violence (e.g., Safe2Tell in Colorado).**
5. **Adopt a cognitive-skills based staff training program in threat assessment to provide a comprehensive safety and follow-up plan for students of concern, which follows the U.S. Secret Service and Department of Education's Threat Assessment in Schools (Fein et al., 2002) and has been empirically validated (e.g., Virginia-Student Threat Assessment Guide).**
6. **Install an evidence-based bullying prevention program whenever school climate data reveal bullying issues (see Blueprints Programs at http://www.blueprintsprograms.com).**
7. **Adopt an evidence-based suicide risk assessment tool (e.g., Columbia-Suicide Severity Rating Scale) and response system.**
8. **Complete a school safety audit to evaluate the physical and non-physical aspects of campus security and student and staff safety, including lockdown and lockout drills, target hardening, and reunification planning (e.g., Standard Response Protocol: http://www.iloveuguys.org/srp.html).**
9. **Adopt a Crime Prevention Through Environmental Design (CP-TED) approach to physical safety to deter criminal behavior through environmental design.**
10. **Follow the Colorado Attorney General's Opinion No. 18-01 on Family Educational Rights and Privacy Act (FERPA) guidelines for information sharing and complete an Interagency Information Sharing Agreement with law enforcement, mental health, social service, court, and corrections agencies to detail information to be shared and not shared (e.g., Colorado legislation: CRS 22-32-109.1(3), CRS 19.1.303 and 304; see also https://coag.gov/node/617).**

THE ACES STUDY:

The Adverse Childhood Experiences Study (ACE Study) is a research study conducted by the American health maintenance organization Kaiser Permanente and the Centers for Disease Control and Prevention. Participants were recruited to the study between 1995 and 1997 and have been in long-term follow up for health outcomes. The study has demonstrated an association of adverse childhood experiences (ACEs) (aka childhood trauma) with health and social problems across the lifespan. The study has produced many scientific articles and conference and workshop presentations that examine ACEs.

In the 1980s, the dropout rate of participants at Kaiser Permanente's obesity clinic in San Diego, California, was about 50%; despite all of the dropouts successfully losing weight under the program.[2] Vincent Felitti, head of Kaiser Permanente's Department of Preventive Medicine in San Diego, conducted interviews with people who had left the program, **and discovered that a majority of 286 people he interviewed had experienced childhood sexual abuse**. The interview findings suggested to Felitti that weight gain might be a coping mechanism for depression, anxiety, and fear.

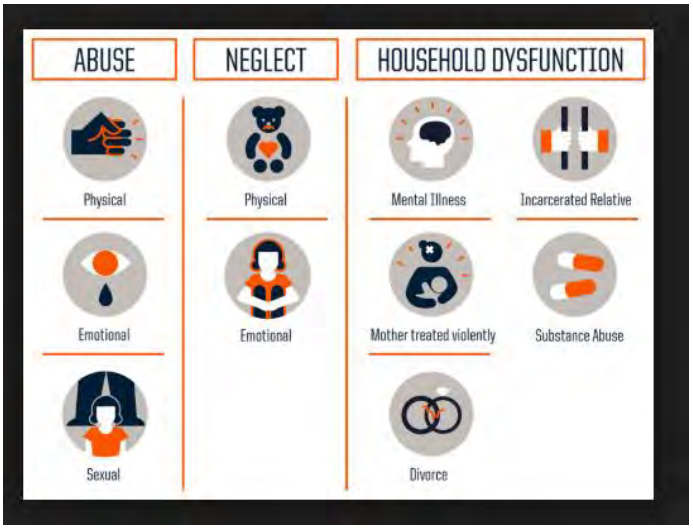
Felitti and Robert Anda from the Centers for Disease Control and Prevention (CDC) went on to survey childhood trauma experiences of over 17,000 Kaiser Permanente patient volunteers. The 17,337 participants were volunteers from approximately 26,000 consecutive Kaiser Permanente members. About half were female; 74.8% were white; the average age was 57; 75.2% had attended college; all had jobs and good health care, because they were members of the Kaiser health maintenance organization.[3] Participants were asked about different types of childhood trauma that had been identified in earlier research literature:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Exposure to domestic violence
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

- Adverse childhood experiences are common. For example, 28% of study participants reported physical abuse and 21% reported sexual abuse. Many also reported experiencing a divorce or parental separation, or having a parent with a mental and/or substance use disorder.
- Adverse childhood experiences often occur together. Almost 40% of the original sample reported two or more ACEs and 12.5% experienced four or more. Because ACEs occur in clusters, many subsequent studies have examined the cumulative effects of ACEs rather than the individual effects of each.
- Adverse childhood experiences have a dose–response relationship with many health problems. As researchers followed participants over time, they discovered that a person's cumulative ACEs score has a strong, graded relationship to numerous health, social, and behavioral problems throughout their lifespan, including substance use disorders. Furthermore, many problems related to ACEs tend to be comorbid, or co-occurring.

About two-thirds of individuals reported at least one adverse childhood experience; 87% of individuals who reported one ACE reported at least one additional ACE. The number of ACEs was strongly associated with adulthood high-risk health behaviors such as smoking, alcohol and drug abuse, promiscuity, and severe obesity, and correlated with ill-health including depression, heart disease, cancer, chronic lung disease and shortened lifespan. Compared to an ACE score of zero, having four adverse childhood experiences was associated with a seven-fold (700%) increase in alcoholism, **a doubling of risk of being diagnosed with cancer**, and a four-fold increase in emphysema; **an ACE score above six was associated with a 30-fold (3000%) increase in attempted suicide.**

The ACE study's results suggest that maltreatment and household dysfunction in childhood contribute to health problems decades later. These include chronic diseases—such as heart disease, cancer, stroke, and diabetes—that are the most common causes of death and disability in the United States. the study's findings, while relating to a specific population within the United States, might reasonably be assumed to reflect similar trends in other parts of the world, according to the World Health Organization.



IDEA! The Michigan ACE Initiative is focused on expanding efforts toward awareness of Adverse Childhood Experiences and creating statewide community coalitions to recommend development of appropriate interventions, state policy, and to provide for the implementation of Medicaid policy for ACE. https://miace.org/

Position Statement 41: Early Identification of Mental Health Issues in Young People

mentalhealthamerica.net/positions/early-identification

October 17, 2013

Policy

Early identification, accurate diagnosis and effective treatment of mental health and substance use conditions[1] can alleviate enormous suffering for young people and their families dealing with behavioral health challenges. Providing early care can help young people to more quickly recover and benefit from their education, to develop positive relationships, to gain access to employment, and ultimately to lead more meaningful and productive lives.

Thus, Mental Health America (MHA) supports universal screening for potential mental health problems for the same reasons and in the same settings that screening has long been mandated for potential physical health problems, like vision and hearing. MHA believes that early identification of mental health and substance use issues should occur where and when young people are mostly likely to present concerns, such as in school. In addition to schools, primary health care providers and other community leaders should be given the tools and supports necessary to identify signs of mental health or substance use issues at the earliest possible time. This position is endorsed by the American Academy of Pediatrics[2] and (for depression in youth over age 11) the United States Preventive Services Task Force.[3] Doing so will reduce the likelihood and consequences of delaying care.

Community outreach and education are necessary to identify problems in order to refer youth to additional comprehensive assessment and to the care they need to cope with mental health and substance use challenges. Funding and promotion of community outreach and education to identify early signs of mental health and substance use conditions can arm parents, teachers, friends, spiritual leaders, mentors, and community leaders with knowledge, skills, and resources for identifying and referring youth into necessary care. Additional research is needed to identify the best curricula for community-wide education that will most likely lead to proper referral and reduce the severity and duration of mental illness and addiction.

Whenever warning signs are observed, resources should be available to parents or guardians to access comprehensive mental health and substance use evaluations and services needed to promote recovery.[4] Access to adequate care can reduce barriers to learning and improve educational, behavioral and health outcomes for our youth. The best services promote collaboration among all of the people available to help, including families, educators, child welfare case workers, health insurers, and community mental health and substance use treatment providers. Barriers should be reduced and incentives created to ensure increase collaboration across systems and funding sources.

Background

Mental health problems affect one in five young people at any given time, and about two-thirds of all young people with mental health problems are not getting the help they need. [5] [6] Research shows that early intervention can prevent significant mental health problems from developing.[7] Epidemiological research confirms the relationship between mental health issues and suicide or self-mutilation, substance abuse, suspension, dropping out, expulsion and involvement with the juvenile justice system.[8] The research also shows that effective treatment can reduce the risk of such consequences.[9] [10]

The 2002 New Freedom Commission on Mental Health proposed as a goal that: "In a transformed mental health system, the early detection of mental health problems in children and adults - - through routine and comprehensive testing and screening - - will be an expected and typical occurrence."

The U.S. Centers for Disease Control and Prevention[11] and the Substance Abuse and Mental Health Services Administration[12] conduct comprehensive research on the prevalence rates of mental health and substance use issues as well as the barriers to accessing care. Key recent findings include:

- Millions of American young people live with depression, anxiety, psychosis, attention problems, autism spectrum disorders, and a host of other mental and behavioral health issues. Attention Deficit and Hyperactivity Disorder (ADHD) was the most prevalent current diagnosis among children and youth aged 3–17 years.[13]
- The number of young people with a mental disorder increased with age, with the exception of autism spectrum disorders, which was highest among 6 to 11 year old children.
- Boys were more likely than girls to have attention, behavioral or conduct problems, autism spectrum disorders, anxiety, and cigarette dependence.
- Adolescent boys aged 12–17 years were more likely than girls to die by suicide.
- Adolescent girls were more likely than boys to have depression or an alcohol use disorder.

Young people aged 3-17 years had:

- Attention problems (6.8%)
- Behavioral or conduct problems (3.5%)
- Anxiety (3.0%)
- Depression (2.1%)
- Autism spectrum disorders (1.1%)

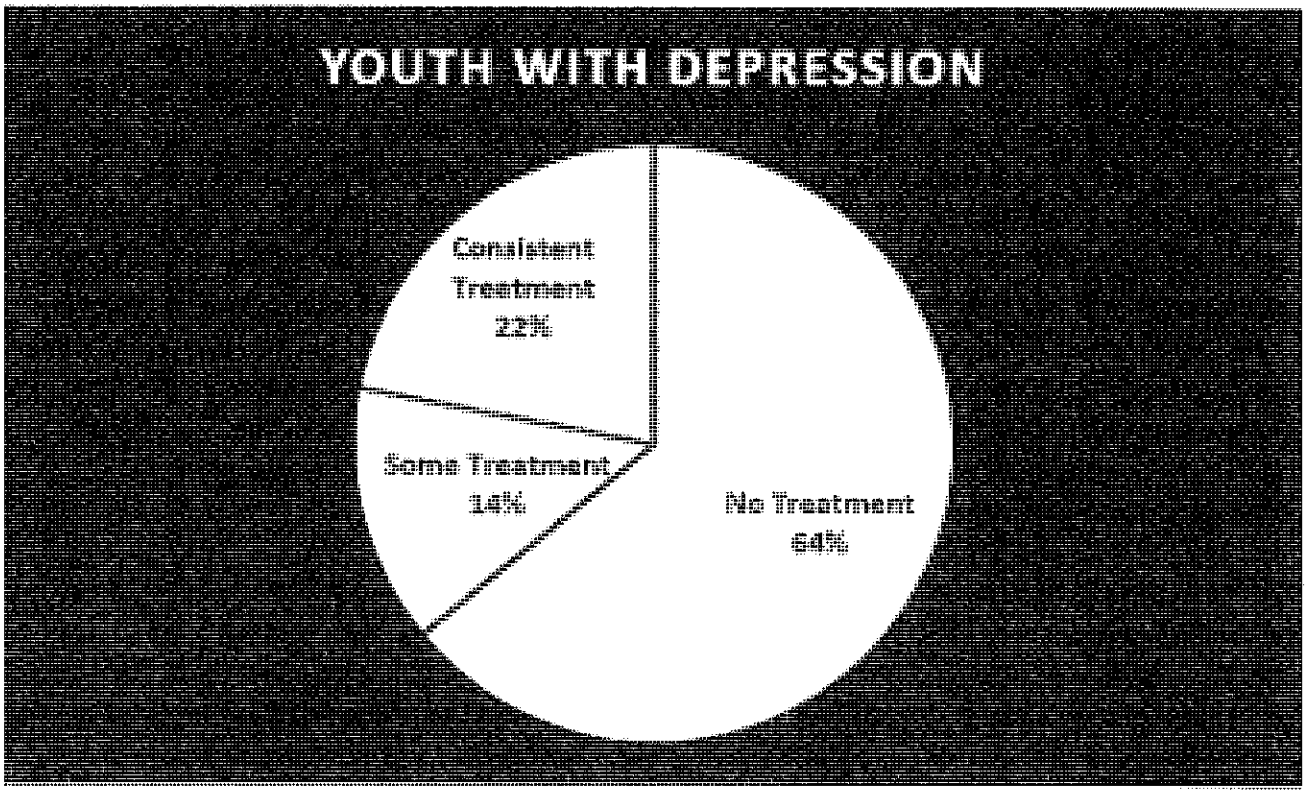
Adolescents aged 12–17 years had:

- Illicit drug or alcohol dependence or abuse in the past year (5.5%)
- Major depression (11%);
- Severe depression[14] (7%)
- Cigarette dependence in the past month (2.8%)
- Bipolar disorder (3%)[15]

- Eating disorder (2.7%)[16]

Recent research on early signs of psychotic illnesses like schizophrenia identified that 100,000 adolescents and young adults experience first episode psychosis each year.[17]

And suicide, which can result from the interaction of mental disorders and other factors, was the second leading cause of death among adolescents aged 12–17 years in 2013.[18]



Evaluating access to care, 64% of youth with major depression did not receive any mental health treatment, while only 22% receive any consistent treatment (7+ visits annually).[19] Despite passage of the Affordable Care Act and mental health parity, 8% of youth do not have any mental health insurance coverage.[20]

Research provides us with an understanding of the prevalence of mental health and substance use problems among youth. The importance of identifying and targeting problems in young people both before and after adolescence is strengthened by the fact that 50 % of mental health problems present themselves before the age of 14 – more often than not tied to brain changes that occur during puberty. [21] [22]

Screening

Universal screening for mental health problems is necessary to reach youth who otherwise would fall through cracks. Pediatricians, primary care physicians and other health care providers are indispensable adjuncts to school-based assessment in identifying signs of mental health problems because they routinely see young people and their families and because confidentiality is assured. Even if specialized mental health treatment is not readily available, the support of a primary care physician and staff can go a long way in providing support and getting people on a path towards

recovery. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions are among the most specific in the Social Security Act,[23] but they cover only Medicaid recipients and have not always been fully implemented. Research has provided reliable, culturally and linguistically competent early identification and diagnostic tools.[24][25] Increasingly, models of collaborative care provide primary care providers with the additional support necessary to provide comprehensive treatment in primary care that meet the individualized needs of the child and family, available on a nondiscriminatory basis.[26][27][28]

Although schools are required to identify all mental and other health impediments to learning under the federal Rehabilitation Act and Individuals with Disabilities Education Improvement Act, including mental health issues, screening for emotional or behavioral difficulties in schools has sometimes been controversial and politicized. The concerns regarding school-based screening include the potential conflict between the Family Educational Rights and Privacy Act,[29] which governs most school records, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[30] which governs all medical and mental health records. There are concerns about how to protect confidentiality of mental health and substance use evaluations in an educational setting, and there are concerns about how best to follow up with parents or guardians by school personnel to ensure linkage to follow up care. In addition, issues of possible cultural and racial bias are a significant concern among people of color. The development of reliable and culturally and linguistically appropriate screening tools remains an urgent priority.[31]

MHA acknowledges these challenges of school-based mental health screening. However, with appropriate safeguards, MHA supports well-designed pre-school-based and school-based screening programs. Because teachers, school psychologists, social workers and other counselors have extended contact with children on a daily basis, they are often in the best position to recognize early patterns of behavior that pose a risk for a child's academic, social, emotional or behavioral functioning. While teachers and other school administrators are not and should not become diagnosticians, their candid communication with the family is vital in promoting students' well-being, including their mental health. Where any health problems are noted, their concerns should be shared with the parents or guardian in a timely manner, and parents and guardians should be counseled to see their primary care physician or a mental health professional concerning their child's need for mental or other health care.
Mental health and substance use problems should be treated no differently than other health-related concerns. School personnel should be trained to recognize the early warning signs of mental health and substance use conditions and to know the appropriate actions to take in notifying parents or guardians and in protecting the rights and privacy of young people.
In so doing, it is important to maintain strict confidentiality in accordance with HIPAA, communicating in a clear and culturally competent manner, and involving the parents or guardians in respectful shared decision-making.

Several states have sought to ban mental health screening in schools. MHA opposes such legislation because it compromises the responsibilities of the schools under federal law to provide an education to all young people, regardless of disability, compromises the schools' obligation to identify and address significant impediments to learning of all kinds, discriminates against young

people with emotional or behavioral difficulties, and risks constraining free communication by teachers and counselors to parents and guardians, which is essential to early identification and effective treatment of mental health and substance use conditions.

Outreach and education

Promoting community education has been identified as a goal in the U.S. Department of Health and Human Services' Healthy People 2020 initiative. The initiative is significant in recognizing that education programs play a key role in preventing disease, improving health, and enhancing quality of life and includes educating communities on mental illness, behavioral health, substance use, tobacco use, and injury prevention.[32] Public education is needed to assure that parents, friends, teachers, school officials, primary care physicians and other health care providers can identify the early signs of mental health and substance use problems so that young people can receive the help that they need in a timely manner. With long-term investment among stakeholders at various levels in communities, programs related to mental health education have been shown to reduce rates of suicide[33], increase student knowledge of depression[34], and increase in help seeking behaviors.[35] Research testing new models for community health education has demonstrated the effectiveness of increased proactive engagement among key stakeholders to improve youth mental health.[36] Specifically, providing effective community-based outreach and education increases the likelihood of effective referral from a community member (like a teacher or spiritual leader) to supportive services that provide additional comprehensive assessment and therapeutic services. Teachers/educators need to learn de-escalation techniques and skills to decrease crisis situations leading to suspensions of young people with mental health conditions.

In order to prioritize community education, additional funding is needed. Despite the research on the benefits of community education for early identification of mental health problems, no current funding is available for comprehensive community-based education on the early warning signs of mental illness, early brief intervention, and linkage and referrals to treatment. New research has provided a starting point for promising programs in community-based education in mental health, and more research and research funding is needed to identify specific curricula and outreach activities that can promote early identification and effective linkage to appropriate treatment and supports.

Linkage

For early identification to have any value, public and private resources must be available to assure effective treatment. Reliable early identification of health problems in schools and primary care settings and effective, nondiscriminatory treatment can help to address a young person's needs before they lead to greater academic or social problems, including suicide or self-injury, substance use, school failure, suspension, dropping out, or expulsion, or involvement with the juvenile justice system.

In January, 2016, the U.S. Department of Education with and the U.S. Department of Health and Human Services called *Healthy Students, Promising Futures*.[37] The toolkit provided five high impact opportunities for collaboration between health care and schools: 1) help eligible students and family members enroll in health insurance, 2) provide and expand reimbursable health services

in schools, 3) provide or expand services that support at-risk students including through Medicaid-funded case management, 4) promote health school practices through nutrition, physical activity, and health education, and 5) build local partnerships and participate in community needs assessments. Implementing the five opportunities would make significant change towards reducing the burden for teachers and parents to coordinate services, improve children's outcomes, and reduce the need for additional special education services.

Call to Action

- As part of parity, private and public health insurers should sufficiently reimburse for psychoeducation, screening, brief intervention, referral, and follow-up in the same way that primary health care prevention is reimbursed;
- EPSDT compliance, i.e. rates of screening, brief intervention, referral, and follow-up, should be publically reported and failures to comply should be routinely investigated. Consent decrees have been entered against several states that were not meeting their EPSDT obligations.[38]
- States should prohibit the grade retention, suspension or expulsion of a child unless the child has received appropriate mental health screening.
- As part of the Every Student Succeeds Act implementation, school districts should identify current programming that supports identification and treatment for mental health and coordinate and augment these efforts to ensure that they fully meet the social and emotional needs of the students, as revealed by the district's needs assessment. Getting and protecting required funding for screening and treatment is essential as schools face cutbacks.[39] States should facilitate the process of health clinics opening branch sites inside of schools to supplement the school-based health center movement.
- The Medicare coverage determination and evaluation by CMS should be revised in light of the U.S. Preventive Services Task Force update on depression screening, so that it covers screening, brief intervention, referral, and follow-up, not only screening when supports are in place;
- The Department of Education and the Department of Health and Human Services should provide additional technical assistance for its toolkit, *Healthy Students, Promising Futures* (cited above), and states should provide guidance on how to implement the recommendations;
- The Office of Civil Rights of the Department of Education should audit states for compliance with the child finding provision of the Individuals with Disabilities Education Act, which requires states to identify children with disabilities.
- Additional federal and state funding can support research and implementation of community based education on early warning signs and early brief strategies for prevention and early intervention.
- Affiliates can offer information and training to pediatricians and other primary care providers about early identification and screening.
- Affiliates can offer training sessions to parents and school personnel on appropriate early identification of children at risk, alternatives for getting help, and effective communication by school personnel.

- Affiliates can support federal efforts in promoting state and local entities in adopting the recommendations from *Healthy Students, Promising Futures.*
- Affiliates and advocates should encourage early identification and early intervention and should work to defeat any legislation that gets in the way of candid discussion of mental health and substance use issues.

Effective Period

Mental Health America Board of Directors adopted this policy on September 18, 2016. It will remain in effect for a period of five (5) years and is reviewed as required by the Mental Health America Public Policy Committee

Expiration Date: December 31, 2021

[1] The term "mental health or substance use conditions" as used in this policy statement is intended to include the federal term "emotional or behavioral disturbance."

[2] AAP *Schedule of Screenings and Assessments for Well-Child Assessments* (February 24, 2014), https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Updates-Schedule-of-Screening-and-Assessments-for-Well-Child-Visits.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR:+No+local+token

[3] PSPSTF *Depression in Children and Adolescents*: *Screening* (February 2016), http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1

[4] Early intervention in response to identified mental health or substance use conditions is distinguished from mental health and sobriety promotion and prevention of mental health and substance use disorders, which are addressed separately in MHA Position Statement 48. http://www.nmha.org/go/about-us/what-we-believe/position-statements/p-48-prevention-in-young-people/position-statement-48-prevention-of-mental-health-and-substance-use-disorders-in-young-people

[6] Merikangas, K.R., He, J,P., Burstein, M.E., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S. & Olfson, M.. "Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child and Adolescent Psychiatry* 50(1):32-45 (2011).

[7] O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.), *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities,* National Academies Press (2009).

[9] U.S. Interagency Working Group of Youth Programs (IWGYP). *How Mental Health Disorders Affect Youth,* http://youth.gov/youth-topics/youth-mental-health/how-mental-health-disorders-affect-youth.

[10] O'Connell, M.E., Boat, T. and Warner, K.E., eds. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities,* op. cit.

[12] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages,* http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.pdf)

[13] This may be misleading, since ADHD is often used to diagnose attention problems that are best diagnosed as other mental health conditions. To learn more, visit: http://childmind.org/article/the-most-common-misdiagnoses-in-children/.

[14] i.e., significant depression below the level needed to confirm a major depression diagnosis.

[15] National Institute of Mental Health, *Bipolar Disorder among Children,* http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-children.shtml

[17]National Institute of Mental Health, *RAISE Questions and Answers,* http://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml

[20] Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health* 2013, op. cit.

[21] Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K.R. & Walters, E.E., "Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication," *Arch Gen Psychiatry*. 62(6):617-27 (2005).

[22] Paus, T., Keshavan, M., & Giedd, J. N., "Why Do Many Psychiatric Disorders Emerge During Adolescence?" *Nature Reviews Neuroscience* 9(12): 947-957 (2008).

[23] See 42 U.S.C.§§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

[24] Wulsin, L., Somoza, E. & Heck, J., "The Feasibility of Using the Spanish PHQ-9 to Screen for Depression in Primary Care in Honduras," *J Clin Psychiatry* 4(5):191-195 (2002).

[25] García-Campayo, J., Zamorano, E., Ruiz, M.A., Pardo, A., Pérez-Páramo, M., López-Gómez, V., Freire, O. & Rejas, J., "Cultural Adaptation into Spanish of the Generalized Anxiety Disorder-7 (GAD-7) Scale as a Screening Tool," *Health and Quality of Life Outcomes* 8(1):1 (2010).

[26] Connor, D.F., McLaughlin, T.J., Jeffers-Terry, M., O'Brien, W.H., Stille, C.J., Young, L.M. & Antonelli, R.C., "Targeted Child Psychiatric Services: a New Model of Pediatric Primary Clinician—Child Psychiatry Collaborative Care," *Clinical Pediatrics* 45(5):423-434 (2006).

[27] Zatzick, D., Russo, J., Lord, S.P., Varley, C., Wang, J., Berliner, L., Jurkovich, G., Whiteside, L.K., O'Connor, S. & Rivara, F.P., "Collaborative care intervention targeting violence risk behaviors, substance use, and posttraumatic stress and depressive symptoms in injured adolescents: a randomized clinical trial. *JAMA Pediatrics* 168(6):532-539 (2014).

[28] Garner, A.S., Shonkoff, J.P., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., Pascoe, J. & Wood, D.L., "Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health," *Pediatrics*, 129(1):e224-e231 (2012).

[29] 20 U.S.C. § 1232g; 34 CFR Part 99

[30] P.L. 104-191, 110 Stat.1936 (1996), 29 U.S.C. §1181, 42 U.S.C. §1320, 1395, and associated rulemaking by the Department of Health and Human Services, 45 C.F.R. §§160-164. HIPAA enforcement was substantially strengthened by the passage of the HITECH Act, Public Law 111–5, 123 Stat. 115 (2009), and sections within 45 CFR part 160 finalized in 2013 that relate to the authority of the Secretary of the HHS to impose civil penalties under Section 1176 of the Social Security Act, 42 U.S.C. 1320d–5.

[31] Feeney-Kettler, K.A., Kratochwill, T.R., Kaiser, A.P., Hemmeter, M.L. & Kettler, R. J., "Screening Young Children's Risk for Mental Health Problems: A Review of Four Measures," *Assessment for Effective Intervention* 35(4):218-230 (2010).

[32] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2020*, Education and Community-Based Programs. https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs

[33] Fountoulakis, K.N., Gonda, X., & Rihmer, Z., "Suicide Prevention Programs Through Community Intervention." *Journal of Affective Disorders* 130(1):10-16 (2011).

[34] Swartz, K.L., Kastelic, E.A., Hess, S.G., Cox, T.S., Gonzales, L.C., Mink, S.P. and DePaulo, J.R., "The Effectiveness of a School-Based Adolescent Depression Education Program," *Health Education & Behavior* 37(1):11-22 (2010).

[35] Ruble, A.E., Leon, P.J., Gilley-Hensley, L., Hess, S.G. and Swartz, K.L., "Depression Knowledge in High School Students: Effectiveness of the Adolescent Depression Awareness Program," *Journal of Affective Disorders* 150(3):1025-1030 (2013).

[37] *Healthy Students, Promising Futures, State and Local Action Steps and Practices to Improve School Based Health,* Department of Health and Human Services and Department of Education (Jan 2016), http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf

[38] Over the years, states have not adhered to the ESPTD mandate, and litigation has resulted. EPSDT establishes a broad scope of benefits—all the services listed within the Social Security Act at 42 U.S.C. § 1396d(a)—and a uniform medical necessity definition—services needed to "correct or ameliorate" the child's physical or mental conditions. 42 U.S.C. §1396d(r)(5). Advocates are citing these broad treatment requirements to obtain coverage for a range of services that children

need to live at home and in the community, including screening, rehabilitative services, case management, home health care, and personal care services. See, generally, National Health Law Program, *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* (October 15, 2013), http://www.healthlaw.org/issues/child-and-adolescent-health/epsdt/health-advocate-epsdt#.V6JEVjUe48I

[39] The Minnesota Association for Children's Mental Health has prepared two exemplary toolkits for teachers: *Unlocking the Mysteries of Children's Mental Health: An Introduction for Future Teachers,* Minnesota Association for Children's Mental Health, St. Paul, MN (Rev. Ed. 2004.) and *A Teacher's Guide to Children's Mental Health*, Minnesota Association for Children's Mental Health, St. Paul, MN (2002). See http://www.macmh.org/macmh-publications/

Dr. Sarah Davidon
Mental Health Colorado

Big picture

- Rates of mental health and substance use problems
- Mental health providers in schools and community
- Rates of suspension/expulsion (though 25% of students with serious emotional disability are suspended or expelled)
- Low commitment to school
- High opportunities for prosocial involvement

School mental health professionals

MENTAL HEALTH COLORADO

Professional	Douglas Ratio	Colorado Ratio	Recommended Ratio	Information Date
Nurses	1:1464	1:1432	1:750	2017-18
Social Workers	1:1491	1:1380	1:250	2017-18
Psychologists	1:966	1:1112	1:700	2017-18
School Counselors	1:655	1:455	1:250	2017-18

Workforce for children

Professional	Douglas Ratio	Denver Ratio
Child Psychiatrists	**2.4** per 100,000 children	**11.4** per 100,000 children
Social Workers	**5** per 100,000 children	**52.4** per 100,000 children
Marriage and Family Therapists	**12.7** per 100,000 children	**17.6** per 100,000 children
Pediatricians	**4.1** per 100,000 children	**17.6** per 100,000 children

Healthy Kids Colorado Survey

Designed to assess adolescent

- substance use
- antisocial behavior
- Violence
- Mental health
- Risk factors
- Protective factors

HKCS highlights

MENTAL HEALTH COLORADO

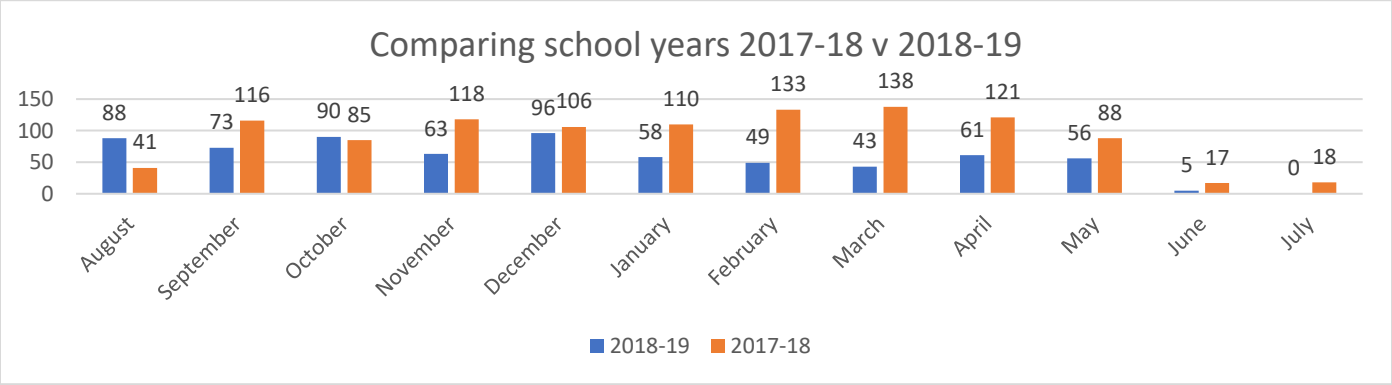
48% report low commitment to school

46% report favorable attitudes toward substance use

69% report opportunities for prosocial involvement

57% report rewards for prosocial involvement

Text-a-Tip Statistics
Douglas County Sheriff's Office
Phyllis Harvey, YESS Program Coordinator – pharvey@dcsheriff.net



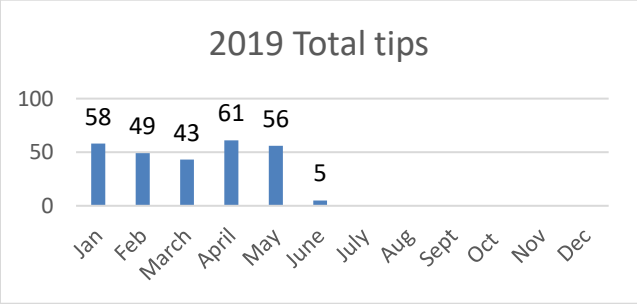
****2018-19 school year total is down 391 tips over prior school year.**

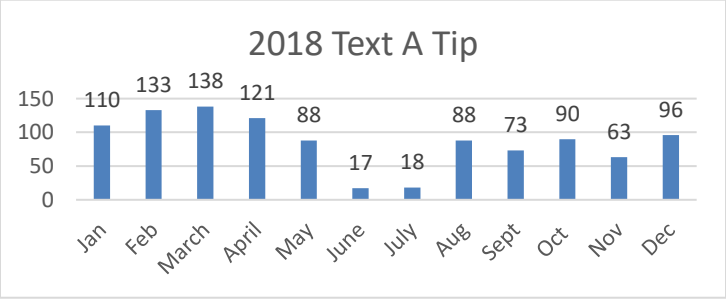
2016-17 school year	2017-18 school year	2018-2019 school year
1 TRHS = 154	1 TRHS = 255	1 TRHS = 198
2 HRHS = 102	2 MVHS = 145	2 MVHS = 93
3 MVHS = 92	3 RCHS = 139	3 RCHS = 64
4 RCHS = 85	4 MRMS = 98	4 HRHS = 60
5 MRMS / RVMS = 36 each	5 HRHS = 85	5 PHS = 52

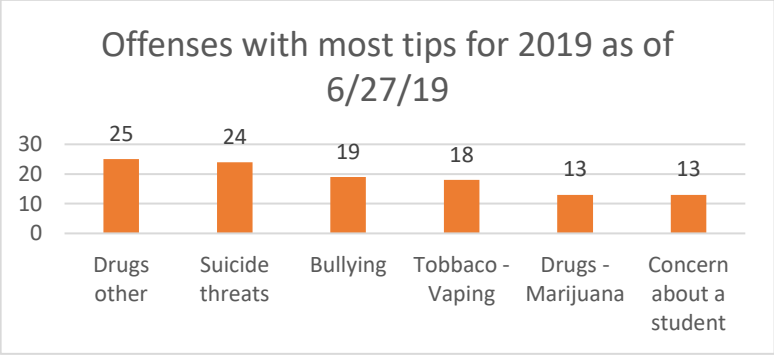
Lives saved:

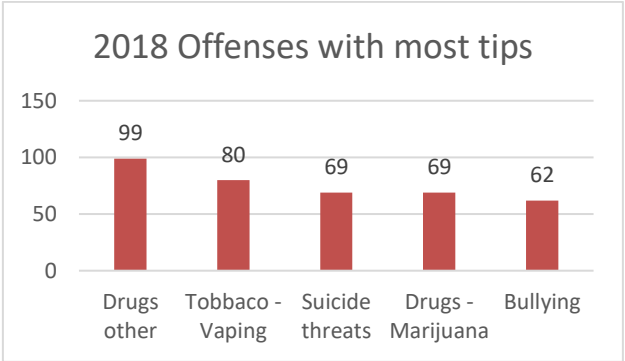
29 that we know of from suicide

MVHS Case

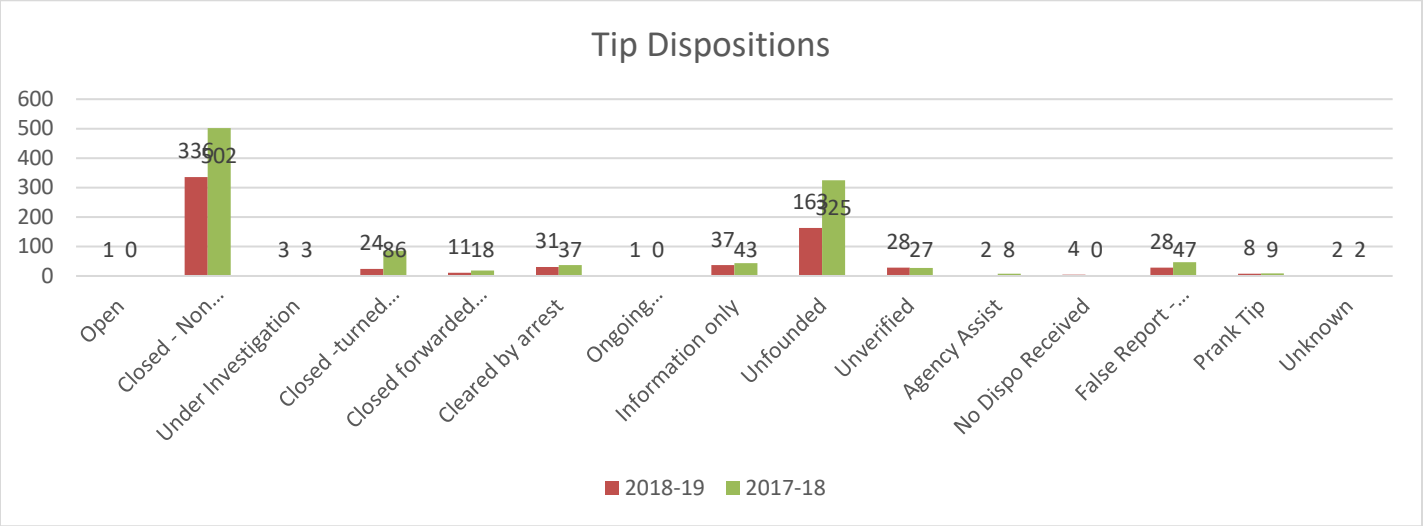


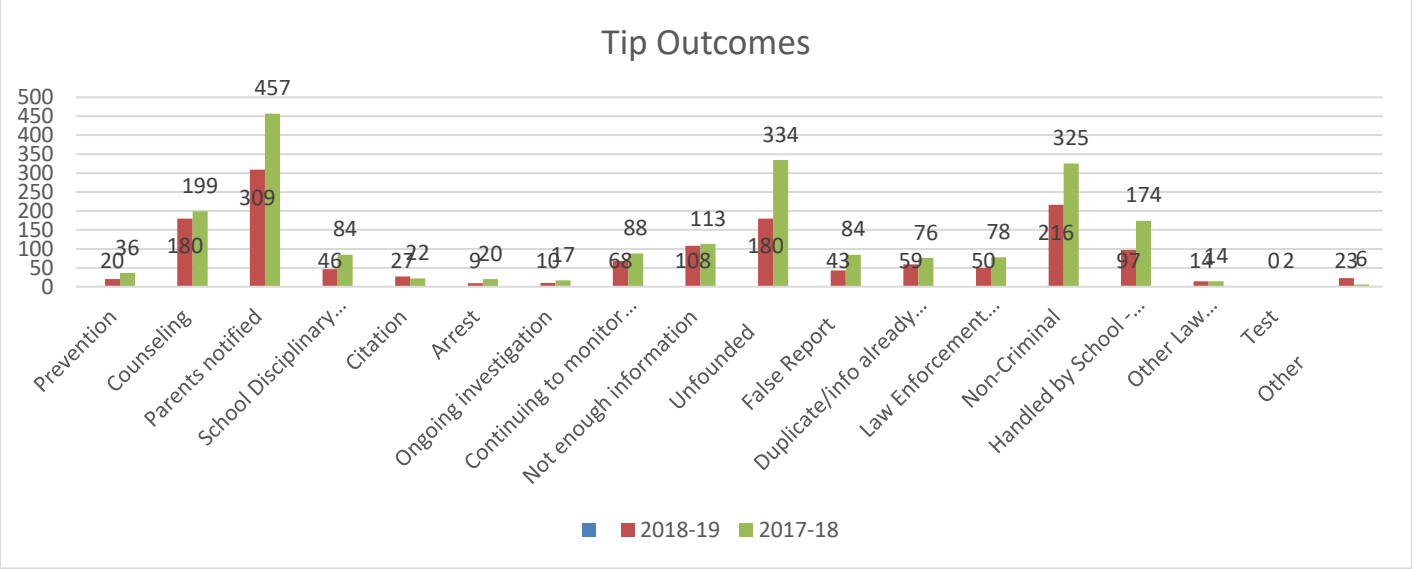


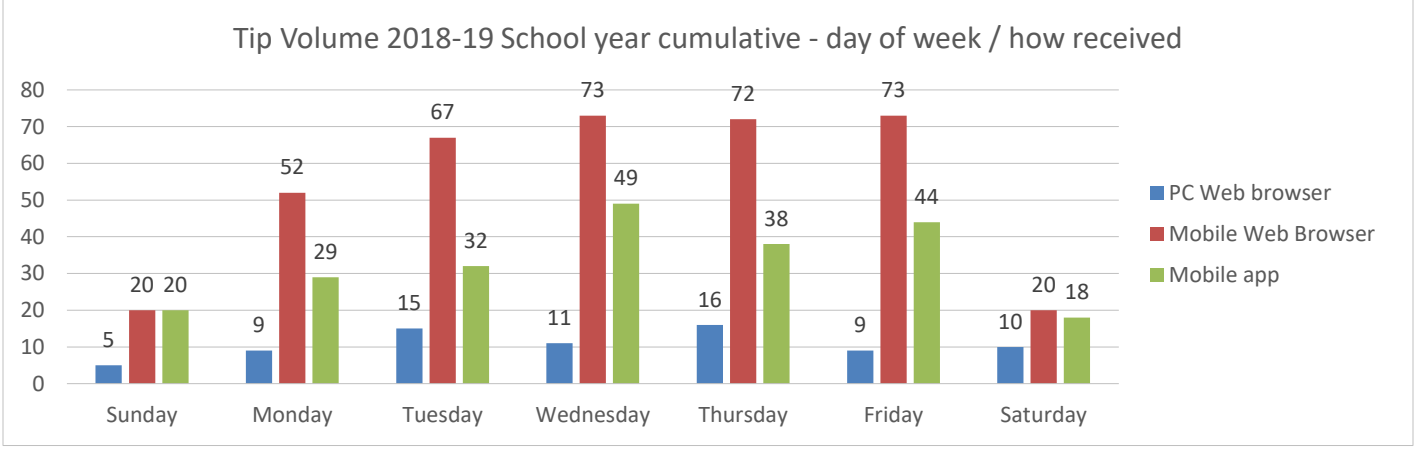




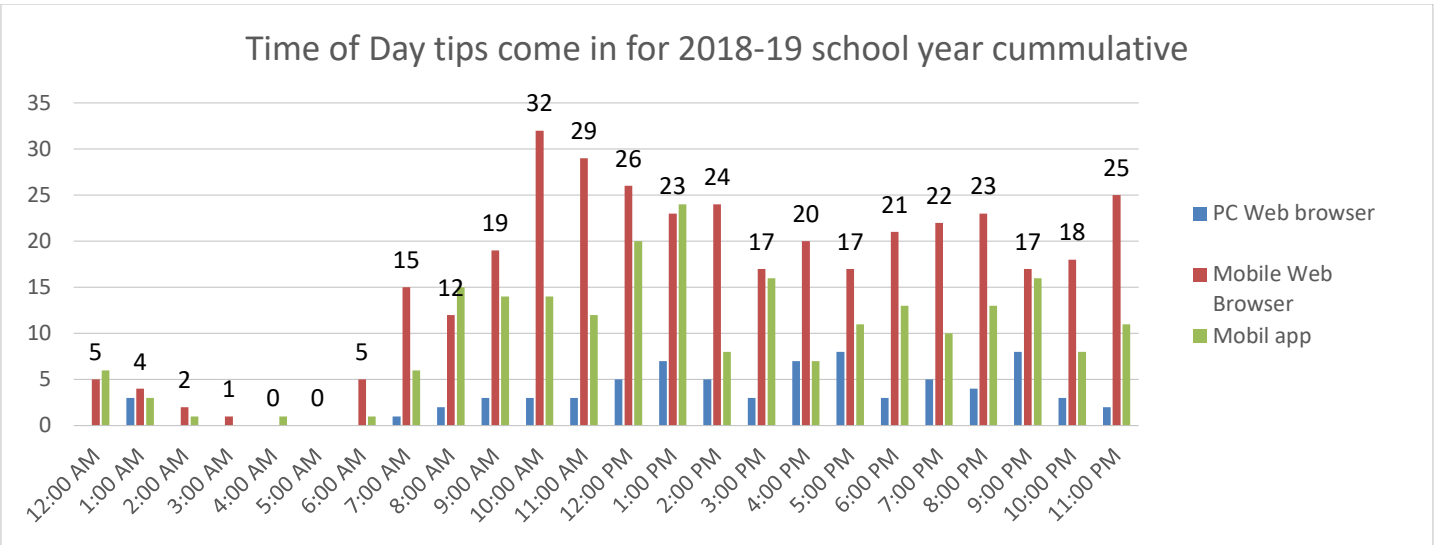
Text-a-Tip Statistics, continued







Text-a-Tip Statistics, continued



Douglas County School District
Mental Health Strategies
6-28-19

Douglas County School District

Learn Today, Lead Tomorrow

Continuum of DCSD Mental Health Services

DCSD's MTSS for Mental and Physical Safety

School Counselors
Work with all students on academics, college and career readiness, and personal and social needs

School Social Workers and School Psychologists
Work with students to help identify and problem solve around barriers that prevent students from learning and being successful in school

Crisis Response Team
Partners with schools when a traumatic event has occurred to provide structure and resources

Autism Team
Collaborates to develop and improve programming for students through coaching and consulting

Behavior Team
Collaborates to build school staff capacity to provide a continuum of behavioral support for all learners

Prevention and School Culture Team
Preventing bullying, substance abuse, suicide, and acts of violence

Health Services
School nurse consultants & registered nurses advancing well-being, academic success, and lifelong achievement

Healthy Schools Team
Incorporates CDC's Whole School, Whole Community, Whole Child model

Tier 1: Prevention

- Sources of Strength
- Building Resilient Me
- The Outrage
- Success in the Middle
- Youth Education & Safety in Schools (Y.E.S.S.)
- Mental Health First Aid
- SafeTALK
- Applied Suicide Intervention Skills Training (ASIST)
- Second Step
- Restorative Practices
- Skillstreaming
- Mindfulness

Tier 2: Targeted

Services

- Individual and Group Counseling
- Behavior Intervention Plans

Curriculum

- Brainwise
- Why Try
- Social Thinking
- Signs of Suicide
- CPI

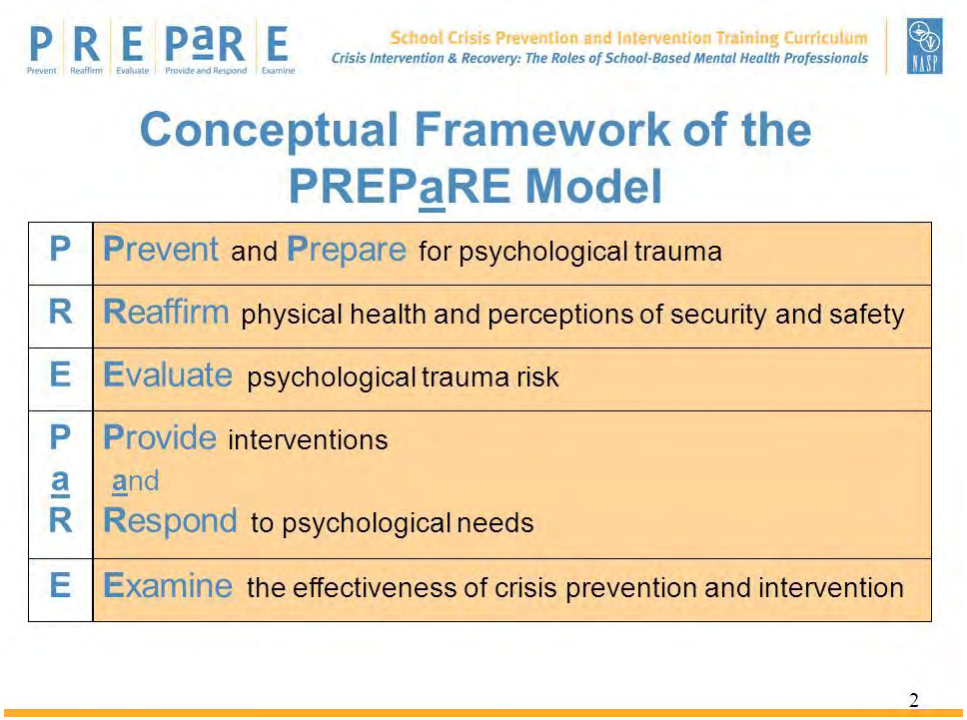
Tier 3: Intensive

Services

- ALPs
- 504 Plans
- IEPs
- Safety Assessments
- Crisis Response

Curriculum & Training

- Facing Your Fears
- Coping Cat
- STEADY Project
- Starfish Grief Training
- Suicide to Hope
- PREPARE 2



School Examples of other programs

Cimarron Middle	Positive Action Collaborating with University of Colorado Boulder using the Safe Communities Safe Schools model	Social and Character Development including positive actions, prevention of substance abuse and problematic behavior
Stone Mountain Elementary	Energy Bus Framework for Schools based on work of Jon Gordon and Niki Spears	Teaches all to lead a more positive life by taking risks, transforming negativity, and being the best version of ourselves

Ideas for Expansion

Additional Training & Materials

- ASIST
- Suicide to Hope
- Sources of Strength
- Signs of Suicide
- PREPARE 3
- All Staff Well Being

Additional SEL Curriculum

- The Incredible Years Series
- The PAX Good Behavior Game
- Riding the Waves

Youth Crisis and Support Resources in Adams, Arapahoe and Douglas Counties

Colorado Crisis Services/ Rocky Mountain Crisis Partners

coloradocrisisservices.org

For any mental health crisis or to find out more mental health resources

- 24 Hour Call (1-844-493-8255)
- 24 Hour Text (TALK to 38255*)
- 24 Hour Chat coloradocrisisservices.org

Walk-In Clinics:

- Westminster 2551 W 84th Ave Westminster, CO 80031
- Littleton 6509 S. Santa Fe Drive Littleton, CO 80120
- Denver 4353 E. Colfax Ave Denver, CO 80220
- Aurora 791 Chambers Ave, Aurora, CO 80011
- Lakewood 12055 W. 2nd Place Lakewood, CO 80228
- Boulder 3180 Airport Road Boulder, CO 80301

Crisis Text Line

www.crisistextline.org

Connect to a volunteer crisis counselor. The service is free and text message charges do not apply to Verizon, AT& T, Sprint, or T-Mobile users.

- 24 Hour Text (text HOME to 741741)

Facebook chat www.facebook.com/crisistextline

National LGBT Youth Suicide Hotline (The Trevor Project)

www.thetrevorproject.org/pages/get-help-now

Suicide crisis especially for LGBT youth

- 24 Hour Call (1-866-488-7386)
- Text Trevor to 1-202-304-1200 (Monday - Friday, 1:00 pm-8:00 pm, Mountain Time)
- TrevorChat (Daily 1:00 pm-8:00 pm, Mountain Time)

Carson J Spencer Foundation

www.carsonjspencer.org 303-837-8466

- Suicide prevention program resources

HelpPRO Suicide Prevention Therapist Finder
www.helppro.com/SPTF/BasicSearch.aspx

Colorado Office of Suicide Prevention

www.coosp.org 303-692-2539

Douglas/Arapahoe Suicide Prevention Alliance

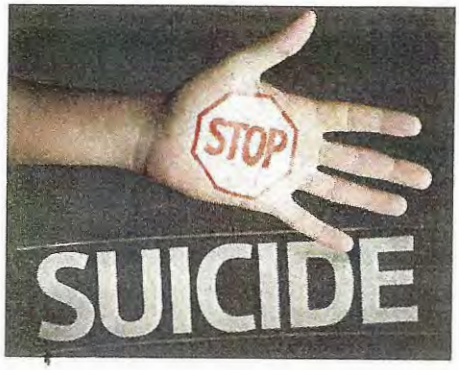
www.dasuicideprevention.org/home

- Offer suicide prevention training
- A.S.I.S.T (Applied Suicide Intervention Skills Training)
- safeTALK
- QPR (Question, Persuade, Refer)

Douglas County Sheriff Office and School District Partnership

Douglas County Sheriff's Office Text-A-Tip Program: Students can anonymously share information with law enforcement and school staff, for example someone selling drugs, bullying, threatening to hurt self or others. Contact the School Resource Officer (law enforcement) assigned to the school or School District Office Staff for more information.

Statewide: Safe2tell (877-542-SAFE) - reporting crime anonymously



Mental Health FIRST AID Colorado

www.mhfaco.org

Training program to empower individuals to identify, understand and respond to those in mental health and substance abuse crisis.

Mental Health First Aid, Youth Mental Health First Aid Class schedule list
www.mhfaco.org/find-a-class

My3app.org

www.my3app.org

Free app for suicide safety plan

All Health Network

www.allhealthnetwork.org

6509 South Santa Fe Drive, Littleton, CO
Walk-In, Crisis care, Acute treatment center

- Emergency and Crisis Intervention 303-730-3303)
- Intake/Appointment 303-730-8858

Aurora Mental Health Center

www.aumhc.org

Multiple locations, children and adolescent services, school-based therapists

- Intake/Appointment (303-617-2300)

Children's Hospital Pediatric Mental Health Institute

www.childrenscolorado.org/doctors-and-departments/departments/psych/

Behavioral and mental health treatment, Family Resource Assistance

- Parent Smart Health Line, for any health questions 720-777-0123 (free)
- Intake/Appointment 720-777-6200
- Resource navigation 720-777-4978

Community Reach Center

www.communityreachcenter.org

- Walk-in-Crisis Center, open 24 hours, every day 303-853-3500, 84th Ave. Neighborhood Health Center, 2551 W. 84th Ave., Westminster, CO 80031
- Mountainland Pediatrics 303-430-0823 8889 Fox Drive, Suite B, Thornton, CO 80260

Family Resource Pavilion/ Shiloh house

www.shilohhouse.org/facilities/family-resource-pavilion

- 24 Hour Call 720-213-1400
- 9700 E. Easter Lane, Centennial, CO 80112 Intensive therapeutic intervention for youth (5-17 years old)

Highlands Behavioral Health System

www.highlandsbhs.com

- 24 Hour Call 720-348-2800
- Adolescent specific treatment, behavioral health hospital 8565 S. Poplar Way, Littleton, CO 80130

NAMI (National Alliance on Mental Illness) of Colorado

www.namicolorado.org

Support and resource navigation for people who need mental health services and their family members.

- NAMI Colorado Helpline - resource navigation 303-321-3104 or email helpline@namicolorado.org

Peak View Behavioral Health

www.peakviewbh.com

24 hour call: 719-444-8484
Inpatient/Outpatient Behavioral Health Hospital
Youth, Adolescent, Adult and Seniors
7353 Sisters Grove Colorado Springs, CO 80923

Second Wind Fund

www.thesecondwindfund.org

Provides financial support for children and youth at risk for suicide to access treatment

- 13701 W. Jewell Ave., Suite 251, Lakewood, CO 80228 720-962-0706
- Referral line 303-988-2645

The GLBT Center/Rainbow Alley

www.glbtcolorado.org

Rainbow Alley is a safe space supporting LGBTQ youth and their allies ages 11 to 21 for various activities, counseling and support groups. The Center also offers other various social engagement and support programs for LGBTQ youth, adults, and families.

- 1301 E Colfax Denver, CO 80218 303-831-0442

Rainbow Alley Drop-in hours:

- Tuesday and Wednesday 12:30pm-7pm
- Thursday and Friday 1pm-8pm

The Juvenile Assessment Center

http://jac18.org

Provide behavioral health assessments / Community Assessment Program.

- Referral line 720-874-3381

Revised 06/01/2017

1. What is Value Up?
2. Power of Story / Main Messages
3. Description of Services
4. Craig Scott Bio
5. Douglas County School District Proposal

VALUE UP
Raising the Value of Human Life

Value Up is a 501c3 established by Craig Scott and Mike Donahue in 2016. Craig was a student in the library of Columbine High School on April 20, 1999. He was under a table with two of his friends who were both killed, and his sister Rachel was the first person killed that day.

Since then, for over 20 years, Craig and Mike have each spoken live to millions of students in American public schools. They have been keynotes for the American Association of School Administrators (AASA), the National Education Association (NEA), the National PTA Conference, and Craig was appointed by President Bush to the National Council on School Safety. Featured in countless news media interviews like Oprah, The Today Show, and Good Morning America, they continue to receive interview requests and have become go to experts concerning teen issues such as:

- anxiety
- bullying
- anger and violence
- suicide/self-harm
- substance abuse
- underachieving academically
- inundation of negative media
- social media issues
- disconnection/loneliness
- abuse at home

After 20 years of partnering with schools and speaking/listening to students, Mike and Craig have come to understand these issues are directly related to how students view and see themselves - a byproduct of not understanding their value. If a student believes they have high intrinsic value and identify with this high value, they choose things that match that identity. Students who value and respect themselves make more positive life choices and are more likely to show value and respect to others. Value Up was created to raise the value of human life on school campuses.

Through powerful school assembly presentations, teacher trainings, student leadership development, at risk student interventions, parent and community gatherings, and school culture building tools, Value Up is positively impacting the school atmosphere and culture and having tremendous results. The leadership team would be honored to discuss how they might partner to help students in your community and strength the culture of your schools.

www.value-up.org

Power of the Story

Craig's story is simply powerful. Barely escaping the school after watching his friends murdered before his eyes, only to learn his sister was the first to be killed has taught him the value of human life. His messages include: inherent self-value, how to deal with negative emotions such as angry and depression, the effects of technology of todays' youth, the importance of how treat others and examples of long reaching chain reactions by simple kindness, forgiveness and how to let go, and how to turn pain into purpose not being a victim but an overcomer.

Effect of the Presentation

The feeling and inspiration in the room during after a presentation is palpable. There is a viewable effect: Many tears, smiles, hugs and laugh. Those thought to have thick defensive walls let their guard down, 100s of students, if given the opportunity, approach Craig to shake his hand or vow to change. Stories of students planning to commit suicide vow to hold on. Others promising to treat others better and with value. Thousands of letters/emails from students who said they were suicidal state of the change of heart because of hearing Rachel and Craig's stories. And even documented school shootings have been prevented over the years.

3 Main Messages

1. *Value Yourself* – You have incredible intrinsic value. You were born with it. It cannot be taken away. Psychology shows how important the perspective of self is . If you see yourself and identify as someone containing value/self-worth and believe in yourself, it dramatically affects how your actions and how you treat others.
2. *Choose Things That Match Your Value* – There are many negative influences in our world today. Negative media, toxic people, and all kinds of developing addictions affect what we think and how we act. Once a person can see their value and potential, it brings desire to choose positive influences. We take care of what we value. The shooters at Columbine chose negative influences daily through media impacting their thinking and attitude significantly while Rachel Scott chose positive influences.
3. *Value Others* – Through sharing stories of the acts of kindness Rachel did, Craig inspires students to treat every person with the value they deserve. A strong challenge to students to eliminate degrading words is given and felt. Often after hearing this, many students come up to Craig vowing to apologize to someone they've mistreated. The biggest thing that leaves with you when you graduate is your character, and how you treat others says a lot about your character.

Other Messages

1. *Eliminate Prejudice or Prejudging Others* - The last words Isaiah, who was killed next to Craig in the library, heard were hateful, racial slurs. Craig gives a challenge to eliminate prejudice or pre-judging others. In today's culture, we are so quick to judge and label others. But everyone has a story and a battle they are fighting. Instead look for the best in people. Psychologists say that how we act is influenced by how we think others see us. If others see us in a positive light, if positively affects how we act around those people. If others see us in a negative way, it negatively affects how we act around those people. Everyone has good and bad things about them, but if we choose SEE THE GOOD, we help BRING OUT THE GOOD.
2. *Effects of Technology - Unplug – Be In the Quiet*
   Research is now showing that brain development for youth is taking longer than did in previous generations citing technology as being part of the problem. With constant stimulation and quickly jumping our attention around, the synapses in our brains take longer to form. Experts are saying today's generation are ACQUIRING A.D.D. For brain synapses and neural pathways to form and connect, time must be spent for thing to sink in. Today, it is more important than ever to unplug – go for a walk, meditate, pray, or just be still – great teachers taught that strength can come from the quiet time with ourselves.
3. *Much more in common than differences*
   There are is a vast amount of similarities and connections we have with other just by being a human. If we see what we have in common and how we can relate, it creates a sense of unity. It is possible that anywhere one goes, they can create a feeling of family with complete strangers by seeing the connection.
4. *4 Powerful Emotions that can be Translated Neurologically*
   a. Anger into Determination
   b. Fear into Courage
   c. Sadness into Appreciation for Life
   d. Anxiety into Excitement
5. *Essence of Destiny*
   Beliefs/Thoughts → Emotions/Actions → Habits → Character → Destiny
   At one point in the assembly, Craig asks the audience, "If you were totally honest with me right now, raise your hand if you want to have a positive influence on this world with your life." Almost everyone hand goes up. Thoughts lead to actions which lead to habits then to character and ultimately our destiny and legacy. Most students don't know that all emotions come from thought – conscious or subconscious. The Columbine shooters did not take responsibility for their emotions, rather they blamed the world for their anger and hatred. Life's contentment has last to do with the circumstances life brings our way, and much more to do with our inner processing and perception of such events. By understanding our deep potential and value, we can own our destiny, and it starts with our thinking.

VALUE UP Change one Change a school

VALUE UP
Raising the Value of Human Life

DAY DESCRIPTION / LIST OF SERVICES

Assembly
The day starts with one or two school assemblies – whatever is most convenient for the school - with the Value Up presentation. It's a powerful session here where I share my story and my sister's story giving challenges and inspiring students towards positive life choices

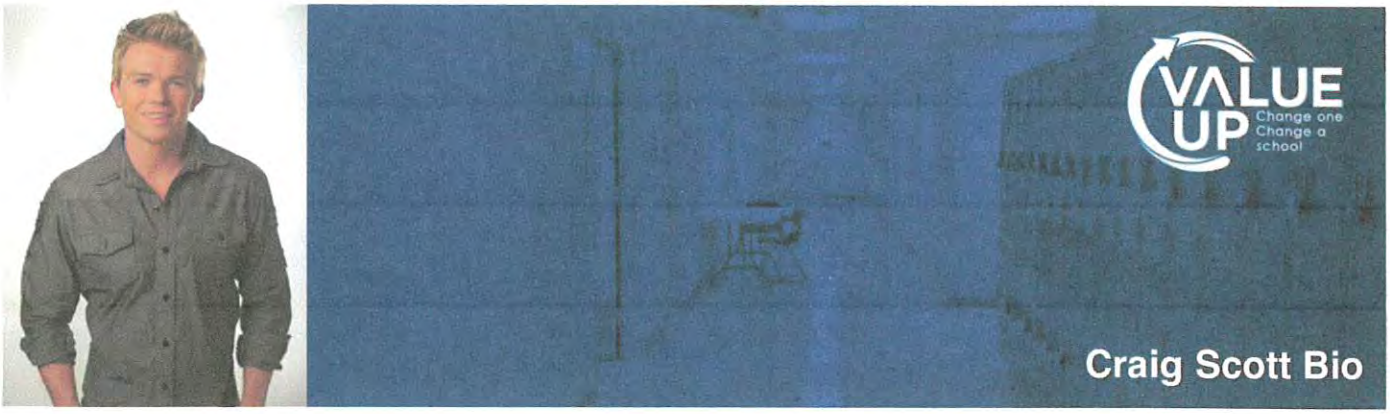
Coachable Moments
After the presentation, I make myself available for any students to talk with me. When given the chance (and time permitting), I usually get 100s of kids lining up. This is my favorite part, as usually they share something deep and personal with me – sometimes issues no one else has been able to break through with them on. Then I'm able to have what I call a "coachable moment" where they take my encouraging words to heart. I am not a licensed counselor but I do know how to speak value, hope, and encouragement into teenagers.

Student Leadership Training
After the assembly, there is a student leadership training. In this I ask for help from administration/teachers to pick out 30 students who have the most "social equity" in the school (aka the popular student). This list is compiled before the assembly day. If training is successful (and always is) you will have the key student influencers in your school buying into the message which causes real cultural improvement can happen.

Staff Training
The staff training can be before, during or after school – whatever is best. This is an educational training that Dr. Robert Morzano along with my father called "*Awaken the Learner.*" Awaken the Learner teaches powerful principals from past great educators and deals with the philosophy of education. Educators love this session! It looks deeply at teaching that doesn't just educate the mind but touches the heart. It incorporates how to take the Value Up message into the classroom without any extra work, so that the effect of the program is lasting.

Community Event
Finally, there is a community event where any parents (really anyone) are welcome. Little kids are welcome, but advised that they have a parent with them as some of the content is heavy. This is a one-hour presentation usually at 6 or 7 PM I usually see a good turnout happens, specifically because I ask students (at the end of the school assembly) to tell their parents to come to it. There is also a press kit sent to the school before the assembly day, and often I have local news media show up to my events giving good media exposure for the school and community.

For More Info:
Contact Program Coordinator Debbie Phillips at Debbie@valueup.org or call 970-800-9550



Craig Scott is a survivor of the Columbine High School shooting. He was in the most intense scene – the library - where 10 students lost their lives. Craig watched as two friends were gunned down on both sides of him. In a short time gap, Craig led a group of students out of the library. He later would learn his sister, Rachel Joy Scott, was the first to be killed.

Since then, Craig has dedicated his life to making a difference in schools sharing his and his sister's story. Speaking on a number of issues, the biggest thing the shooting taught him was the value of human life. Because of his work and experiences, Craig has had numerous appearances on Oprah, the Today Show, Good Morning America, and many others. He was appointed to a Presidential panel on school safety and has been a consistent voice in the media after incidents of school violence. His presentations have helped to stop hundreds of documented suicides as well as several school shootings. He has spoken to over a million people in live settings.

If there is any interest in his speaking,
please contact Debbie Phillips
Debbie@value-up.org
888-571-7168
WWW.VALUE-UP.ORG

VALUE UP COLORADO SCHOOL SECURITY DISBURSEMENT PROGRAM APPROVAL

PROPOSPAL: To approve Value Up, a Colorado non-profit organization, as an eligible partner for which Colorado schools can draw funds from the **SCHOOL SECURITY DISBURSEMENT PROGRAM** established by Colorado **SENATE BILL 18-269.**

SUMMARY: Value Up will partner with Colorado Schools to help students and educators create a safer school culture and environment by educating students and training educators on threat awareness and by assisting schools in developing a violence free culture on their campuses.

Value Up will assist schools in the following ways:

- General Student Assembly – Wherein students will be educated and motivated to partner with school administrators on school safety and threat awareness.
- Teacher Training – Wherein educators will be taught how to engage with students in such a way as to help create safer schools.
- Student Training – Wherein student leaders will be trained to identify and solve on campus issues and engage disenfranchised students in project based, student led programs.
- Community Event – Wherein parents and families of students are engaged and educated about teen issues and trained in connecting with one another to foster a healthier, safer community environment.
- Culture Building Tool kit – Value Up will provide schools with a culture building tool kit that schools can plug into their current programs, clubs and classrooms to strengthen healthier school environments. The culture building toolkit includes media resources, classroom discussion guides, print material, and additional culture building training.

COST: Schools may opt in at $3,500 which will include everything but the culture building tool kit or $5,000 for the entire program.

LEE POLICE DEPARTMENT

32 Main Street
Lee, Massachusetts 01238

Jeffrey D. Roosa
Chief of Police

Bus: (413) 243-5530
Fax: (413) 243-5532

Dear Mr. Scott,

I was invited to your "Value Up" Raising the Value of Human life presentation at Lee High School by our Wellness Committee, who in the past has brought several speakers to our student body. These presenters covered topics from drug addiction to drunken driving consequences. I have attended all presentations and you by far have had the most profound impact on me and I feel on our student body. In the day and age of disconnection from each other and oneself, due to daily distractions such as social media, electronics, and news media, yours is a message of reconnection and caring. As a survivor of the Columbine tragedy in 1999 in which you lost your sister Rachel, and several close friends, some right before your eyes, you have a unique perspective that cannot be dismissed. Refreshing was your delivery in which everyone in the room was involved and had contact with their fellow students and staff. When I became Police Chief, I discovered the values that you speak about in taking time to listen to everyone's story and not be so quick to judge, the luxury not always available to the Officer on patrol or in people's quick day-to-day encounters. Your message of self-worth and the worth of everyone around you that, at times you may have to look for, was delivered loud and clear. We are a better and now more safer school and community for having you here today.

Thank You

Jeffrey D. Roosa

Chief of Police

Craig and Mike.

You two can never come here again. I have been cleaning up after you for two days and there is no end in sight! But what a clean-up it is. So many stories from kids whose lives were impacted in deep and abiding ways. Here are just a couple.

A junior girl said this: "All these speakers come in and tell us not to do drugs and how they are bad for you. Mike said, 'If someone is doing drugs, there's a reason,' and he talked about how it really is. **Now I don't want to do any of that stuff anymore**." This girl is one of my favorites who was **well on her way toward a life of self-medication**. Her mom was killed in a car accident when she was in 6th grade - an accident that definitely involved mom drinking and may have been intentional on the mom's part. Today she told me that she wants to start what is essentially a grief group for her and three other girls who have lost parents!

The two high school boys that everyone recognized were crying and hugging at the end of the assembly... Everyone who say them were impacted. These are NOT the guys anyone would have expected to show any emotion even if they felt it.

A girl was asked what she learned: "We don't have to think we are trash, because **we actually DO have value**." She also said, "We don't have to be mean just because we are angry." Thank you for sharing stories Craig of how they can **take control and are responsible for their emotions**.

We are pressing on with application of the Value Up Club Craig did during the student training. The group is getting together Tuesday, but they have already started on their project! There is an Instagram account that will go active today for social media project for students to complement each other. Student greeters will be at the doors at the school in the morning. And they can't wait to do the high five hallway! There's more.

I've been in the game a long time as a school psychologist. In 35 years, since 1984, I've never seen anything like it. I am so grateful for you and your commitment to fulfilling this work in schools.

Jim Ott
School Psychologist
Bellevue Community School District, Iowa

School Superintendency Union #29
Lee~Tyringham

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Superintendent
H. Jake Eberwein, Ed.D.

To Whom It May Concern,

To say Craig Scott is an inspiration is an understatement

We have hosted many speakers at Lee Middle and High School throughout the years to speak on an array of topics including addiction, drug use, compassion, and wellness, but none of them were as dynamic or as captivating as Craig. His presentation to our student body was expertly crafted and had students constantly engaged with moments of levity, laughter, hugging, and singing followed by somber and captivating moments where you could hear the drop of a pin as every single student was on the edge of their seat hanging on Craig's every word

The positive outlook that Craig has on life after experiencing such deep tragedy was certainly heard throughout the school as one junior told me that his presentation "shined a new light on trauma, mental health and well-being, and seeing the good in life and in the people that surround us." After the school wide assembly, Craig spoke to a group of student leaders to inspire them to be a catalyst of change. This is the first time a speaker has taken actionable steps to have his story and his sister's loving heart touch students beyond the presentation. During this session, students brainstormed ideas to better the climate of our school. After participating in a series of fun activities and hearing a little bit more of Craig's story, another student expressed to me that "speakers in the past weren't as motivated to approach and interact with the actual student body about issues in the school to create an action plan for change. I think it was really cool that he came and pitched us ideas to make our school a more positive and accepting place."

Craig's message of kindness, compassion, and recognizing the value of human life is one that everyone from young children to adults can benefit. Many members in the audience throughout the day were moved to tears, both happy and sad. And many more walked out of our small auditorium changed and inspired. Since hosting Craig, the wellness committee has been approached by multiple community members, educators, and students with stories of how moved they were, how incredible Craig was to listen to, and how thankful they were to hear Craig's message.

Outside of the assembly, Craig walks how he talks, practices what he preaches, and is all around a genuine man that we had the pleasure of getting to know. We would recommend Craig to any school or organization that is looking for a message of positivity and who is looking to start a chain reaction of good deeds and giving hearts at their school.

If you have any further questions or would like to hear more about our experience with Craig Scott and Value-Up please do not hesitate to contact us.

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Lee Public Schools Wellness Committee
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(413) 243-0336

Lewis-Palmer High School

1300 Higby Road, Monument, CO 80132 - (719) 488-4720 - FAX (719) 488-4723

August 24, 2017

To Whom It May Concern:

It is with great enthusiasm that we as an administrative team endorse Mike Donahue and the Value Up Program. In just a short time, Mike has positively impacted thousands of our students through his message and his book. His message is authentic and his style immediately engages students with humor and depth of character..

This fall, Lewis-Palmer High School will implement the Sources of Strength program in our school. We have been through extensive training and feel like it is going to be very beneficial for our students. Through the training and working with Mike, we are still brainstorming the best ways to combine Sources and Mike Donahue and his Value Up assembly program. After his assembly and a parent community meeting, we realized that the two programs are a perfect fit! Mike's message that Value is intrinsic and does not depend on social performance was a home run with our students. You could have heard a pin drop during the one hour and fifteen minute assembly of 1100 plus students. Mike did a great job of taking away the stigma of getting help when things are tough. He talked about not masking pain or pressure with substances or other negative coping mechanisms, but reaching out for help (taking advantage of sources of strength) and reaching for the "top shelf." Here are some of the comments that came in after Mike's presentation:

"Value Up is brilliant and Amazing!."

"I wanted to say how mueh you have impacted me and changed my view on life and on other people, and I also felt inspired to share my story with you."

"You taught me a lot and helped me to strive to see myself in a new light. You're honestly the only speaker who has come to my school that people actually listen to. You tell real stories, real things kids can relate to."

"You really changed my perspective and my whole life really. Everything is different now. It's almost like everything has color again."

"This is exactly what our school needed. Thank you so much for taking the time to talk to us today."

"Thanks Mike, now I know I'm not alone."

Even though Mike's message was inspirational and very well received by our students, the content of his message has deep roots and is very complimentary to the Sources of Strength program. We are very excited to be able to now begin the process of implementing Sources knowing that we can give legs to Mike's message that everyone has Value. Mike was also very willing to adapt his program to meet the needs of our specific student body. We highly recommend the Value Up program for any school, but specifically if you are using the Sources of Strength program it is a great way to stir up momentum and get the students on board with you right away.

As administrators, we appreciate that Mike is willing to work with our existing structure and initiatives to strengthen our culture. He is weaving his message into our existing Pillars of Excellence and he has met with our athletic director to find ways to build on the work the Athletic department has done as well. With tremendous partnering such as this, we look forward to working with Mike and moving our school culture where each student does, indeed, feel that they have Value.

Sincerely,

Bridget O'Connor, Assistant Principal

Anthony Karr, Principal 2017-18

Dawn Klein, Assistant Principal

Nick Baker, Athletic Director/Assistant Principal

SOURCES OF STRENGTH IS:

Sources of Strength is a universal suicide prevention program designed to build socioecological protective influences around youth and to reduce the likelihood that vulnerable youth/young adults will become suicidal.

Sources is a best practice youth suicide prevention project designed to harness the power of peer social networks to change unhealthy norms and culture, ultimately preventing suicide, bullying, and substance abuse.

The mission of Sources of Strength is to prevent suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. Sources of Strength moves beyond a singular focus on risk factors by utilizing an upstream approach for youth suicide prevention. This upstream model strengthens multiple sources of support (protective factors, or the "wheel") around young individuals so that when times get hard, they have strengths to rely on.

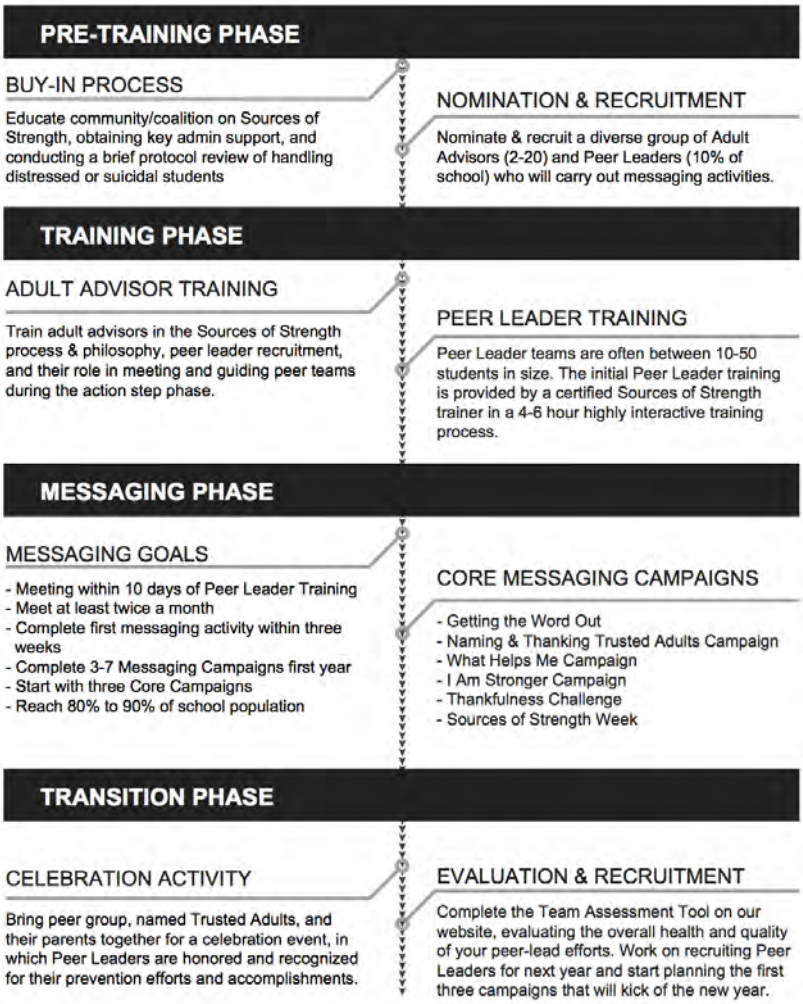
The program trains students as peer leaders and connects them with adult advisors at school and in the community. Adult advisors facilitate peer leader meetings over 3-4 months to plan, design, and practice tailored messaging activities, including individual messaging, classroom presentations, and media messaging.

The peer leaders have one-on-one conversations within their network of friends; develop posters and public service announcements with local faces and voices; give peer-to-peer presentations; and develop messages to be delivered via video, the Internet, or text messages.

Depending on the size of the high school, 10-50 students are recruited through staff and student nominations to form a team of peer leaders, who are mentored by 2-5 adult advisors. Certified Sources of Strength trainers provide the peer leaders with an initial 4-hour interactive training, which the adult advisors must also attend.

Sources of Strength was the subject of one of the nation's largest studies on peer leaders and their impact in suicide prevention. The results of this study were published in 2010 in the American Journal of Public Health, showing:

- Increase in peer leaders' connectedness to adults
- Increase in peer leaders' school engagement
- Peer leaders in larger schools were four times more likely to refer a suicidal friend to an adult
- Among general student population the program increased positive perceptions of adult support for suicidal youth and the acceptability of seeking help
- Positive perception of adult support increased most in students with a history of suicidal thoughts



DC SCHOOLS WITH SOURCES: CRMS, Sierra, C. View, Ponderosa, Chap, Thunder Ridge, Rock Canyon, Mt. Vista, DC Oakes, Mesa, Global Village Academy, Mt Ridge, Rocky Heights, Ranch View, STEM, Sagewood, Legend (Fall 2019), DC Montessori,

DC SCHOOLS WITHOUT SOURCES: Crest Hill, Cimarron, DCHS, HRHS and Eagle Academy

- **Sources is on the Registry of Best Practices**
- **Sources is $5,000 per school 1st year. DCSD has funded this cost for each school currently implementing the program**
- **Sources must be approved by each individual school and must have staff to support the program**
- **Students from Legend HS, who did not have Sources, lobbied for Sources, presented to Town of Parker and Partnership of DC Governments, and Legend now has Sources!**
- **Sources is credited with saving at least seven students**