SHARED RISK AND PROTECTIVE FACTORS WORKGROUP REPORT

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EXECUTIVE SUMMARY

Shared Factors: Focusing on shared risk and protective factors (SRPF) in both public and behavioral health work allows prevention efforts to have greater reach across multiple areas of concern, and creates opportunities to leverage resources. It also presents opportunities for sustainability. Focusing on factors that are shared across multiple health concerns allows prevention efforts to continue despite changes in health issues prioritized by funders. Interest in this work is growing in Alaska, across a broad swath of health issues. They have included substance abuse, violence and injury prevention, high school graduation, child maltreatment, domestic violence and sexual assault, suicide, and others. There are many influencing factors that cross those areas.

When the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP) began developing a plan for addressing injury in Alaska, SRPFs were one of the prioritization considerations. Injury areas affected by factors shared by other areas received higher priority.

There have been several efforts to create a matrix showing which factors are shared by various health interest areas, similar to work done previously in Colorado. The shared factor matrix developed for the ASVIPP is included in the appendix of this report for reference. Becky Judd, of Strength-Based Strategies, recently updated the SRPF adolescent behavioral health originally compiled for the Behavioral Health Epidemiological Outcomes Workgroup in 2007. The matrix from that report is also included in this report. The State's Section of Women's, Children's, and Family Health is researching shared protective factors associated with sexual violence. There are others who are actively furthering the development of this framework in Alaska.

The Workgroup: Building from the momentum of the ASVIPP, the Center for Safe Alaskans brought together over 30 individuals who participated in a shared risk and protective factor workgroup, from a variety of non-profit organizations, tribal healthcare organizations, researchers, in addition to the leading and funding organizations. Facilitation and project management support was provided by Denali Daniels & Associates, Inc.. Funding was provided by the Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion.

Over the course of nine weeks and five biweekly meetings from April to June 2018, a workgroup began a process to pull SRPF together into a research-based and data-driven broad-issue-based matrix. The goal was to create Alaska specific guidance for SRPF work in the future. It was intended to create opportunities to allow public and behavioral health initiatives to cross-pollinate and leverage prevention resources. The initial work of this group lead to the beginning of developing an index of definitions of risk and protective factors and investigating best and promising practices which would be implemented in Alaska.

Based on feedback from the workgroup, a template was set up to collect information on health issues and risk and protective factors. The template included the following information: health issue, age group, data sources that define and measure the issue, protective and risk factors and relevant data sources, related funding sources, evidenced-based best practices, identify gaps.

Over the course of this project, 13 working documents were populated with data by 19 workgroup members. Working documents were populated on the following topic areas: bullying, connectedness, cultural connectedness, falls, feeling alone, sad, or hopeless, hopefulness/wellbeing, interpersonal violence and intimate partner violence, positive school climate, sexual violence, social and emotional learning, transportation, underage drinking, youth mattering to the community, and youth violence and teen dating. The information was then presented to the workgroup, and members had the opportunity to ask questions and discuss. Resources were compiled that provide background information on the concept of shared risk and protective factors as well as references in the working documents.

This document is a culmination of that initial work, and a jumping off place for the future. The matrix from the workgroup is included in the main body of this document. The working documents are included in the appendices. The contents of the working documents were edited to utilize a common format. However, there is still much work to be done on multiple levels, from standardizing criteria for inclusion, developing shared understanding of definitions (even if not sharing exact definitions) to using a common citation format.

The work begun by the workgroup and others, engaging in the same type of work, is exciting and energizing. A big thank you to those who worked on this initiative, and all of those undertaking similar work in Alaska, the United States and worldwide.

Marcia Howell
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MATRIX

The data from the process working documents was compiled into the following matrix to provide the starting point for showing important connections between health issues and risk and protective factors. The workgroup recognizes this is not a comprehensive matrix of all health issues and risk and protective factors but includes those that were addressed through this project.

The workgroup expressed interest in a more visually appealing option than a matrix. To address this interest, a template was created for the process working document in more of a mind map design. Multiple mind mapping software services were tested by workgroup members to connect data across issues and/or factors. After some effort, it was determined that the timeline and budget for this project were not sufficient for mind mapping, and that this would be a recommended next step for the data compiled.

Two other matrices are included in the appendix. The first was created by the Alaska Statewide Violence and Injury Prevention Partnership. The full report is available at:

http://dhss.alaska.gov/dph/Chronic/Documents/InjuryPrevention/documents/2018-2022_AKStatewide_InjuryAndViolencePreventionPlan.pdf

The second is from the Shared Risk and Protective Factors Impacting Adolescent Behavior and Positive Development by Becky Judd of Strength-Based Strategies, which is available at: https://safealaskans.org/wp-content/uploads/2019/01/Shared-Factors-for-Adolescents-Jan-2019-1.pdf. The health areas covered in them are narrower than this report, but were developed using more rigorous standards for inclusion. They can provide valuable guidance for future shared risk and protective factor work in Alaska.

PROTECTIVE FACTORS This is a list of factors mentioned in more than one working document from the workgroup. It is not an inclusive list. For other examples of SRPF matrices, see Appendices 1 and 2.	Underage drinking	Feeling alone, sad, and/or hopeless	Bullying	Sexual violence	Teen Dating Violence	Youth Violence	Transportation related Injuries	Intimate partner violence (domestic violence)	Falls	Suicide	Youth Marijuana Use	Opioid Misuse
Connectedness	x	x	x					x	x	x		
Connection to a caring adult	x	x	x		x	x						
School connectedness	x				x	x						
Feeling of mattering to the community	x	x	x				x	x		x	x	
Family connectedness/communication	x		x							x		
Cultural identity and connection	x									x		
Healthy social, problem-solving, and emotional regulation skills/Life skills and social competence	x		x		x	x	x			x		
Hopefulness/Wellbeing	x	x								x		
Positive/caring school climate	x		x			x				x	x	x
School readiness	x					x						
academic achievement	x			x		x						
Positive parent relationships	x				x	x	x					
Interacting with prosocial and nonviolent peers	x				x	x	x					
Household financial security	x					x						
Safe and stable housing	x					x						
Economic opportunities	x					x						
Increasing access to services and social support	x					x						
Empathy	x			x								
Having parents who use reasoning to resolve family conflicts	x			x								
Religious beliefs/identity (important, influence decisions, shared by friends, services attended)	x									x		
Talk about serious problems	x									x		
Positive self-concept	x									x		
Positive peer role models	x						x					
Coordination of resources								x	x			
Communication campaigns focusing on young males							x					x

RISK FACTORS This is a list of factors mentioned in more than one working document from the workgroup. It is not an inclusive list. For other examples of SRPF matrices, see Appendices 1 and 2.	Underage drinking	Feeling alone, sad, and/or hopeless	Bullying	Sexual violence perpetration	Teen Dating Violence	Youth Violence	Transportation related Injuries	Intimate partner violence (domestic violence)	Falls	Suicide	Youth Marijuana Use	Opioid Misuse
Feeling alone, sad, and/or hopeless (individual/peers)	x	x	x						x	x		
Involvement in bullying as victim, bystander or engaging in	x	x	x								x	x
Poor mental health	x	x			x			x		x		x
History of violent victimization					x			x				
Lack of healthy problem-solving skills	x		x		x			x		x		
Impulsiveness/poor self-control					x	x	x	x		x		
Child abuse and neglect	x			x		x						
Exposure to violence in the home or community				x	x	x		x				
Involvement with delinquent peers or gangs				x		x						
Depression and anxiety	x		x			x						
Chronic stress and trauma		x				x						
Poor economic growth or stability				x		x						
Concentrated poverty	x					x						
Views that drug use and violence are acceptable				x		x						
Favorable attitudes towards the problem behavior/low perceived risk of harm	x			x								
Friends who engage in the problem behavior	x		x	x								
Childhood media exposure to violence and alcohol	x					x						
Loss of cultural identity and connection	x									x		
Community norms and laws	x		x			x	x	x			x	x
Availability of alcohol/drugs	x											x
Household access to substances or guns	x									X		
Favorable parental attitudes and involvement in problem behaviors	x											x
Not seeking help	x	x							x	x		x
Poor sense of self and self-worth	x	x								x		
Current alcohol use and binging	x	x		x								
Density of alcohol-related businesses	x					x	x					

NEXT STEPS AND RECOMMENDATIONS

General activities supporting partnerships include regular meetings, forming smaller working groups around health topics or strategies, ensuring statewide representation, and collaborative use of resources. By the end of FY19, the group plans to be designing an Alaska pilot project or replication of a pilot project.

The workgroup recognized this project was the beginning and that next steps and recommendations would be identified as a deliverable. The last workgroup meeting, on June 21, used an interactive process to create an action plan to advance shared risk and protective factors. Some of the action items were accomplished including:

- Presenting information about Alaska shared risk and protective factors at
    - the Division of Behavioral Health Comprehensive Prevention Grantee conference and
    - the Alaska Public Health Summit,
- Advocating for and securing two new protective questions for the Youth Risk Behavior Survey
- Working with funders to promote inclusion of shared risk and protective factor concepts in requests for proposals.

There is much more work to be done. The list below contains additional next steps. A plan to move them forward will be developed at the post session of the Alaska Public Health Summit on January 25, 2019.

Future Activities of the Shared Risk and Protective Factors Workgroup

- **Create infrastructure for the Shared Factors Workgroup going forward**
    - *Potential tasks and considerations:*
        - Create smaller workgroups with specific work
        - Determine frequency of meetings for large workgroup
        - Seek funding for next steps – possibly to include stipends for workgroup members
        - Collaborate with others doing similar work in AK, and nationally to avoid duplication and enhance synergy

- **Develop living matrix of shared factors to address document/toolkit/resource needs**
    - *Potential tasks and considerations:*
        - Ensure quality management and a uniform format
        - Develop criteria for inclusion of shared factors (possibly tiered)
        - Prioritize common factors to further develop
        - Include age groups when appropriate

- **Develop documents/materials to better communicate about shared factors work**
    - *Potential tasks and considerations:*
        - Ensure quality management and a uniform format
        - Develop web-based resources
        - Create summary/1 pagers/white papers

- **Develop a honed list of major risk and protective factors and recommend a short list of high priority related interventions**
    - *Potential tasks and considerations:*
        - Identify critical common risk and protective factors to inform cross-cutting interventions
        - Create a short list of recommended high priority interventions

- Encourage cross-pollination of resources and successful strategies for interventions across various injury and violence topics
- Determine process for collaboratively seeking funding to support recommended interventions

- **Discover and address gaps that were not already covered as part of the shared factors work**
  - *Potential tasks and considerations:*
    - Explore less common public health factors (i.e., land use and planning, socio-economic factors, etc.) as potential shared risk and protective factors
    - Develop list of Traditional Practices (traditional native ways)
    - Develop list of Social Determinants/Community Indicators

- **Encourage implementation of evidence-based and/or promising practices that support shared risk and protective factors approach**
  - *Potential tasks and considerations:*
    - Develop criteria for inclusion of practices (possibly tiered)
    - Incorporate more practices into subject matter documents (online, paper, etc.)

- **Evaluate and research ongoing efforts**
  - *Potential tasks and considerations:*
    - Develop list of shared measures/signals/indicators/data sources for shared factors
    - Encourage original research using Alaska data
    - Design pilot project or replication of pilots that apply the shared risk and protective factor approach and conduct process and outcome evaluation

- **Promote Shared Risk and Protective Factor framework for real life use**
  - *Potential tasks and considerations:*
    - Explore and advocate for inclusion of protective factor questions in BRFSS
    - Explore and advocate for inclusion of protective factor questions in YRBS
    - Advocate for use of shared factor framework in strategic plans (HA2030, etc.)
    - Advocate for use of shared factor framework in RFPs
    - Advocate for increased access to data, query ability, and training (IBIS, ?)

APPENDICES

APPENDIX 1: STRENGTH-BASED STRATEGIES SRPF MATRICES

Becky Judd (2019)Shared Risk and Protective Factors, Impacting Adolescent Behavior and Positive Development, Strength-Based Strategies: https://safealaskans.org/wp-content/uploads/2019/01/Shared-Factors-for-Adolescents-Jan-2019-1.pdf

Shared RISK Factors Impacting Adolescent Behaviors

Risk factors are characteristics within the individual or conditions in the family, school or community that increase the likelihood youth will engage in unhealthy behaviors. See criteria below. The factors in bold were selected as priority prevention indicators by SPF/SIG Epidemiological Influences Workgroup in 2010.	Unhealthy Behaviors			
	Suicidal (thoughts & attempts)	Substance Use	Violence	Unsafe Sexual Activity
Comty./Society — *** Unhealthy community laws, norms and beliefs** (re. alcohol/ drug use, firearms & gender roles) [8,11,18, 52, 96,105,112]	✔	✔	✔	✔
* Easy availability of alcohol and drugs [8,12,18,112]		✔	✔	
* Easy availability of firearms [8,12,18,112]	✔		✔	
Low neighborhood cohesion and support [8,18,65,105,107,112]		✔	✔	
Frequent transitions, turnover and mobility [6,8,18,85,107]	✔	✔	✔	✔
* High neighborhood poverty and inequities [2,8,11,18,61,65,69, 96,103,105,112]		✔	✔	✔
Family — Family conflict, instability and management problems [8,18,65,67,69,103,112]	✔	✔	✔	✔
Family history of problems (addiction, crime, or mental illness) [2,4,8,11,18,61,65,67,69, 96,105, 106,112]	✔	✔	✔	✔
Adverse childhood experiences: abuse, neglect, household dysfunction [1,6,11,12, 37,61,65-69, 84,85,95,103,105-107,112]	✔	✔	✔	✔
Favorable parental attitudes about unhealthy behavior [8,18,41,65,103]		✔	✔	
Easy access to substances or guns at home [1,11,112]	✔	✔	✔	
Chronic Poverty [87,88.89, 96,105,107,112]		✔	✔	✔
Homelessness [83,84,85, 96,105,107]	✔	✔	✔	✔
Peers — Friends' attitudes and involvement in unhealthy behaviors [8,18,83,93,94,103-105,112]		✔	✔	✔
Indiv. — Cognitive impairments [8,18, 61,65, 96,105,107]	✔	✔	✔	
Early and persistent antisocial behavior [8,18, 96,103,105,112]	✔	✔	✔	✔
Childhood media exposure to violence & alcohol [54-60,107]		✔	✔	
Failing grades (beginning in elementary school) [1, 2, 8,18,65,121-124]	✔	✔	✔	✔
Lack of personal commitment to school [1, 8,9,11,18,61]	✔	✔	✔	✔
Bullying others+ or victimized by bullying- [112,132,133]	✔ -	✔ +	✔ +	
Early onset of unhealthy behaviors [6,8,18, 90-92, 103,112]		✔	✔	✔
Loss of cultural identity and connection [47,48,49,61,64]	✔	✔		
Personal attitudes favorable toward the problem behavior (including low perceived-risk of harm) [8,18,52]	✔	✔	✔	✔
Sexual Orientation (LGBTQ) [1, 108-111]	✔	✔	✔	✔
Feeling alone or depressed [1,7,11,61-63,69, 95-102,]	✔	✔	✔	
Older physical appearance (than peers) [1,6]	✔	✔		✔

✔ Each check represents a correlation between the risk factor and two or more unhealthy behaviors. Each factor was cited in two or more peer-reviewed studies, reports or analyses conducted by University of Alaska, State of Alaska or national government agencies.

* Societal factors may be impacted through partnerships with community coalitions and state and local policy makers

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Shared PROTECTIVE Factors Impacting Adolescent Behaviors

Protective factors are characteristics within the individual or conditions in the family, school or community that decrease the likelihood youth will engage in unhealthy behaviors. Protective factors help youth cope with life challenges and risk factors, and increase positive development. See criteria below.

The factors in bold were selected as priority prevention indicators by SPF/SIG Epidemiological Influences Workgroup in 2010.

		Unhealthy Behaviors			
		Suicide (thoughts & attempts)	Substance Use	Violence	Unsafe Sexual Activity
Comty./ Society	**Positive connection to *other* positive adults** [1,3,4,5,9-11,13a, 21,61,65,66,69,95,105,112,127]	✔	✔	✔	✔
	Safe, supportive, friendly neighborhood/community [1,6,9,11,14,21,34,61,95,105,120]	✔	✔	✔	✔
	*Clinical care and therapeutic support services for those in need [6,12,14,16,61,112-114]	✔	✔	✔	✔
	*Public policies, practices and norms supporting health and safety [6,8,12-14,16,17,33,,95104,105,112,116, 119]	✔	✔	✔	✔
	A range of community-based out-of-school time programs and opportunities for meaningful youth involvement (see individual factors, below.)				
School	**Connected to school** [1,6,8,9,10,15,34 53,105 112,115,116]	✔	✔	✔	✔
	Caring school climate [2,3,8,9,15, 23, 25,53]	✔	✔	✔	✔
	Student participation in extracurricular activities and governance [6, 8,9, 13b,15,28,29,30,117]		✔		✔
	Early intervention student services [2,6,31,32, 42,43,113]	✔	✔		✔
Family	**Connected to Family** [1,4,6,7,15,25,46,53,61,68,69,112,113,125]	✔	✔	✔	✔
	Positive, warm parenting style [6,8,11,15,21,53,65,69,112]	✔	✔	✔	✔
	Living in a two-parent family [6,21,25,65,69]	✔	✔		✔
	Higher parent education [2,4,6,8,11,17,21]		✔	✔	✔
	Higher parental expectations about school [1,8,11,18,24]	✔	✔	✔	
Peers	Positive friends and peer role models [6,7,9,17,25,46,105,112]		✔	✔	✔
Indiv. / Peers	**Engaged in out-of-school time programs & positive meaningful activities** [3,4,6,8,9,11,25, 38,39,40,112,117,]		✔	✔	✔
	Social/emotional competence and self regulation skills [3,4,5,8,9,11,44,45,53,61,71-78, 112,118]	✔	✔	✔	✔
	Cultural identity and connection [47,48,49,61,126-131]	✔	✔	✔	
	Positive temperament [3,4,5,8,9,15,19,112]		✔	✔	✔
	Positive self concept [1,6,9,11]	✔	✔		✔
	Feeling valued and mattering to others [9,34,79, 80,81,82,112]	✔	✔		
	High grade point average [1,6,7,9,112]	✔	✔	✔	✔
	Religious or spiritual beliefs [1,6,9,25,61,135-137]	✔	✔		✔

✔ Each check represents a correlation between the risk factor and two or more unhealthy behaviors. Each factor was cited in two or more peer-reviewed studies, reports or analyses conducted by University of Alaska, State of Alaska or national government agencies.

* Societal factors may be impacted through partnerships with community coalitions and state and local policy makers

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APPENDIX 2: ASVIPP SHARED RISK AND PROTECTIVE FACTOR MATRIX

Alaska Statewide Violence and Injury Prevention Plan. 2018.
http://dhss.alaska.gov/dph/Chronic/Documents/InjuryPrevention/documents/2018-
2022_AKStatewide_InjuryAndViolencePreventionPlan.pdf

Appendix A: Shared Protective and Risk Factors for Six ASVIPP Priority Areas

Socio-Ecological Level	Protective Factor	Suicide	Poisoning	Falls	Child Maltreatment	Domestic Violence Sexual Assault	Transportation
Societal	Poison prevention laws and policies: such as good samaritan law, mandatory prescription drug monitoring program, or access to Naloxone	4, 7, 8	7, 4	4	4	4, 7, 8	4
	Strong community infrastructure such as: access to health care, counseling and evidence-based treatment, Home visiting, suicide prevention training, or talking openly about suicide	7, 8	7, 8		8	8	
	Adoption of safe driving policies including Complete Streets and graduated drivers licensing						8, 12
	Positive/healthy social behavioral norms		8				12, 13, 18
		Suicide	**Poisoning**	**Falls**	**CM**	**DV/SA**	**Transportation**
Community/School	Accessible and available mental health and substance use disorder or health care services	1, 4, 7, 8	4, 7	4, 6	1, 4	1, 7, 4	4
	Coordination of resources and services among community agencies, including exercise programs and prescription drug monitoring programs, etc.	1, 7	4, 7, 8	6	1	1	
	Safe supportive connected community	1, 7, 8	7	6	1		13
	Caring school climate	7	7			7	7, 8
	Student participation in extracurricular activities	7					7, 8
		Suicide	**Poisoning**	**Falls**	**CM**	**DV/SA**	**Transportation**
Family/Interpersonal	Family support/connectedness (e.g. caring adult mentors/ connection to a caring adult)	1, 7	7	6	1, 8	1, 7	3, 13
	Positive parenting style	8	7, 8		8	7, 8	3
	Connected/committed to school or community	1, 2, 7	2, 7	6		1, 7, 8	2
	Economic stability			6	4, 8	4	
	Higher parental expectations about school	7	7			7	
	Connection to a caring adult	1				1	
	Association with pro-social peers					1	8, 12, 13

Family/Interpersonal		Suicide	Poisoning	Falls	CM	DV/SA	Transportation
Family/Interpersonal	Parents who use communication and anger management skills with teens	2					2, 14
	Home safety practices: Proper storage and disposal of poisons (including medications) and other lethal means of suicide	8	8				
	Home safety practices: handrails, ramp, no loose rugs, adequate lighting, carbon monoxide detector		8	8			
	Higher parent education		7			7	
		Suicide	**Poisoning**	**Falls**	**CM**	**DV/SA**	**Transportation**
Individual	Resilience	4, 7	4, 7	4, 7	4, 7	4	4, 8
	Social competencies and life skills	7			7		7, 8, 13, 18
	Skills in solving problems nonviolently	1			1	1	
	School achievement	1, 7	7			1, 7	
	Engagement in positive activities		7			7	
	Cultural identity and connection	7	7				
	Positive self-concept	7	7				13
	Positive peer role models		7				7, 8, 13
	Physical strength/ regular activity	8		5, 6			
	Feeling like you matter to community	7		6			
	Religious or spiritual beliefs	7	7				
	Positive personal qualities		7				

Socio-Ecological Level	Risk Factors	Suicide	Poisoning	Falls	Child Maltreatment	Domestic Violence/ Sexual Assault	Transportation
Societal	Weak health, educational, economic and social policy laws including mandatory use of safety devices	1			1	1	8
	Harmful norms around masculinity and femininity/gender identity	8			1	1	
	Unsafe media portrayal of violence and suicide	1, 8	7			1, 7	
	Cultural norms that support aggression towards others				1	1	
	Societal income inequity				1	1	

		Suicide	Poisoning	Falls	CM	DV/SA	Transportation
Community/School	Poor neighborhood support and cohesion	1	7	6	1	1, 7	
	High alcohol outlet density/social-retail availability of substances	1	8		1	1	
	Diminished economic opportunities/high unemployment	1	7		1	1, 7	
	Neighborhood poverty	1			1	1	
	Icy roads and sidewalks			8			8, 13
	High density of violence and crime in community				1,8	1	
	Lack of transportation safety factors such as marked trails, roadway lighting, etc.						8, 13
	[Home Environment] Slippery surfaces (indoor and out), stairs and steps (especially if uneven or lacking sturdy handrails), floor clutter or throw rugs, poor lighting, and hard to reach items			11, 12			
		Suicide	Poisoning	Falls	CM	DV/SA	Transportation
Family/Interpersonal	Economic stress/low socioeconomic status/unemployment	1	7	6	1	1, 7	
	Social isolation/ lack of support	1		6	1	1	
	Poor parent-child relationships	1, 7	7		1	1, 7	
	Associating with high risk taking/delinquent peers, especially those who approve of substance use		7			1	8, 13
	Familial violence including history of suicide	8			1		
	Family conflict/poor family cohesion/poor parent-child relationships				1	1	
		Suicide	Poisoning	Falls	CM	DV/SA	Transportation
Individual	Substance use/misuse (by caregiver in CM)	1, 8	7, 8	5, 6	1,8	1, 8	8, 13, 14
	Depression/poor mental health	1, 8		5	1, 8	1, 8	17
	Low educational achievement	1			1	1	
	Lack of nonviolent social and problem-solving skills	1			1	1	
	Poor behavioral control/impulsiveness	1			1	1	13, 14, 17
	History of violent victimization	1			1	1	
	Witnessing violence	1, 8			1,8	1, 8	
	Psychological/mental health problems including feelings of hopelessness and purposeless	1, 8			1	1	17
	Early sexual activity	8	7				

Factor					
Gang involvement		7		7, 8	
Low perception of risk of harm and peer approval (substance use)		7, 8			8, 15
Impaired Vision/ Balance/ Hearing			5		8
Having been bullied and/or engaging in bullying	1, 8				
Prior falls			8		
Changes in memory and mental status (e.g. dementia, Alzheimer's, and other cognitive impairments)			8		
Poor nutrition and/or medication factors: polypharmacy, dosage			8		
Unsafe driving including cellphone use, and inexperience					8, 13, 14
Slowed reflexes, weak muscles or sarcopenia (loss of muscle mass)			9,10		
Lack of exercise and sleep			9		16

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2   Centers for Disease Control and Prevention. School Connectedness: Strategies for Increasing Protective Factors Among Youth. Atlanta, GA: U.S. Department of Health and Human Services; 2009.

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4   Colorado Violence and Injury Prevention- Mental Health Promotion Strategic Plan, 2016-2020. https://drive.google.com/file/d/0B4u1qfqmSaHjYmI5RDhwaElDUFU/view

5   Institute of Medicine (US) Division of Health Promotion and Disease Prevention; Berg RL, Cassells JS, editors. The Second Fifty Years: Promoting Health and Preventing Disability. Washington (DC): National Academies Press (US); 1992. 15, Falls in Older Persons: Risk Factors and Prevention. Available from: https://www.ncbi.nlm.nih.gov/books/NBK235613/

6   WHO global report on falls prevention in older age. WHO Press, World Health Organization (2007) http://www.who.int/ageing/publications/Falls_prevention7March.pdf site visited 12-11-2017

7   Alaska Behavioral Health Epidemiological workgroup findings, January 2011. http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/Risk_Protective_Factors.pdf cite visited 12-11-2017

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16 Cummings, P., Koepsell, T., (2001). Drowsiness, countermeasures to drowsiness, and the risk of a motor vehicle crash. Injury Prevention. 7:194-9

17 Dula, C., Geller, E., (2003). Risky, aggressive, or emotional driving: addressing the need for consistent communication in research. Journal of Safety Research. 34:559-66.

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APPENDIX 3: AREAS OF HEALTH CONCERN WORKING DOCUMENTS

Based on feedback from the workgroup, a template was set up to collect information on health issues and risk and protective factors. The template included the following information: health issue, age group, data sources that define and measure the issue, protective and risk factors and relevant data sources, related funding sources, evidenced-based best practices, identify gaps. A template was also set up to start from the risk or protective factor first, and then note health issues that are connected to that risk or protective factor.

In order to collect the health issue and risk and protective factor information from the workgroup members, a Google Drive folder was set up. The main "Shared Risk and Protective Factors Workgroup" folder contained three subfolders: Process Working Documents, Resources, and Meeting materials. An instructional document was created to explain how to use the Drive and create working documents from the templates.

Over the course of this project, 13 working documents were populated with data by 19 workgroup members. The information was then presented to the workgroup, and members had the opportunity to ask questions and discuss. Resources were compiled that provide background information on the concept of shared risk and protective factors as well as references in the working documents, as available.

BULLYING

Health Concern: Youth bullying
Contributors: Lindsey Hajduk, Charles Utermohle, Marcia Howell
Age Group: Youth ages 12-24 years old.

Definition: Bullying is unwanted, aggressive, intentional behavior that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Bullying includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose.[1]

Data sources that help define and measure bullying among high school-aged youth:

- During the past 12 months, have you ever been bullied on school property? Yes, No[2]
- During the past 12 months, have you ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)[3]
- This school is being ruined by bullies.[4]
- Students and staff reported how often they observed students engage in delinquent behaviors at school and at school events within the past 12 months: Threaten or bully other students.[5]

Influencing Factors:

Risk Factors[6]

- Current alcohol use and binge drinking
- Feeling alone
- Feeling sad or hopeless Suicide ideation
- Truancy (i.e., missed school)
- Feeling unsafe in school

Protective Factors[7]

- Having teachers who really cared and gave encouragement
- Feeling like they mattered in their community

Bullying also serves as a Risk Factor for:[8]

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[1] Anchorage Collaborative Coalitions. Community Behavioral Health Assessment Report: Anchorage Youth & Young Adults. www.anchoragecollaborative.org

[2] 2017 YRBS Question 23

[3] 2017 YRBS Question 24

[4] School Climate and Connectedness Survey. School Safety question.

[5] School Climate and Connectedness Survey. Student Delinquent Behaviors question.

[6] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

[7] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

[8] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

- Engaging in bullying behavior may lead to substance use, school problems, criminal activity, early sexual activity, and abusive/ assaultive behavior.
- Victims of bullying experience increased likelihood of depression, anxiety, feeling of sadness and loneliness, changes in sleep and eating patterns, loss of interest in activities they used to enjoy, health complaints, decreased academic achievement, and increased likelihood of skipping and/or dropping out of school.
- Effects on bystanders include increased substance use, mental health problems, including depression and anxiety, and increased school absence.

Funding Sources:

- State of Alaska Department of Health and Social Services Division of Behavioral Health: Comprehensive Behavioral Health Prevention and Early Intervention Grant
  - Anchorage Collaborative Coalitions: offers pass-through funds to coalition members based in Anchorage

Promising and Evidence-based interventions (programs, practices and policies):

- Substance Abuse and Mental Health Services Administration - National Registry of Evidence-Based Programs and Practices: all programs are in review for various best practices for bullying prevention, such as self-regulation, self-concept, cognitive functioning, and more.
  - Adventures in a Caring Community[9]
  - Aggressors, Victims, and Bystanders: Thinking and Acting to Prevent Violence[10]
  - Attachment-Based Family Therapy (ABFT)[11]
  - Cool Kids Child and Adolescent Anxiety Management Program[12]
  - Kognito Step In, Speak Up![13]
  - Lions Quest Skills for Action[14]
  - Lions Quest Skills for Adolescence[15]
  - Media Literacy for Safe and Healthy Choices[16]
  - Olweus Bullying Prevention Program[17]
  - School-Connect: Optimizing the High School Experience[18]
  - Second Step: Student Success Through Prevention (SS-SSTP) Middle School Program
  - Student Success Skills[19]
  - Too Good for Violence K-5[20]

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[9] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=2

[10] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=82

[11] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=208

[12] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=1273

[13] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=1258

[14] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=173

[15] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=113

[16] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=54

[17] https://www.nrepp.samhsa.gov/NewProgramProfile.aspx?id=6

[18] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=137

[19] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=106

[20] https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=1261

Identify gaps:

- Bullying among adults over the age of 18.
- Long-term consequences of bullying for perpetrators, targets, and bystanders.

References, Resources, End Notes: See footnotes

CONNECTEDNESS

Health Issue: Connectedness (multi-dimensional)

Contributors: Becky Judd, Jenni Lefing, Summer Chitwood, Charles Utermohle

Age Group: Adolescents.

Definition: Connectedness refers to feelings of belonging to, or having affinity with a particular person or group. Multiple studies have explored the relationships youth have to their family, peers, schools and communities and its impact on health behaviors. It is most useful to examine the concept of connectedness ecologically for definition, measurement and actionable purposes.

> Overarching Definition: Connectedness relates to the extent to which youth <u>perceive</u> adults (in their social settings) as warm, caring, respectful, trusting, and providing age appropriate support, supervision and autonomy.

> Theoretical Background: The *connectedness* construct has its origins in the theories of bonding and attachment. Some of the earliest connectedness research emerged from Resnick and his colleagues, who described adolescents' connection to others and to social institutions as protective factors related to adolescent problem behavior (1993). Over the following decades, numerous studies continued to explore of the role of *connectedness* in the health and development of children and adolescents. The findings consistently document a correlation between connectedness across several health indicators.

> The Connectedness research has followed two general constructs:

> 1. Connectedness as a relational component - the bond youth experience with significant others, that is*, feelings of support, closeness, trust, caring and dependency*. This theme of connectedness has similar descriptors to the "Mattering to Others" protective factor definition. Generally, a close supportive relationship is a precursor for "mattering to a significant other."

>   A subset of the relational component is a focus on the degree to which youth feel that their individuality is validated or supported by significant others. Barber (2004) references this as the drive for having one's basic needs met via attachment, and security. This definition emphasizes <u>validation </u>by significant others.

> 2. Connectedness as an environmental component - the bond youth feel to a group or social institution.
>   a. <u>School Connectedness:</u>   Schools are the most prominently researched social environment that is, *feelings of support, cared for, closeness and treated fairly by teachers, staff and* peers; *liking school and* feeling *part of and committed to one's school.* The school connectedness definition is related to the theories of attachment and belonging; it has the potential to be expanded to other social environments, such as after-school programs (pending- youth's interest and desire for acceptance by that social environment or group.) See Protective Factor: School Climate.
>   b. <u>Community Connectedness:</u> Whitlock (2004, 2006, 2007, 2010, 2014) extensively studied adolescent's connection to the broader community (and

school) by exploring both relational and social institutions connectedness. Her research examined the multiple contexts for belonging and connectedness related to adolescent wellbeing <u>and </u>protection from self harming behaviors.

Community Connectedness has a synergistic relationship with other protective factors: connection to *other* positive adults; youth mattering to community, involvement in after-school activities. Whitlock's findings have greatly informed the "connection to community" work associated with YRBS connectedness indicators in Anchorage.

Data sources that define and measure the factor

Relational Connectedness

Family connectedness (Proxy Indicators)

- Indicator: How often does one of your parents talk with you about what you are doing in school (YRBS)
- Indicators from SCCS ?
- Indicators from Mat-Su Healthy Kids Survey (From CA Healthy Kids Survey, 2008)
- Indicators from NSDUH survey

Connection to other positive adults

- Indicator: Besides your parents, how many adults would you feel comfortable seeking help from if you had an important question affecting your life (YRBS)
- Indicator: Outside of school and home I know at least one adult I can talk to, if I have a problem. (SCCS)
- Indicator: Outside of school and home I know at least one adult who encourages me to do my best. (SCCS)
- Indicators from Mat-Su Healthy Kids Survey (From CA Healthy Kids Survey, 2008)

Environmental (Social groups & organizations) Connectedness

School Connectedness

- Indicator: Do you agree or disagree that your teachers really care about you and give you a lot of encouragement. (YRBS)
- Multiple indicators: School Climate and Connectedness Survey. *(See Protective Factor: School Climate, indicators)*
- Indicators from Mat-Su Healthy Kids Survey (From CA Healthy Kids Survey, 2008)
- Indicators from NSDUH survey

Community Connectedness

- Indicator: Do you agree or disagree that in your community you feel like you matter to people (YRBS)
- Indicator: Do you agree or disagree that you feel alone in life. (YRBS, reverse scored)
- Involvement in community-based activities
    - During an average week, how many hours do you spend helping or volunteering at school or in the community (such as helping elders or neighbors; watching young children; teaching or tutoring; peer helping; mentoring; or helping out at local programs, health clinics, faith organizations, tribal organizations, or environmental organizations)? YRBS
    - During an average week, on how many days do you take part in organized after school, evening, or weekend activities (such as school clubs; community center groups; music, art, or dance lessons; drama; church; or cultural or other supervised activities)? YRBS
    - During an average week, how much time do you spend helping other people without getting paid? (Examples: helping elders or neighbors; watching younger children; peer teaching, tutoring, mentoring; helping the environment or doing other volunteer activities.)   SCCS
    - During an average week, how much time do you spend participating in organized activities after school or on weekends? (Examples: sports, clubs, youth groups, music/art/dance/drama activities, cultural, religious or other community activities.) SCCS
- Indicators from Mat-Su Healthy Kids Survey (From CA Healthy Kids Survey, 2008)

Connected to culture

- Six indicators on SCCS. *(See protective factor: Cultural Identity/Connection)*

Importance:

Relational Connectedness

Family Connectedness: Multidimensional

Description: Family Connectedness refers to the feelings of warmth, love and caring that children get from their parents. Children who feel support and connection report a high degree of closeness, feelings of being understood, loved, and wanted. A parental presence is related to connection, this involves a parent being present during key times: before school, after school, dinner, bedtime and doing activities together. Family connectedness is the most powerful protective factor related to all risk behaviors (Suicide ideation, attempts, substance use, violence, and early sexual activity and pregnancy. SPF/SIG Epidemiological Influences Workgroup (2010) References 1, 4, 6, 7,15, 25, 46, 53, 61, 68, 69

Connection to other positive adults

Description: This refers to the support and caring youth receive in relationships with adults, other than family members (i.e. neighbors, coaches, teachers, mentors or ministers). As children grow, they become involved in an expanded network of significant relationships. This broad network includes many adults who can provide regular contact, mentoring, support, and guidance. Connection to other adults is associated with less suicidal ideation, attempts, substance use, early sexual activity and teen pregnancy [SPF/SIG Epidemiological Influences Workgroup (2010) References 1,3,4,5,9,10,11,13a,14, 21, 33, 61,65,66,69]

Environmental (Social groups & organizations) Connectedness

School Connectedness: Multidimensional

(Also see See Protective Factor - School Climate)

Description: Students feel "connected" (attached/bonded) to their school based on their feelings about the people at school, both staff and other students. School connectedness is closely related to caring school climate. Connectedness is described as being treated fairly by teachers, feeling close to people at school, being safe and feeling like a part of the school. School connectedness protects youth against many health risks, including smoking, alcohol, drug use, and early sexual initiation. Strong connectedness with school has also been shown to contribute positively to academic achievement. [SPF/SIG Epidemiological Influences Workgroup (2010) References 1, 6, 8, 9, 10, 15, 34, 53]

Community Connectedness: Multidimensional

Also see Protective Factor - Youth Mattering to Community)

Description: Youth perception that they and other youth are cared for, trusted, and respected by adults individually and collectively. This includes a youth sense of belongingness, safety knowledge of and involvement in community programs and activities. (Whitlock 2003)

Connected to safe, supportive neighborhood

While relationships with caring adults on an individual basis are very important, the collective feeling of safety and support coming from the community or neighborhood as a whole adds a synergistic component of protection against risk behaviors.

This protective factor has three features: connection, positive social norms, and monitoring. Connection refers to young people's perception of feeling safe, valued, attached, and "belonging to" their neighborhood, community, or in some cases, youth programs. Positive social norms are maintained when community members have high expectations for children. Monitoring and accountability refers to the degree to which neighbors watch out for each other and monitor the whereabouts and behaviors of their children, as well as hold them accountable for their behaviors. Connected to a safe supportive neighborhood is associated with less suicidal

ideation, attempts, substance use, early sexual activity and teen pregnancy [SPF/SIG Epidemiological Influences Workgroup (2010) References 1, 6,9,21,34, 61]

Engagement After-School Activities

This refers to activities involving volunteering and helping others in community or peer-based programs, or service-learning projects. This protective factor is associated with the reduction of several risk-taking behaviors (alcohol, tobacco or drug use, delinquency, anti-social behaviors, teen pregnancy, school suspensions or school dropout. Programs increase skills and positive development when youth are involved in all phases: planning, organizing, implementation and evaluation. [SPF/SIG Epidemiological Influences Workgroup (2010) References 3,4,7,6,8,9,11,25, 38, 39, 40]

Cultural Identity and Connection Multidimensional

(See Protective Factor: Cultural Identity and Connection)

Culture is the sum total of ways of living, this includes: values, beliefs, traditions, protocols,rituals, language, behavioral norms, ways of knowing and styles of communication. One's <u>cultural identity</u> is the extent to which someone connects to and practices the values,beliefs and traditions of their *identified culture*. Cultural identity and connection is associated with less suicidal ideation, attempts, substance use, and early sexual activity. [SPF/SIG Epidemiological Influences Workgroup (2010) References 47, 48, 49, 61, 62,]

Additional References for each section identified in Section VII

Funding sources

- Issues:
  - o Family Connectedness – TBD?
  - o School Connectedness (see Protective Factor: School Climate)
  - o Cultural Connectedness   (See Protective Factor - Cultural Identity and Connection)
  - o Community Connectedness
- Funding entities:
  - o Association of Alaska School Boards, Initiative for Community Engagement
  - o Others? RurAL CAP?
  - o Center for Safe Alaskans - AYDC Youth Matter Grants

Promising and Evidence-based interventions (programs, practices and policies

- Family Connectedness: TBD
- School Connectedness: See Protective Factor: School Climate
- Cultural Connectedness: See Protective Factor - Cultural Identity and Connection
- Community Connectedness: See Youth Matter to Community best practices

Identify gaps

Alaska Data:

- School climate and connectedness index of indicators correlated to health behaviors. (we have a data set nationally, only one question on YRBS.)
- Youth Cultural Identity and connection correlated to health behaviors.

References, Resources, End Notes:

General Connectedness (and/or across domains)

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Scales, P. C.. et al (2010) Teen Voice: Relationships that Matter to America's Teens. Search Institute and Best Buy Children's Foundation.

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Whitlock, J. et al (2014) Connectedness and Suicide Prevention in Adolescents: Pathways and Implications. Suicide and Life-Threatening Behavior. *Journal of American Association of Suicidology.* 44 (2). 46–272

Whitlock J. (2004). *Places to Be and Places to Belong: Youth Connectedness in School and Community.* Cornell University.

School Connectedness**:**   See Protective Factor: School Climate for additional references)

Community Connectedness

Chiessi, M. et. al.   (2010) Assessing Sense of Community on adolescents: validating the brief scale of Sense of Community in adolescents (SOC). *Journal of Community Psychology.* 50 38 (3):276–92.

Eccles, J.S. and Gootman, J. A. (2002) *Community Programs to Promote Youth Development*, National Research Council, Institutes of Medicine. National Academy Press, Washington, DC.

Huberman, B., et al. (2014) *Strategies Guided by Best Practice for Community Mobilization.* Advocates for Youth.

Lenzi, M., et. al. (2013). Neighborhood social connectednesss and adolescent civic engagement: An integrative model, *Journal of Environmental Psychology.* 34 (45).

Mannes, M. et al. (2002) *Cultivating Developmentally Attentive Communities: A Report on the First Wave of the National Asset-Building Case Study Project*. Search Institute and Harvard University.

Lerner, R. M. (2005). Promoting Positive Youth Development: Theoretical and Empirical Bases. White paper prepared for the Workshop on the Science of Adolescent Health and Development, National Research Council/Institute of Medicine. Washington, DC: National Academies of Science. In Learner R.M. et al. (2011). *The Positive Development of Youth.* Institute for Applied Research in Youth Development. Tufts University.

Murdock, S. et al. (2008) Trying hard an investigation of youth engagement and voice in community programs. *Youth Engagement and Voice.* Chapter 3. University of California Cooperative Extension.

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CULTURAL CONNECTEDNESS

Health Issue: Cultural Identity and Connection to Culture
Contributors: Jenni Lefing, Becky Judd, Hope Finkelstein
Age Group: Cross age.

Definition: Data sources that define and measure the issue:

Association of Alaska School Board's (AASB) School Climate & Connectedness Survey (SCCS)
for students grade 6-12, students, staff: Cultural Connectedness Topic

Students Grade 6-12

- I have a strong sense of belonging to my culture.
- In general, my culture is an important of my self-image.
- My school teachers about the history and culture of people who live in my community.
- My school values the language and culture of my family.
- My teachers makes an effort to represent my culture in class lessons.
- I see my family's culture represented in class lessons, materials, posters, and art around the school,etc.

Staff

- Students in my school have a strong sense of belonging to their culture.
- In general, my culture is an important part of my self-image.
- This school values the language and cultures of students' families.
- This school prioritizes closing the racial/ethnic achievement gap.
- This school use instructional materials that reflect the culture or ethnicity of its students.

Family

- This school values the language and culture of my family.
- This school teachers about the history and culture of people who live in my community.
- I see my family's culture represented in class lessons, materials, posters and art around the school, etc.
- My child's teachers makes an effort to represent my family's culture in class lessons.

Other Sources

Research used by AASB to develop the Cultural Connectedness indicators for SCCS (a process that included multiple statewide stakeholders):

- Alaska Standards for Cultural Responsive Schools -
  http://ankn.uaf.edu/Publications/CulturalStandards.pdf
- Multilgroup Ethnic Identity Measure (MEIM) - Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. Journal of Adolescent Research, 7, 156-176.

- Multidimentional Model of Black Identity (MMBI) **-** Sellers, R. (2013). The Mutlidimensional Model of Black Identity (MMB)). Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie
- First Nations Youth Cultural Connectedness Scale **-** Snowshoe, Crookse, Tremblay, Craig, and Hinson. (2015). Development of a Cultural Connectedness Scale for First Nations Youth. Psychological Assessment, 27,249-259.
- California School Climate, Health & Learning Survey - California Safe and Supportive Schools Californias. wested.org/tools

Influencing Factors:

Risk Factors

Protective Factors

Funding Sources

- Culture Camp and Youth Leadership Grants - The Resource Basket (RurAL CAP, DHSS, DJJ) http://www.resourcebasket.org/2018/03/11/culture-camp-and-youth-leadership-grants/
- First Alaskans?
- Alaska Native Heritage Center?
- Regional Native Health Corporations - cultural camps and activities
- DBH – Prevention Grants? DJJ- efforts?
- AASB – Support for Culture Integration into Schools?

Promising and Evidence-based interventions (programs, practices and policies): TBD

Identify Gaps: TBD

References, Resources, End Notes:

Substance Use & Mental Health Outcomes

Berry, J.W. (1985) Acculturation and mental health among circumpolar peoples. *Circumpolar Health* 84.

Mohatt, G.et.al. Tied together like a woven hat: Protective pathways to Alaska native sobriety. *Harm Reduction Journal.* 2004, Vol1;10.

Segal, B. (1999) Alaska Natives combating substance abuse and related violence through self-healing: a report for the people. *A report to the Alaska Federation of Natives.* The Center for Alcohol and Addiction Studies. The Institute of Circumpolar Health Studies. University of Alaska Anchorage.

Wolsko, C (2007) Stress, coping, and the well being among the Yup'ik of the Yukon-Kuskokwim Delta, the role of enculturation and acculturation. International Journal of Circumpolar Health, Vol. 66; 1.

U.S. Department of Health and Human Services. (2010) *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. SAMHSA. http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

Additional Resources

- Alaska Native Cultural Competencies The Alaska Native Heritage Center developed a list of cultural competencies by region. Competencies include: subsistence hunting practices, food preparation, language, tools, trade practices, housing, clothing, life passages, rituals, healing practices; governance structures, etc. http://hss.state.ak.us/dbh/prevention/programs/spfsig/pdfs/Alaska_Native_Cultural_Competencies.pdf
- Alaska Native Knowledge Network (ANKN) compiles and exchanges information related to Alaska Native knowledge systems and ways of knowing. http://ankn.uaf.edu/
- Center for Alaska Native Health Research conducts research to prevent and reduce health disparities among Alaska Natives, through participatory and cultural awareness methods. http://canhr.uaf.edu/
- First Alaskans Institute works to advance Alaska Natives through community engagement, information and research, collaboration, and leadership development, www.firstalaskans.org

FALLS

Health Issue: Elder Falls
Contributors: Marcia Howell, Dawn Groth, Hillary Strayer, Lulu Jensen
Age Group: Adults 65 years and older

Definition:

Data sources that define and measure the issue

Behavior Risk Factor Surveillance Survey:

- In the past 12 months, how many times have you fallen?[21]
- Did this fall cause an injury that limited your regular activities for at least a day or caused you to to see a doctor?[22]
- How many of these falls caused an injury that limited your regular activities for at least a day or caused you to go see a doctor?[23]
-

Trauma Registry (hospitalizations) variables:

- Injury Coding narrative,
- ICD10, W00-W19
- Health Facilities Data
    - Emergency Department Visit
- Bureau of Vital Statistics Deaths
- IBIS
- HAVRS
- Center for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): Cost of Injury Reports [online] www.cdc.gov/injury/wisqars
- WISQARS, Fatal Injury Reports

Importance:

Nationally:

- Millions of people age 65 and older fall each year—one out of three in this age range.[24]
- Falls are the leading cause of both fatal and nonfatal injuries among older adults, causing severe injuries such as hip fractures, head trauma, and death.[25]

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[22] BRFSS 2018, Core Section 12: Falls, question 2

[23] BRFSS 2018, Core Section 12: Falls, question 2

[24] Tromp, A.M., Pluijm, S.M.F., Smit, J.H., et al. (2001). Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly. Journal of Clinical Epidemiology, 54(8), 837–844.

[25] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Injury Prevention & Control: Data & Statistics (WISQARSTM). Retrieved from http://www.cdc.gov/injury/wisqars/ (2013, August 15).

- Every 13 seconds an older adult is seen in an emergency department (ED) for a fall. In 2013, about 25,500 older adults died from unintentional fall injuries, 2.5 million were treated in emergency departments for nonfatal falls, and more than 734,000 were hospitalized.[26]
- Older adults are hospitalized for fall-related injuries five times more often than for injuries from other causes.[27]

Alaska

- Injuries from falls are the leading cause of injury in Alaska and deaths from injury for Alaskans aged 65 and older.[28] [29]
- In 2015, 36 older adults died from injuries caused by a fall and 1,600 were hospitalized. The rate of fall hospitalization injuries in Alaska for older Alaskans has not shown a significant decrease over time, indicating that fall prevention efforts have not yet had a substantial impact.
- National studies have shown that only 8-10% of falls for older Alaskans are serious enough to require medical care, so the mortality and morbidity data only report a small proportion of falls that older Alaskans experience that may alter their lives dramatically.[30] Older Alaskan adults who fall may respond by restricting their activities out of fear of falling or because of a resulting injury, which may modify their physical capabilities. This, in turn, can increase their risk for falls due to reduced muscle tone and mobility.[31]
- Alaska Trauma Registry data indicate that the average direct cost of hospital care for Alaskans age 60 and older increased from $42,000 in 2009 to $56,000 in 2013. These do not reflect indirect costs, such as nursing home, rehabilitation or therapeutic care the patient may require after the injury is treated. With improved medical care extending the average life expectancy and the increase in the older Alaskan adult population anticipated with the "baby boomer" generation, the U.S. Census Bureau estimates that the United States population aged 65 and older will increase by 35% between 2015 and 2030.[32] The resources for hospital care, rehabilitation and long-term care will need to be increased to match patient needs if the rate of falls is not lowered.

Influencing Factors:

Risk Factors:

26 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Injury Prevention & Control: Data & Statistics (WISQARSTM). Retrieved from http://www.cdc.gov/injury/wisqars/ (2013, August 15).

27 Alexander, B.H., Rivara, F.P., Wolf, M.E. (1992). The cost and frequency of hospitalization for fall-related injuries in older adults. American Journal of Public Health, 82(7), 1020–1023.

28 Kellogg International Work Group on the Prevention of Falls by the Elderly. The prevention of falls in later life. Danish Medical Bulletin 1987 Apr;34(4):1-24.

29 State of Alaska Division of Health and Social Services Commission on Aging. Alaska Senior Fall Prevention: Your choices make a difference. Available at http://dhss.alaska.gov/acoa/Pages/falls/default.aspx. Accessed August 19, 2018

30 Institute of Medicine (US), Berg RL, Cassells JS. The Second Fifty Years: Promoting Health and Preventing Disability. Falls in Older Persons: Risk Factors and Prevention. 1992. Available at: https://www.ncbi.nlm.nih.gov/books/NBK235613. Accessed August 19, 2018

31 Kronfol N. Biological, Medical and Behavioral Risk Factors on Falls. 2005. Available at http://www.who.int/ageing/projects/2.Biological,%20medical%20and%20behavioural%20risk%20factors%20on%20falls.pdf. Accessed Augsut 19, 2018

32 United States Census Bureau. 2014 National Population Projections: Summary Tables. Available at https://www.census.gov/data/tables/2014/demo/popproj/2014-summary-tables.html. Accessed August 19, 2018.

- Hearing Loss[33]
- Vision Changes[34]
- Medical, or intrinsic, risk factors for falls include many different aspects of a person's health. Vestibular and other balance disorders, stroke, impaired or distorted vision, slowed reflexes, weak muscles or sarcopenia (loss of muscle mass) can all affect how well someone recovers their postural stability when challenged.[35][36] Foot disorders and arthritis in the lower limbs can alter motility and reactions to uneven surfaces, leading to falls. Incontinence (the frequent need to urinate) can cause rushed activities resulting in falls. Polypharmacy (taking four or more medications) can cause postural hypotension from a combination of side effects or an interaction between the drugs.[37] Many types of medications can individually increase dizziness, fatigue and postural hypotension, and if one is a component of polypharmacy, the risk of falling is still greater.[38]
- Dementia, Alzheimer's, and other cognitive impairments can lead to tripping over forgotten items or panicked, sudden reactions to confusing or alarming stimuli.
  - **Behavioral Factors:** As people age, their ability to compensate for balance during normal activities may diminish. Reaching too far/high, wearing loose or thickly-soled shoes, poor diet and lack of exercise, and alcohol use are behavioral factors that can increase the risk of falls as a person ages.[39] Not adjusting for the changes in physical ability during routine or recreational activities is a behavior that makes a previously safe activity a fall risk.
- Fear of falling, which studies have been shown contributes to fall risks, may stem from concerns about being hurt, not being able to raise oneself from the floor after a fall, public embarrassment, loss of independence, and being relocated away from their home community.[43] This fear can stimulate an Alaskan older adult to increase their strength and balance training to improve their mobility. But more frequently it reduces their quality of life through reduction in confidence and exercise, leading to poor mobility.
- **Environmental Factors:** For healthy, active Alaskan older adults, environmental factors may be the most common source of fall risks.[40] Other Alaskan older adults may be increasingly challenged by activities in an environment that they had no earlier difficulties with, such as getting out of bed or going up and down steps. Environmental factors contribute to one-third

33 Lin, FR, Ferucci L. Hearing Loss and Falls among Older Adults in the United States. Archives of Internal Medicine 2012; 172(4):369-371.

34 Zhang,X, Shuai, J, Li, L. Vision and Relevant Risk Factor Interventions for Preventing Falls among Older People: A Network Meta-analysis. Scientific Reports 2015

35 Kronfol N. Biological, Medical and Behavioral Risk Factors on Falls. 2005. Available at http://www.who.int/ageing/projects/2.Biological,%20medical%20and%20behavioural%20risk%20factors%20on%20falls.pdf. Accessed August 19, 2018.

36 Institute of Medicine (US), Berg RL, Cassells JS. The Second Fifty Years: Promoting Health and Preventing Disability. Falls in Older Persons: Risk Factors and Prevention. 1992. Available at: https://www.ncbi.nlm.nih.gov/books/NBK235613. Accessed August 19, 2018.

37 Kojima T, Akishita M, Nakamura T, et al. Polypharmacy as a risk for fall occurrence in geriatric outpatients. Geriatrics & Gerontology International 2012:12(3):725-30.

38 Ziere G, Dieleman JP, Hofman A, et al. Polypharmacy and falls in the middle age and older population. British Journal of Clinical Pharmacology 2006 Feb;61(2):218–223.

39 Kronfol N. Biological, Medical and Behavioral Risk Factors on Falls. 2005. Available at http://www.who.int/ageing/projects/2.Biological,%20medical%20and%20behavioural%20risk%20factors%20on%20falls.pdf. Accessed August 19, 2018.

40 Institute of Medicine (US), Berg RL, Cassells JS. The Second Fifty Years: Promoting Health and Preventing Disability. Falls in Older Persons: Risk Factors and Prevention. 1992. Available at: https://www.ncbi.nlm.nih.gov/books/NBK235613. Accessed August 19, 2018.

to nearly one-half of falls.[41, 42]The most commonly cited factors are slippery surfaces (indoor and out), stairs and steps (especially if uneven or lacking sturdy handrails), floor clutter or throw rugs, poor lighting, and hard to reach items.

- Environmental hazards that increase fall risks for older adults can also occur from a community level. If the community does not have safe public access laws, requiring ramps with railings for public buildings, or stop lights timed to allow a slower pedestrian enough time to get across the intersection, older pedestrians may either risk falling or limit their circulation in the community to avoid these challenges. Other community practices, such as not developing clear walkways or poor sidewalk maintenance would provide similar challenges to older Alaskans.
- Medications[43],[44]
  - Fall Risk Increasing Drugs (FRID)
  - Not taking as prescribed
  - Unclear Instructions
  - Contraindications with:
    - Other meds (polypharmacy) or supplements (herbal or otherwise)
    - Alcohol

Protective:

- Exercise- Stay Safe, Stay Active, Tai Chi: Moving for Better Balance
- Ice Grippers
- Veterans Affairs Group Exercise Program
- CDC's STEADI (Home Modifications- The Vip Taila
- Home fall prevention visits

Funding Sources

- Center for Disease Control
- ACL
- NIH
- NCoA
- Alaska Mental Health Trust Authority
- Alaska Division of Public Health, Section of Chronic Disease Prevention and Health Promotion
- Alaska Department of Health and Social Services
- Alaska Native Tribal Health Consortium

Promising and Evidence-based interventions (programs, practices and policies

What Works: Evidence-Based Strategies

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41 Kellogg International Work Group on the Prevention of Falls by the Older. The prevention of falls in later life. Danish Medical Bulletin 1987 Apr;34(4):1-24.

42 Josephson KR, Fabacher DA, Rubenstein LZ. Home safety and fall prevention. Clin Geriatr Med 1991; 7:707–731.

43 De Jong, M, Van der Elst, M, Hartholt, K. Drug-related falls in older patients: implicated drugs, consequences, and possible prevention strategies. Therapeutic Advances in Drug Safety 2013; Volume 4(4):147-154

44 Woolcott J., Richardson K., Wiens M., Patel B., Marin J., Khan K., et al. . (2009) Meta-analysis of the impact of 9 medication classes on falls in elderly persons. Arch Intern Med 169: 1952–1960

Because the causes of a fall can involve multiple and varied factors, effective prevention requires efforts at multiple levels, tailored to the physical condition and living environment of the individual at risk. The CDC provides a listing of prevention efforts that include published evidence that the intervention is effective in reducing fall occurrence or fall-related injuries in older adults.[45] It is unlikely that these interventions have been evaluated in Alaska, or in all community types in Alaska (city, hub, village) so cultural and resource context must be considered when applying them in this state.

The evidence-based intervention strategies are separated into four categories: exercise, home modification, clinical, and multifaceted:

Exercise programs involve activities focusing on muscle strength, endurance, flexibility, balance, and motor coordination appropriate for the ability level of the patient. Some of the specific activities recommended are Tai Chi, Otago, group walking (with winter traction gear when appropriate), and aerobic dance and floor exercises.

Most evidence-based **home modification** interventions describe the involvement of an occupational therapist, not commonly available in Alaska, so a qualified surrogate would need to be identified. These interventions involve home assessment, patient performance assessment, home modification and equipment recommendations (sometimes with supplemental funding provided), and training/education of the participant to raise their awareness of the most common home hazards associated with falls.

Clinical interventions focus on individual intrinsic fall risks: medical assessments of Alaskan older adults for fall risks, provision of vitamin D and calcium supplements (to improve bone strength), medication review and reduction of psychotropic drug medication where appropriate, eye exams to determine if updated glasses or cataract surgery are necessary, and examination of the patient's feet by a podiatrist, who provides recommendations on footwear and foot exercise appropriate for each patient.

The fourth strategy type, **multifaceted**, incorporates varying groups of exercise, home modification, and clinical intervention. Evidence-based interventions are described in detail on the National Council on Aging and CDC websites:

https://www.ncoa.org/resources/select-evidence-based-falls-prevention-programs/

and

https://www.cdc.gov/homeandrecreationalsafety/pdf/falls/CDC_Falls_Compendium-2015-a.pdf#nameddest=appendixc.47,46

Current Strategies:

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[45] Stevens JA, Burns E. A CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults, 3rd Edition. 2015. Available at https://www.cdc.gov/homeandrecreationalsafety/falls/compendium.html. Accessed August 19, 2018.

[46] National Council on Aging. Select Evidence-Based Falls Prevention Programs. 2017. Available at https://www.ncoa.org/resources/select-evidence-based-falls-prevention-programs/. Accessed August 19, 2018.

In Alaska, several organizations have some level of fall prevention programming, but it is not a consistent or concerted effort. The State of Alaska Department of Health and Social Services Injury Prevention Program and Commission on Aging both provide informational resources on occurrence, risks, and prevention. These agencies work together to organize and promote the annual Fall Prevention Week in Alaska. In a few areas of the state, staffing is available to send public health nurses or other caregivers to visit all older Alaskans in rural communities to do both a health assessment and a home safety check. The less populated regions of the state may have one or two physical therapists available to work with older Alaskans and other patients via telemedicine. Few areas have occupational therapists.

The Alaska Community Health Aide Program, which provides medical staff to rural areas served by the tribal health system, includes many sections on fall prevention in its reference manuals, including a home safety checklist and a patient assessment for falls. On-line and in-person trainings have been developed to encourage Community Health Aides/Practitioners (CHA/Ps) to use these materials to promote fall prevention behaviors.

When funding is available, CHA/Ps and Injury Prevention Programs provide ice cleats, mobility devices, and home fall prevention equipment to the older Alaskans in their communities, but the funding is sporadic. Many communities and local senior centers around the state provide meal and exercise programs for older adults in their area.

Identify gaps

- Fall Prevention Studies specific to social isolation[47]
- Annual eye examinations and follow up eye care of elderly populations; especially those with Diabetes and chronic eye disease (glaucoma, macular degenerations, etc…) do not meet recommended rates. [48]

References, Resources, End Notes:

FEELING ALONE, SAD, OR HOPELESS

Health Issue: Feeling alone, sad, and/or hopeless
Contributors: Lindsey Hajduk, Charles Utermohle, Marcia Howell
Age Group: Youth 12-18

Definition: Data sources that define and measure the factor

2017 Alaska Youth Risk Behavior Survey questions include:

- Do you agree or disagree that you feel alone in your life?[49]

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[47] Pohl JS, Cochrane BB, Schepp KG, Woods NF, Falls and Social Isolation of Older Adults in the National Health and Aging Trends Study. Research in Gerentological Nursing 2018 Mar1:11(2):61-70

[48] Lee PP, Feldman Z. W., Ostermann J., Brown D. S. & Sloan F. A. Longitudinal rates of annual eye examinations of persons with diabetes and chronic eye diseases. Ophthalmology 110, 1952–1959 (2003). [PubMed]

[49] 2017 YRBS Question 94

- 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?[50]

Importance:

Loneliness is a common problem among youth that can have serious consequences. Feeling alone can have increased risk for school dropout, delinquency and violence, suicide ideation, depression, anxiety and substance use, as well as poor physical health. The causes or contributing factors of loneliness are complex and potentially interwoven. Both individual traits (intrapersonal) and interpersonal factors influence loneliness. Youth who are at higher risk of feeling alone have low social acceptance and low self-esteem. Protective factors that buffer against loneliness include self-esteem, empathy, coping skills, social acceptance, social capital (i.e., friendship quality and quantity), and school engagement.

Some youth are at higher risk of feeling alone. Homeless youth have higher levels of loneliness compared to non-homeless youth. Loneliness in homeless youth can be related to self-esteem, neglect by caregivers, and abuse. Gay, lesbian, and transgender youth are considered higher risk for loneliness as a result of abuse, victimization, and being thrown out of their home as a result of coming out to parents. Also, feelings of loneliness change with age with higher levels of loneliness around age 12 and decreasing by age 18.51

Influencing Factors:

Risk Factors:[52]

- Individual
  - Social isolation
  - Withdrawal
  - Not knowing where to go for help
  - Poor sense of self and self-worth
  - Not seeking help
  - Experiencing transitions or major life changes
  - Feeling unsafe in the community
- Family
  - Trauma
  - People at home who don't care
  - Parents not around or available
  - Family far away and/ or unsupportive
- Geographical
  - Long, cold, dark winters with possible seasonal affective disorder
  - Poor transportation in and around Anchorage
- Community or Social

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[50] 2017 YRBS Question 25

[51] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

[52] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

- ○ Unsupportive friend/ peer group
- ○ Bullying
- ○ Feeling like they don't matter to their community
- ○ Lack of opportunities to connect with others
- ○ Lack of trusted adults
- ○ Negative social media
- ○ Negative youth culture
- ○ Racial, cultural and/ or gendered norms
- ○ Perceived societal expectations

Protective Factors:[53]

- Feeling like they mattered in their community
- Having teachers who really cared and gave encouragement

Funding sources: TBD

Promising and Evidenced-based interventions: TBD

Identify gaps: TBD

References, Resources, End Notes: See footnotes

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[53] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

HOPEFULNESS/WELLBEING

Health issue: Hopefulness/Well-being
Contributors: Marcia Howell, Jenni Lefing, Becky Judd, Eliza Muse, Charles Utermohle
Age Group: Ages 12-18???

Definition: Data sources that define and measure the factor

Hope scale:

- I know I will graduate from high school
- There is an adult in my life who cares about my future
- I can think of many ways to get good grades
- I energetically pursue my goals
- I can find lots of ways around any problem
- I know I will find a good job after I graduate.[54]
- 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[55]   *(Reverse scored)*
- Have you ever felt things were hopeless[56] *(Reverse scored)*

Wellbeing scale:

- Were you treated with respect all day yesterday
- Did you smile or laugh a lot yesterday
- Did you learn something interesting yesterday
- Did you have enough energy to get things done yesterday
- Did you have health problems that keep you from doing any of the things other people your age normally can do
- If you are in trouble, do you have family or friends you can count on to help whenever you need them[57]

High Expectations (grades 6-12 scale) statements in School Climate and Connectedness Survey (SCCS)

- I want very much to get more education after high school
- I try hard to do well in school.
- I have given up on school. *(Reverse scored)*
- At this school, students are encouraged to work to the best of their abilities.
- Adults in my community encourage me to take school seriously.
- Teachers and other adults at this school believe that all students can do good work.

Importance: TBD
- Suicide: During the past 12 months, did you ever seriously consider suicide[58], [59]

Influencing Factors:

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54 2013 Gallup Student Poll

55 YRBS 2017 question 25

56 National College Health Assessment (2015) question 30

57 2013 Gallup Student Poll

58 YRBS 2017 question 26

59 Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.Growing up Anchorage, https://www.uaa.alaska.edu/academics/college-of-health/_documents/growing-up-anchorage-2015.pdf

Risk Factor: TBD

Protective Factor

- Hope and Wellbeing[60]

Funding sources: TBD

Promising and Evidenced-based interventions: TBD

Identify gaps:

- Correlational analysis of adult shared factors and issue data

References, Resources, End Notes: See footnotes

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[60] 2013 Gallup Student Poll - see resource folder - measures hope, wellbeing and engagement 5-12 grade, National and ASD

INTERPERSONAL VIOLENCE AND INTIMATE PARTNER VIOLENCE

Health issue: Interpersonal Violence
Contributors: Summer Chitwood, Becky Judd, Charles Utermohle
Age Group: TBD based on intervention types

Definitions:

Intimate Partner Violence (IPV), also commonly referred to as domestic violence, includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/ girlfriend, dating partner, or ongoing sexual partner)." Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. Family violence is another commonly used term in prevention efforts. While the term domestic violence encompasses the same behaviors and dynamics as IPV, the term family violence is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others.[61]

Importance:

IPV affects millions of people in the United States each year. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that nearly 1 in 4 adult women (23%) and approximately 1 in 7 men (14%) in the U.S. report having experienced severe physical violence (e.g., being kicked, beaten, choked, or burned on purpose, having a weapon used against them, etc.) from an intimate partner in their lifetime. Additionally, 16% of women and 7% of men have experienced contact sexual violence (this includes rape, being made to penetrate 8 Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices someone else, sexual coercion, and/or unwanted sexual contact) from an intimate partner. Ten percent of women and 2% of men in the U.S. report having been stalked by an intimate partner, and nearly half of all women (47%) and men (47%) have experienced psychological aggression, such as humiliating or controlling behaviors.[62]

Influencing Factors:

Risk Factors:[63]

- Low educational achievement
- Lack of nonviolent social problem-solving skills
- Poor behavioral control/impulsiveness
- History of violent victimization
- #Witnessing violence
- Psychological/mental health problems
- Substance use

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[61] https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

[62] https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

[63] https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

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<u>Protective Factors:</u>[64]

- Coordination of resources and services among community agencies
- Community support
- Connectedness

Funding sources: TBD

Promising and Evidenced-based Interventions:

- Teen Dating Violence: Safe Dates[65]
- Shifting Boundaries[66]
- The 4th R: Strategies for Healthy Teen Relationships[67]
- Expect Respect support groups[68]
- Coaching Boys into Men[69]
- Green Dot[70]
- Intimate Partner Violence: Pre-marital Relationship Enhancement Program (PREP)[71]

Identify gaps: TBD

References, Resources, End Notes: See footnotes

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[64] https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

[65] https://www.hazelden.org/web/go/safedates

[66] https://www.childtrends.org/programs/shifting-boundaries/

[67] https://youthrelationships.org/

[68] http://www.expectrespectaustin.org/support-groups/

[69] http://www.coachescorner.org/

[70] https://cultureofrespect.org/program/green-dot-etc/

[71] https://www.prepinc.com/

MARIJUANA USE - YOUTH

Health Concern: Youth Marijuana Use
Contributors: Lindsey Hajduk
Age Group: Youth under age 21, which is the state's legal age for recreational marijuana use in Alaska. It remains illegal for youth and young adults under the age of 21 to cultivate, possess, sell, or use marijuana products in Alaska. (McDowell, THRIVE)

Definition:

- Marijuana, or cannabis, refers to the dried leaves, flowers, stems, and seeds from Cannabis sativa plants. Marijuana contains tetrahydrocannabinol (THC), a psychoactive compound that is the primary chemical responsible for marijuana's mind-altering effects. Marijuana can be smoked, concentrated as a resin or oil, mixed with food, or brewed as tea. (McDowell, THRIVE)
- Recreational marijuana refers in this report to marijuana use that has no medical or therapeutic objective. (McDowell, THRIVE)

Importance:

- Child health and development:
  - Maternal marijuana smoking during pregnancy is associated with lower birth weights.
  - In states where marijuana use is legal, an increased risk of overdose injuries and respiratory distress has been documented among children.
  - Substantial evidence associates marijuana use with the development of schizophrenia or other psychoses among youth and young adults, particularly among those who use marijuana frequently.
  - Marijuana use negatively affects driving skills and driving behavior among youth.
  - Adolescents who use marijuana have a higher risk of dependence and substance use problems in adulthood.
  - Substantial evidence links youth marijuana use with increased frequency of marijuana use and problem marijuana use in adulthood.
- Youth marijuana use and education:
  - Limited evidence suggests youth who smoke marijuana in high school are more likely to drop out of school and report lower levels of educational achievement.
  - School environments and social norms can influence marijuana use. For example, when students feel policies are not strongly enforced, marijuana use is greater.

Influencing Factors (risk and protective factors):

Risk factors

- Individual (McDowell, THRIVE)
  - Youth exhibiting aggressive behavior, oppositional behavior, conduct problems, and other antisocial traits and behaviors
  - Personal traits like impulsivity, or a tendency to act without considering consequences, as well as sensation seeking (a trait of seeking out varied, new, complex, or intense experiences)

- - Education-related factors such as attention and concentration problems, poor academic performance, and truancy
    - Experience of depression or generalized and social anxiety
    - Sleep problems and insomnia in childhood and adolescence
    - Prior or current substance use
    - Positive attitudes and beliefs towards substance use
  - Relationship Level (McDowell, THRIVE)
    - Experiences of child abuse and childhood sexual abuse
    - Family and parental history of substance use and substance use disorders, as well as favorable family attitudes towards drugs
    - Limited family management and parental monitoring and communication
    - Friends and peers' substance use, as well as favorable attitudes, perceptions, and intentions towards substance use
  - Community Level (McDowell, THRIVE)
    - Community violence and crime
    - Availability of marijuana and other drugs, as well as community norms that are favorable to marijuana
    - Neighborhood poverty
    - Residential instability and mobility
  - Society Level (McDowell, THRIVE)
    - Increased exposure to popular music and culture
    - Cultural factors related to immigration status and acculturation
    - Widespread economic hardship during a child's infancy

Protective factors

- - Individual (McDowell, THRIVE)
    - Resilience and good behavioral health
    - Religiosity, often defined as religious affiliation, and or traditional religious beliefs and practices.
  - Relationship Level (McDowell, THRIVE)
    - Family relationships where youth report closeness to a parent
    - Strong family communication
    - Frequent family meals
    - High parental monitoring
  - Community Level (McDowell, THRIVE)
    - Neighborhood economic stability
    - Connectedness, neighborhood cohesion, and intergenerational networks
  - Society Level (McDowell, THRIVE)
    - Traditional religious beliefs and practices
    - Community economic stability
    - Perception of higher social status
  - Strength of Association Between Protective Factors and Current Marijuana Use for Anchorage Students at Traditional High Schools: (Garcia et al. 2014)
    - Talking to parents about school every day - 39% less likely
    - Having one or more adults to ask for help - not significant

- ○ Spending at least one hour/week volunteering at school or in the community - 33% less likely
- ○ Not feeling alone - 35% less likely
- ○ Having teachers who really care about him/her - 45% less likely
- ○ Attending a school with clear rules and consequences for behavior - 29% less likely
- ○ Participating on organized afterschool activities
  - ■ At least once a day per week - 31% less likely
  - ■ At least two days per week - 39% less likely

Funding sources: Alaska and national sources of funding to address this health topic. A notation regarding current or year of funding is provided, if known.

- ● The State of Alaska Department of Health and Social Services: Marijuana Education and Treatment Fund
  - ○ Community Based Grant Support: Afterschool Services Fund
  - ○ Education

Promising and Evidence-based interventions (programs, practices and policies):

More research is needed to study youth marijuana prevention programs, particularly as the legal status of marijuana and the marijuana industry changes. Most prevention programs reviewed in this report focus on youth drug use prevention strategies. While important, the majority of these programs did not focus explicitly on the complexities of marijuana use in perceptions, risks, harms, etc. This type of research would be helpful to understand the issues affecting use before developing preventive practices. (McDowell, THRIVE)

- ● Most prevention programs are school-based curriculums focused on drug prevention. School-based prevention programs have shown some success. In schools where students receive messages about abstinence from marijuana at school or counseling on the risks of marijuana use, students report using less marijuana.
- ● The majority of the programs focus on social emotional learning skills and/or other social skills to know how to deal with the activities in the youth's lives without using drugs as a coping mechanism.
- ● Few programs focus on environmental strategies and/or policies around marketing, retail, social norms, and community acceptability.

Identify Gaps:

- ● Due to the illegal federal status of marijuana, the U.S. government maintains restrictive policies and regulations with respect to research on the health effects of marijuana. Further, most research that does exist was published prior to the recent wave of legalization legislation at the state level. Partly as a result, the long-term effects and unintended consequences of marijuana use are not well understood or documented. (McDowell, THRIVE)
- ● The shifting cultural and legal landscape of marijuana mean that most conclusions about the drug's long-term impacts, and about programs to address them, must be regarded as tentative. (McDowell, THRIVE)

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POSITIVE SCHOOL CLIMATE

Health Issue: Positive School Climate
Contributors: Jenni Lefing, Becky Judd, Ann Wombat, Charles Utermohle
Age Group: Youth in grades 3-12 (ages 9-18)

> **Definition**: *(Also see Protective Factor: Connectedness and school connectedness)*

Positive School Climate refers to the quality and character of school life, the foundation for learning and positive youth development. For students and staff it includes how connected they are to adults and peers, family and community involvement in school, social and emotional learning, feeling safe at school, high and clearly stated expectations, and teachers and staff who consistently treat them with respect and fairly address their behavior.

School Climate & Connectedness Survey (SCCS)

Below are the topics for each of the school climate surveys. Question/statements for each topic are included in the Appendix..

> *Students (Grade 3-5 and Grade 6-12)*
>
> - Respectful Climate
> - Caring Adults
> - Peer Climate
> - High Expectations
> - Student Involvement
> - Family and Community Involvement
> - School Safety
> - Cultural Connectedness (grade 6-12 only)
> - Community Support
> - Social and Emotional Learning
> - Observed Risk Behaviors (grade 6-12 only)
> - Caring Others (grade 3-5 only)
>
> *Staff*
>
> - Student (peer) climate
> - Family and Community Involvement
> - School Leadership and Involvement
> - Staff Attitudes
> - Student Involvement
> - School Safety
> - Cultural Connectedness
> - Observed Student Behaviors
>
> *Family Survey* (new in 2018)
>
> - Cultural Connectedness

- Family and Community Involvement
- Communication
- Student Support at Home
- Family Engagement at Home
- Opportunities for Involvement

Proxies for School Connection

- *YRBS Indicator: "*Do you agree or disagree that your teachers really care about you and give you a lot of encouragement?"
- *NSDUH Indicators related to Commitment to School*
  - School: Courses Interesting
  - School: Received HS Diploma
  - School: Related Feelings
  - School: Work is Meaningful

Importance:

School Climate makes up a "large portion of a student's school experience and can be connected to almost any issue of concern in school" (k12engagement.unl.edu).

Research indicates that school climate is positively correlated to students academic achievement, graduation rates, social and emotional outcomes, and negatively correlated with risk behaviors (such as bullying, drug & alcohol use, bullying, etc.) School staff also benefit from a positive school climate. Research indicates that staff attrition and job satisfaction are connected to school climate.

Influencing Factors:

- Risk Factors:
  Drug & Alcohol Use

  - Alaska data sources:
    - Alaska School Climate and Connectedness Survey
    - Alaska Youth Risk Behavior Survey
  - National data sources:
    - Bernard, B. (2004)
    - Centers for Disease Control and Prevention. (2009)
    - Dryfoos, J. (1990)
    - Hawkins, J.D., et al. (1992)
    - Resnick, M.D., et al. (1997)
    - Rutter, M. (1985)
    - Scales, P.C. & Leffert, N. (1999)
    - Springer, F. (2001)
    - Thapa, A. et. al (2013)
  Bullying

  - Alaska data sources:
    - Alaska School Climate and Connectedness Survey

- Alaska Youth Risk Behavior Survey

Mental Health - Suicide and Suicide Ideation

- Alaska data source: Alaska Youth Risk Behavior Survey
- National data sources:
    - Centers for Disease Control and Prevention. (2009)
    - Marraccini, M. and Brier, Z. (2017)
    - Resnick, M.D., et al. (1997)
    - Thapa, A. et. al (2013)
    - Whitlock J. (2005)

Youth Violence

- Alaska data source: Alaska Youth Risk Behavior Survey
- National data sources:
    - Centers for Disease Control and Prevention (2009)
    - Chapman, R.L., et al. (2011)
    - Resnick, M.D., et al. (1997)
    - Thapa, A. et al (2013)
- Protective Factors
Academic Achievement

- Alaska data sources
    - Alaska School Climate and Connectedness Survey
    - Alaska Youth Risk Behavior Survey
- National data sources
    - Suldo, McMahon, Chappel, & Loker (2012)
    - O'Malley, Voight, Renshaw, & Eklund (2014)
    - American Institutes of Research (2009)

High School Graduation

- National data Source: Battin-Pearson, S et.al. . (2000)

Funding Sources: TBD

- Center for Disease Control?
- US Department of Education
- DEED or Association of Alaska School Boards?

Promising and Evidence-Based Interventions:

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 National School Climate Standards, developed by the National School Climate Council. (www.schoolclimate.org/climate/standards.php) Includes a vision and framework for a positive and sustainable school climate.

Identify Gaps:

- TBD
- Additional Resources:
    - National School Climate Center https://www.schoolclimate.org/
    - The Forum for Youth Investment
    - National Center on Safe Supportive Learning Environments https://safesupportivelearning.ed.gov/safe-and-healthy-students/school-climate
    - The Importance of School Climate Research Brief https://www.nea.org/assets/docs/15584_Bully_Free_Research_Brief-4pg.pdf

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PRESCRIPTION OPIOID MISUSE AND ABUSE

Health Concern: Prescription opioid misuse and abuse
Contributors: Lindsey Hajduk
Age Group: 12-24 years old. Much of the information referenced here regards those ages 18-24 years old, as noted.

Definition:

- Non-medical use of prescription drugs: NMUPD.
- Prescription drug* OR Opioid* OR Opiate* OR Tranquilizer* OR Sedative* OR Stimulant
- Drug misuse: The use of a substance for a purpose not consistent with legal or medical guidelines.

Importance:

- NMUPD is a serious concern among adolescents and emerging adults. Several areas exist for prevention efforts within the context of the community, school, interpersonal, and individual domains. Thus, to curb NMUPD, multifaceted approaches are needed that target factors across multiple domains. (Nargiso 2015)

Influencing Factors (risk and protective factors):

<u>Risk factors</u>

- Individual
  - At the individual level, previous use of substances was found to be a significant risk factor for NMUPD, as was adolescent aggressive/delinquent behavior and lower [corrected] perceived risk or harm of use. (Nargiso et al. 2015)
  - At the individual level, individuals most at risk of NMUPD include those with a: (SAMHSA 2016)
    - History of mental illness: admitted to psychiatric hospital, history of depression, posttraumatic stress disorder, anti-social personality disorder, anxiety, suicidal ideation, mood disorders
    - Acute and chronic pain: having a current painful physical disorder, chronic pain, past-year back pain, lower pain tolerance, greater pain sensitivity
    - Physical health problems: fatigue, headaches, having been hospitalized, high levels of fatigue,12 or more physical health care visits in one year, poor appetite, one or more limitations on activities of daily living, "poor" health, Injury during deployment
    - Heightened physiological reactions to certain types of drugs: having a greater subjective euphoric reaction, genetic factors, reduced response inhibition, change in tolerance related to incarceration history
    - Substance use or misuse: current cigarette smoker,Co-occurring use of prescription opioids and benzodiazepines, Ever injecting a tranquilizer, Ever non-orally ingesting a prescription drug, Having a history of illicit drug abuse, Heavy alcohol use
    - Behavior: Ever being incarcerated, Having a history of doctor shopping behavior, Participation in organized sports, Paying for prescriptions with cash, School delinquency
    - Prescription Access: Concurrent use of multiple prescriptions, Having a prescription for anxiety/depression, Obtaining four or more filled prescriptions

- ■ Religiosity: Having decreased religiosity, Spiritual beliefs influence decision-making
- ■ Risk Perception: Having the perception that stimulant misuse is necessary to complete tasks, Perceive drug test as easy to predict, Perception that prescription drug misuse is acceptable and safe
- ■ Past 90-day homelessness
- ○ Having a past history of other substance use or misuse is also linked to NMUPD. People who have a history of substance use disorder, who use alcohol heavily, or who use illicit drugs are more likely to engage in NMUPD. (SAMHSA 2016)
- ○ Ages 18-25 years old (SAMHSA 2015):
  - ■ "Impulsive sensation-seeking" personality characteristic; Psychological distress/internal restlessness; sensation seeking
  - ■ Low perception of harm about nonmedical use of stimulants and analgesics
  - ■ Alcohol and illicit drug use; past-year substance abuse; past- year binge drinking; past-year illicit drug use; past-year marijuana use
  - ■ Risky sexual behavior (e.g., unprotected sex, multiple partners)
  - ■ White students; Hispanic
  - ■ Older students; Age
  - ■ Male
  - ■ Pain-relief motive
  - ■ Lifetime depression
  - ■ Availability of prescription drugs,
  - ■ First and second year of college (for initiation)
  - ■ Lower grade point average
  - ■ Fair/poor health
  - ■ Less involvement in conventional activity
- ○ State of Alaska - Infancy & Early Childhood
  - ■ Difficult temperament
- ○ State of Alaska - Middle School
  - ■ Poor impulse control
  - ■ Low harm avoidance
  - ■ Sensation seeking
  - ■ Lack of behavioral self-control/regulation
  - ■ Aggressiveness
  - ■ Anxiety, Depression, Hyperactivity/ADHD
  - ■ Antisocial behavior
  - ■ Early persistent problem behaviors
  - ■ Early substance use
- ○ State of Alaska - Adolescence
  - ■ Behavioral disengagement coping • Negative emotionality • Conduct disorder • Favorable attitudes toward drugs • Rebelliousness • Early substance use • Antisocial behavior
- ● Relationship Level
  - ○ Parental and peer prescription drug use and approval of NMUPD were associated with misuse of prescription drugs within the interpersonal domain. (Nargiso et al. 2015) (SAMHSA 2015)

- Normative alcohol beliefs (attitudes or beliefs that excuse, justify, or normalize the misuse of alcohol). (SAMHSA 2015)
- Availability/Opportunity to use: Social Access
- Availability/Opportunity to use: Retail Access
- (SAMHSA 2016)
  - Intimate Partner Relationship: being divorced, Having unprotected sex
  - Parents and Family: Experienced childhood sexual abuse, Experiencing a larger number of negative life events, Greater parental favorable attitudes towards substance abuse, Household being the source of first misused stimulant, Lifetime witnessing a family member overdose
  - Having a lower household income (18–25; 50+)
  - Peers: Greater peer prescription drug misuse, Greater peer favorable attitudes towards substance abuse, Greater peer substance abuse or use, Having a "Greek" organization affiliation, Living with non-spousal other(s)
  - Social Networks: Alcohol misuse or illicit substance use among social networks, Having weaker social bonds, Past 30-day experiences of discriminatory behavior in routine interactions
- State of Alaska - Infancy & Early Childhood
  - Cold and unresponsive mother behavior
  - Parental modeling of drug/alcohol use
- State of Alaska - Middle School
  - Permissive parenting • Parent–child conflict • Inadequate supervision and monitoring • Low parental warmth • Lack of or inconsistent discipline • Parental hostility • Harsh discipline • Low parental aspirations for child • Child abuse/maltreatment • Substance use among parents or siblings • Parental favorable attitudes toward alcohol and/or drugs
- State of Alaska - Adolescence
  - Substance use among parents • Lack of adult supervision • Poor attachment with parents
- Community Level
  - Evidence suggested that ease of access increased the risk of NMUPD. (Nargiso et al. 2015)
  - At the school level, academic failure/low educational attainment was associated with high school student NMUPD. However, results for college students' academic failure and NMUPD were inconclusive. (Nargiso et al. 2015)
  - (SAMHSA 2016)
    - Living Arrangements: Living in a rural area, Urban environment, Moving three or more times in the past year
    - Workplace: Absence of random drug testing program
  - State of Alaska - Middle School
    - School failure • Low commitment to school • Accessibility/ availability of substances • Peer rejection • Laws and norms favorable substance use • Deviant peer group • Peer attitudes toward drugs • Interpersonal alienation • Extreme poverty for those children antisocial in childhood
- State of Alaska - Adolescence

- School failure • Low commitment to school • Associating with drug-using peers • Not college bound • Aggression toward peers • Norms (e.g., advertising) favorable toward alcohol use • Accessibility/ availability
  - Society Level (SAMHSA 2016)
    - Past-year experiences of discriminatory events
    - Societally influenced perception of risks of substance use
    - Belonging to a lower social class during adolescence

Protective factors

- Individual Level
  - State of Alaska - Infancy & Early Childhood
    - Self-regulation
    - Secure attachment
    - Mastery of communication and language skills
  - State of Alaska - Middle School
    - Mastery of academic skills (math, reading, writing)
    - Following rules for behavior at home, at school, and in public places
    - Ability to make friends
    - Good peer relationships
    - Ability to make friends and get along with others
  - State of Alaska - Adolescence
    - Positive physical development • Emotional self-regulation • High self-esteem • Good coping skills and problem-solving skills • Engagement and connections in two or more of the following contexts: at school, with peers, in athletics, employment, religion, culture
  - (SAMHSA 2016)
    - Individuals who commit to doing well and finishing school are less likely to misuse prescription drugs. These include individuals who are current students, have a high school diploma, or have attended a prevention class.Students who are committed to school and have a strong school bond are less likely to engage in risky behaviors.
    - Perceptions about prescription drug misuse
    - Positive wellbeing
    - Prescription access: Prescribed tapentadol Immediate Release (IR; type of opioid drug) instead of oxycodone IR; Having a prescription for Schedule III or IV opioids, Having a prescription for stimulants,
    - Education: Attending a prevention class, Being a current student, Having a high school diploma, Having a higher commitment to doing well in school
    - Risk perception: Having greater perception of substance abuse risks
- Relationship Level
  - State of Alaska - Infancy & Early Childhood
    - Reliable support and discipline from caregivers
    - Responsiveness
    - Protection from harm and fear
    - Opportunities to resolve conflict
    - Adequate socioeconomic resources for the family
  - State of Alaska - Middle School

- ■ Consistent discipline
- ■ Language-based, rather than physical, discipline
- ■ Extended family support
  - ○ State of Alaska - Adolescence
    - ■ Family provides structure, limits, rules, monitoring, and predictability • Supportive relationships with family members • Clear expectations for behavior and values
  - ○ (SAMHSA 2016)
    - ■ Parents and Family: Greater parental disapproval towards prescription drug misuse, Having a stronger parental bond, Having previously been in foster care(?)
    - ■ Having a higher household income
- ● Community Level
  - ○ State of Alaska - Infancy & Early Childhood
    - ■ Support for early learning
    - ■ Access to supplemental services such as feeding, and screening for vision and hearing
    - ■ Stable, secure attachment to childcare provider
    - ■ Low ratio of caregivers to children
    - ■ Regulatory systems that support high quality of care
  - ○ State of Alaska - Adolescence
    - ■ Presence of mentors and support for development of skills and interests • Opportunities for engagement within school and community • Positive norms • Clear expectations for behavior • Physical and psychological safety
  - ○ (SAMHSA 2016)
    - ■ School: Presence of Gay-Straight Alliance (GSA) in school
    - ■ Community norms against use
- ● Society Level

Funding sources:

- ● State of Alaska Department of Health and Social Services Office of Substance Misuse and Abuse Prevention - Partnerships for Success Grant

Promising and Evidence-based interventions (programs, practices and policies):

- ● (SAMHSA 2016. Factors and Strategies)
  - ○ Education is implemented to increase awareness of prescription drug misuse dangers for the public and health care providers. It also provides opportunities to teach individuals how to properly dispense, store, and dispose of controlled substances.
  - ○ Tracking and monitoring helps detect "doctor shoppers" and identify prescribers who have aberrant prescribing practices. The objective of tracking and monitoring is to reduce access and availability of prescription drugs to those who would misuse them.
  - ○ Proper medication disposal provides ways for people to safely and responsibly get rid of controlled substances that they have in their household. The objective of proper medication disposal is to limit access and availability, as well as raise awareness of prescription drug misuse.
  - ○ Harm reduction mitigates risks associated with prescription drug misuse and overdose. These strategies are not necessarily focused on preventing drug misuse, rather they are designed to reduce death, disability, and other negative consequences associated with prescription drug misuse and overdose.

- Multi-component programs combine more than one type of strategy in order to address multiple risk factors (e.g., lack of awareness, perceptions of harm, access and availability, overdose antidote use) associated with prescription drug misuse and overdose.
- Studies have shown a specific correlation between ACEs and opioid addiction. Studies have shown that individuals who have experienced childhood trauma are more likely to report chronic pain symptoms that interfere with daily activities and are more likely to be prescribed multiple prescription medications making them more likely to seek opioids for pain relief in adulthood 9 and creating a likely pathway to addiction. (CTIPP 2017)
  - There are at least two ways in which the knowledge of the correlation between ACEs and opioid addiction can be put to work. The first is through programs to prevent exposure to trauma (primary prevention) and to promote resilience in groups put at risk by exposure to adversity (secondary prevention).
  - Home Visiting Programs, where a trained home visitor provides services to pregnant women and families with young children, have proven effective at reducing child abuse, neglect, and domestic violence and improving health outcomes for children and parents. One such program is the Nurse Family Partnership (NFP).
  - The Positive Parenting (Triple P) Program is an intervention that provides parents with tools to raise healthier children and deal with stressors.
  - Parent Child Interaction Therapy is a tool that assists parents in improving the quality of the parent-child interaction and relationship.
- State of Alaska - Research Based Curricula: (2017)
  - Fourth R Healthy Relationships • Fourth R Healthy Relationships Plus • The Great Body Shop, and • Second Step
  - http://nrepp.samhsa.gov/landing.aspx
  - https://teens.drugabuse.gov/teachers/lessonplans#/questions
  - https://casel.org/; http://secondaryguide.casel.org/casel-secondary-guide.pdf
  - https://education.alaska.gov/ELearning

Identify Gaps: What are the data or analysis gaps that could provide further evidence of the importance of this topic.

- The body of research on risk and protective factors associated with NMUPD is relatively young and meager, so that one or a few studies could dramatically shape our understanding of the association between a risk or protective factor and NMUPD (either positively or negatively). (SAMHSA 2015)
- The fact that a given risk or protective factor does not have multiple, well-designed research studies establishing a strong, uni-directional relationship with NMPUD may say less about whether that factor is a potent driver of the problem and more about the current paucity of related literature. (SAMHSA 2015)
- Most of the literature reviewed focused on adolescents or young adults; little has been published about those over 21 years of age. (SAMHSA 2015)

References, Resources End Notes: Citations for the focus area and additional resources that may of interest to the reader.

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SEXUAL VIOLENCE

Health Issue: Sexual Violence
Contributors: Summer Chitwood, Charles Utermohle
Age Group: TBD

Definition:

Sexual Violence (SV) is a serious public health problem that affects millions of people each year. SV involves a range of acts including attempted or completed forced or alcohol/drug facilitated penetration (i.e., rape), being made to penetrate someone else, verbal (non-physical) pressure that results in unwanted penetration (i.e., sexual coercion), unwanted sexual contact (e.g., fondling), and non-contact unwanted sexual experiences (e.g., verbal harassment, voyeurism).[72]

Importance:

Approximately 1 in 5 women (19.3%) in the United States have experienced rape or attempted rape in their lifetime and 43.9% have experienced other forms of SV. For instance, 12.5% have experienced sexual coercion, 27.3% have experienced unwanted sexual contact, and 32.1% have experienced non-contact unwanted sexual experiences. Although national prevalence studies indicate that women carry the greatest burden of SV over their lifetimes, men are also impacted by SV. Approximately 1 in 15 men (6.7%) have been made to penetrate someone at some point during their lives, 5.8% have experienced sexual coercion, 10.8% have experienced unwanted sexual contact, and 13.3% have experienced non-contact unwanted sexual experiences.[73]

Influencing Factors:

Risk Factors:[74]

- History of child physical abuse
- Exposure to parental violence
- Involvement in delinquent behavior
- Acceptance of violence
- Hyper-masculinity
- Traditional gender role norms
- Excessive alcohol use
- Early sexual initiation and sexual risk-taking behavior (e.g., sex without a condom)
- Association with sexually-aggressive peer groups
- Poverty or low socioeconomic status
- Gender inequality
- Exposure to community crime and violence
- Social norms supportive of SV and male sexual entitlement
- Weak laws and policies related to SV

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[72] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[73] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[74] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

<u>Protective Factors:</u>[75]

- Empathy
- Emotional health and connectedness
- Academic achievement
- Having parents who use reasoning to resolve family conflicts

Funding sources: TBD

Promising and Evidence-Based Interventions: TBD

- Bystander Education: Bringing in the Bystander, Green Dot[76]
- Engage Men as Allies: Coaching Boys into Men[77]
- Teach Healthy Relationships: Safe Dates, Shifting Boundaries[78]
- Social Emotional Learning approaches, Safer Choices[79]
- Empowerment-based training[80]

Identify Gaps: TBD

References, Resources, End Notes: See footnotes

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[75] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[76] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[77] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[78] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[79] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[80] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

SOCIAL EMOTIONAL LEARNING (SEL)

Health Issue: Social Emotional Learning (SEL)
Contributors: Michael Kerosky, Becky Judd,
Age Groups:

- Youth in grades 3-5 and grades 5-12
- Adults years 18 and older

Definition:

Youth SEL Definition: Social and Emotional Learning (SEL) is the process through which we learn to recognize and manage emotions, care about others, make good decisions, behave ethically and responsibly, develop positive relationships, and avoid negative behaviors. It is the process through which youth enhance their ability to integrate thinking, feeling, and behaving in order to achieve important life tasks. (SCCS Statewide Report, 2013)

Other names for SEL include "Social and Employability Learning" and "Emotional Intelligence" especially when referring to adults 18 years and older.

Resources and Data sources that define and measure the factor

Youth SEL Definitions and Metrics

- National Source: Collaborative For Social & Emotional Learning (CASEL)'s SEL Component Definitions:
  - **Self-Awareness:** identifying and recognizing own emotions, strengths, limitations, external supports, etc.
  - **Social Awareness**: empathy, respect for others, reading social cues, consideration, etc.
  - **Self-Management, Self-Regulation**: impulse control, stress management, "will power," integrity.
  - **Social Management**, Relationship Skills: working cooperatively, help seeking and providing , dealing effectively with conflict, etc.
  - **Responsible Decision Making**: evaluation and reflection, personal responsibility, goal setting, etc.
- Alaska Source: School Climate and Connectedness Survey (Association of Alaska School Boards)'s SEL Topic Area and Indicators within SCCS uses the following scale for the questions below. "Please let us know how easy or difficult each of the following are for you:" 1 = Very Difficult; 2 = Difficult; 3 = Easy; 4 = Very Easy
  - **Self-Awareness – Self Concept**
    - Knowing ways I calm myself down.
    - Knowing what my strengths are.
  - **Self-Awareness – Emotions**
    - Knowing when my feelings are making it hard for me to focus.

- Knowing the emotions I feel.
    - **Social Awareness**
        - Learning from people with different opinions than me.
        - Knowing what people may be feeling by the look on their face.
        - Knowing when someone needs help.
    - **Self-Management - Emotions**
        - Getting through something even when I feel frustrated.
        - Being patient even when I am really excited.
    - **Self-Management - Goals**
        - Finishing tasks even if they are hard for me.
        - Setting goals for myself.
    - **Self-Management - School**
        - Doing my schoolwork even when I do not feel like it.
        - Being prepared for tests.
    - **Relationship Skills**
        - Respecting a classmate's opinions during a disagreement.
        - Getting along with my classmates.
    - **Responsible Decision Making**
        - Thinking about what might happen before making a decision.
        - Knowing what is right or wrong.

Adult SEL Definitions and Metrics

- National and Alaska Source: The Anchorage Youth Development Coalition is using the "SEL Program the Program Quality assessment" from the Weikart Center/Forum for Youth Investment with partner youth serving agencies 2017-2019. The Center for Youth Program Quality (Weikart Center/Forum for Youth Investment)'s SEL (Adult) Domains definitions with indicators from the SEL Youth Program Quality Assessment tool include:
    - **Emotional Management**: The ability to be aware of, and constructively handle both positive and challenging emotions.
        - Emotion Coaching
            - Staff acknowledges emotions
            - Youth name emotions
            - Discusses constructive handling
            - Discusses emotion causes or consequences
            - Addresses emotional upset supportively
    - **Empathy**: The ability to see things from others' perspectives, to suspend judgement, actively listen, and recognize how different values, life opportunities and obstacles have shaped others.
        - Belonging
            - Opportunities for youth to get to know each other
            - Inclusive relationships
            - Personal interest in child
            - Staff sets program culture
            - Sharing their culture

- Empathy
    - Listen to experiences of others
    - Understand emotions of others
    - Kindness and affirmation
    - Respect for differences
- **Teamwork**: The ability to collaborate and coordinate action with others.
    - Collaboration
        - Active collaboration
        - Shared goals
        - Practice group process skills
    - Leadership
        - Mentoring opportunities
        - All youth lead group
- **Responsibility**: The disposition and ability to reliably meet commitments and fulfill obligations of challenging roles.
    - Responsibility
        - Opportunities to take on tasks
        - Staff do not intervene intrusively
- **Initiative**: The capacity to take action, sustain motivation, and preserve through challenge toward an identified goal.
    - Encouragement
        - Supportive when mistakes are made
        - Staff encourages youth to try skills
        - Staff uses non-evaluative language
        - Connect to youth interests
        - Effort-achievement beliefs
    - Choice
        - Open ended choice
        - Multiple authentic choices
- **Problem Solving**: The ability to plan, strategize, and implement complex tasks.
    - Planning
        - Opportunities to make plans
        - Multiple planning strategies used
        - Share plans in tangible way
        - Monitoring progress toward goal
    - Problem Solving
        - Connect to previous knowledge
        - Link examples to principles
        - Youth extend knowledge
        - Multiple problem solving methods
        - Youth identify learning strategy
        - Think creatively
        - Self-correct and improve
        - Explain thinking
        - Use logical reasoning

■ Reflection
  o Multiple reflection strategies
  o Reflection on successes or challenges

Importance:

Extensive research has demonstrated links between social emotional competence (SEL) and academic achievement, as well as decreases in risk behaviors. Social emotional competence is malleable. Multiple studies across diverse age populations and settings have demonstrated an increase in social emotional competence through intentional skill building strategies, processes and curricula. (Philliber Research Associates. 2013)

- Research conducted during the past few decades indicates that social and emotional learning (SEL) programming for elementary- and middle-school students is a very promising approach to reducing problem behaviors, promoting positive adjustment, and enhancing academic performance. (Payton et. al. 2008)
- A meta-analysis of 82 school-based, universal SEL interventions involving 97,406 kindergarten to high school students. Follow-up outcomes (6 months to 18 years after students participated in SEL programs) demonstrate SEL's enhancement of positive youth development, including positive increases in SEL skills, attitudes, positive social behavior, and academic performance while finding decreases in conduct problems, emotional distress, and drug use. (Taylor et. al. 2017)
- A meta-analysis of social and emotional learning interventions (including 213 school-based SEL programs and 270,000 students from rural, suburban and urban areas) showed that social and emotional learning interventions had the following effects on students ages 5-18:
  o decreased emotional distress such as anxiety and depression
  o improved social and emotional skills (e.g., self-awareness, self-management, etc.)
  o improved attitudes about self, others, and school (including higher academic motivation
  o stronger bonding with school and teachers, and more positive attitudes about school)
  o improvement in pro-social school and classroom behavior (e.g., following classroom rules)
  o decreased classroom misbehavior and aggression and,
  o improved academic performance (e.g. standardized achievement test scores).
Students showed gains in these outcomes when social and emotional learning programs were implemented with fidelity. (Durlak, et. al. 2011)

- A review of the research on SEL programs at the elementary school level, found that SEL programs can promote academic achievement and positive social behavior, and reduce conduct problems, substance abuse, and emotional distress for elementary school students. (Dusenbury & Weissberg 2017)
- A Harvard study examined the two-year experimental impacts of an integrated school-based intervention in social-emotional learning and literacy development on children's social-emotional, behavioral, and academic functioning. Eighteen elementary schools (N = 1,184) were randomly assigned to receive the 4Rs program, based on the Resolving Conflict Creatively Program (RCCP), or no program. Children in the intervention schools showed improvements across several domains: self-reports of hostile attribution bias, aggressive interpersonal

negotiation strategies, and depression, and teacher reports of attention skills and aggressive and socially competent behavior. The intervention also improved math and reading achievement among children identified by teachers at baseline at highest behavioral risk. (Jones et. al. 2011)

- Researchers from Columbia University analyzed the economic impact of six widely-used SEL programs and found that on average, every dollar invested yields $11 in long-term benefits, ranging from reduced juvenile crime, higher lifetime earnings, and better mental and physical health. (Belfield et al. 2015)
- An analysis of research on the long-term benefits of SEL finds that investing in effective programs for all children can increase the number of productive, well-adjusted adults and yield tremendous economic benefits in the future. (Jones et. al. 2017)
- The Alaska statewide School Climate and Connectedness Survey (SCCS) found significant positive relationships between SEL and math, reading and writing SBAs. The higher the school's student-reported social emotional learning (a scale of 15 questions), the higher the school-wide SBA proficiency rates in all three subjects. (American Institutes of Research 2012)

Funding sources:

- National:
  - CASEL: Collaborative For Social and Emotional Learning
- State:
  - Center for Safe Alaskans' Anchorage Youth Development Coalition
  - Association of Alaska School Boards
  - State of Alaska, Department of Health and Social Services, Division of Behavioral Health
  - Cook Inlet Tribal Council

Promising and Evidence-Based Interventions:

- Collaborative for Academic, Social, and Emotional Learning. (2013). *2013 CASEL Guide: Effective Social and Emotional Learning Programs—Preschool and Elementary School Edition*. Chicago, IL.
- Collaborative for Academic, Social, and Emotional Learning. (2015). *2015 CASEL Guide: Effective Social and Emotional Learning Programs—Middle and High School Edition*. Chicago, IL.
- *US Department of Education (2014) The Guiding Principles: A Resource Guide for Improving School Climate and Discipline.* The US Department of Education, recommended increasing student's social and emotional competencies as a way to increase a positive school climate.

Identify Gaps:

- Alaska Data: While we have Alaska SEL data correlated with academic outcomes we don't have the SEL index of indicators correleated to youth health behaviors. There is national data establishing health outcome linkages, but there are not questions SEL questions on YRBS or youth self-report health behavior on the SCCS to conduct this analysis.

References, Resources, End Notes:

The early *social skills* research provided the foundation for deeper research into the domains related to Social Emotional skill development. Early Social Skills research demonstrated reductions across several youth risk behaviors.

<u>Social Skills Research</u>:

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<u>Specific SEL References</u>

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Dusenbury, L., & Weissberg R. P. (2017). *Social Emotional Learning in Elementary School: Preparations for Success*. Edna Bennett Pierce Prevention Research Center, Pennsylvania State University.

Jones, D., Crowley, D. M., & Greenberg, M.T. (2017). "Improving Social Emotional Skills in Childhood Enhances Long-Term Well-Being and Economic Outcomes," Edna Bennet Pierce Prevention Research Center, Pennsylvania State University.

Jones, S. M., Brown, J. L., & Aber J. L. (2011). Two-Year Impacts of a Universal School-Based Social-Emotional and Literacy Intervention: An Experiment in Translational Developmental Research (PDF) *Child Development 82*(2), 533-554.

Payton, J., Weissberg, R.P., Durlak, J.A., Dymnicki, A.B., Taylor, R.D., Schellinger, K.B., & Pachan, M. (2008). *The positive impact of social and emotional learning for kindergarten to eighth-grade students: Findings from three scientific reviews.* Chicago, IL: Collaborative for Academic, Social, and Emotional Learning.

Payton, J.W. et.al. (2000) Social and Emotional Learning: A Framework for Promoting Mental Health and Reducing Risk Behaviors in Children and Youth; *Journal of School Health, May 2000, 70. No. 5.*

Philliber Research Associates (2013) *Beyond Content: Incorporating Social and Emotional Learning into the Strive Framework.* Vol.1   Social and Emotional Competencies and their relationship to Academic Achievement. August, 2013

Taylor, R. D., Oberle, E., Durlak, J. A., & Weissberg, R. P. (2017). Promoting Positive Youth Development Through School-Based Social and Emotional Learning Interventions: A Meta-Analysis of Follow-Up Effects. *Child Development, 88*(4), 1156-1171.

Additional Resources

Vega, V. *Social and Emotional Learning Research: Annotated Bibliography, Edutopia*

http://www.edutopia.org/sel-research-annotated-bibliography

University of Chicago, Illinois. The Collaborative for Academic, Social and Emotional Learning. CASEL http://www.casel.org/projects_products/safeandsound.php.

SUICIDE

Health Issue: Suicide
Contributors: Marcia Howell, Becky Judd, Lindsey Hajduk
Age Group: All ages

Definition:

The CDC provides the following definitions for suicide, suicide attempts, and suicidal ideation:

- Suicide: death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
- Suicide attempt: A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
- Suicidal ideation: thinking about, considering, or planning suicide.

Data sources that define and measure the issue

Alaska Youth Risk Behavior Survey (2017):

- Q25: 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/No
- Q26: During the past 12 months, did you ever **seriously** consider attempting suicide? Yes/No
- Q27: During the past 12 months, did you make a plan about how you would attempt suicide? Yes/No
- Q28: During the past 12 months, did you make a plan about how you would attempt suicide? Yes/No
- Q29: **If you attempted suicide** during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?
- Q30: If you considered, planned, or attempted suicide during the past 12 months, did you talk about it to someone such as a friend, family member, teacher, doctor, counselor, or hotline?
-
Alaska Health Analytics and Vital Records

National Center for Injury Prevention and Control Web-based Injury Statistics Query and Reporting System (WISQARS)

Importance:

- Alaska Data
  - The State of Alaska is ranked 8th among states with the highest rates of unintentional injury in the U.S. and has the 2nd highest rate of suicide in 2014 at 22.3 per 100,000.[11]
  - In Alaska, unintentional injury is the leading cause of Years of Potential Life Lost (YPLL) and intentional self-harm/suicide is the fourth leading cause of YPLL . In 2016, Intentional self-harm (suicide) involved 186 deaths (142 male and 44 females) with 7,242 years of potential life lost. (Source: Alaska Vital Statistics 2016 Annual Report)
    - More Alaskans died from discharge of firearms than any other mechanism in 2016 (110 people, or 59.1% of all suicides).[12]
    - American Indian/Alaska Native people were 2.1 times as likely to commit suicide than white people in 2016.[12]
  - Between 2011 and 2015, there were more than 18,000 injury-related hospitalizations in Alaska. During this time period, the top five leading causes of injury-related hospitalizations included

falls (46%), assaults (8%), motor vehicles crashes (8%), attempted suicide (5%) and ATV crashes (4%).[13]

- ○ Alaska Suicide mortality rates:[14]

  - ■ Statewide adults 25 years and older: 27.0 individuals per 100,000 (2014)
  - ■ Alaska Native adults 25 years and older: 35.7 individuals per 100,000 (2014)
  - ■ Statewide individuals ages 15-24 years old: 37.9 individuals per 100,000 (2014)
  - ■ Alaska Native individuals ages 15-24 years old: 67.8 individuals per 100,000 (2014)

- ○ Alaska had the second highest age-adjusted suicide rate in the nation in 2014 at 22.3 per 100,000. In 2015, the rate was 27.1 per 100,000. Intentional self-harm, or suicide, is the fifth leading cause of death in Alaska. In 2015, suicide claimed the lives of 200 Alaskans. Firearms were the leading mechanism of death by suicide, making up 61% of all suicide deaths (98 males and 24 females). Among the leading causes of death in Alaska in 2015, suicide ranked third in total years of potential life lost with 7,510 years lost. On average 37.5 years of life were lost prematurely for each suicide death. From 2006 to 2015, the age-adjusted rate has increased 38.3%. On average, one person dies of suicide every two days in the state. In 2015, suicide was the leading cause of death for 10-24 year olds and the 2nd leading cause of death for Alaskans ages 25-44. Alaska's suicide rates continue to be the highest among males, young adults (18-24 year olds), American Indian/Alaska Native people and persons living in rural regions of the state. Residents in Northern and Southwest Alaska are at significantly higher risk for suicide. There is extreme annual variability in the suicide mortality rate for Alaska Native people; since 2000, the annual suicide mortality rate has fluctuated between extremes of 50.4 per 100,000 in 2015 to the recent low of 29.5 per 100,000 in 2014.[14]

- ○ Analysis of suicides in Alaska between 2003 and 2008 found:

  - ■ Firearms were the primary method of self-inflicted injury (54% for Alaska Native people; 68% for Alaska non-Native people) followed by hanging/strangulation/suffocation (37% for Alaska Native people; 16 % for Alaska non-Native people) and poisoning (5% for Alaska Native people; 12 % for Alaska non-Native people.)
  - ■ Of those tested, a large proportion of Alaska Native and Alaska non-Native suicide decedents were positive for alcohol (54% and 47%, respectively).
  - ■ Mental health issues were the most commonly identified precipitating circumstance for Alaska Native suicide decedents and Alaska non-Native suicide decedents, at 38% and 44%, respectively.
  - ■ Forty-two percent of all decedents were described as experiencing a depressed mood near the time of their death. [15]

- ● National Data:

  - ○ Nationally, 45% of suicide victims had contact with primary care providers within 1 month of suicide. Older adults had higher rates of contact with primary care providers within 1 month of suicide than younger adults.[16]

    - ■ A 3-year Alaska Follow-back' study reviewed suicide decedents' prior access to health care. It showed that 64% of all suicide decedents had seen a primary care physician within 6 months of their death. [17]
    - ■ A study of Alaska Native males who died from suicide in northern Alaska found that almost 75% of male cases received some type of care within the region's medical facilities during the year preceding their death.[18]
    - ■ Youth who report attempting suicide are approximately five times more likely to have also been in a physical fight in the last year. [3]

Influencing Factors:

- More than 90% of people who die by suicide have depression or another diagnosable, treatable mental or substance abuse disorder, according to American Association of Suicidology.[19]
- People with substance abuse disorders are six times more likely to complete suicide than those without. The rate of completed suicide among men with alcohol/drug abuse problems is 2-3 times higher than among those without a problem. Women who abuse substances are at 6-9 times higher risk of suicide compared to women who do not have a problem. [20,21]

Risk Factors:

The relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status. [22]

Individual

- Low educational achievement [2]
- Lack of nonviolent social problem-solving skills [2]
- Poor behavioral control, aggression, impulsiveness [1, 14]
- History of violent victimization [1]
- Witnessing violence [5]
- Psychological/mental health problems [1, 14]
- Substance use [1, 14]
- Adverse Childhood Experiences (ACEs)[14]
- Previous suicide attempt [14]

Relationship

- High conflict or violent relationships [14]
- Family history of suicide [14]
- Social isolation/lack of social support [1]
- Poor parent-child relationships [2]
- Economic stress [1]

Community

- Few available sources of supportive relationships [14]
- Barriers to health care (e.g. lack of access to providers or medications, prejudice) [14]
- Youth who feel connected and committed to school [1]
- Neighborhood poverty [6]
- High alcohol outlet density [8]
- Diminished economic opportunities/high unemployment rates [9, 10]
- Poor neighborhood support and cohesion [1]

Societal

- Availability of lethal means of suicide [14]
- Media violence, unsafe media portrayals of suicide [4,5, 14]
- Weak health, educational, economic, and social policies/laws [7]

Protective Factors

Individual

- Coping and problem solving skills [14]
- Resources for living (e.g. children in the home) [14]
- Moral objection to suicide [14]
- Skills in solving problems non-violently [1]

Relationship

- Connectedness to individuals, family, community, and social institutions [14]
- Supportive relationships with health care providers [14]
- Family support/connectedness [1]
- Connecting to a caring adult [1]
- Connection/commitment to school [1]

Community

- Safe and supportive school and community environment [14]
- Sources of continued care after psychiatric hospitalization [14]
- Coordination of resources and services among community agencies [1]
- Access to mental health and substance abuse services [1]
- Community support/connectedness [1]

Societal

- Availability of physical and mental health care [14]
- Restrictions on lethal means of suicide [14]

Funding Sources:

- Alaska Department of Health and Social Services
  - Alaska Division of Behavioral Health
  - Healthy Alaskans 2020
- Alaska Health Care Commission
- Alaska Mental Health Trust Authority
- Alaska Statewide Suicide Prevention Council
- Substance Abuse and Mental Health Services Administration Native Connections grant

Promising and Evidence-Based Interventions:

- Statewide Suicide Prevention Council's Alaska State Suicide Prevention Plan envisions suicide prevention to include wellness promotion, suicide prevention, crisis intervention, and postvention.[14]
  - Wellness Promotion: the overall health and environmental conditions that can increase or decrease the risk of suicide.
  - Suicide Prevention: universal efforts to improve awareness and understanding about suicide among all Alaskans.
  - Crisis Intervention: services and supports provided to a person who is experiencing a mental or emotional crisis that creates a serious risk of suicide.
  - Postvention: responses after a suicide occurs to prevent further loss and support survivors of a loss to suicide.
- SAMHSA Evidence-Based Practices Resource center: www.samhsa.gov/ebp-resource-center
  - Applied Suicide Intervention Skills Training (ASIST): www.livingworks.net/programs/asist/
  - SafeTALK: www.livingworks.net/programs/safetalk/
  - Survivor Voices: www.sprc.org/resources-programs/survivor-voices-sharing-story-suicide-loss
  - Mental Health First Aid: www.mentalhealthfirstaid.org/
  - Question. Persuade. Refer. (QPR) Gatekeeper Training: qprinstitute.com/
- HA2020
  - Kognito Family of Heroes,
  - The QPR (Question, Persuade, and Refer)
  - Gatekeeper Training for Suicide Prevention.
- Centers for Disease Control and Prevention Recommendations: The CDC summarized the programs,

practices, and policies with evidence of impact on suicide or its risk or protective factors, in the table below. Specific examples of each strategy are described in their Suicide Prevention Technical Package.

Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

Identify gaps:

● A more complete picture of the risks of suicide in the state would be achieved with comprehensive data on suicide attempts. For example, data for every adult poisoning resulting in hospitalization has not been available in a statewide database since 2010: only select categories of poisoning are currently reported.

References, Resources, End Notes:

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14. Alaska Statewide Violence and Injury Prevention Partnership. "Alaska Statewide violence and injury prevention plan 2018-2022." Last updated November 27, 2018.

TRANSPORTATION

Health Issue: Transportation-related injuries
Contributors: Marcia Howell, Dawn Groth, Charles Utermohle
Age Group: All ages

Definition:

> Transportation-related injuries refers to morbidity and mortality associated with transportation related crashes. Subcategories include:
>
> - Bicycle
> - Pedestrian
> - Motor Vehicle including Snow Machine and ATV
>
> Data sources that define and measure the issue include:
>
> - Alaska Trauma Registry
> - Statewide and Local Police Crash Reports
> - YRBS Questions
> - BRFSS Questions
> - OPUS (Occupant Protection Use Survey)
> - Booster Seat Observation Survey
> - Transportation Telephone marketing survey

Importance: Transportation-related injuries and deaths are a significant health problem in Alaska. In Alaska, transportation-related injuries and deaths have long been ranked the 2nd and 3rd leading cause of injury fatalities[81] and nonfatal injuries.[82] From 2011-2015, there were 4,692 people hospitalized in Alaska for transportation-related injuries.[83] Of those, 10% (n-479) involved a snow machines[84]and 18% (n=866) involved off-road vehicles.[85] Additionally, 12% (n=553) involved bicyclists.[86] During that time frame, 8% (n=384) of those injured were pedestrians.[87]

As reported in the Fatality Analysis Reporting System (FARS), in 2015 the rate of roadway transportation-related fatalities in Alaska was 8.8 per 100,000.[88] From 2011- 2015, there were 294 roadway fatal crashes, for an average of 58.8 per year.[89] In 2016, there were 84 roadway traffic crash fatalities.[90] The Alaska Department of Transportation

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[81] Romig, A. (2016). 10 leading causes of fatal injuries in Alaska by age group 2011-2015. DHSS, DPH, Section of Emergency Programs, Alaska Trauma Registry, Alaska Bureau of Vital Statistics.

[82] Romig, A. (2016). 10 leading causes of non-fatal hospitalized injuries Alaska residents 2011-2015. State of Alaska, DHSS, DPH, Section of Emergency Programs, Alaska Trauma Registry.

[83] ICD E Codes 800-829.

[84] ICD Code 820

[85] ICD E Code 821

[86] ICD E Codes 826, 812.6, 813.6, 814.6, 816.6, 818.6, 821.6, 822.6, 824.6, and 825.6

[87] ICD Codes 812.7, 813.7, 814.7, 816.7, 818.7, 819.7, 821.7, 822.7, 823.7, and 825.7.

[88] Alaska Highway Safety Office. (2016, December 19). Fatality Analysis Reporting System. Retrieved April 21, 2017, from Alaska Department of Transportation and Public Facilities, Alaska Highway Safety Office:

http://dot.alaska.gov/stwdplng/hwysafety/assets/pdf/2016_All_Fatals_by_Roadway.pdf. Accessed August 19, 2018.

[89] Alaska Highway Safety Office. (2016, December 19). Fatality Analysis Reporting System. Retrieved April 21, 2017, from Alaska Department of Transportation and Public Facilities, Alaska Highway Safety Office:

[90] Alaska Highway Safety Office. (2016, September 9). Fatal Crash Data. Retrieved April 21, 2017, from Alaska Department of Transportation and Public Facilities: Alaska Highway Safety Office: http://dot.alaska.gov/stwdplng/hwysafety/data.shtml

(DOT) also tracks serious injuries resulting from traffic crashes. From 2009-2013 there were 2,044 serious injuries, counted by police crash reports, for an average of 408 per year.[91] The determination of whether an injury is "serious" is made at the discretion of the police officer.

In more rural parts of Alaska many communities have little or no built roads, and ATVs and snow machines are the dominant modes of transportation. Travel between communities is done over trails, some well-defined and marked, others less established, or in the winter on ice roads over frozen rivers. Changes in climate have increased risks of falling through rivers and lake ice roads, especially in early and late winter. Incomplete or deteriorating trail markings can lead to a lost traveler experiencing hypothermia or frostbite.

Influencing Factors:

Risk Factors
- Driving under the influence[92]
- Inexperienced drivers[93]
- Extreme weather: ice, ice highways, climate change
- Poor lighting or marking on motorways and trails
- Driver behavior: aggressive, distracted, speeding[94]
- Exceeding maximum passenger capacity
- Fatigued drivers[95]
- Not using safety gear [96]
- Feelings of invincibility[97]

Protective Factors
- Good behavioral norms: seat belt use, non-distracted driving, sober driving, norms for safety gear use
- No cellphone use while driving[98]
- Community connectedness: Communities adopting *Complete Streets* policies[99]
- Safe environment: transportation facilities designed and maintained for the safety of all users and vehicle types

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[91] The Department of Transportation and Public Facilities, Alaska Highway Safety Office. (2016, July 1). Alaska Highway Safety Plan, Federal Fiscal Year 2017. Retrieved April 21, 2017, from National Highway Transportation Safety Administration: https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/ak_fy17hsp.pdf. Accessed August 19, 2018.

[92] Savage, S. (2015*). Alaska young driver safety: Distracted driving, seatbelt use and drinking and driving.* (Master's Thesis University of Alaska Anchorage).

[93] Savage (2015).

[94] Savage (2015).

[95] Cummings, P., Koepsell, T., (2001). Drowsiness, countermeasures to drowsiness, and the risk of a motor vehicle crash. *Injury Prevention.* 7:194-9

[96] Reisner, S.L., Van Wagenen, A., Gordon, A., & Calzo, J. P., (2013). Disparities in safety belt use by sexual orientation identity among US high school students. *American Journal of Public Health.* 104(2).

[97] Adeola, R. Gibbons, M. (2013). Get the message: Distracted driving and teens. *Journal of Trauma Nursing: The Official Journal of the Society of Trauma Nurses,* 20(3), 146.

[98] Distraction.gov. (2012, June). Blueprint for ending distracted driving. Washington, DC: National Highway Traffic Safety Administration.

[99] Smart Growth America. Complete Streets Program. https://smartgrowthamerica.org/program/national-complete-streets-coalition/what-are-complete-streets/. Accessed August 19, 2018.

- Graduated Driver's Licensing Laws[100]
- Restrictions on cellphone use while driving [101]
- Resiliency
- Pro-social peers[102]
- Low propensity for risk-taking[103]
- Mental wellbeing[104]
- Well-lit motorways and trails
- Self control/ self regulation[105]
- Experiencing a real life crash or exposure to well crafted video depicting crash consequences[106]

Funding Sources:

- Alaska Highway Safety Office
- Insurance Companies like State Farm, AllState
- People for Bikes
- American Heart Association - Voices for Healthy Kids
- Alliance for Biking and Walking
- AARP Community Challenge
- League of American Bicyclists

Promising and Evidence-Based Interventions:

o Best Practices for Teen Safe Driving in Alaska: http://alaskainjurypreventioncenter.org/wp-content/uploads/2016/10/Teen-Driving-Resource.Guide_v2.pdf

o CDC's Community Guide:
https://www.thecommunityguide.org/search/transportation#topic=7615&page=1Lists

o National Highway Transportation Safety Administration's Countermeasures that Work:
https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/812202-countermeasuresthatwork8th.pdf

Current Strategies

Transportation strategies primarily revolve around data linkage (to create detailed descriptions of how transportation injuries occur), decreasing impaired driving and improving occupant protection behaviors. Below are examples of currently funded initiatives through the Alaska Highway Safety Office. In addition to the strategies below, there are efforts to improve pedestrian and bicyclist safety on the local level in many communities, both urban and rural. There are also rural transportation safety initiatives involving safe trails between communities, landfilling to improve roadways, dust control on rural roadways to improve visibility, and helmet use campaigns, among other efforts.

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[100] Simons-Morton, B., Ehasni, J., Gershon, P., Klauer, S., Dingus, T. (2017) Teen driving risk and prevention: Naturalistic driving research contributions and challenges. *Safety*. 3, 29.

[101] Distraction.gov.

[102] Juarez (2006).

[103] Juarez (2006).

[104] Dula, C., Geller, E., (2003). Risky, aggressive, or emotional driving: addressing the need for consistent communication in research. *Journal of Safety Research*. 34:559-66.

[105] Berg, H-Y. (2006). Reducing crashes among young drivers: what kind of prevention should we be focusing on? *Injury Prevention*. June, 12(Suppl 1): i15-i18.

[106] Howell, M., Ekman, D., Almond, A. Bolls, P. (2018). Switched on: How the timing of aversive content in traffic safety videos impacts psychophysiological indicators of message processing. *Health Communication*, DOI 10.1080/10410236.2018.1517706

Traffic Records and Trauma Registry data linkage: Develop a Data Integration Master Plan as a component of the Alaska Traffic Records Strategic Plan

- Identify and prioritize data integration opportunities for the State
- Identify stakeholders and custodians for proposed linked datasets
- Identify key date fields which should exist to facilitate linking traffic records information
- Review and adopt state and national standards, best practices, and technologies that support seamless, secure, and efficient linkage of traffic records data between Alaska's traffic records data systems
- Support traffic records projects that implement state and national standards to improve interoperability, reusability, consistency, and other efficiencies in the sharing of traffic record data http://www.dot.state.ak.us/highwaysafety/trafficrecords_comm.shtml.

Impaired Driving Prevention Strategic Highway Safety Plan:

Strategy 1: Strengthen leadership and participation to enhance impaired driving improvements.

- Build partnerships designed to reduce impaired driving. Enhance enforcement in safety corridors.
- Effectively integrate traffic enforcement with other enforcement activities at agencies, i.e., Data Driven Approaches to Crime and Traffic Safety.

Strategy 2: Prevent excessive drinking, underage drinking, and impaired driving.

- Continue mandatory alcohol server training.
- Conduct well publicized compliance checks of alcohol retailers to reduce sales to underage persons. Improve understanding of impaired driving among youth and implement outreach programs.
- Improve and enhance the effectiveness of Alaska's Ignition Interlock (IID) program through an effective and consistent policy and oversight.

·Strategy 3: Enhance law enforcement training in alcohol and drug detection.

- Increase the number of officers trained in standardized DUI/drugged driving detection and apprehension, i.e., Standard Field Sobriety Test (SFST), Drug Recognition Evaluation (DRE), and Advanced Roadside Impaired Driving Enforcement (ARIDE).
- Develop a Statewide Law Enforcement Liaison (LEL) program.

·Strategy 4: Enforce and publicize DUI laws.

- Continue statewide, high-visibility saturation enforcement and media campaigns to reduce impaired driving.

Strategy 5: Encourage consistent and vigorous DUI prosecution.

- Educate prosecutors and court system on traffic safety issues specifically impaired driving.

Strategy 6: Use licensing sanctions shown to be effective at reducing recidivism and protecting the public.

- Suspend driver license administratively upon arrest.
- Increase penalties for repeat offenders.

Strategy 7: Support impaired driving priority policies and program efforts.

- Establish a comprehensive communications plan that includes impaired driving initiatives.

Strategy 8: Establish programs to facilitate close monitoring of impaired drivers.

- Develop a program to increase enforcement of drug impaired driving.
- Develop and implement a screening, treatment, and rehabilitation program.

Strategy 9: Provide timely, accurate, integrated, and accessible traffic records data.

- Explore the feasibility of allowing crash and Trauma Registry data to be linked.

Strategy 10: Access to forensic drug toxicology services.

- Improve toxicology services for impaired driving cases.

Occupant Protection

Strategy 1: Continue high-visibility enforcement (Click It or Ticket) programs and stress occupant protection in all standard enforcement activities.

Strategy 2: Conduct education and awareness efforts to promote the importance and need for occupant protection.

 Strategy 3: Continue and expand child passenger safety programs.

- Work with the Injury Prevention Program from the Alaska Native Tribe Health Consortium (ANTHC) to encourage people to use child safety seats and emphasize occupant protection education to families traveling to regional and state hubs.
- Partner and share data from the Trauma Registry on child incidents involving off-highway vehicles operating on public roads with agencies servicing rural Alaska.
- Increase booster seat use through seat checks, consultations and outreach opportunities with special emphasis on Stage 3 use.
- Determine the need for additional child passenger safety technicians or for law enforcement training on child passenger safety.

Strategy 4: Provide data on occupant protection.

- Identify sources of occupant protection data and make it accessible to stakeholders, i.e., Trauma Registry, crash data, etc.
- Determine the cost of occupant protection crashes and promote the information through education and outreach efforts.

Strategy 5: Pursue statutory or regulatory changes which encourage occupant restraint use.

- Explore options to reduce fines or other punishments for child passenger safety violators who take action to properly restrain their children (i.e., receive a certificate for attending a class).
- Investigate ways to overturn the law that allows passengers to ride on the floorboards of vehicles. **https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/ak_fy17hsp.pdf**

Other Transportation Safety Initiatives in Alaska:

- The Center for Safe Alaskans is involved in teen driving safety and bicycle and pedestrian safety projects. This project uses hands-on and classroom safety skills training, bicycle helmets, technical assistance to community safety events, and broadcasting educational messages to reduce bicycle and pedestrian fatalities and serious injuries. Center for Safe Alaskans develops projects to educate teens about critical safe driving practices, including: seat belt use, the importance of refraining from drinking and driving, inattentive/distracted driving, aggressive driving, and sharing the road with pedestrians and cyclists.
- Center for Safe Alaskans also conducts various teen peer-to-peer projects in high schools which promote safe driving. The peer-to- peer intervention is designed to educate teens about the lifesaving importance of seat belts by rewarding drivers and passengers "caught" buckling up. Since its introduction in 2006, teen belt use at participating high schools has increased from 70% to 91%; the highest observed use at one high school was 94%.
- Center for Safe Alaskans uses evidence-based communication strategies for reaching teen drivers with safe driving messages focusing on speed, impairment, distraction, and seat belt use. Parents, who have tremendous influence over their teen drivers, are also the focus of this outreach. Ensuring that parents are fully informed about the crash risk for their teen drivers, and how Alaska's graduated driver licensing program works to address that risk, is essential. Key themes that Center for Safe Alaskans seeks to convey to parents include the importance of significant practice during the learner's phase, the use of a parent-teen driving agreement, and controlling the keys and staying involved after licensure.

Identify Gaps:

References, Resources, End Notes: See footnotes

UNDERAGE DRINKING

Health Issue: Underage Drinking
Contributors: Marcia Howell, Becky Judd, Lindsey Hajduk, Jess Limbird, Jenni Lefing
Age Group: Youth under 18 years of age (though the legal drinking age is 21)

Definition:

Underage drinking refers to people under the legal age of 21 consuming alcohol.

Additional terms include:

- Binge Drinking: A pattern of drinking that brings blood alcohol concentration levels to 0.08 g/dL. This typically occurs after 4 drinks for women and 5 drinks for men in about 2 hours.[107]
- Heavy Drinking: 5 or more drinks on one occasion on five or more days in the past 30 days.[108]
- Alcoholism: physical dependence on alcohol.

Data sources that define and measure the issue

Alaska Youth Risk Behavior Survey:

- During the last 30 days how many times did you ride in a car or other motor vehicle with someone who had been drinking alcohol.[109]
- During the last 30 days how many times did you drive a car or other motor vehicle when you had been drinking alcohol.[110]
- During your life on how many days have you had at least one drink of alcohol[111]
- How old were you when you had your first drink of alcohol other than a few sips.[112]
- During the last 30 days, on how many days did you have at least one drink of alcohol[113]
- During the past 30 days how did you usually get the alcohol you drank[114]

Alaska School Climate and Connectedness Survey (SCCS)

- 2017 SCCS
  - During the last 30 days, on how many days do you think most students in your school had at least one drink of alcohol. (SCCS Anchorage question)
  - During the last 30 days, on how many days do you think the average student in your school had at least one drink of alcohol. (SCCS Anchorage question)
- 2018+ SCCS
  - In the past 12 months, how many times have you personally seen other students do these things at your school or school events? (Response options: 0 times, 1-2 times, 3-6 times, 7-12 times, more than 12 times)
  - …Under the influence of alcohol (such as beer, wine, liquor, such as vodka or whiskey, etc.)? (Response options: 0 times, 1-2 times, 3-6 times, 7-12 times, more than 12 times)

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[107] National Institute on Drug Abuse

[108] Substance and Mental Health Services Administration

[109] YRBS 2017 question 10

[110] YRBS 2017 question 11

[111] YRBS 2017 question 46

[112] YRBS 2017 question 47

[113] YRBS 2017 question 48

[114] YRBS 2017 question 49

Trauma Registry variables[115]:

- Referring facility ETOH
- ED ETOH
- Injury Coding narrative
- ICD10 X45, X65, R78Y15, T51.0, T 51.1, T51.9

Alaska Crash Reports: variables[116]:

- V1_D1ALCDRGSUSP
- V1_D1ALCDRGTEST
- V1_D1BAC

Court Records: Minor consuming/possession AS 04.16.050

NSDUH: Perceived Risk

Importance:

- National Data:[117]

    - By age 15, about 33 percent of teens have had at least 1 drink.[118]
    - By age 18, about 60 percent of teens have had at least 1 drink.[119]
    - In 2015, 7.7 million young people ages 12–20 reported that they drank alcohol beyond "just a few sips" in the past month.[120]
    - Based on data from 2006–2010, the Centers for Disease Control and Prevention (CDC) estimates that, on average, alcohol is a factor in the deaths of 4,358 young people under age 21 each year.[121] This includes:

        - 1,580 deaths from motor vehicle crashes
        - 1,269 from homicides
        - 245 from alcohol poisoning, falls, burns, and drowning
        - 492 from suicides

    - **Causes many injuries: Drinking alcohol can cause kids to have accidents and get hurt. In 2011 alone, about 188,000 people under age 21 visited an emergency room for alcohol-related injuries.[122]**

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[115] http://dhss.alaska.gov/dph/Emergency/Pages/trauma/registry.aspx (accessed 5-17-18)

[116] https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=102486 (accessed 5-17-18)

[117] https://pubs.niaaa.nih.gov/publications/UnderageDrinking/UnderageFact.htm (accessed 12-26-18)

[118] Substance Abuse and Mental Health Services Administration (SAMHSA). *2015 National Survey on Drug Use and Health (NSDUH)*. Table 2.19B: Alcohol Use in Lifetime, Past Year, and Past Month, by Detailed Age Category: Percentages, 2014 and 2015. Rockville, MD: SAMHSA, 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab2-19b. Accessed 1/20/17

[119] Substance Abuse and Mental Health Services Administration (SAMHSA). *2015 National Survey on Drug Use and Health (NSDUH)*. Table 2.19B: Alcohol Use in Lifetime, Past Year, and Past Month, by Detailed Age Category: Percentages, 2014 and 2015. Rockville, MD: SAMHSA, 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab2-19b. Accessed 1/20/17

[120] Substance Abuse and Mental Health Services Administration (SAMHSA). *2015 Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*. Figure 24. Rockville, MD: SAMHSA, 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm#fig24. Accessed 1/20/17.

[121] Centers for Disease Control and Prevention (CDC). *Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI)*. Atlanta, GA: CDC, 2016. Available at: http://go.usa.gov/xkde2. Accessed 1/20/17.

[122] Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. *The DAWN Report: Highlights of the 2014 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits*. Rockville, MD:

- **Impairs judgment: Drinking can lead to poor decisions about engaging in risky behavior, including drinking and driving, sexual activity (such as unprotected sex), and aggressive or violent behavior.**
- **Increases the risk of physical and sexual assault: Underage youth who drink are more likely to carry out or be the victim of a physical or sexual assault after drinking than others their age who do not drink.**
- **Can lead to other problems: Drinking may cause youth to have trouble in school or with the law. Drinking alcohol also is associated with the use of other drugs.**
- **Increases the risk of alcohol problems later in life: Research shows that people who start drinking before the age of 15 are 4 times more likely to meet the criteria for alcohol dependence at some point in their lives.**
- **Interferes with brain development: Research shows that young people's brains keep developing well into their 20s. Alcohol can alter this development, potentially affecting both brain structure and function. This may cause cognitive or learning problems and/or make the brain more prone to alcohol dependence. This is especially a risk when people start drinking young and drink heavily.**

Influencing Factors:

Risk Factors:[123]

Factors with * currently have population-based AK indicators, proxy measures or community data available.

Factors in **bold** were identified by the SPF/SIG Epidemiological Influences Workgroup in 2010 as priority prevention factors for Alaska.

Individual - Peers

- **Early initiation of the problem behavior*** (YRBS)
- **Feeling depressed or suicidal*** (YRBS)
- **Loss of cultural identity and connection*** (SCCS)
- Constitutional factors (see definition)
- Childhood media exposure to violence and alcohol
- Early and persistent antisocial behavior
- Friends who engage in the problem behavior
- Favorable attitudes toward the problem behavior / low perceived-risk of harm * (YRBS)
- Older physical appearance than peers
- Paid work more than 20 hrs/week
- Perceived risk of untimely death

Family

- **Experienced child abuse (physical, sexual) or other family violence*** (YRBS limited)
- Family history of the problem behavior
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement in problem behaviors * (YRBS)
- Household access to substances or guns

School

- Academic failure* (YRBS & SCCS)
- Lack of personal commitment to school* (SCCS)

SAMHSA, 2014. Available at: http://www.samhsa.gov/data/sites/default/files/spot143-underage-drinking-2014/spot143-underage-drinking-2014/spot143-underage-drinking-2014.pdf. Accessed 1/20/17.

[123] *Risk and Protective Factors for Adolescent Substance Use (and other Problem Behavior)* from Alaska Division of Behavioral Health, 2012.

Community
- **Availability of alcohol/other drugs*** (Community Data)
- **Community norms and laws**
- Transitions and mobility* (Community Data)
- Low neighborhood attachment & community disorganization
- Poverty * (NSDUH & Community Data)
    - Indicator: Receiving Any Cash Assistance
    - Indicator: Receiving Food Stamps
    - Indicator: Receiving Other Kind of Welfare

Other Possible Factors:

- Exercise- YRBS 82-87
- Homelessness YRBS 92

Protective Factors[124]

Factors with * (currently have population-based AK indicators or proxy measures in place)

Factors in **bold** were identified by the SPF/SIG Epidemiological Influences Workgroup in 2010 as priority prevention factors for Alaska.

Individual - Peer

- **Engagement in meaningful activities*** (YRBS & SCCS)
- **Life skills and social competence -** *Social Emotional/Employability Skills* ***** (SCCS)
- **Cultural identity and connection*** (SCCS)[125]
    - Cultural Identity/Connection Index (SEE Cultural Connectedness, and indicators from SCCS)
    - Engagement in meaningful activities *ibid*
- Positive personal qualities *(Pending the definition, integrated into some surveillance systems)*
- Positive self concept *(Pending the definition, integrated into some surveillance systems)*
- Positive peer role models *(Pending the definition, integrated into some surveillance systems)*
- Religious identity (NSDUH)
- High grade point average* (YRBS & SCCS)
- Individual/peer connectedness[126]: Feeling alone in life (the inverse being not feeling alone in life)
    - Indicator: Do you agree or disagree that you feel alone in life (YRBS)[127]

Family

- **Family connectedness** (attachment & bonding)* (YRBS & SCCS, NSDUH)[128],[129]
    - Indicator: How often does one of your parents talk with you about what you are doing in school[130]
    - Parents Helped with Homework
    - Parents Proud of Teen

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[124] *Risk and Protective Factors for Adolescent Substance Use (and other Problem Behavior)* from Alaska Division of Behavioral Health, 2012.

[125] Alaska Division of Behavioral Health, Risk and Protective Factors for Adolescent Substance Use (2012)

[126] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig,

S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness

assessment. University of Alaska Anchorage: Center for Human Development.Growing up Anchorage,

https://www.uaa.alaska.edu/academics/college-of-health/_documents/growing-up-anchorage-2015.pdf (accessed 5-17-18)

[127] YRBS 2017 question 94

[128] Judd, B. (2016). Youth's perceptions of mattering, being valued, and connecting to their community: A summary of literature and best

practices.

[129] Heath (2015)

[130] YRBS 2017 question 96

- ○ Parents Said Good Job
  - ○ Religious Beliefs Important
  - ○ Religious Beliefs Influence Decisions
  - ○ Religious Beliefs Shared by Friends
  - ○ Religious Services Attended
- Positive parenting style (NSDUH indicators)
- Living in a two parent family
- Higher parent education
- High parental expectations about school* (YRBS SCCS, NSDUH)

School

- **Connected to school*** (SCCS, NSDUH)
- Caring school climate* (SCCS)
- Student participation in extracurricular activities* (YRBS & SCCS)
- Early Intervention and student support services
- Caring School Staff[131]
  - ○ Indicator: Do you agree or disagree that your teachers really care about you and give you a lot of encouragement.[132]
  - ○ Additional related indicators: See SCCS
- Commitment to School
  - ○ School: Courses Interesting
  - ○ School: Received HS Diploma
  - ○ School: Related Feelings
  - ○ School: Work is Meaningful

Community

- **Positive connection to *other* adults*** (YRBS & SCCS)
- Strong community infrastructure (services for those in need)
- Local, state policies and practices that support healthy norms and child-youth programs
- Range of opportunities *in the community* for meaningful youth engagement
- Community Connectedness:
  - ○ Indicator: Besides your parents, how many adults would you feel comfortable seeking help from if you had an important question affecting your life [133]
  - ○ Indicator: Do you agree or disagree that in your community you feel like you matter to people[134]
- Social Norms and Perception of Harm[135]
  - ○ Indicator: How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice a week[136]
  - ○ Indicator: How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day[137]
  - ○ Indicator: How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day
  - ○ Indicator Perceived Harm[138]

Other

- Talks About Serious Problems

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[131] Alaska's Strategies to Prevent Underage Drinking" (2012)

[132] YRBS 2017 question 97

[133] YRBS 2017 question 95

[134] YRBS 2017 question 99

[135] Alaska Division of Behavioral Health, Risk and Protective Factors for Adolescent Substance Use (2012), http://dhss.alaska.gov/dbh/documents/prevention/programs/spfsig/pdfs/risk_protective_factors.pdf, (accessed May 17, 2018)

[136] YRBS 2017 question 106

[137] YRBS 2017 question 107

[138] NSDUH

- NSDUH Protective Factor Indicators (Alaska ages 12-17 sample)[139]

Funding Sources:

- Alaska Highway Safety Office
- Substance Abuse Mental Health Services Administration
- State of Alaska, Department of Health and Social Services, Division of Behavioral Health
- National Institute of Health
- Alaska Mental Health Trust Authority
- Association of Alaska School Boards

Promising and Evidence-Based Interventions:

- National Highway Traffic Safety Administrations - Countermeasures That Work
- Redesigned National Registry for Evidence-based Programs and Practices
- Center for Disease Control

Identify gaps:

- Actual consumption data

References, Resources, End Notes: See footnotes

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[139] NASDUH Dashboard, in Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET) https://sappet-epi.com/new/mapdata.asp?p_state=AK&Consumption=0&Consequences=0&Risk=1&Protective=0&MentalHealth=0&Other=0&ALL=0&Opioid=0&CSTE=0&font=

YOUTH MATTERING TO THE COMMUNITY

Health Issue: Youth Perception of Mattering to People in the Community
Contributors: Lindsey Hajduk, Becky Judd, Marcia Howell
Age Group: Youth 12-18 years old

Definition: Youth's perception they are respected, trusted, valued, cared for by others, and able to make a difference in their community.[140]

> Data sources that define and measure the issue:
>
> - Do you agree or disagree that in your community you feel like you matter to people?[141]

Importance: A youth's perception that they matter to people in the community is associated with a number of risk factors.

Influencing Factor:

> <u>Protective Factor</u>
>
> *Alaska Data*
>
> - According to (Anchorage) YRBS strength of association findings, youth feeling like they matter to their community is the second ranked protective factor against:
>   - Bullying
>   - Feeling sad/hopeless
>   - Suicide ideation
>   - A planned attempt at suicide
>   - Less likely to report ever being bullied in school or electronically,
>   - less likely to feel sad or hopeless
>   - less likely to seriously consider suicide
>   - Improving mental health.[142]
> - Statistically significant associations of "Feeling like s/he matters to people in the community:"
>   - Current underage drinking: 19%
>   - Binge drinking ever: 17%
>   - Current marijuana use: 35%
>   - Recently missed class without permission: 34%[143]
> *National Research[144]*

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[140] Judd, B. (2016). Youth's perceptions of mattering, being valued, and connecting to their community: A summary of literature and best practices.

[141] YRBS 2017 question 99

[142] Heath, K., Garcia, G., Hanson, B., Rivera, M., Hedwig, T., Moras, R., Reed, D., Smith, C., Craig, S. (2015). Growing up Anchorage: Anchorage youth and young adult behavioral health and wellness assessment. University of Alaska Anchorage: Center for Human Development.

[143] McDowell Group. (2018). Protective Factors for Youth Substance Abuse and Delinquency: The Role of Afterschool Programs.

[144] Judd, B. (2016). Youth's perceptions of mattering, being valued, and connecting to their community: A summary of literature and best practices.

- Rosenberg and McCullough (1981) pioneered the conceptualization of mattering in the social science field. Mattering was described as a form of external validation from others both at the interpersonal level and at the broader, societal level. Rosenberg explained societal mattering as 'the feeling that one's actions can make a difference and have an impact' (1985). Rosenberg and McCullough's early research focused on the relationship of interpersonal mattering to adolescent well-being. Subsequent studies demonstrated the perceptions of significance and mattering to others was related to lower depression and greater overall psycho-social wellbeing in both adolescents and young adults (Marshall 2001, 2011, Taylor and Turner 2001, Dixon 2009.)
- Taylor & Turner (2001) found, youth who perceived that others care about them and what happens to them, will experience fewer feelings of insignificance and depression.
- Scales & Leffert (1999) in their synthesis of the Developmental assets research determined that youth who feel valued and useful by the community *(proxies for mattering)*are associated with several positive outcomes including better mental health, higher self concept, self actualization, sense of optimism, and less risk behaviors.
- Whitlock (2004, 2006, 2007, 2010, 2014) extensively studied youth and young-adult's connection to community, school and college environments. Her connectedness research greatly overlaps with the construct of *mattering to others* and provides useful insights to this protective factor. (See Connectedness protective factor)

Funding sources

- Anchorage Youth Development Coalition Youth Matter Grants - funding through the Division of Behavioral Health's Comprehensive Behavioral Health Prevention and Early Intervention Grant[145]

Promising and Evidence-Based Interventions:

There are not specific "best practice" studies examining youth's perception of mattering and significance. There is a body of research related to increasing "youth connectedness, empowerment, and self-efficacy" through personal actions, within youth programs and community-wide strategies.[146]

- Youth Program Best Practices - Resources:
  - Community Programs to Promote Positive Youth Development, National Research Council and Institute of Medicine (2002). The report identifies opportunities for self-efficacy and mattering, as one of eight fundamental feature of a positive developmental setting.[147]
  - The Weikart Center for Youth Program Quality (2015) provides training for youth workers on best practices that increase efficacy, mattering, and positive

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[145] http://safealaskans.org/our-work/programs-initiatives/aydc/youth-matter-grants/

[146] Judd, B. (2016). Youth's perceptions of mattering, being valued, and connecting to their community: A summary of literature and best practices.

[147] Eccles, J.S. and Gootman, J. A. (2002) Community Programs to Promote Youth Development, National Research Council, Institutes of Medicine. National Academy Press, Washington, DC.

health outcomes.[148]
- AYDC's Second Order Change professional development increases Social Emotional Learning skills of youth program staff.
- Positive Youth Development 101 Training and an online PYD handbook are provided by the ACT for Youth Center of Excellence.

- Community-wide strategies[149]
    - Create a "developmentally attentive culture" in school and community by targeting attitude change among adults – particularly those with regular but anonymous contact with youth such as business, police, and general community members
    - Create formal structures or forums for youth representatives to solicit input from their youth constituents. (Strategies to help youth represent a constituency need not be cumbersome. Help arrange focus groups, youth forums, town meetings or even youth developed and administered surveys periodically
    - Diversify the range of opportunities for youth to participate in community life; opportunities need not and should not be solely related to issues directly affecting youth
    - In designing initiatives, focus on the supports and opportunities that can create the greatest breadth and depth. (Focus on meaningful roles, creative engagement and positive relationships with adults.)
    - Capitalize on the opportunities already provided to young people in schools *[and in the community]* by clearly advertising the roles youth play and the effects they have on school/*community* life.
    - Actively recruit high–risk and/or low achieving youth for involvement in school and community level leadership opportunities.
    - Increase the number of developmental supports young people perceive in school and community.
    - Create engaging opportunities for youth of all ages in as many levels as possible.

Identify gaps:

- Studies to examine youth's perception of mattering and best practices to increase it.
- Funding sources that align with promoting this factor.

References, Resources, End Notes: See footnotes

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[148] Smith, C., Akiva, T., Sugar, S., Devaney, T., Lo, Y., Frank, K., Peck, S.C., Cortina, K.S. (2012). Continuous Quality Improvement in Afterschool Settings: Impact Findings from the Youth Program Quality Intervention Study.

[149] Whitlock J. (2004). *Places to Be and Places to Belong: Youth Connectedness in School and Community*. Cornell University. And, Whitlock, J. L. (2007). The role of adults, public space, and power in adolescent community connectedness. *Journal of Community Psychology*. 35, 499–518.

YOUTH VIOLENCE AND TEEN DATING

Health Issue: Youth Violence and Teen Dating
Contributors: Summer Chitwood, Charles Utermohle
Age Group: People between the ages of 10 and 24 years old

Definition:

Youth Violence

Youth violence is a significant public health problem that affects thousands of young people each day, and in turn, their families, schools, and communities. Youth violence occurs when young people between the ages of 10 and 24 years intentionally use physical force or power to threaten or harm others. Youth violence typically involves young people hurting other peers who are unrelated to them and who they may or may not know well. Youth violence can take different forms. Examples include fights, bullying, threats with weapons, and gang-related violence. A young person can be involved with youth violence as a victim, offender, or witness. Different forms of youth violence can also vary in the harm that results and can include physical harm, such as injuries or death, as well as psychological harm, increased medical and justice costs, decreased property values, and disruption of community services.[150]

Teen Dating Violence

Teen Dating Violence (TDV) refers to Intimate Partner Violence (IPV) that happens when individuals first begin dating, usually in their teen years. IPV (also commonly referred to as domestic violence) includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/ girlfriend, dating partner, or ongoing sexual partner)." Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. Family violence is another commonly used term in prevention efforts. While the term domestic violence encompasses the same behaviors and dynamics as IPV, the term family violence is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others.[151]

Importance:

Youth Violence

- 21% of Alaskan youth were involved in a physical fight in the previous year.[152]
- 6.8% of Alaskan youth were involved in a physical fight on school grounds in previous year.[153]

Teen Dating Violence

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[150] https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf

[151] https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

[152] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

[153] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

- 8.2% of Alaskan youth were forced to have sex when they did not want to.[154]
- 10.7% of Alaskan youth experienced sexual violence.[155]
- 5.5% of Alaskan youth experienced sexual dating violence.[156]
- 7.3% of Alaskan youth experienced physical dating violence.[157]

Influencing Factors:

Youth Violence - Risk Factors:

- Impulsiveness
- Youth substance use
- Antisocial or aggressive beliefs and attitudes
- Low levels of school achievement
- Weak connection to school
- Experiencing child abuse and neglect
- Exposure to violence in the home or community
- Involvement with delinquent peers or gangs
- Lack of appropriate supervision
- Parental substance abuse
- Parental or caregiver use of harsh or inconsistent discipline
- Depression, anxiety, chronic stress and trauma, and peer conflict and rejection
- Youth who are arrested, particularly before age 13, have a heighten risk for future violence and crime, school dropout, and substance abuse
- Unsupervised access to a firearm is a contributing factor for lethal youth violence
- Community factors
  - Residential instability
  - Crowded housing
  - Density of alcohol-related businesses
  - Poor economic growth or stability
  - Unemployment
  - Concentrated poverty
  - Neighborhood violence and crime
  - Lack of positive relationships among residents
  - Views that drug use and violence are acceptable behaviors
  - Some racial/ethnic minority youth are exposed to high levels of community violence and other neighborhood problems, which contribute to disparities in youth violence, violence-related injuries and death, and other difficulties.[158]

Youth Violence - Protective Factors:[159]

- Healthy social, problem-solving, and emotional regulation skills
- School readiness and academic achievement
- Positive and warm parent-youth relationships in which parents set consistent, developmentally appropriate limits
- Parents or caregivers that demonstrate interest in their children's education and social relationships are associated with healthy child and adolescent development and the prevention of violent behavior.

[154] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

[155] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

[156] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

[157] http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2017AKTradHS_YRBS_SummaryTables.pdf

[158] https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf

[159] https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf

- Youth feeling connected to their schools
- Experiencing academic success
- Having positive relationships with teachers and other caring adults
- Interacting with prosocial and nonviolent peers
- Physical environments of schools, parks, and business and residential areas that are regularly repaired and maintained and designed to increase visibility, control access, and promote positive interactions and appropriate use of public spaces also are buffers to violence
- Community buffers against violence and associated risks include
  - Household financial security
  - Safe and stable housing
  - Economic opportunities
  - Increasing access to services and social support
  - Residents willingness to assist each other
  - Collective views that violence is not acceptable

Teen Dating Violence - Risk Factors[160]

- Low educational achievement
- Lack of nonviolent social problem-solving skills
- Poor behavioral control/impulsiveness
- History of violent victimization
- Witnessing violence
- Psychological/mental health problems
- Substance use

Teen Dating Violence - Protective Factors:

- Family support/connectedness, connection to a caring adult, association with prosocial peers, connection/commitment to school, skills in solving problems nonviolently.[161]

Funding Sources: TBD

Promising and Evidence-Based Interventions:

- Teen Dating Violence: Safe Dates[162],
- Shifting Boundaries[163]
- The 4th R: Strategies for Healthy Teen Relationships[164]
- Expect Respect support groups[165]
- Coaching Boys into Men[166]
- Green Dot[167]
- Families for Safe Dates

Identify Gaps: TBD

References, Resources, End Notes: See footnotes

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[160] https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

[161] https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

[162] https://www.hazelden.org/web/go/safedates

[163] https://www.childtrends.org/programs/shifting-boundaries/

[164] https://youthrelationships.org/

[165] http://www.expectrespectaustin.org/support-groups/

[166] http://www.coachescorner.org/

[167] https://cultureofrespect.org/program/green-dot-etc/

APPENDIX 4: STRENGTHS, CHALLENGES, BENEFITS, & DANGERS

During the first workgroup meeting on April 26, 2018, the workgroup identified strengths, challenges, benefits, and dangers. The strengths and challenges are focused on the internal group, while the benefits and dangers address external influences.

Strengths	Benefits
Data analysis	Not duplicating efforts
Experience	New relationships/networking
Innovative ideas	Conditions in state, opportunities
Motivation	Shared definitions
Data stewards	Shared understanding
Potential for saving money	Shared measures
Common language	HA2030
Multiple stakeholders	Different "a-ha"s
Opportunities for collaboration	Lower ACEs
Diverse interests	Prevention cheaper than treatment
Cross-sector	Use for strategic planning
Aligned goals and objectives	Inform funding decisions
Plan for going forward	Program sustainability
Less fragmentation	Inform data collection
Heart and soul	Measure protective factors
Going upstream	Shared programming
	Correlation work with risk and protective factors → so what?
	Shared funding
	Alignment
Challenges	**Dangers**
Divided attentions	Political will
Distractions/other responsibilities	Not representative of those most in need
Technical difficulties/geographic distance	May be hard to get funding support
Siloed finding	Lack of follow through support
Funding structure nationally based on risk	Variations in ideology
Missing stakeholders	Hard to shift social norms
Exclusive group	Large saturation necessary
No people off the road system	Institutional change
Missing treatment providers	Reactive
	Discouragement
	Proper measures
	Cultural changes

APPENDIX 5: WORKGROUP QUESTIONNAIRE

At the first meeting, there was general consensus on building the process around the expertise in the room. The facilitators sent out a Survey Monkey questionnaire to the group to develop a list of health and wellness issues, risk and protective factors, and resources. Thirteen workgroup members responded to the questionnaire, spending an average of 23 minutes answering questions.

RESPONSES

What health and wellness issues do you care about? Please select all.
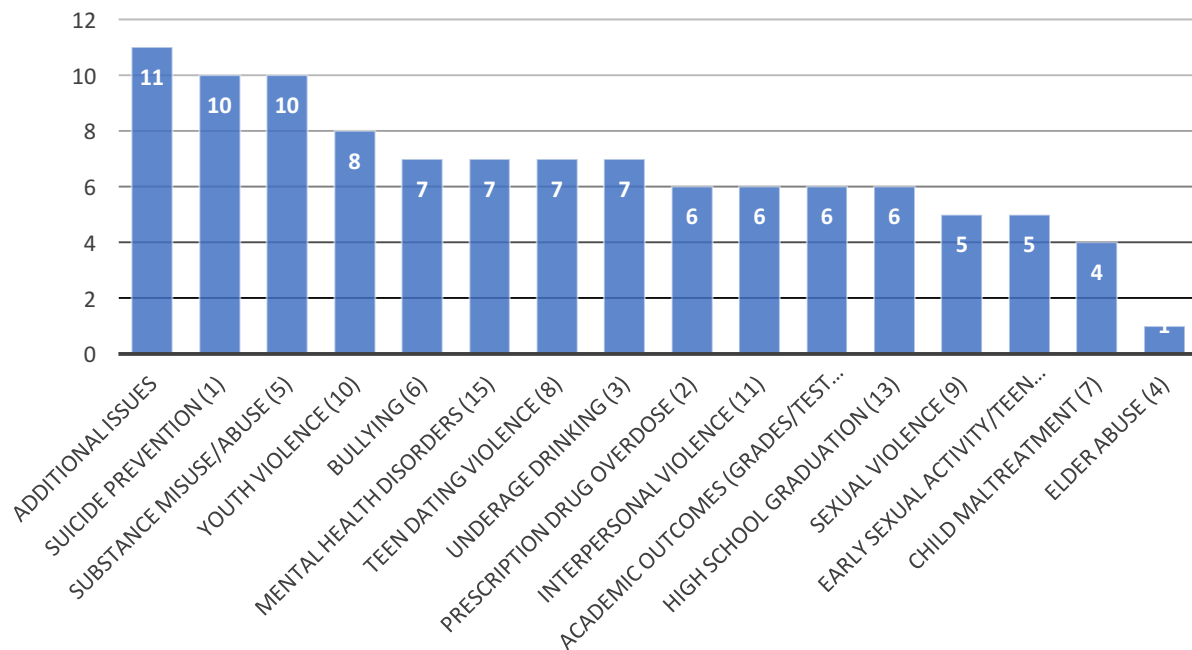
ADDITIONAL HEALTH AND WELLNESS ISSUES:

- Historical trauma
- Fall prevention
- Physical health
- School safety
- Social and emotional outcomes
- Health equity
- Food security
- Addiction
- Access to healthcare
- Healthy relationships

- Unintentional injuries
- Youth
- Drowning
- Motor vehicle crashes
- Tobacco use
- Alcohol use
- Diet
- Student connectedness
- Bicycle and pedestrian

In your experience, what big-picture risk and protective factors contribute to each health and wellness issue you checked above? (open-ended)

Factors mentioned more than once:

- Connectedness
- Community
- Positive school climate
- Afterschool programs
- Meaningful roles
- Caring adults
- ACEs
- Intergenerational trauma
- Mental health
- Physical health

- Family
- Racism
- Economic stability
- Housing
- Access to care
- Substance use
- Interpersonal violence
- Poverty
- Employment
- Social and behavioral norms

What datasets, resources, or literature reviews are you familiar with that would help inform this initiative? (open-ended)

Mentioned more than once:

- Alaska's School Climate and Connectedness Survey (SCCS)
- Youth Risk Behavior Survey (YRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- CDC
- Trauma Registry
- Many others

Who is missing from this group? (open-ended)

- Individuals with contact information were invited to the following workgroup meeting.
- Additional representation:
    - Rural
    - Tribal

- o Minority
- o Alaska Children's Trust
- o Covenant House
- o Elected Officials
- o The University

For you, what would success of this initiative look like in 6 weeks, and also over the next couple years? (open-ended)

Summary of responses:

- Protective factors and root causes rather than risk behaviors
- Encourage collaboration, partnerships
- List/matrix/visual of protective and risk factors
    - o Includes agreed definitions, measures, data sources
- Evidenced-based, best practices
- Identify gaps in measures, data collection
- List of funding opportunities
- Targets, goals, and outcomes
- Findings inform statewide plans, funding opportunities, data collection, departmental structure

Based on the discussion in the first workgroup meeting and the questionnaire feedback, desired goals were further defined. The group will aim to create a model, tool, or process for collaboration and funding application and distribution. The tool will be able to be replicated, and a visually appealing option will be considered in addition to a matrix. Through this process, this workgroup will create an inventory of existing definitions to use as a crosswalk, rather than create definitions through consensus. Acknowledging that each workgroup member has their own priority issue, the group decided not to prioritize issues. The group also recognized they will not cover every public and behavioral health issue in this 6-week project, but rather identify opportunities and gaps to be addressed through future work.

APPENDIX 6: 2018 SCHOOL CLIMATE AND CONNECTEDNESS SURVEY©

Student surveys (3-5 & 6-12) Staff surveys, and Family Surveys

2018 School Climate and Connectedness Survey© SCCS© Topic Definitions
STUDENT GRADE 6- 12 SURVEY
Background Information
● What grade are you in?
● Are you a Male Female?
● Which group describes you best?
● Is there a language other than English spoken in your home?
● What grades do you usually get?
● During the past year, how many days did you miss (skip) school without permission?

School Safety: Reflects student and staff perceptions of bullies and gangs at school, as well as community crime and violence that affect school life.
● I am safe at school.
● This school is being ruined by bullies   (reverse-scored)
●This school is badly affected by crime and violence in the community (reverse-scored)

Family and Community Involvement: Reflects perceptions of families' and community members' degree of involvement in their school.
● This school is a welcoming place for families like mine.
● Adults in my community know what goes on inside schools.
● Adults in my community support this school.
● Lots of parents come to events at my school.
●This school does not involve parents in most school events or activities. (reverse-scored)

Student Involvement: Reflects student and staff perceptions of student participation in school governance.
● In my school, students are given a chance to help make decisions.
● Students are involved in helping to solve school problems.
● The principal asks students about their ideas.

High Expectations: Reflects student perceptions of their own academic expectations as well as those of adults in their school and community.
● I try hard to do well in school.
● At this school, students are encouraged to work to the best of their abilities.
● I want very much to get more education after high school.
● Adults in my community encourage me to take school seriously.
● Teachers and other adults at this school believe that all students can do good work.
● I have given up on school. (reverse-scored)

2018 School Climate and Connectedness Survey© SCCS© Topic Definitions

Caring Adults: Reflects students' perceptions of their closeness to adults in the school.
● There is at least one adult at this school whom I feel comfortable talking to about things that are bothering me.
● At school, there is a teacher or some other adult who will miss me when I'm absent.
● There are a lot of chances for students in my school to talk with teachers one-on-one.
● I can name at least five adults who really care about me.
● Other adults at school besides my teachers know my name.

Peer Climate: Reflects students' perceptions of how respectful and helpful students are to one another.
● Students in this school help each other, even if they are not friends.
● Students in this school treat each other with respect.
● When students see another student being picked on, they try to stop it.
● Students at this school are often teased or picked on. (reverse-scored)
● Most students in this school like to put others down. (reverse-scored)

Respectful Climate: Reflects student perceptions of the fairness of rules and the respectful relationships between students and staff.
● My teachers treat me with respect.
● When students break rules, they are treated fairly.
● My teachers are fair.
● Our school rules are fair.

Community Support: Reflects the extent to which students are involved in their communities, and the extent to which students feel supported by their communities.
● During an average week, how much time do you spend helping other people without getting paid? (Examples: helping elders or neighbors; watching younger children; peer teaching, tutoring, mentoring; helping the environment or doing other volunteer activities)
● During an average week, how much time do you spend participating in organized activities after school or on weekends? (Examples: sports, clubs, youth groups, music/art/dance/drama activities, cultural, religious or other community activities)
● Outside of school and home, I know at least one adult who encourages me to do my best.
● Outside of school and home, I know at least one adult I can talk to, if I have a problem.
● Do you have someone outside of school who can help you with your homework?

Cultural Connectedness: Reflects perceptions of cultural identity, cultural responsiveness/sensitivity, and instructional equity.
● I have a strong sense of belonging to my culture.
● In general, my culture is an important part of my self - image.
● My school teaches about the history and culture of people who live in my community.
● My school values the language and culture of my family.
● My teachers make an effort to represent my culture in class lessons.
● I see my family's culture represented in class lessons, posters, and art around the school, etc.

2018 School Climate and Connectedness Survey© SCCS© Topic Definitions

Social and Emotional Learning (SEL) Students rated how easy or difficult it is for them to use SEL skills in self-awareness, social awareness, self-management, relationship skills, and good decision making. (response options were Very Easy, Easy, Difficult, Very Difficult
● Knowing the emotions I feel.
● Knowing ways I calm myself down.
● Knowing what my strengths are.
● Knowing when my feelings are making it hard for me to focus.
● Being patient even when I am really excited.
● Finishing tasks even if they are hard for me.
● Setting goals for myself.
● Doing schoolwork even when I do not feel like it.
● Being prepared for tests.
● Getting through something even when I feel frustrated.
● Learning from people with different opinions than me.
● Knowing what people may be feeling by the look on their face.
● Knowing when someone needs help.

● Respecting a classmate's opinions during a disagreement.
● Getting along with my classmates.
● Thinking about what might happen before making a decision.
● Knowing what is right or wrong.

Student Delinquent Behaviors: Students and staff reported how often they observed students engage in delinquent behaviors at school and at school events within the past 12 months. Lower scores are better because they reflect fewer instances of observed risk behaviors.
● Destroy things (such as school property, or other people's personal items)
● Get into fights with other students
● Steal things (such as taking things from the school or other people)
● Threaten or bully other students
● Carry weapons (such as knives or guns)

Student Drug and Alcohol Use: Students and staff reported often they observed students engage in drug and alcohol use at school or school events within the past 12 months. Lower scores are better because they reflect fewer instances of observed risk behavior.
● Under the influence of drugs (such as meth, heroin, cocaine, etc.)
● Under the influence of marijuana
● Under the influence of alcohol (such as beer, wine, liquor, such as vodka or whiskey, etc.)

2018 School Climate and Connectedness Survey© SCCS© Topic Definitions

STAFF SURVEY
Background Information
● What is your role in this school?
● How many years have you worked, in any position, in this school?
● How many years have you worked, in any position, in this district?
● What is your gender?
● Which groups describe you best?

School Safety: Reflects student and staff perceptions of bullies and gangs at school, as well as community crime and violence that affect school life.
● I feel safe at my school.
● This school is being ruined by bullies . (reverse-scored)
●This school is badly affected by crime and violence in the community. (reverse-scored)

Staff Attitudes: Reflects staff perceptions of the competence of teachers and of teachers' attitudes toward their work.
● The teachers at this school are good at their jobs.
● Teachers here set high standards for themselves.
● In this school, staff members have a "can do" attitude.
● Teachers and staff in this school believe that all students can do good work.
● Teachers here are nice people.

School Leadership and Involvement: Staff perceptions of the decision making of school leaders, as well as the fairness of school rules.
● At school, decisions are made based on what is best for students.
● I trust the principal will keep his or her word.
● The principal and other leaders in this school make good decisions.
● The principal looks out for the personal welfare of school staff members.
● I am satisfied with my involvement with decision-making at this school.
● When students break rules, they are treated fairly.

● School staff members have a lot of informal opportunities to influence what happens here.
● The work rules at this school are fair.

Peer Climate: Reflects staff perceptions of how respectful and helpful students are to one another, and towards their teachers. (In years past, this scale was called Respectful Climate).
● At this school, students and teachers get along really well.
● Students in this school help each other, even if they are not friends.
● Teachers and students treat each other with respect in this school.
● Students in this school treat each other with respect.
● The students in this school don't really care about each other. (reverse-scored)

Family and Community Involvement: Reflects perceptions of families' and community members' degree of involvement in their school.
● The school is a welcoming place for families.
● Adults in the community support this school.
● Lots of parents come to events at this school.
● Adults in the community encourage youth to take school seriously.
● Adults in the community know what goes on inside of schools.
●This school does not involve parents in most school events or activities. (reverse-scored)
● At this school it is difficult to overcome the cultural barriers between teachers and parents. (reverse-scored)

Student Involvement: Reflects student and staff perceptions of student participation in school governance.
● In this school, students are given a chance to help make decisions.
● Students are involved in helping to solve school problems.
● The principal asks students about their ideas.

Cultural Connectedness: Reflects students and staff perceptions of cultural identity, cultural responsiveness/sensitivity, and instructional equity.
● Students in my school have a strong sense of belonging to their culture.
● In general, my culture is an important part of my self - image.
● This school values the language and cultures of students' families.
● This school prioritizes closing the racial/ethnic achievement gap.
● This school uses instructional materials that reflect the culture or ethnicity of its students.

Student Delinquent Behaviors: Staff were asked to report how often they observed students engage in delinquent behaviors at school and at school events within the past 12 months. Lower scores are better because they reflect fewer instances of observed risk behaviors.
● Destroy things (such as school property, or people's personal items)
● Get into fights with other students
● Steal things (such as taking things from the school or other people)
● Threaten or bully students
● Carry weapons (such as knives or guns)

Student Drug and Alcohol Use: Staff were asked to report how often they observed students engage in drug and alcohol use at school or school events within the past 12 months. Lower scores are better because they reflect fewer instances of observed risk behavior.
● Under the influence of drugs (such as meth, heroin, cocaine, etc.)
● Under the influence of marijuana
● Under the influence of alcohol (such as beer, wine, liquor, such as vodka or whiskey, etc.)

2018 School Climate and Connectedness Survey© SCCS© Topic Definitions

GRADE 3-5 STUDENT SURVEY
Background Information
● What grade are you in?
● Are you a __ Boy __Girl?
● Which groups describe you best?
● Is there a language other than English spoken in your home?

Response Options for the below statements were Yes, Sometimes, No.

Caring Others: Reflects the level of caring and support that students received from peers, staff, and community members at school.
● Students in this school help each other, even if they are not friends.
● Students here treat me with respect.
● When students see another student being picked on, they try to stop it.
● At this school, students are encouraged to do their very best.
● The adults at this school believe that all students can do good work.
● Adults in my community let me know that school is important.
● There is an adult at this school who I can talk to about things that are bothering me.
● At school, there is a teacher or some other adult who will miss me when I'm absent.
● There are lots of chances for students in my school to talk with teachers one-on-one.
● I can name at least five adults who really care about me.
● At school, other adults besides my teachers know my name.

Social and Emotional Learning (SEL): Students marked how often they use SEL skills in self-awareness, social awareness, self-management, relationship skills, and good decision-making.
● I try hard to do well in school.
● If someone asks me I can tell them how I am feeling.
● I know what kinds of work I need help with to be successful.
● I ask for help from my teachers or others when I need it.
● I am careful when I use something that belongs to someone else.
● I can control myself when I am frustrated, or disappointed.
● I can explain why it is important to tell the truth.
● If something is bothering me, I think of different ways I can react.
● I set goals and then work to reach them.
● I care about other people's feelings and what they think.
● It is important for me to help others in my school.
● I respect people even if they are different.
● I can tell when someone is getting angry or upset before they say anything.
● I know how to disagree without starting a fight or an argument.
● I get along well with other students.
● I know how to make friends with new people.

Other Questions
● I feel safe at school.
● I think other students would like going to my school.

FAMILY SURVEY
Background Information
● What is your gender?
● What is your age?
● What groups describe you best?
● Please describe your relationship to the child attending this school
● How many children in your household are currently attending this school?

- Please indicate which grade your child is in.
- What is your child's gender?
- Which groups describe your child best?
- Do you speak a language other than English with your child?

Communication: Reflects the way families communicate with the school, and the ways that families would like the school to communicate with them.
- How often do you use each of these sources to get information about your school?
    - O District or School Website
    - O Social Media (ex. Facebook)
    - O Newsletter
    - O Text messages
    - O Email
    - O Newspaper
    - O School Activity Calendar
    - O Notes sent home from school
    - O Conversations with school staff
    - O Conversations with other parents
    - O Conversations with your child

- How would you like the school to communicate with you?
    - o District or School Website
    - o Social Media (ex. Facebook)
    - o School Newsletter
    - o School Activity Calendar
    - o Text messages
    - o Email
    - o Notes sent home from school
    - o Conversations with school staff
    - o Other

Cultural Connectedness: Reflects perceptions of cultural identity, cultural responsiveness/sensitivity, and instructional equity.
- This school values the language and culture of my family.
- This school teachers about the history and the culture of people who live in my community.
- I see my family's culture represented in class lessons, materials, posters, and art around the school, etc.
- My child's teacher makes an effort to represent my family's culture in class lessons.

Family and Community Involvement: Perceptions of families' and community members' degree of involvement in their child's school.
- This school is a welcoming place for families like mine.
- Adults in the community support this school.
- Adults in the community know what goes on inside of schools
- Adults in the community encourage youth to take school seriously.
- This school values and welcomes elders.

School Communication with Families: Reflects families' perceptions of how the school communicates with them. Perceptions on how often the school reaches out to them.

How often does your child's school…
    - O Seek your guidance on how to help your child do well in school?
    - OShare ideas on what you can do at home to support your child's learning?
    - O Reach out to you to tell you how your child is doing?
    - O Ask you to volunteer at school events

Student Support at Home: Reflects families' perceptions on how supportive they are of their child's education.
● How often do you...
        O Help your child with school work?
        O Make sure your child has a designated time and space to do school work?
        O Have conversations with your child about what they are learning at school?
        O Have conversations with your child about career or college preparation?

Family Engagement at School: Reflects families' perceptions of how involved they are at their child's school.
● How often do you meet in person with teachers at your child's school?
● How often do you go to events at your child's school during the school year?
● How often have you helped out at your child's school during the school year?
● How often do you participate in decision-making at school?
Opportunities for Involvement at School
● What would help you to be more involved in your child's school?
        o Addressing childcare needs
        o Transportation to school
        o Timing of meetings
        o Food provided at meetings
        o Strong relationships with school staff
        o Feeling welcomed by school staff
        o Clear roles for school involvement
        o Personal Invitation
        o More involvement by school staff within the community
        o Other