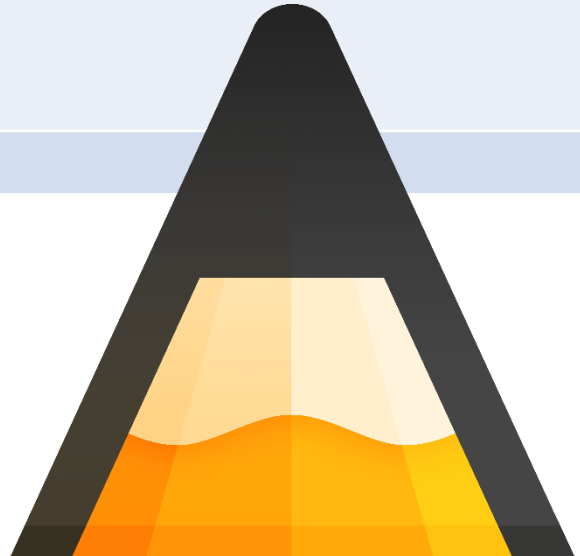

Monroe
Community Coalition
WELCOME
September, 2019

# Today's Agenda

| September, 2019 – Welcome Back! | | |
|---|---|---|
| 1:00 | **Welcome & Introductions** | Leadership |
| 1:10 | **Coalition Orientation + Q & A** | Coordinator |
| 1:50 | **Business Updates** | Coordinator |
| 2:00 | **Discussion**<br>- **Outreach Priorities – Topics & Locations**<br>- **Rebranding**<br>- **Diversity & Inclusion** | All |
| 2:30 | **Closing Thoughts and Adjourn** | Leadership |



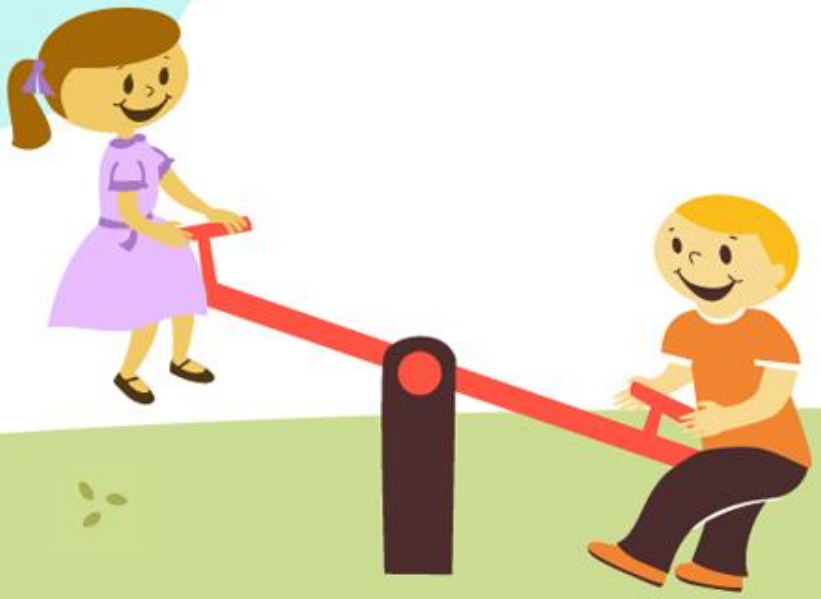
# Monroe Community Coalition

Making a difference for community and kids.

Joe Neigel
September, 2019
Monroe, WA

# Who's in the Room?

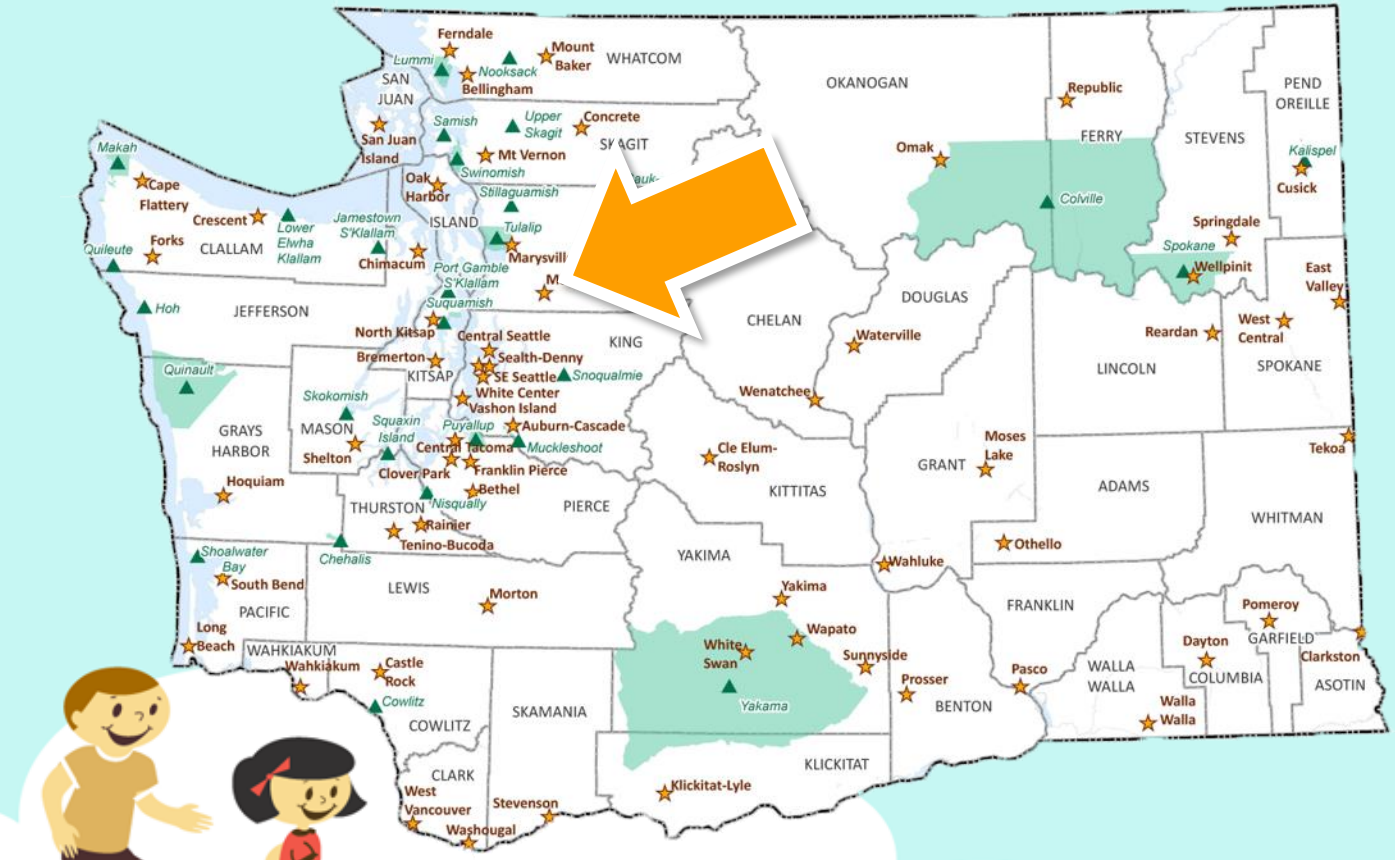
# Community Prevention & Wellness



## You Can't Do It Alone

Substance Use and Mental Health are challenges too large for any one person or agency to address on their own.

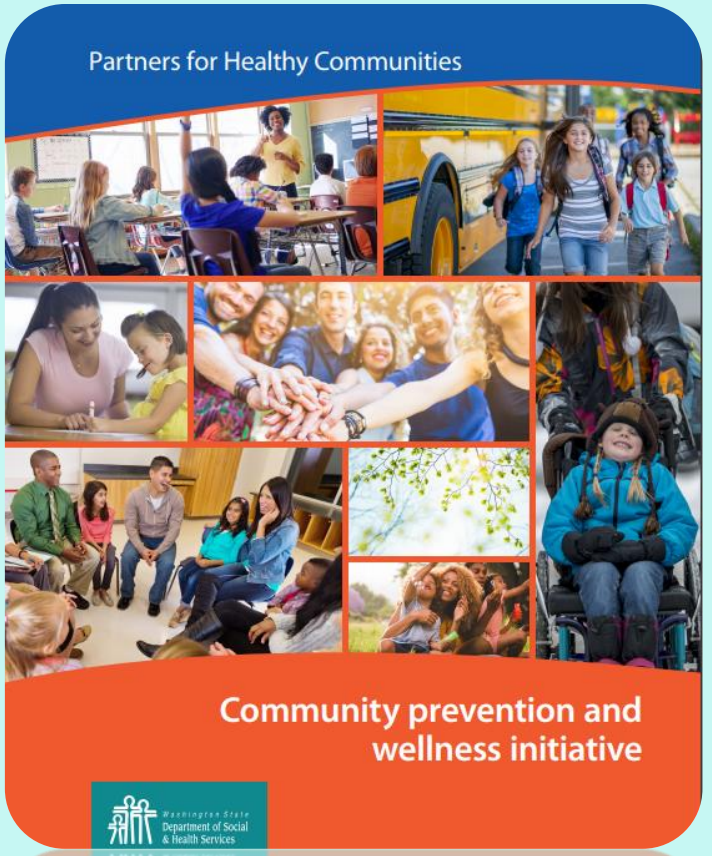
# Community Prevention & Wellness Initiative




- 64 sites
- 95 schools
- All 39 counties

# Community Prevention & Wellness Initiative

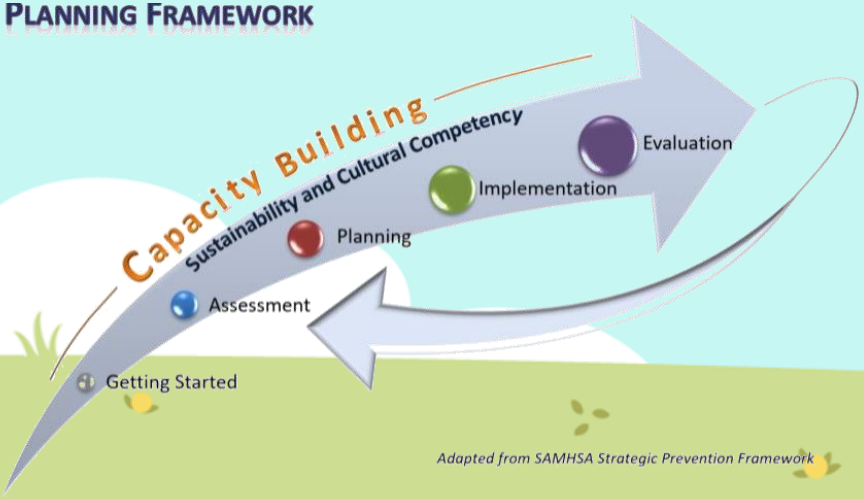
- Community-based model for delivering prevention strategies and activities.
- Data-informed, community-level decision making approach to identify and respond to root social and emotional causes of problem behaviors.
- Our Coalition is a formal arrangement for cooperation and collaboration between groups or sectors within our community.
    - It is an acknowledgement that many issues impacting education and society are too large and complex for one person or agency to address on their own.




# Focus on the Fire, Not the Smoke!

- The Coalition analyzes HYS and other data to find out what makes our kids vulnerable to substance use and mental health issues like depression and suicide..
- We maintain a strategic plan that addresses root causes rather than symptoms.
- We proactively fund multi-tiered *evidence-based* programs, strategies and personnel to improve outcomes for youth.

**PLANNING FRAMEWORK**




*Adapted from SAMHSA Strategic Prevention Framework*

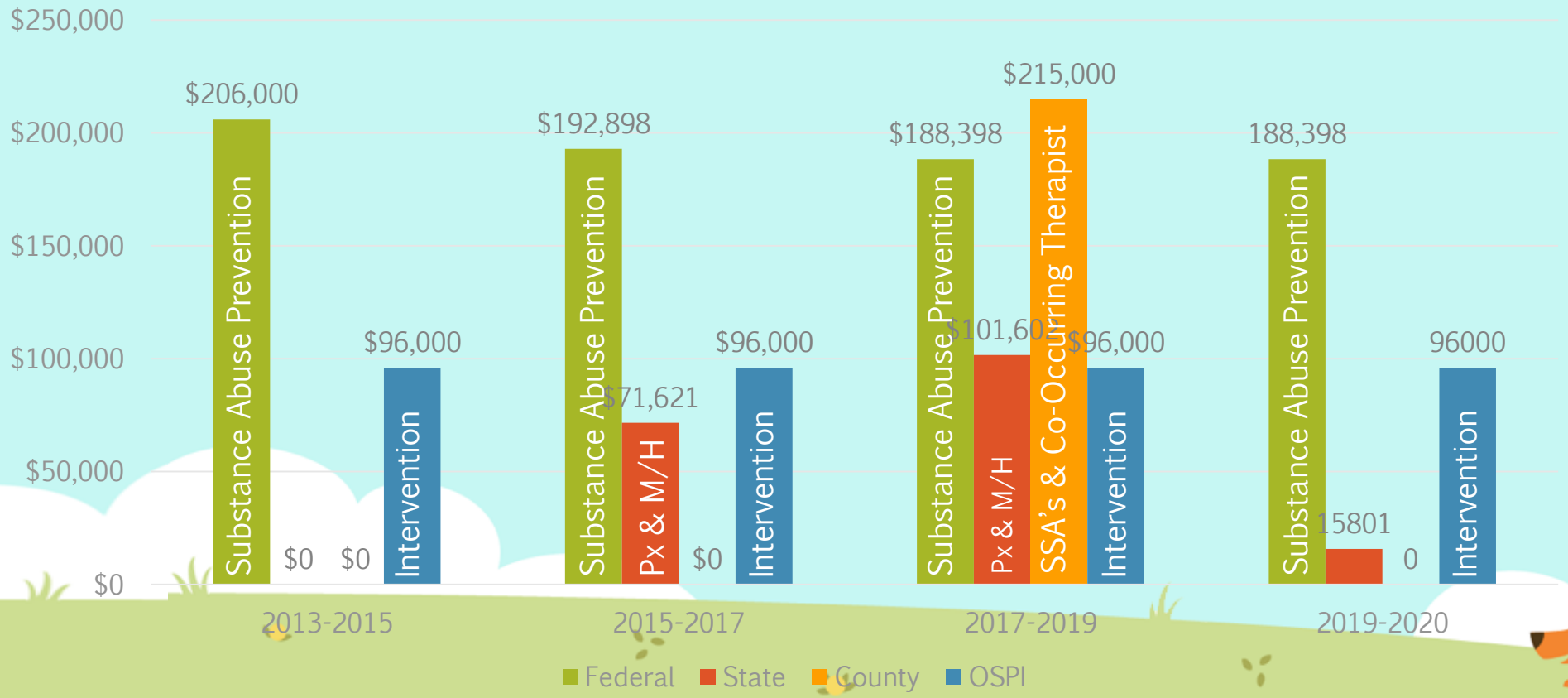

| Community Risk Factors | Substance Abuse | Delinquency | Teen Pregnancy | School Drop-Out | Violence | Depression Anxiety |
|---|---|---|---|---|---|---|
| Availability of Drugs | | | | | | |
| Availability of Firearms | | | | | | |
| Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime | | | | | | |
| Media Portrayals of Violence | | | | | | |
| Transitions and Mobility | | | | x | | x |
| Low Neighborhood Attachment and Community Disorganization | x | x | | | x | |
| Extreme Economic Deprivation | x | x | x | x | x | |
| **Family Risk Factors** | | | | | | |
| Family History of the Problem Behavior | x | x | x | x | x | x |
| Family Management Problems | x | x | x | x | x | x |
| Family Conflict | x | x | x | x | x | x |
| Favorable Parental Attitudes and Involvement in the Problem Behavior | x | x | | | x | |
| **School Factors** | | | | | | |
| Academic Failure Beginning in Late Elementary School | x | x | x | x | x | x |
| Lack of Commitment to School | x | x | x | x | x | |
| **Peer/Individual Factors** | | | | | | |
| Early and Persistent Antisocial Behavior | x | x | x | x | x | |
| Rebelliousness | x | x | | x | x | |
| Friends Who Engage in the Problem Behavior | x | x | x | x | x | |
| Favorable Attitudes Toward the Problem Behavior | x | x | x | x | x | |
| Early Initiation of the Problem Behavior | x | x | x | x | x | |
| Constitutional Factors | x | x | | | x | x |

| | | |
|---|---|---|
| Moms & Dads | Grandparents | Youth |
| Law Enforcement | Business | Healthcare |
| Media | Schools | Government |
| Mental Health Treatment | Substance Use Treatment | Faith Community |
| Volunteer Groups | Family Serving Agencies | More |

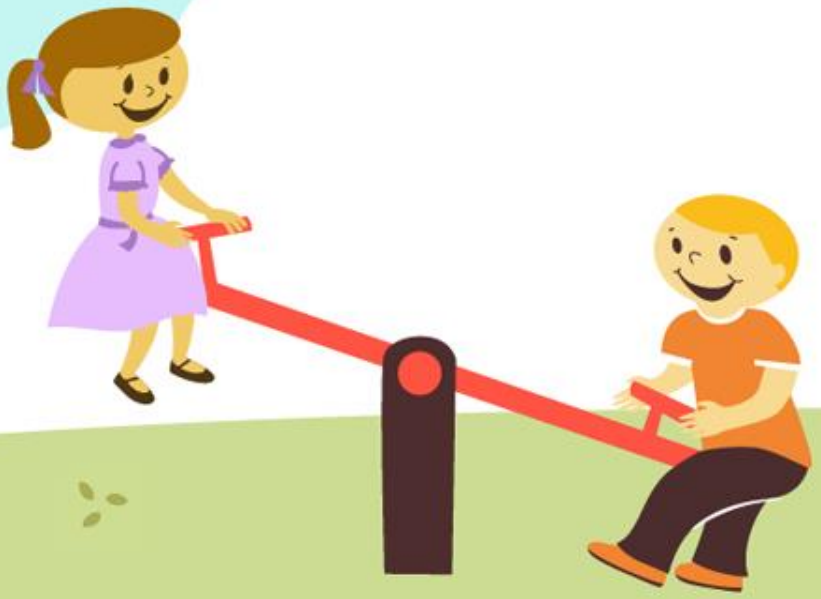
Our local network of neighbors and experts.

# Leveraging Resources

- Since 2013, the Monroe Community Coalition has been awarded more than $1.6 million in grant funding and resources for our schools and community.



# A Public Health Approach



## Reach Youth Where They're At.

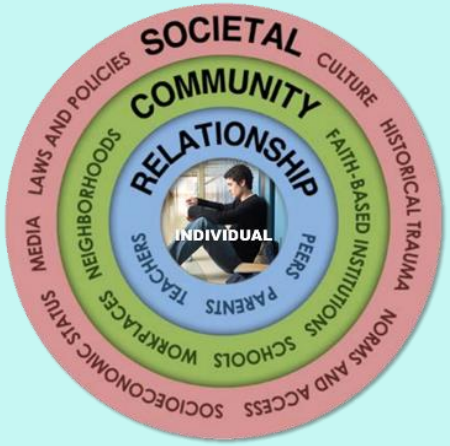
Multi-tiered primary prevention in schools and community.

# Planning and Integration

- **Mandate**
  School Board Commitment #2: Equitable Access – *We will provide ALL students with the time, support and instruction needed to meet high standards. We believe in meeting every student at every level to help them achieve new heights.*

- **Goal**
  Systematically address the behavioral health needs of students in our District to increase their readiness to learn.

- **Principles**
  - Do no harm
  - Prioritize evidence-based strategies
  - Provide training to staff & community
  - Shift from compliance-based strategies to youth development focused strategies
  - Acknowledge the whole child
  - Engage the family and teachers
  - **Identify and replace counterproductive strategies and practices**



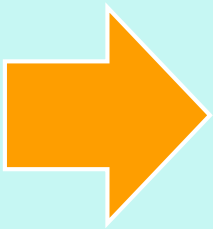

- **Domains of non-academic support that produce academic gains**
  - Substance Abuse
  - Bullying and Bystander Behavior
  - Mental Health
  - Trauma-informed Practices
  - Suicide Prevention
  - Strengths Based Education

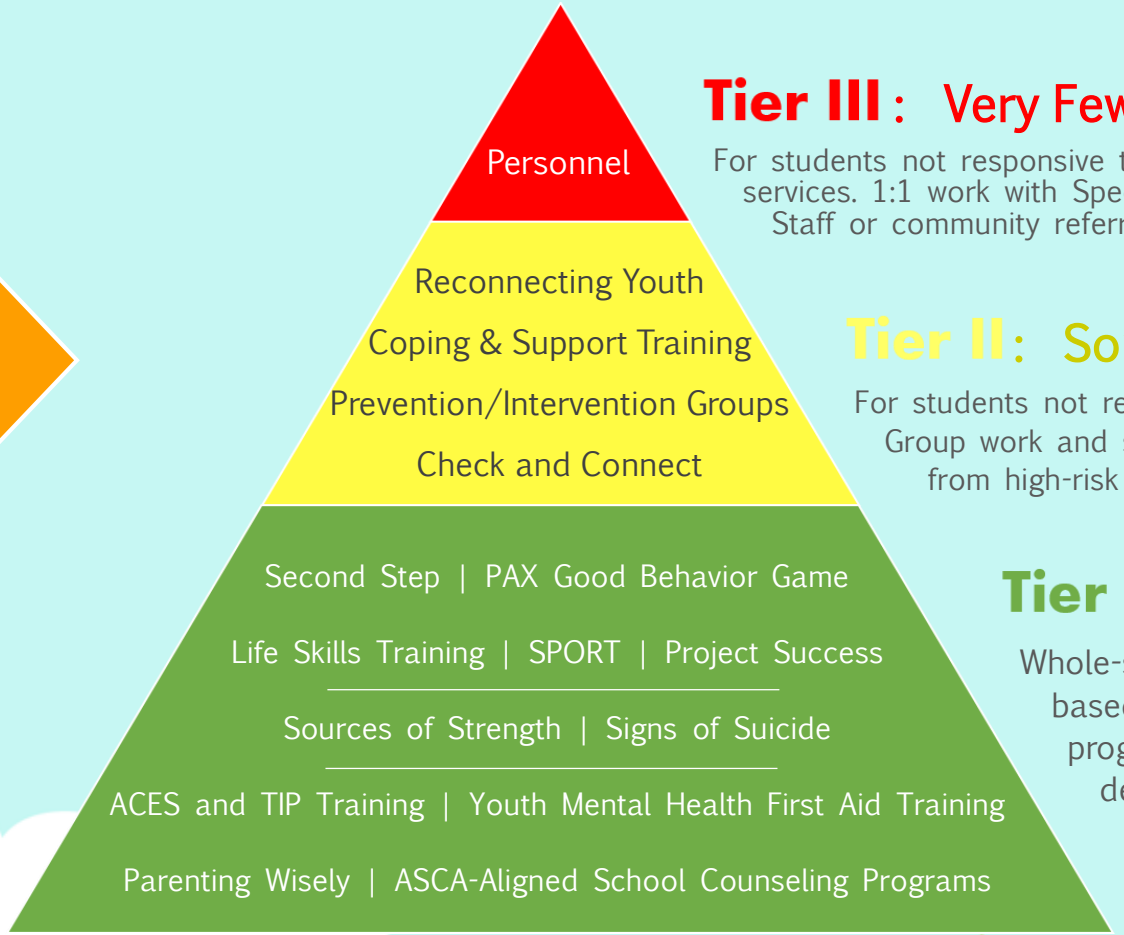
# Multi-Tiered Public Health Approach

**Public Health Model**

Versus

**Medical Model**






**Tier III: Very Few Students**

For students not responsive to Tier II services. 1:1 work with Specialist Staff or community referrals.

**Tier II: Some Students**

For students not responsive to Tier 1. Group work and supports for students from high-risk populations.

**Tier I: All Students**

Whole-school or grade-level evidence-based prevention and intervention programs, activities and practices designed to support all students.

# PREVENTION
## AND STUDENT MENTAL HEALTH

In the Monroe School District, we believe that effective prevention services are vital for the health and well-being of our students.

Our Behavioral Health Team works with principals, educators, students, families, and the community to address behavior and mental health challenges that impact student learning and success. Our goal is to increase readiness to learn, attendance, grades, and graduation rates!

To accomplish our goals, we work simultaneously at several different levels of prevention and intervention known as "tiers." At the first tier, we provide training and support to our building leaders and staff so they have access to research-based tools and practices necessary for managing their campus and classrooms effectively.

We also provide core classroom instruction to all students (**Tier 1**) designed to reduce their risk for engaging in substance abuse, violence, and many other problem behaviors that put them at risk for school dropout. Gone are the days of "Just Say No" campaigns and DARE. Today's curricula and strategies are science-based and proven to keep students performing at their personal best, including: a sense of belonging, self-control, social skills, and decision-making abilities. We also address suicide prevention with yearly middle and high school implementations of the Signs of Suicide program, which empowers students to recognize signs of distress and connecting struggling peers with helping adults. We estimate that 85% of our students will not need support beyond this first level of prevention. That said, we know programs that reach all students may not be effective for all students, so we also use more focused strategies to help groups of students who are at higher risk (**Tier 2**). This targeted small group instruction includes evidence-based programs as well as other social/emotional skills groups. This level of intervention serves about 10% of our students. Where we really stand out from other school districts is at **Tier 3**, our most intensive level of individual intervention. Monroe School District has an array of expert professionals who work 1:1 with students who are not well served by whole-school and small group interventions. We estimate this level of intensive intervention is for 3-5% of our students.


**Matt Hill**, our Co-Occurring Disorders Therapist and newest addition to the Behavioral Health Team, specializes in serving students with significant mental health and co-occurring substance abuse issues. Although stationed at Monroe High School, he has the flexibility to serve students at other schools in the district. Only two other schools in Snohomish County have a Co-Occurring Disorders Therapist on their team. Mr. Hill's position is 100% grant funded.

**Lorena Lee and Adrienne Williams** are our school-based social workers stationed at both middle and high schools, called Student Support Advocates (SSA's). The SSA's provide case management, emergency needs assistance, and wrap-around services for students and their families. They are able to provides support and connection beyond traditional K-12 hours, including making themselves available when and where families are most able to meet, even if that means early morning or evening hours, home visits or weekend meetings. Our Student Support Advocates are 100% grant funded.

### What makes us different from other school districts?

Our Behavioral Health Team is the envy of school districts across the state. Many people are surprised to learn about the team of specialists we've been able to assemble through decisions made by the School Board, partnerships facilitated by the Monroe Community Coalition and through grant funding.

### What makes us *really* different from other school districts?

Monroe is one of three communities in Snohomish County participating in the statewide Community Prevention and Wellness Initiative (CPWI). This provides the District with funding and the opportunity to engage in a unique community partnership called the Monroe Community Coalition.

The Coalition uses data to identify student and community vulnerabilities contributing to youth substance abuse, violence, juvenile delinquency, teen pregnancy, dropout, and the development of mental health disorders like depression and anxiety. Equipped with this data, they then develop targeted strategies and partnerships to reduce our vulnerability in these areas. This data-based decision making process allows the Coalition to target resources to actual areas of risk, rather than investing in gut-feelings or best guesses.

### The result?

We can say with certainty that: Our elementary and middle school students are among the most protected in Washington State.

*Our elementary and middle school students are among the most protected in Washington State.*

While opiate and opioid use grabs local and national headlines, our student use rates hover between just 1-3%. Our community partnerships and understanding of true needs has attracted a stunning level of expertise and investment in our community, including a virtually fully grant funded Behavioral Health Team. We are responsive to the needs of our community and proactively address them.

### How can families and community members get involved?

We provide many opportunities for families and community members to make a difference for Monroe. You can host or attend an evidence-based parenting seminar called Parenting Wisely. You can volunteer to be a mentor, or nominate your child to be a mentee, in our new community-based mentoring program. You can host or attend one of our many trainings on trauma-informed practices, suicide prevention, youth mental health first aid and more. You can have a voice at the table by attending monthly Monroe Community Coalition meetings, or at least stay in the loop about goings-on by joining our mailing list. You can join us for community screenings of important films like *Paper Tigers*, *Screenagers*, *Resilience*, or *Angst*. You can even help just by spreading the word about the District and Coalition's efforts to improve the health, wellness and long-term success of our kids.

### Do you want to get involved or learn more?

Reach out to:
**Joe Nalgel**
Prevention Services Coordinator
nalgelj@monroe.wednet.edu

**Chris Jury** is our Substance Abuse Prevention & Intervention Specialist who offers individual and group counseling for students at Monroe High School. Mr. Jury also leads the MHS Prevention Club and is an adult leader for Sources of Strength, an evidence-based suicide prevention program that builds connections to trusted adults. 80% of Mr. Jury's position is paid for by Educational Service District 189.

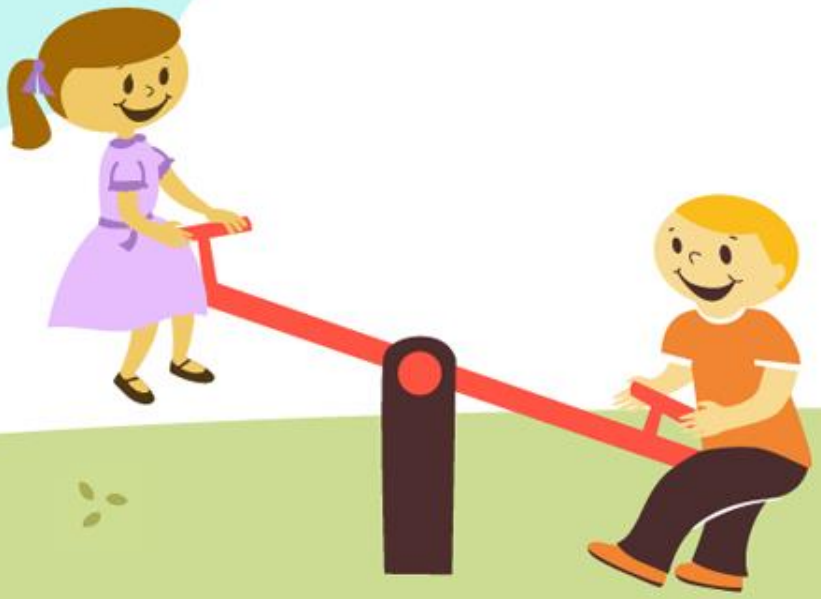
**John Campbell** is a licensed Child and Family Therapist who provides ongoing mental health treatment to students at Monroe High School. The school district recognized that living five miles away from a community mental health provider is the same as living 500 miles away for some of our most impacted students and families; so we entered into an agreement with Sea Mar Behavioral Health to address this barrier. Sea Mar Behavioral Health pays for 100% of Mr. Campbell's time at Monroe High School.

**Erin Wood** serves the entire District as our Behavioral Health Specialist. She is a Licensed Mental Health Counselor who provides crisis intervention for our students who struggle with self-harm behavior, thoughts of suicide or other serious symptoms of depression and anxiety. Ms. Wood works to stabilize students before connecting them with providers who can provide long-term support. She also leads the District's Suicide Prevention Advisory Group. The School District funds Ms. Wood's position.

# Following the Evidence

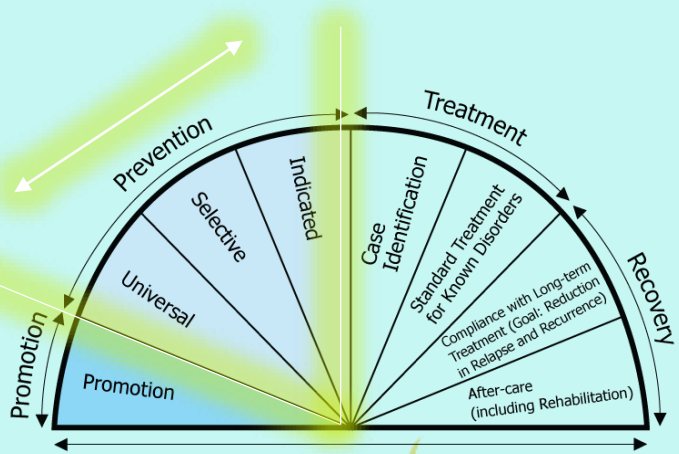
## Best Intentions can Work Against Our Best Interests

Common school-based strategies increase risk for vulnerable students.



# Working Against Our Best Interests

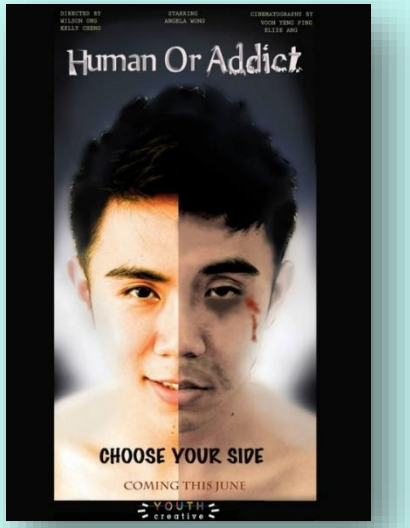
- This part of the conversation may challenge you.
- It will ask you to reconsider traditional ideas about what works.
- Avoid red flag rationale:
  - “If it helps just one…”
  - “It worked for me…”
  - “This is the way we’ve always done it…”




# Fear Arousal Strategies

- When exaggerated dangers, grotesque images, false information or distant consequences are delivered, teens tend to disbelieve the message and discredit the messenger.
- Researchers point out that fear arousal often backfires when youth have access to contrary information and experience.






*J. Beck, 1998; Golub and Johnson, 2001*

# One Time School Assemblies or Events

- Stand-alone assemblies, events, and gruesome displays create temporary emotional arousal but do not impact behavior or intention to use drugs.
- Students sheltered from explicit media, or who have suffered a tragedy similar to the recreated display, may be re-traumatized.



*Brown, D'Emidio-Caston and Pollard,1997; CDE, 2006*

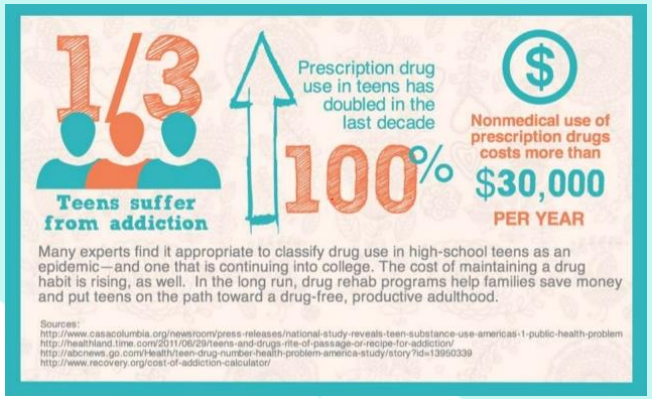
# Personal Testimony

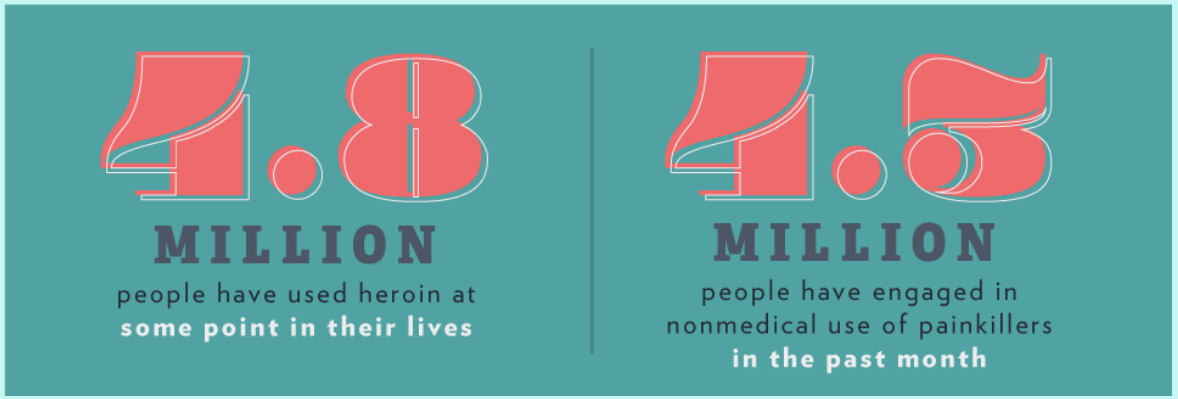
- Even if their story is powerful, testimony normalizes drug use by reinforcing the incorrect norm that “everybody uses.”
- Young people see the positive attention the speaker gets, will learn that this person was able to stop using alcohol or other drugs, and the prevention message backfires.


*D’Emidio-Caston and Pollard, 1997; Hansen, 1997*

# Reinforcing Sensationalized Norms

- Many well-intended communities and agencies try to create a community-wide response to youth substance abuse by sensationalizing information about high rates of use.
- These messages normalize the perception that everybody uses and actually undermines healthy responses to pressure to use.




*Perkins, H. 2002*

# Use of Impairment Props

- Unstructured role play and the use of impairment props (like fatal vision drunk goggles) can actually result in peer the reinforcement of anti-social behavior. In fact, there is zero evidence that impairment goggles decrease drunk driving and no research supports their use with youth in the 10-17 age group at all!


# Knowledge Only Strategies

- Curricula that only provide information about the consequences of substance use do not produce measurable and long-lasting changes in behavior or attitudes. This approach is considered among the least effective educational strategies.

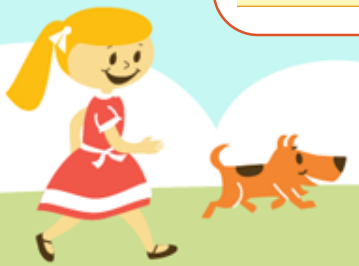
*Effectiveness of Fatal Vision Goggles in Youth, 2010*

# Drug Fact Sheets

- Fact sheets and posters that describe reasons for use, methods of use, street names, and potential benefits of use are ineffective at best and may increase experimentation in children who are at risk.
- There is significant data to demonstrate that fact sheets in the hands of middle school students show them how to defy adults and enhance peer reputation by engaging in risky behaviors.


*Embry, 2009; Tobler, 1986*

| | Alcohol | Cocaine/Crack | Cough Medicine/DXM | Ecstasy/MDMA | Heroin | Inhalants | Marijuana | Methamphetamine | Prescription Pain Relievers | Prescription Sedatives and/or Tranquilizers | Prescription Stimulants | Steroids | Tobacco |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Street Names / Commercial** | Booze | Big C, Blow, Bump, Coke, Nose Candy, Rock, Snow | Dex, Red Devils, Robo, Triple C, Tussin, Skittles, Syrup | Adam, Bean, E, Roll, X, XTC | Big H, Black Tar, Dope, Junk, Skunk, Smack | Whippets, Bagging, Huffing, Poppers, Snappers, Dusting | Blunt, Boom, Dope, Grass, Hash, Herb, Mary Jane, Pot, Reefer, Skunk, Weed | Ice, Chalk, Crank, Crystal, Fire, Glass, Meth, Speed | Codeine, OxyContin (Oxy, O.C.), Percocet (Percs), Vicodin (Vike, Vitamin V) | Mebaral, Quaaludes, Xanax, Valium | Adderall, Dexedrine, Ritalin | Juice, Rhoids, Stackers, Pumpers, Gym Candy | Cancer Sticks, Chew, Cigarettes, Dip, Fags, Smokes |
| **Looks Like** | Liquid (types include beer, wine, liquor) | White crystalline powder, chips, chunks or white rocks | Liquid, pills, powder, gel caps | Branded tablets (Playboy bunnies, Nike swoosh) | White to dark brown powder or tar-like substance | Paint thinners, glues, nail polish remover, whipped cream aerosal, air conditioner fluid (Freon) and more | A green or gray mixture of dried, shredded flowers and leaves of the hemp plant | White or slightly yellow crystal-like powder, large rock-like chunks | Tablets and capsules | Multi-colored tablets and capsules; some can be in liquid form | Tablets and capsules | Tablet, liquid or skin application | Brown, cut up leaves |
| **How It's Used/Abused** | Alcohol is drunk | Cocaine can be snorted or injected; crack can be smoked | Swallowed | Swallowed | Injected, smoked, freebased or snorted | Inhaled through nose or mouth | Smoked, brewed into tea or mixed into foods | Swallowed, injected, snorted or smoked | Swallowed or injected | Swallowed or injected | Swallowed, injected or snorted | Swallowed, applied to skin or injected | Smoked or chewed |
| **What Teens Have Heard** | Makes a boring night fun | Keeps you amped up; you'll be the life of the party | Causes a trippy high with various plateaus | Enhances the senses and you'll love everyone | Full-on euphoria, but super risky | A cheap, 20-minute high | Relaxing, not dangerous and often easier to get than alcohol | Can keep you going for days | A free high, straight from the medicine cabinet | A great release of tension | Keeps you attentive and focused | Will guarantee a spot on the starting lineup | An oral fixation and appetite suppressant |
| **Dangerous Because** | Impairs reasoning, clouds judgement. Long-term heavy drinking can lead to alcoholism and liver and heart disease | Can cause heart attacks, strokes and seizures. In rare cases, sudden death on the first use | Can cause abdominal pain, extreme nausea, liver damage | Can cause severe dehydration, liver and heart failure and even death | Chronic heroin users risk death by overdose | Chronic exposure can produce significant damage to the heart, lungs, liver and kidneys. Can induce death | Can cause memory and learning problems, hallucinations, delusions and depersonalization | Chronic long-term use, or high dosages, can cause psychotic behavior (including paranoia, delusions, hallucinations, violent behavior, insomnia and strokes) | A large single dose can cause severe respiratory depression that can lead to death | Slows down the brain's activity and when a user stops taking them, there can be a rebound effect, possibly leading to seizures and other harmful consequences | Taking high doses may result in dangerously high body temperatures and an irregular heartbeat. Potential for heart attacks or lethal seizures | Boys can develop breasts, girls can develop facial hair and a deepened voice. Can cause heart attacks and strokes | Cigarette smoking harms every organ in the body and causes coronary heart disease, and stroke, as well as many forms of cancer |
| **Teen Usage (Grades 9-12)** | 1 in 2 teens drank alcohol in the last year | 1 in 10 teens has abused cocaine or crack in their lifetime | 1 in 7 teens has abused cough medicine in their lifetime | 1 in 8 teens has abused Ecstasy in their lifetime | 1 in 20 teens has abused heroin in their lifetime | 1 in 6 teens has abused inhalants in their lifetime | Nearly 1 in 2 teens has abused marijuana in their lifetime | 1 in 12 teens has abused methamphetamine in their lifetime | 1 in 7 teens has abused prescription pain relievers in their lifetime | 1 in 13 12th graders has abused sedatives and/or tranquilizers in their lifetime | 1 in 8 teens has abused Ritalin or Adderall in their lifetime | 1 in 15 teens has abused steroids in their lifetime | 1 in 5 teens smoked cigarettes in the last 30 days |
| **Signs of Abuse** | Slurred speech, lack of coordination, nausea, vomiting, hangovers | Nervous behavior, restlessness, bloody noses, high energy | Slurred speech, loss of coordination, disorientation, vomiting | Teeth clenching, chills, sweating, dehydration, anxiety, unusual displays of affection | Track marks on arms, slowed and slurred speech, vomiting | Missing household products, a drunk, dazed or dizzy appearance | Slowed thinking and reaction time, impaired coordination, paranoia | Nervous physical activity, scabs and open sores, decreased appetite, inability to sleep | Medicine bottles present without illness, Rx bottles missing, disrupted eating and sleeping patterns | Slurred speech, shallow breathing, sluggishness, disorientation, lack of coordination | Lack of appetite, increased alertness, attention span and energy | Rapid growth of muscles, opposite sex characteristics and extreme irritability | Smell on clothes and hair, yellowing of teeth and fingers that hold cigarettes |
| **Important to Know** | Being a child of an alcoholic places children at greater risk for developing alcohol problems | Cocaine is one of the most powerfully addictive drugs | The "high" from cough medicine is caused by ingesting a large amount of dextromethorphan (DXM), a common active ingredient | Can be addictive. A popular club drug because of its stimulant properties which allow users to dance for long periods of time | Heroin overdose is a particular risk on the street, where the purity of the drug cannot be accurately known | More than 1000 common products are potential inhalants that can kill on the first use or any time thereafter | Contrary to popular belief, marijuana can be addictive | Meth has a high potential for abuse and addiction, putting children at risk, increasing crime and causing environmental harm | Abusing prescription painkillers is just as dangerous, addictive and deadly as using heroin | Using prescription sedatives and tranquilizers with alcohol can slow both the heart and respiration and possibly lead to death | Many teens abuse this prescribed medication to help them cram for exams or suppress their appetite | Teens who abuse steroids before the typical adolescent growth spurt risk staying short and never reaching their full adult height | Secondhand smoke contributes to more than 35,000 deaths related to cardiovascular disease |



Well meaning, but counterproductive

*Partnership for a Drug Free America*

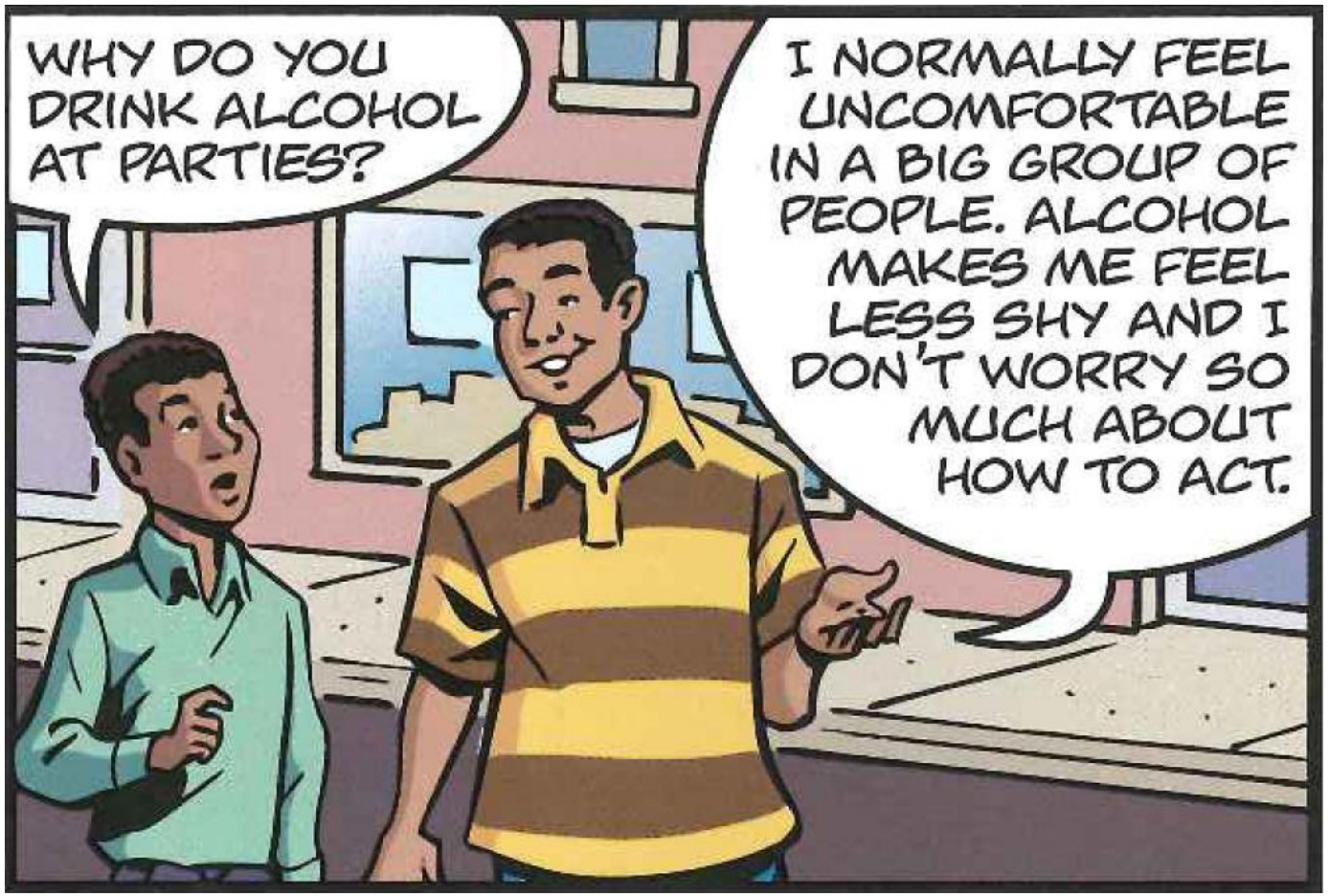
# Myth Busting

- Myth-busting is common across all types of health communication.
- “Illusion of Truth” effect shows people are more likely to recall myths as fact upon follow-up.
- Simple, factual statements increase knowledge retention over myth-busting techniques which reinforce incorrect norms.

**Myth** Drinking is a good way to loosen up at parties.

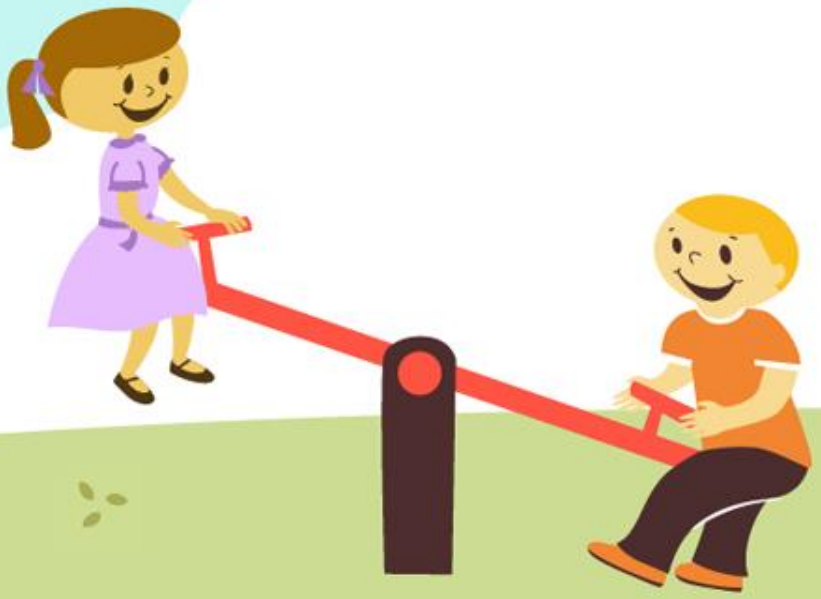
**FACT** Drinking is a dumb way to loosen up. It can make you act silly, say things you shouldn't say, and do things you wouldn't normally do (like get into fights or have sex).

*Skurnik, Yoon and Schwarz, 2007; Stout, Rodgers, and Guard, 2013*




Well meaning, but counterproductive

# Implementation Fidelity is Key



## Use What Works!

Implementing evidence-based programs with fidelity

# Theory Guided vs. Evidence-based

- Theory-guided practices lean on rationality and philosophy to achieve a common goal. They generally make claims of effectiveness **without actually proving the practice does what it says.**
- Evidence-based practices and programs are rigorously evaluated for effectiveness across populations. To be recognized as an evidence-based practice, scientists measure **both positive and adverse outcomes** through peer-reviewed randomized comparative effectiveness trials.
- **Beware of programs that cite generic literature as proof that their practices actually benefit students. Research-based DOES NOT mean evidence-based.** Just because a program aims to do good based on reviews of literature doesn't mean its efforts will actually produce that good in either real time or over time.

*"You are very ill, General Washington. We must bleed you again."*

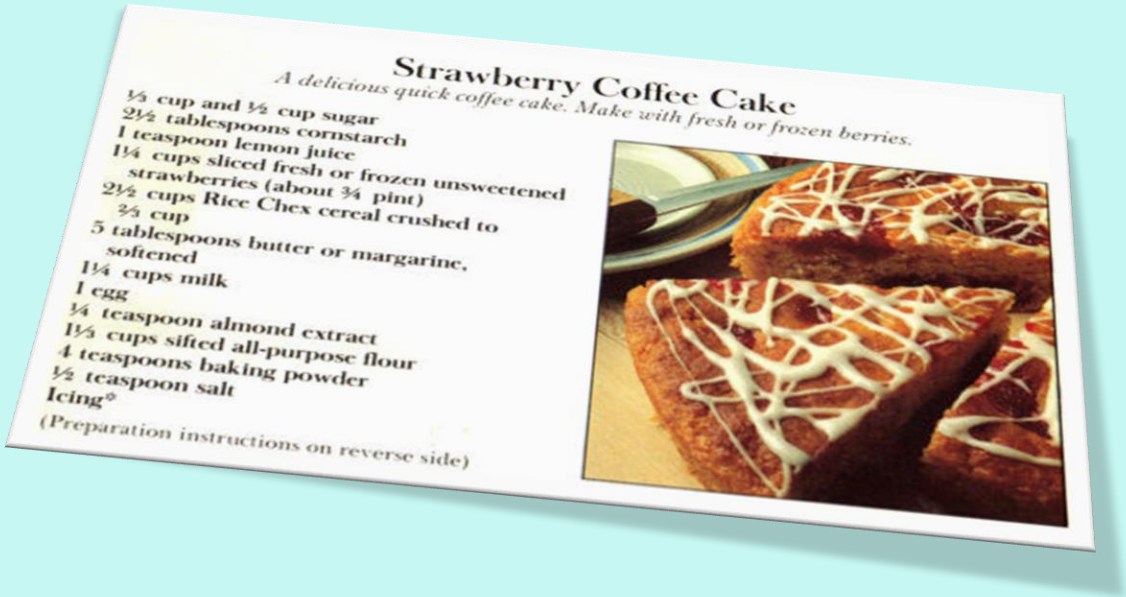
# D.A.R.E.  to Keep Kids Off of Drugs


- Project DARE is a self-esteem and drug resistance program developed by Los Angeles teachers and police officers in 1983.
- At its peak, DARE was practiced in 75% of American schools and in 52 countries at an annual cost of $1.3 billion.
- At least 8 studies have concluded that DARE had no effectiveness in preventing drug use among elementary, middle or high school students in general, and actually increased the likelihood of substance use and criminal justice involvement among vulnerable student populations.

Rosenbaum, D. and Hanson, G. (1998) “Assessing the Effects of School-Based Drug Education: A Six-Year Multilevel Analysis of Project D.A.R.E.” Journal of Research in Crime and Delinquency, Vol 35, Issue 4, pp. 381 – 412 | retrieved online at: http://journals.sagepub.com/doi/abs/10.1177/0022427898035004002

# Fidelity is Key

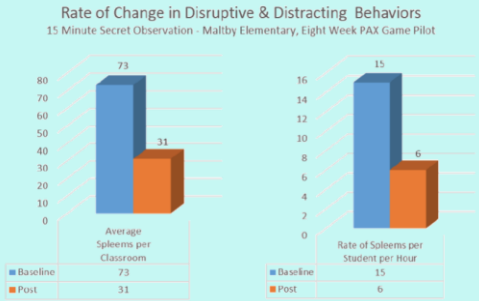
- The key to obtaining the published outcomes associated with an evidence-based practice is implementation fidelity.
- Program fidelity simply means you implement a strategy the way it was intended by its developers.
- Unplanned adaptations may render your evidence-based program inert.

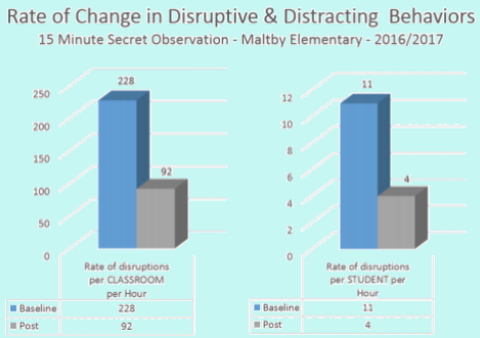


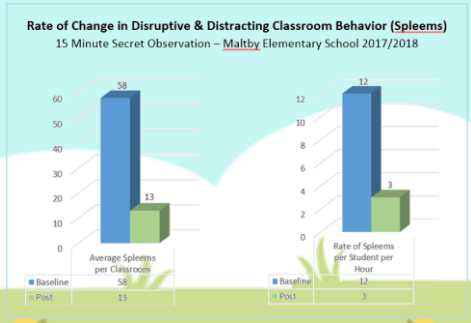

# PAX Good Behavior Game

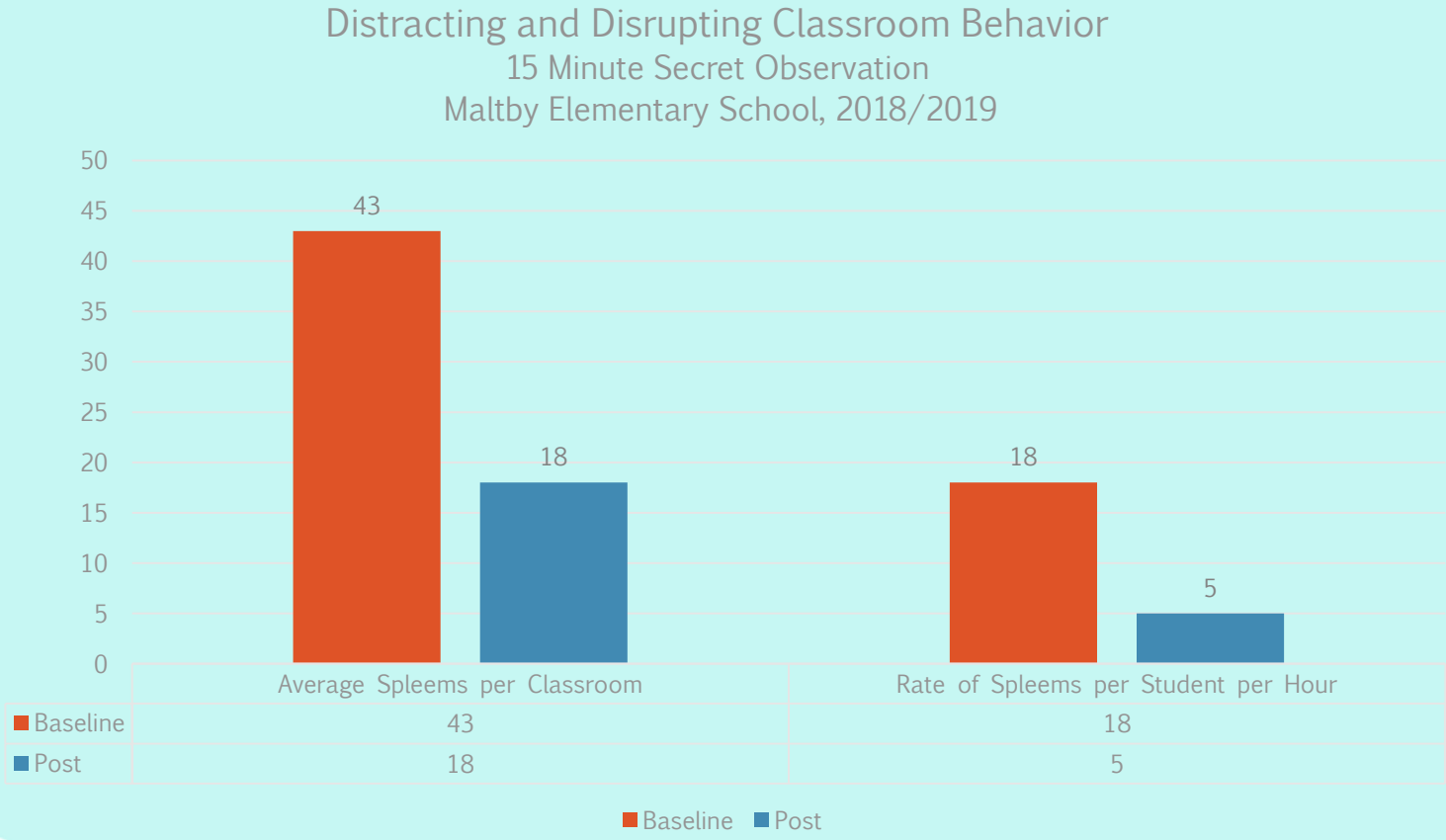
- PAX Good Behavior Game is a set of classroom strategies that help students learn self-management skills while collaborating to make their classroom a peaceful and productive learning environment.
- Although PAX is not a classroom management program – it is an evidence-based environmental strategy – it makes managing classrooms much easier.
    - Evidence-based outcomes – PAX has no adverse impacts on students. It is proven to:
        - Decrease disruptive and disorderly behaviors in class and on campus
        - Decrease need for special education services
        - Decrease office discipline referrals, suspensions and expulsions
        - Decrease alcohol, tobacco and other drug initiation over the child's lifetime
        - Decrease development of mental health disorders, including depression, anxiety and suicidality
        - Increase graduation and college admission rates

# PAX Reduces Distracting and Disruptive Behavior

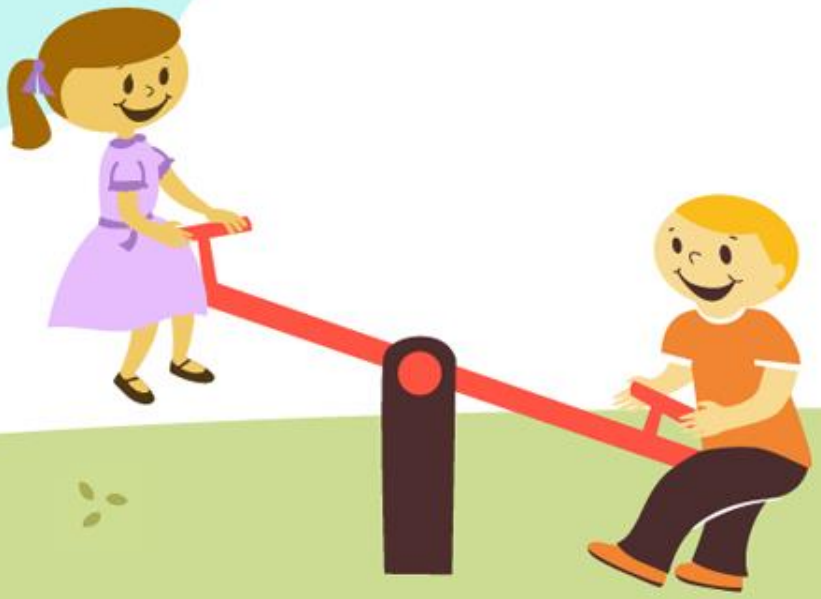


# The Results



## Prevention Works!

Changing population level outcomes.

# CPWI Closes the Achievement Gap

| School Outcomes | Cohort 1 | | |
|---|---|---|---|
| | T1 | T2 | Improved? |
| 4-Year On-time Graduation Rate | 76% | 83% | 👍 |
| 4-Year Dropout Rate | 14% | 10% | 👍 |
| 5-Year On-time Graduation Rate | 78% | 85% | 👍 |
| 5-Year Dropout Rate | 19% | 12% | 👍 |

👍 Improvement in outcomes (percent change of 5% or more)

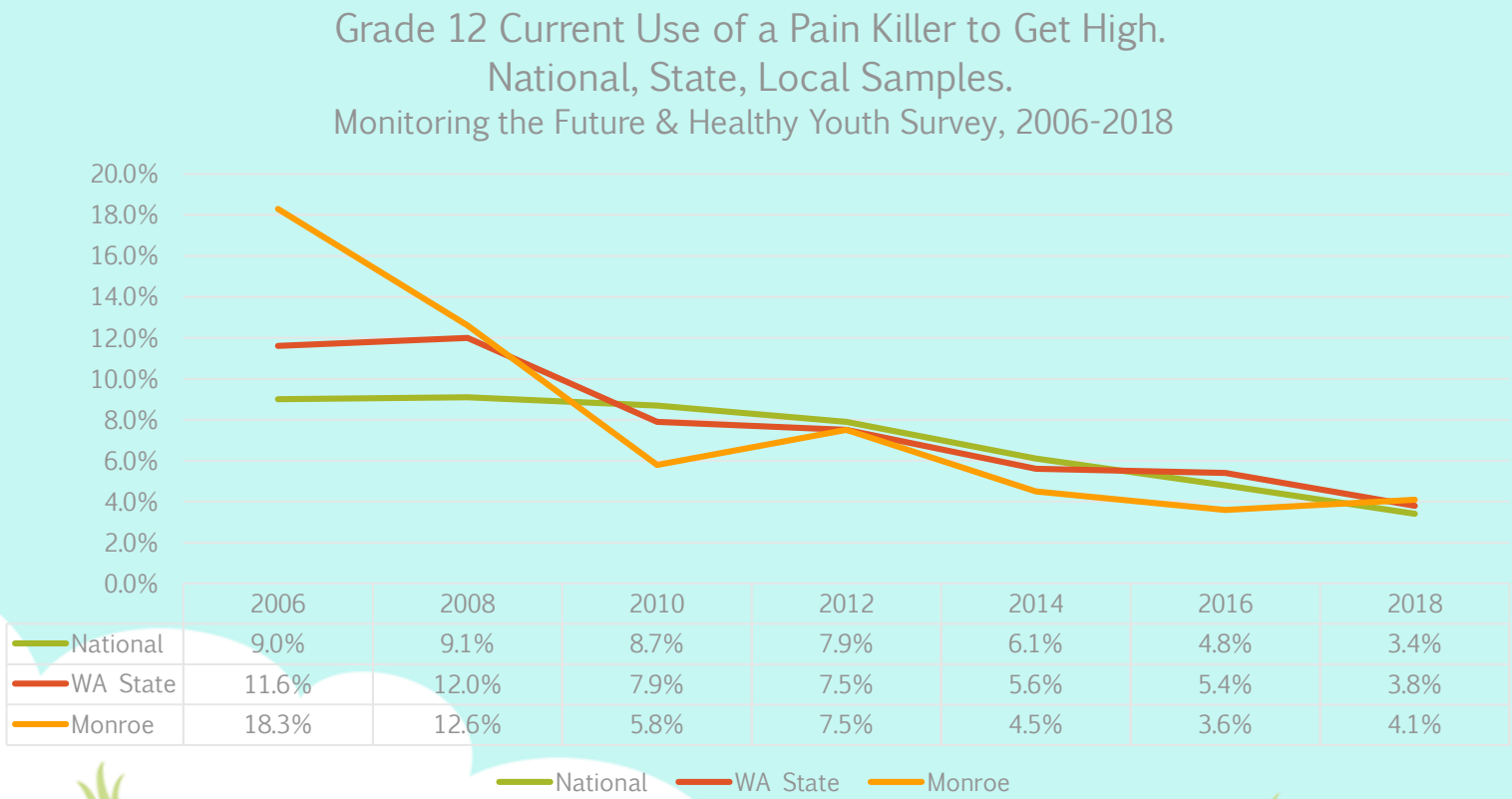
| School Outcomes | Cohort 1 | | |
|---|---|---|---|
| | T1 | T2 | Closed Gap? |
| Adjusted 4-Year Cohort Graduation Rate | | | Yes |
| Adjusted 4-Year Cohort Dropout Rate | | | Yes |
| Adjusted 5-Year Cohort Graduation Rate | | | Yes |
| Adjusted 5-Year Cohort Dropout Rate | | | Yes |

CPWI communities were at significantly higher risk than other similar Washington communities for poor school outcomes ($p<.05$).

CPWI communities closed existing gap in level of risk following CPWI implementation ($p<.05$).

# Restoring the Community

- CPWI has helped Monroe and communities around the State to bring opioid and other youth substance use rates within national norms.



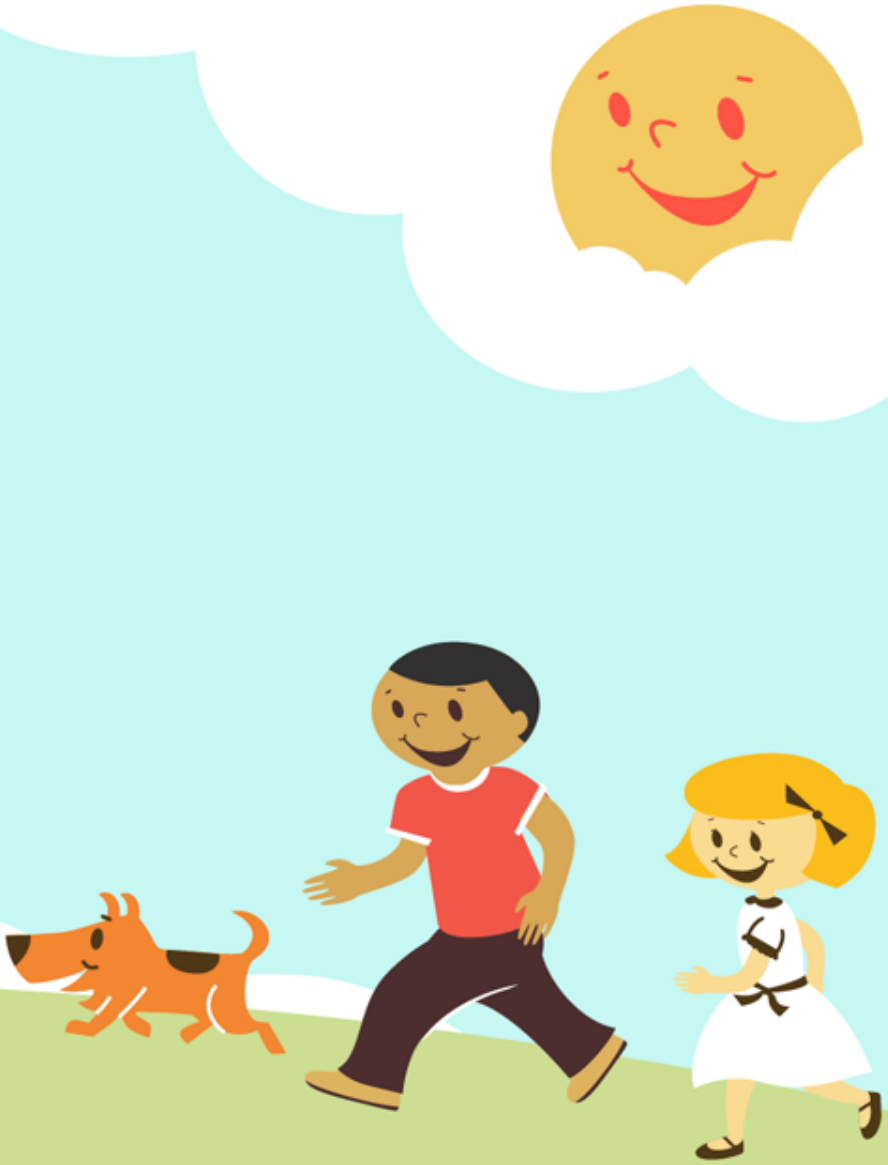

| | 2006 | 2008 | 2010 | 2012 | 2014 | 2016 | 2018 |
|---|---|---|---|---|---|---|---|
| National | 9.0% | 9.1% | 8.7% | 7.9% | 6.1% | 4.8% | 3.4% |
| WA State | 11.6% | 12.0% | 7.9% | 7.5% | 5.6% | 5.4% | 3.8% |
| Monroe | 18.3% | 12.6% | 5.8% | 7.5% | 4.5% | 3.6% | 4.1% |

# A Healthy Community

The results? On our most recent Healthy Youth Survey, Monroe has achieved:

- Adults to turn to for help : Highest rate ever recorded.
- Attempted suicide: 2nd lowest rate ever; lowest since 2006!
- Current alcohol use: Lowest rate ever recorded.
- Binge drinking: Second lowest rate ever recorded.
- Marijuana: Second lowest rate ever recorded.
- Pain Killer use: Tied for lowest rate ever.
- Rx use (Not Prescribed): 6th year of decline.

# Questions?

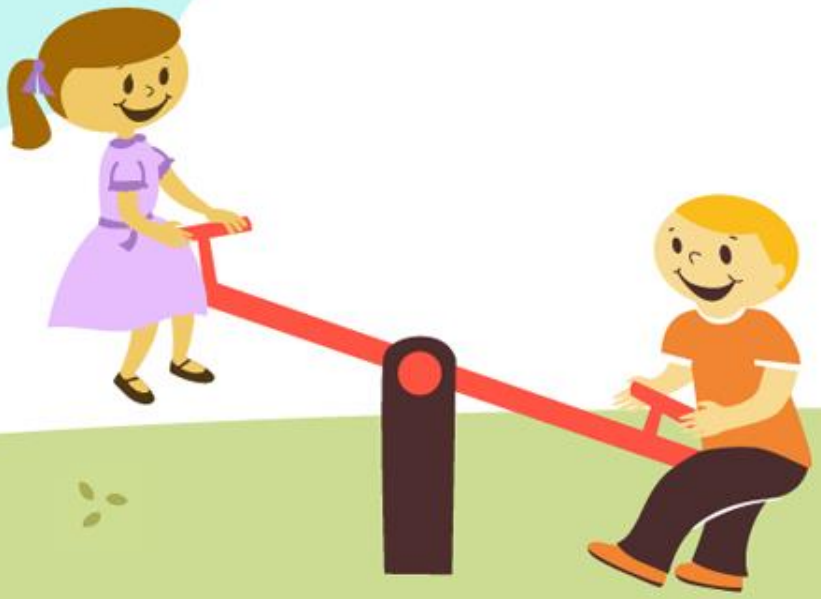


Joe Neigel
neigelj@monroe.wednet.edu

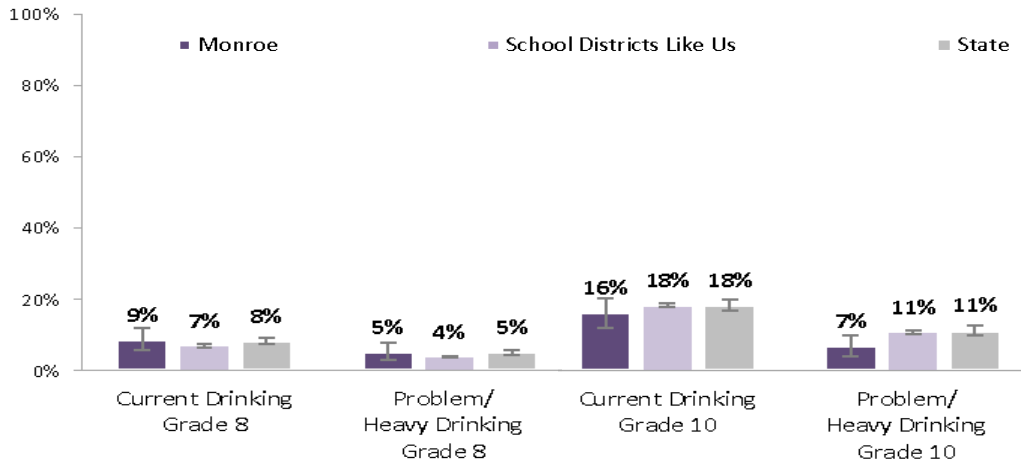
# Consumption Measures

## Healthy Youth Survey

Moving in the right direction!

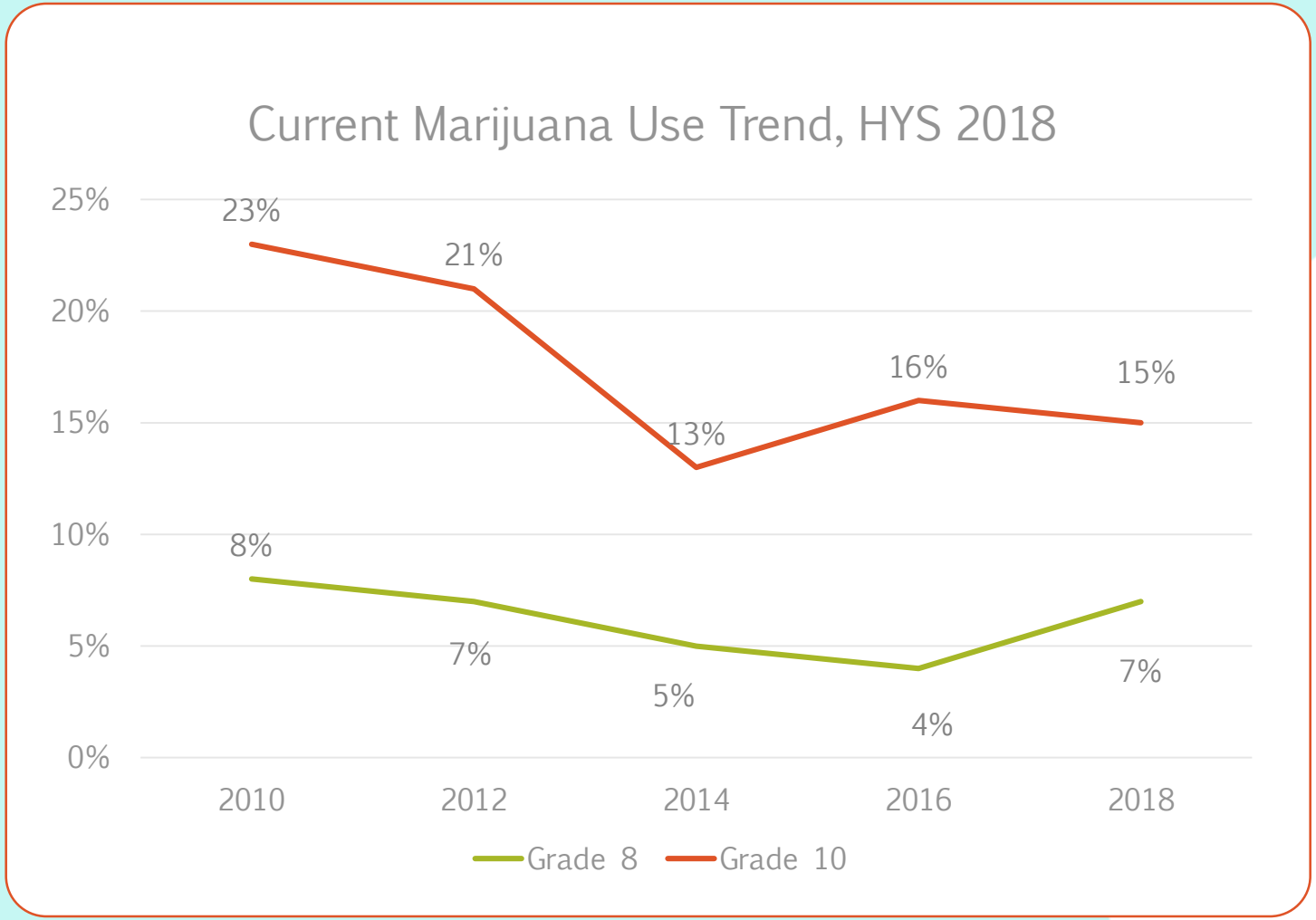


# Alcohol



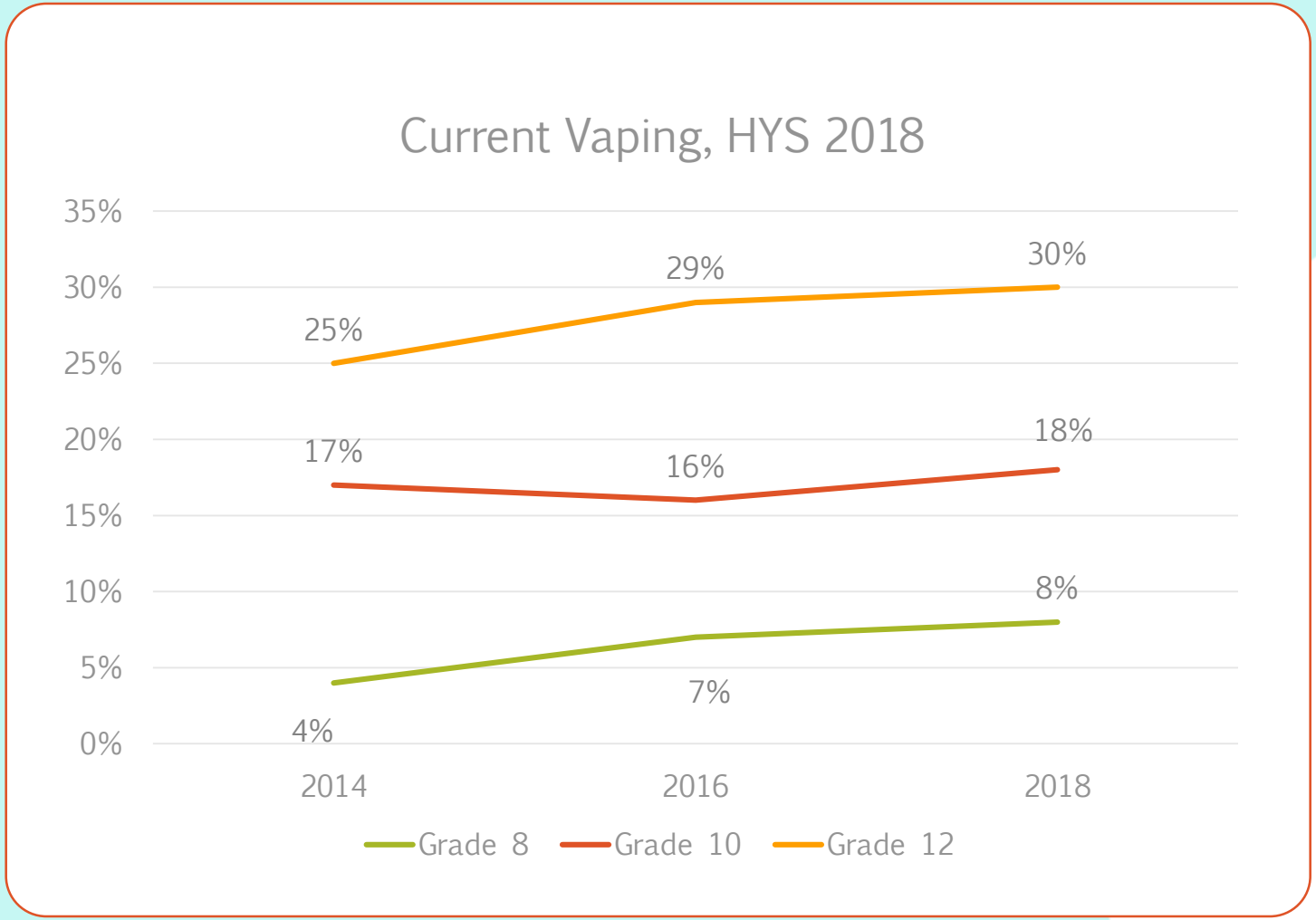

| | | Monroe | | School Districts Like Us | | State | |
|---|---|---|---|---|---|---|---|
| HYS Measures of Youth Substance Use | GRADE | 2016 | 2018 | 2016 | 2018 | 2016 | 2018 |
| **Current Drinking**. During the past 30 days, on how many days did you: Drink a glass, can or bottle of beer? *(District results: Drink any days)* | 8 | 11% | 9% | 6% [b] | 7% | 8% | 8% |
| | 10 | 25% | 16% [a] | 18% [b] | 18% | 20% | 18% |
| **Problem/Heavy Drinking.** *(District results: 3-5 days drinking in the past 30 days and/or 1 binge past 2 weeks, or 6+ days drinking in the past 30 days and/or 2+ binge past 2 weeks)* | 8 | 5% | 5% | 4% | 4% | 5% | 5% |
| | 10 | 15% | 7% [a] | 11% | 11% [b] | 13% | 11% [c] |

- Underage drinking is **sharply declining** in Monroe!
- Change in 10th grade rates are statistically significant compared to district's like us and the State.
- **At 16%, 10th Grade regular drinking rates are the lowest ever recorded!**
- 10th Grade binge drinking is the second lowest rate ever recorded.



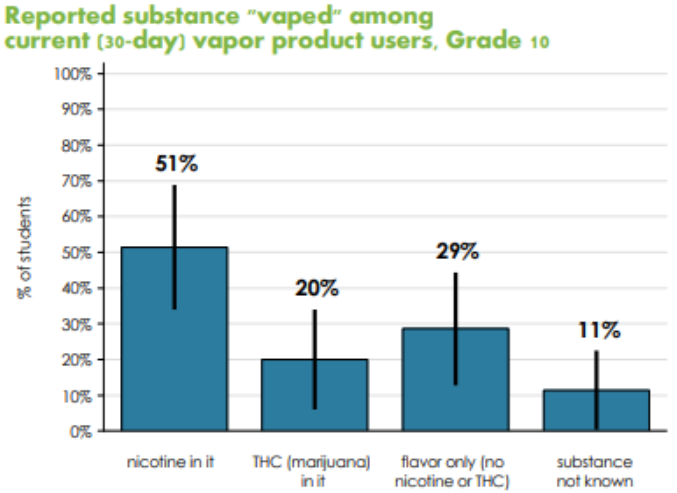

# Marijuana

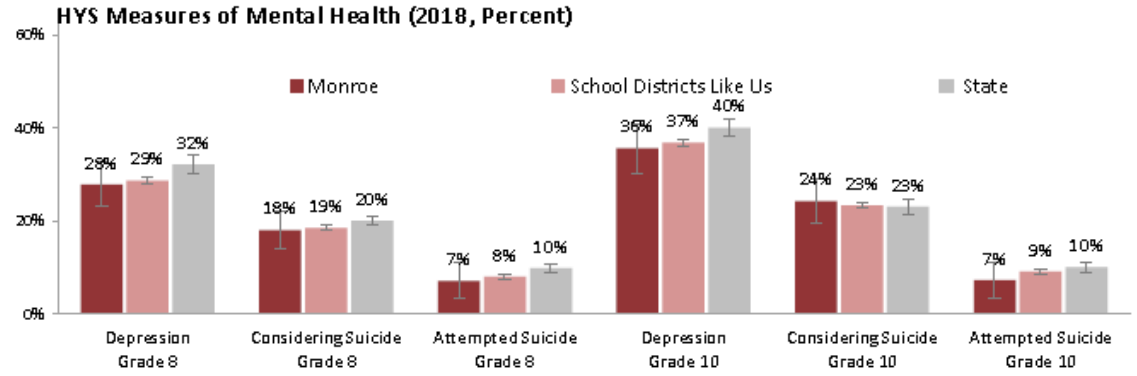
- **Marijuana use rates remain historically low for our students.**
- After eight years of steady decline, 8th grade marijuana use rates increased to 7%, but not statistically significant.
- 10th grade marijuana current use rates = 15%.




# Vaping

- Rates are holding steady, but increased awareness and security measures leading to more student interventions.






| HYS Measures of Mental Health | Grade | Monroe 2016 | Monroe 2018 | School Districts Like Us 2016 | School Districts Like Us 2018 | State 2016 | State 2018 |
|---|---|---|---|---|---|---|---|
| **Depression.** 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? *(District results: "Yes")* | 8 | 29% | 28% | 25% | 29% | 28% | 32% |
| | 10 | 35% | 36% | 33% | 37% | 34% | 40% |
| **Considering Suicide.** During the past 12 months, did you ever seriously consider attempting suicide? *(District results: "Yes")* | 8 | 16% | 18% | 15% | 19% | 17% | 20% |
| | 10 | 23% | 24% | 20% | 23% | 21% | 23% |
| **Attempted Suicide.** During the past 12 months, how many times did you actually attempt suicide? *(District results: Any suicide attempts)* | 8 | 8% | 7% | 7% | 8% | 8% | 10% |
| | 10 | 17% | 7% a | 9% b | 9% | 10% c | 10% |

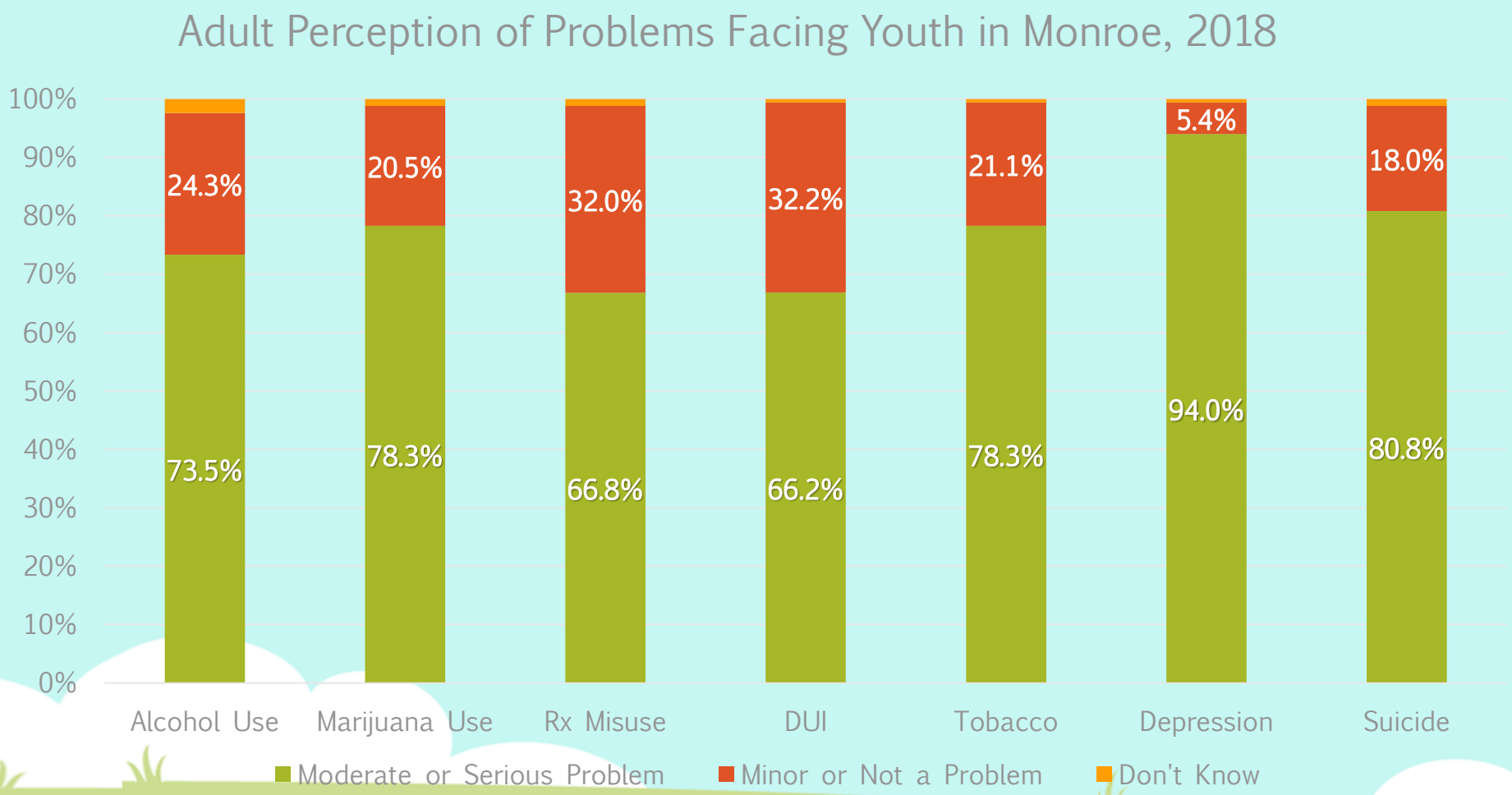
# Mental Health

- Depression affects about **1 in 3** students within the Monroe School District.
- Our rates have held steady while State rates grew in 2018.
- **We have reduced 10th Grade attempted suicide rates to just 7%, from a high 17% in 2016.**

# Community Survey Summary

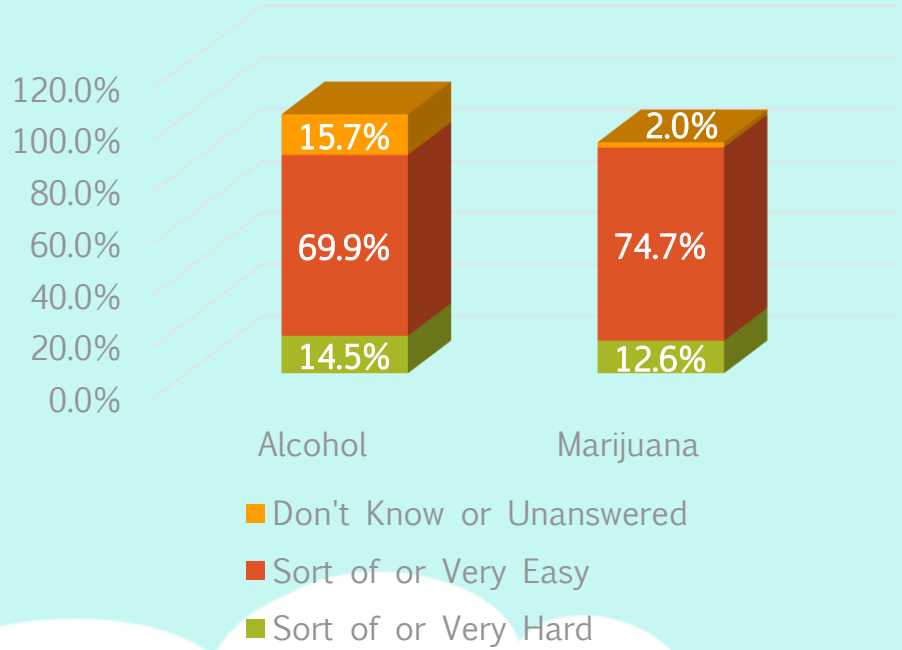
- Adults in Monroe believe:
  - Depression and Suicide are the two biggest challenges facing youth, followed by Marijuana and Tobacco use.
  - Drinking and prescription drug misuse are more harmful than marijuana use.
  - Overwhelmingly perceive youth drinking as wrong, but believe the community is more permissive than they are.
  - Community believes alcohol and marijuana are very easy to get, but don't favor restricting alcohol availability at public events as a means of limiting access or changing community norms.
  - Favor enforcement of current law and enacting civil nuisance fines for properties on which underage drinking parties occur.

# Severity of Problems Facing Youth in Monroe

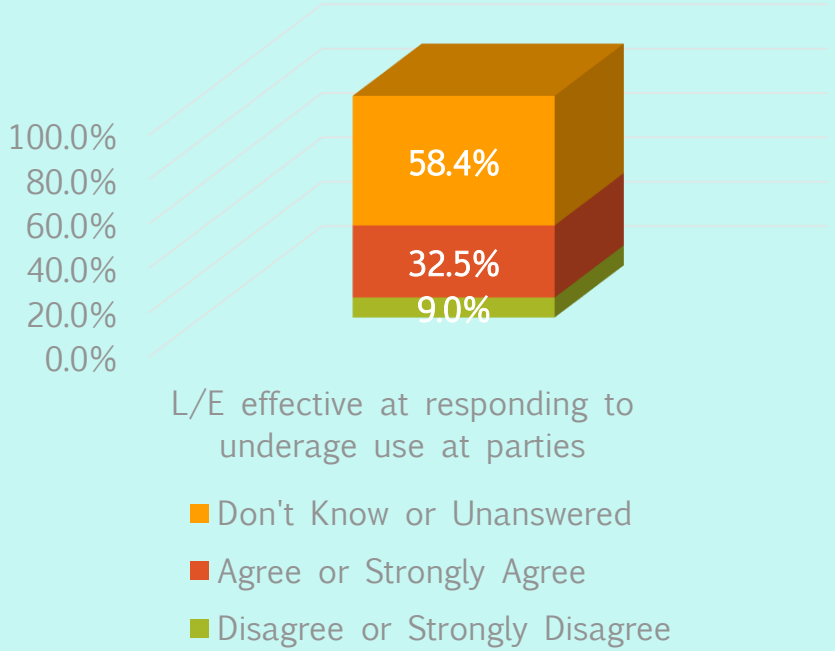


# Adult Perception: Ease of Access & Enforcement

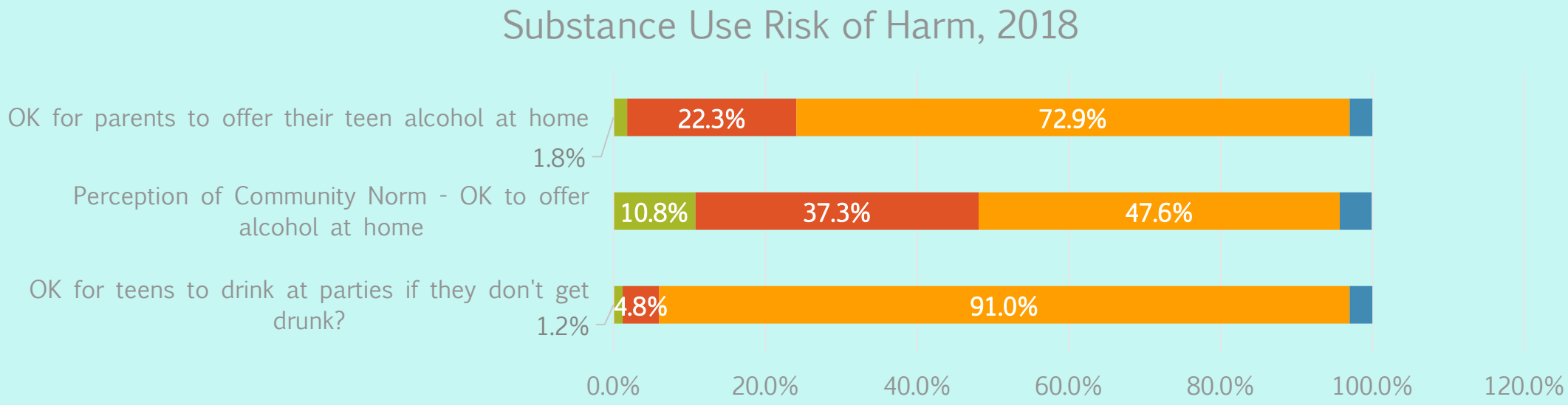
## Perception of Access, 2018




## Effective L/E Response, 2018



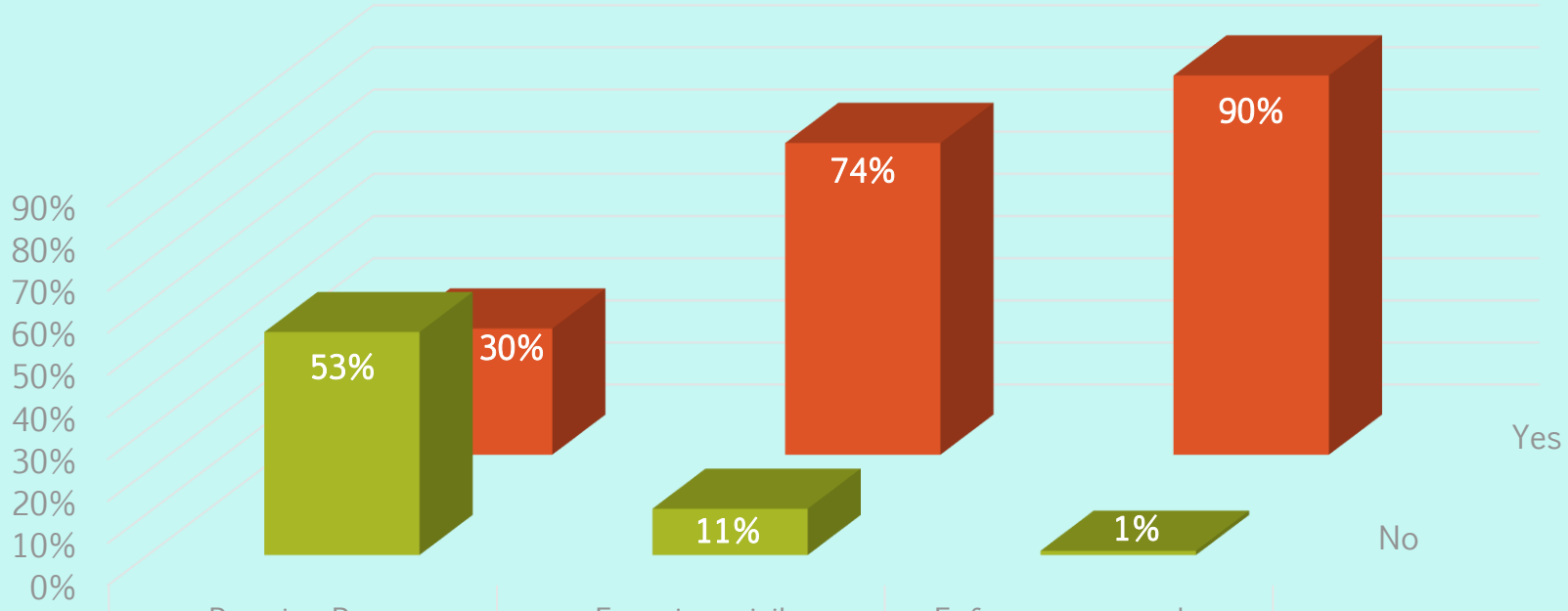
# Beliefs and Perceptions: Underage Drinking




| | OK for teens to drink at parties if they don't get drunk? | Perception of Community Norm - OK to offer alcohol at home | OK for parents to offer their teen alcohol at home |
|---|---|---|---|
| Yes. | 1.2% | 10.8% | 1.8% |
| Yes. Special Occasions. | 4.8% | 37.3% | 22.3% |
| No | 91.0% | 47.6% | 72.9% |
| Unanswered | 3.0% | 4.2% | 3.0% |

# Laws and Norms: Underage Drinking

## Community Policy and Enforcement, 2018




| | Restrict Beer Gardens at public events | Enacting civil nuisance property fines for underage drinking parties | Enforce current law |
|---|---|---|---|
| No | 53% | 11% | 1% |
| Yes | 30% | 74% | 90% |

# Business Updates

- **Strategic Plan Approved!**

pax Good Behavior Game

Botvin LifeSkills Training
Evidence-Based Prevention Programs for Schools, Families, and Communities

SOURCES OF STRENGTH

Project SUCCESS™

TRAINING

Prevention Plus Wellness™

cast
Coping And Support Training


- **Community Survey Ready**
- **OSPI Feature**
- **School-based Behavioral Health Subcommittee**

# Sources of Strength Highlight

# Outreach Priorities

## Community Training & Outreach

- ACES
- Kernels
- Resilience
- Self-Care
- Suicide
- Substance Abuse
- Diversity & Inclusion
- Depression/Anxiety
- Communicating Rules and Expectations
- …
- (Be sure to discuss location)