

YOUTH HEALTH RISK BEHAVIORS

*How Rhode Island
Schools Can Use
Survey Data to Create a
Healthy Environment
for Students*

2005 Update

The Rhode Island Department of Health and the Rhode Island Department of Education have updated the 2004 publication Youth Health Risk Behaviors: How Rhode Island Schools Can Use Survey Data to Create a Healthy School Environment for Students. We are pleased to present this update to Rhode Island school staff and administrators.

These updates reflect findings from the 2005 Youth Risk Behavior Survey (YRBS), along with key School Accountability for Learning and Teaching (SALT) student survey data. The updates highlight recent trends in health risk behaviors among Rhode Island high school students in Physical Activity and Nutrition, Sexual Activity, Alcohol and Other Drugs, Tobacco Use, and Injury and include suggestions for best practices and questions to stimulate further discussion within the school community.

Using Data in Local Decision-Making

Research shows that data-driven decision-making leads to improved student outcomes. Data-driven decision-making is the process of collecting, analyzing, and interpreting meaningful school improvement data and using it to guide decisions about curriculum, instruction, teacher training, and resource allocation to make a positive impact on student learning. Data must be aligned and tied to student performance goals at the classroom, school, and district level.

The combined state and school level data presented in these updates can help school leaders assess a myriad of student, family, and community health needs. The data help to paint a broad picture of the school community, and can be used to initiate discussions about health concerns locally.

*“Our job was
to do for all children
what we did for our own
—no excuses.”
Patrick Cooper 2005,
Superintendent of Schools,
Mc Comb School District,
Mississippi.*



“School success and academic achievement are built on a strong foundation of healthy students who learn in safe and caring school environments.”

Rhode Island Department of Education, 1997

thrive is Rhode Island’s Coordinated School Health Program. Developed in 1994 with funding from the Centers for Disease Control and Prevention (CDC), **thrive** was designed to prevent serious health problems and improve educational outcomes. According to the CDC, *schools by themselves cannot—and should not be expected to—address the nation’s most serious health and social problems.* As partners in **thrive**, the Rhode Island Departments of Education and Health work to build infrastructure supports with state, school, and community partners to help create safe, healthy, and nurturing schools that reduce barriers to learning.

The nine interactive components of **thrive** include: health education; physical education and activity; health services; nutrition services; guidance counseling and social services; school environment; school climate; health promotion for school staff; and family and community involvement. Through these interactive components, **thrive** hopes to achieve:

- » Safe, healthy, and nurturing schools for students, families, and communities;
- » Effective leadership and partnerships at the state and local levels; and
- » Evident health and academic success for all.

For more information about **thrive**, contact Midge Sabatini at Margaret.Sabatini@ride.ri.gov or Rosemary Reilly-Chammat at Rosemary.Reilly-Chammat@health.ri.gov.



Building Capacity for Data-Driven Decision-Making: Lessons learned from the literature

- » School improvement is multi-dimensional and includes and transcends instruction.
- » Leadership is critical for system wide implementation of data-driven decision-making as a means to school improvement.
- » Administrative organizational structures that are supported by school boards play a key role in the system wide use of data-driven decision-making.
- » Data summaries in key school improvement areas are a useful way of sharing school-based information with a variety of key school community constituents.
- » School districts must build the staff’s technology capacity at the classroom, school, and district levels. School leaders must work collaboratively to examine data to determine school improvement goals and monitor progress towards the goals.
- » Data on key indicators for student academic success, such as motivational readiness and ability to learn, are critical for effective School Improvement Plans. Students can become disengaged and alienated without a learning support system and improvement in instruction.

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PHYSICAL ACTIVITY AND NUTRITION



Lack of physical activity and poor nutrition contribute to overweight and obesity among Rhode Island students. Overweight and obesity are associated with significant health risks, higher rates of absenteeism, lower test scores, and social and emotional problems.

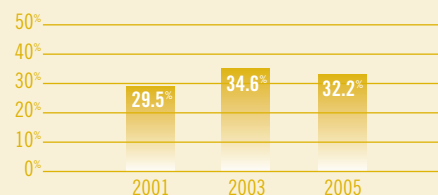
Results from the 2005 Youth Risk Behavior Survey (YRBS) show improvement in some risk factors for overweight and obesity among Rhode Island students, such as the amount of time children are physically active during physical education class.

However, about one-third of students continue to report insufficient moderate and vigorous physical activity on a weekly basis (see Graph 1), with female students getting less physical activity than male students. There has also been a decrease in consumption of the recommended servings of fruit, vegetables, and milk (see Graph 2).

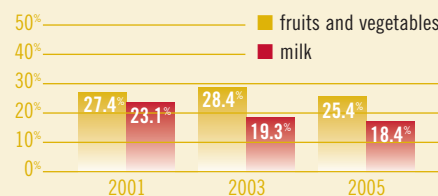
Data from the 2005–2006 School Accountability for Learning and Teaching (SALT) survey on television, computer, and video game use also reflect a lack of physical activity among students, with many students watching 2–4 or more hours of television after school (see Graph 3). A majority of students also report playing computer and video games before or after school, particularly at the elementary and middle school levels (see Graph 4).

Further, researchers at the Center for Weight and Health at the University of California at Berkeley concluded that overweight children and adolescents are more likely to consume a few large meals per day rather than smaller, more frequent meals and are more likely to skip breakfast. SALT data show that the percentage of students who eat breakfast decreases with age (see Graph 5).

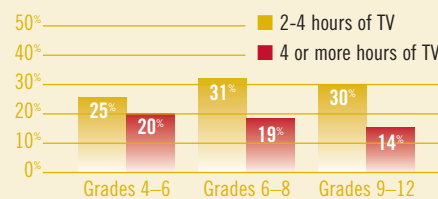
GRAPH 1: Percent of students with insufficient moderate and vigorous physical activity in the past week, 2001–2005 (YRBS).



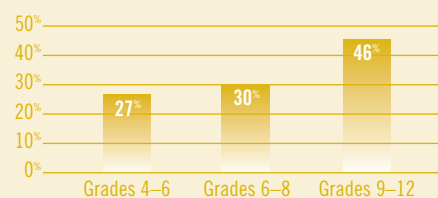
GRAPH 2: Percent of students who ate 5 or more servings of fruits and vegetables, or drank 3 or more glasses of milk per day in the past week, 2001–2005 (YRBS).



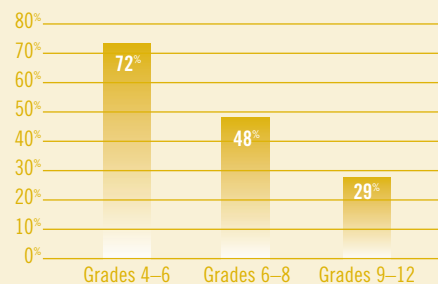
GRAPH 3: Percent of students watching television before or after school on an average day, 2005–2006 (SALT).



GRAPH 4: Percent of students who do not play computer/video games before or after school on an average day, 2005–2006 (SALT).



GRAPH 5: Percent of students who report eating breakfast everyday, 2005–2006 (SALT).



WHAT SCHOOLS AND DISTRICTS CAN DO TO HELP PROMOTE PHYSICAL ACTIVITY AND GOOD NUTRITION

Schools can use a variety of approaches to help reduce the risk of overweight and obesity for their students to improve students' health and academic performance.

Discussion Questions

District and school leaders can use the following questions to start a conversation in the school community about ways to promote physical activity and good nutrition.

1. How do students in our school or district compare to the rest of the state?
2. Are students getting enough physical activity and good nutrition during the school day?
3. How are overweight and obesity affecting students' ability to learn, their self-esteem, and the school culture?
4. Are our physical activity and nutrition policies properly implemented, enforced, and communicated to the school community?
5. Are the messages we give students about nutrition in the cafeteria or hallways the same as those we give in the classroom?
6. Are our physical education and nutrition education programs aligned with state standards?
7. Are there other ways students could be active during the school day?
8. Are there ways we could support families in increasing physical activity and good nutrition?
9. What can we do to make our staff better role models?
10. What are our goals around physical activity, nutrition, and obesity and how can we achieve them?

Best Practices

Below is a list of best practices—policies, activities, or programs to reduce overweight and obesity—that other schools have implemented successfully.

- » Implement a daily, high-quality physical education program for all students throughout the school year and do not allow exemptions from physical education for participation in other activities (e.g., interscholastic sports, band, chorus, academic classes).
- » Offer a variety of interscholastic athletics, intramural activities, and non-competitive physical activity clubs for all students, with no fees or fees that are waived for any student who cannot afford to pay.
- » Provide skills-focused nutrition education as part of a comprehensive K–12 health education curriculum.
- » Promote healthy eating with strategies that reduce the prices of nutritious food and beverage choices sold to students and increase the prices of less nutritious choices.
- » Collect suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating.
- » Provide students with information on the nutrition and caloric content of available foods.
- » Conduct taste tests with students to determine food preferences for nutritious items.
- » Provide information to students about nutrition, food marketing, and food safety, and promote the school meal program by having students visit the cafeteria.
- » Include physical activity and nutrition education in after-school programming.

“School can be a powerful catalyst for change when it comes to preventing and reducing overweight and obesity.”

David Satcher, MD, former U.S. Surgeon General, 2005

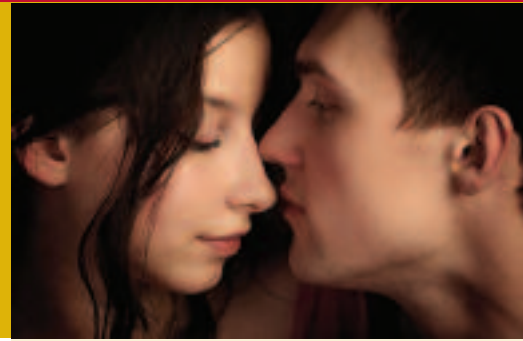
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For additional ideas, visit www.thriveri.org/issues/physical_activity or www.thriveri.org/issues/nutrition.

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SEXUAL ACTIVITY



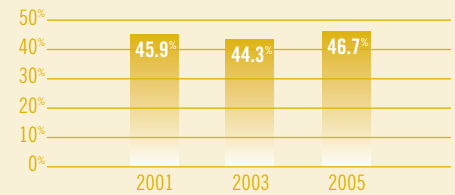
Sexual intercourse, particularly without the use of a condom, among adolescents and young adults contributes to their risk for unintended pregnancy, HIV/AIDS, and other sexually transmitted diseases. These consequences can negatively affect the short- and long-term health and academic performance of Rhode Island students.

Data from the 2005 Youth Risk Behavior Survey (YRBS) show a small but continued increase in the percent of students who reported ever having had sexual intercourse (see Graph 1).

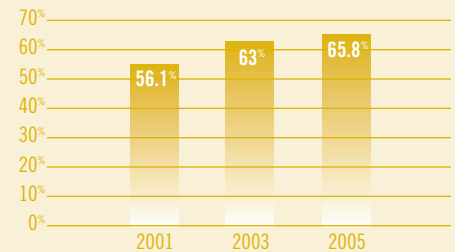
While the percent of sexually active students reporting condom use again increased, the rate remains at less than two-thirds (see Graph 2).

Sexual activity is best addressed by using a multi-pronged approach that meets the developmental needs of students, including boundaries, constructive use of time, and commitment to learning. After school activities connect students with caring adults and keep them safe and constructively occupied in the after school and summer hours. The School Accountability for Learning and Teaching (SALT) data from 2005–2006 do not reveal significant changes in the percent of high school students who are unsupervised for three or more hours on three or more days a week. Likewise, the 2005 YRBS rates of sexual activity among high school students also remained similar to the 2003 data. While not conclusive, the new data continue to suggest a possible correlation between lack of supervision and sexual activity (see Graph 3). Schools should continue to consider this relationship when developing programs to reduce sexual risk behavior.

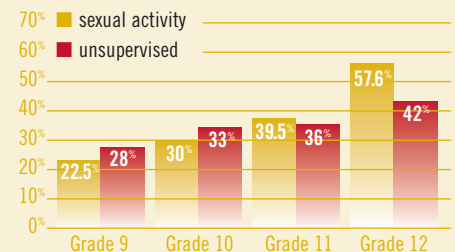
GRAPH 1: Percent of students who have ever had sexual intercourse, 2001–2005 (YRBS).



GRAPH 2: Percent of students who had sexual intercourse during the past 3 months who used a condom the last time they had sex, 2001–2005 (YRBS).



GRAPH 3: Percent of high-school students who had sexual intercourse during the past 3 months, 2005 (YRBS) and percent of high-school students who are unsupervised 3 or more days per week for more than 3 hours per occasion, 2005–2006 (SALT).



WHAT SCHOOLS AND DISTRICTS CAN DO TO PREVENT AND REDUCE SEXUAL ACTIVITY

There are many strategies for schools to help reduce sexual risk behavior and ultimately improve students' health and academic success. In the family life and sexuality education component of Rhode Island's Mandated Health Instructional Outcomes, the curricula should include the responsibilities of family membership and adulthood, including issues related to reproduction, abstinence, dating, marriage, and parenthood, as well as information about sexually transmitted diseases, sexuality, and lifestyles.

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Discussion Questions

District and school leaders can use the following questions to start a conversation in the school community about how to promote students' sexual health.

1. How do students in our school or district compare to the rest of the state?
2. How can we improve our health education, including family life and sexuality education?
3. How can we provide more appealing and enriching after school opportunities for our students in the school and in the community?
4. How can we better make use of technical assistance and professional development opportunities provided by the Rhode Island Department of Education on standards based HIV/STD instruction?
5. How can we make school and classroom climates that are more nurturing and supportive and that better connect students with caring adults?
6. How can we support parents in their efforts to communicate with and set limits for their children?
7. What are our goals around preventing and reducing sexual activity and how can we achieve them?

Best Practices

Below is a list of best practices—policies, activities, or programs to reduce sexual risk behavior—available to Rhode Island schools.

- » Create school-based health centers (SBHCs) and school-linked services. There are currently eight SBHCs in Rhode Island. SBHCs:
 - ~ Provide clinical primary and behavioral health care services.
 - ~ Provide students with information on human sexuality with an emphasis on the health and psychosocial benefits of abstinence, and HIV screening and treatment.
 - ~ Refer students to community health centers for additional care, education, and counseling; access to contraceptives including condoms; and referrals to other health services.
- » Promote HIV/AIDS training and professional development in sexuality education for school teachers. The Rhode Island Department of Education, in collaboration with the Rhode Island Department of Health, provides internet-based training to interested Rhode Island teachers.
- » Encourage parents to participate in *Can We Talk?*, a Rhode Island program that helps parents talk with their kids about puberty and sexuality, alcohol and drugs, bullying, and harassment. There is also a web-based *Can We Talk?* professional development program for Rhode Island educators.
- » Promote ParentLinkRI (www.ParentLinkRI.org), a web-based resource for parents of teens and preteens that promotes youth development and offers parents strategies to help their youth abstain from sexual risk-taking behaviors.

For additional ideas, visit www.thriveri.org/issues/hiv.html#schools.
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ALCOHOL AND OTHER DRUGS



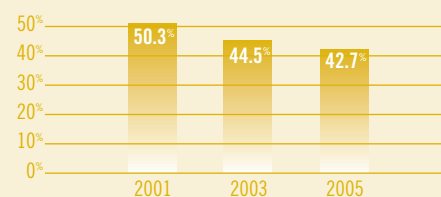
Alcohol abuse is associated with motor vehicle crashes, homicides, suicides, and drowning—the leading causes of death among youth. Alcohol and illicit drug use can also increase students' risk for school failure, sexually transmitted diseases, and unintended pregnancy.

Based on Youth Risk Behavior Survey (YRBS) data from 2005, students' use of alcohol and marijuana has continued to decline. However, more than 4 out of 10 high school students still report using alcohol, and 1 out of 4 report using marijuana.

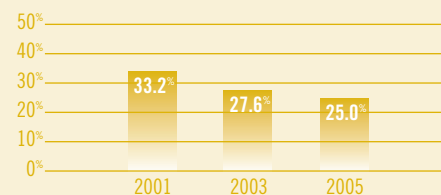
The percentage of students who had at least one drink of alcohol on one or more of the last thirty days has decreased from 50.3% in 2001 to 42.7% in 2005 (see Graph 1). The percentage of students who used marijuana one or more times in the past thirty days has also decreased from a high of 33.2% in 2001 to 25% in 2005 (see Graph 2).

Data from the 2005–2006 School Accountability for Learning and Teaching (SALT) survey show that 44% of Rhode Island high school students used alcohol at least once in the past thirty days, and 28% of high school students reported using illegal drugs (see Graph 3). For Rhode Island middle schools, 19% of students reported drinking alcohol at least once, and 9% reported they used illegal drugs.

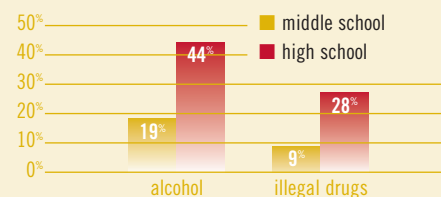
GRAPH 1: Percent of students who had at least one drink of alcohol one or more times in the last 30 days, 2001–2005 (YRBS).



GRAPH 2: Percent of students who used marijuana one or more times in the last 30 days, 2001–2005 (YRBS).



GRAPH 3: Percent of middle school and high school students who used alcohol at least once, or used illegal drugs, in the past 30 days, 2005–2006 (SALT).



WHAT SCHOOLS AND DISTRICTS CAN DO TO PREVENT AND REDUCE STUDENTS' USE OF ALCOHOL AND OTHER DRUGS

Schools and districts can use a variety of strategies to prevent and reduce students' use of alcohol and other drugs, and avoid the negative effects on school performance and health.

Discussion Questions

District and school leaders can use the following questions to start a conversation in the school community about ways to prevent substance abuse.

1. How do students' overall substance abuse rates in our school or district compare to the rest of the state?
2. How do these rates correlate with what we as administrators, teachers, and nurses see in the student body?
3. Is substance abuse a key discipline or attendance issue in this school or district?
4. How strong are our substance abuse policies? Are these policies properly implemented, enforced, and communicated to the school community?
5. How can we better educate our students and staff on substance abuse prevention?
6. How can we improve our substance abuse prevention services for students and employee assistance programs for staff?
7. How can we better educate families about substance abuse and inform them about community resources for students?
8. What are our goals around substance abuse prevention and how can we achieve them?

Best Practices

Below is a list of best practices—ideas, activities, or programs to reduce alcohol and other drug use—that Rhode Island schools can apply.

- » Engage your Rhode Island community based substance abuse prevention task force to ensure that effective prevention interventions are implemented locally at the individual, peer, family, school, and community levels.
- » Enforce the substance abuse school policies consistently.
- » Use comprehensive substance abuse prevention curricula that are planned, sequential, skill-based, and evidence-based in all grades.
- » Make information about substance abuse prevention available to students and staff in each building in the school district.
- » Promote the district's Employee Assistance Program (EAP).
- » Offer learning opportunities for parents on adolescent development as it relates to alcohol and other drug use, in coordination with Student Assistance Counselors.
- » Encourage parents to participate in *Can We Talk?*, a Rhode Island program that helps parents talk with their kids about puberty and sexuality, alcohol and drugs, bullying, and harassment. There is also a web-based *Can We Talk?* professional development program for Rhode Island educators.
- » Put protocols in place that ensure every student is connected with a caring school adult mentor.
- » *Project ALERT* is a drug prevention curriculum for middle-school students (11–14 years old), which dramatically reduces both the onset and regular use of substances.
- » *Project Northland* is a multi-level, multi-year program designed for sixth to eighth grade students (10–14 years old) proven to delay the age at which young people begin drinking, reduce alcohol use among those who have already tried drinking, and limit the number of alcohol-related problems of young drinkers.

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For additional ideas, visit www.mhrh.ri.gov/substance_abuse.htm.
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TOBACCO USE



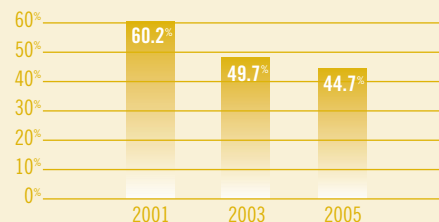
As the number one preventable cause of death in the United States, tobacco use not only puts Rhode Island students at risk for heart disease, stroke, and lung diseases later in life, but also affects them now. Tobacco use can lead to and exacerbate asthma, a significant cause of absenteeism, and has also been linked to use of alcohol and other drugs. Exposure to secondhand smoke is also a health risk for non-smoking students.

Following decreasing trends in tobacco use in previous years, 2005 Youth Risk Behavior Survey (YRBS) data shows a continued drop in the percentage of students who have ever tried smoking (see Graph 1), who smoked cigarettes on one or more of the past thirty days (see Graph 3), and who smoked cigarettes on twenty or

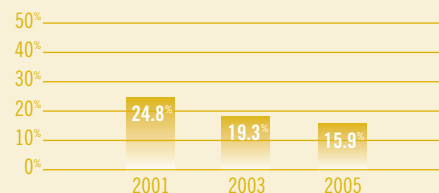
more of the past thirty days (see Graph 3). The percentage of students who have smoked on school property within the past thirty days has also declined (see Graph 4). In addition, about half (51.5%) of current smokers have tried to quit during the past twelve months (YRBS 2005).

Data from the 2004–2005 School Accountability for Learning and Teaching (SALT) survey show the number of tobacco related suspensions in Rhode Island schools (see Graph 5). The rates of in school and out of school suspensions are particularly high for high school students. These results will be useful for tracking changes in tobacco use in the future, as well as its effects on school performance and behavior. The National Association of State Boards of Education recommends promoting education and cessation and limiting punitive sanctions for tobacco use.

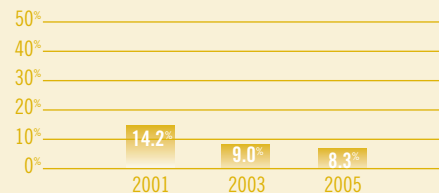
GRAPH 1: Percent of students who ever tried cigarette smoking, 2001–2005 (YRBS).



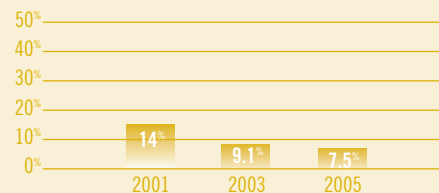
GRAPH 2: Percent of students who smoked cigarettes on one or more of the past 30 days, 2001–2005 (YRBS).



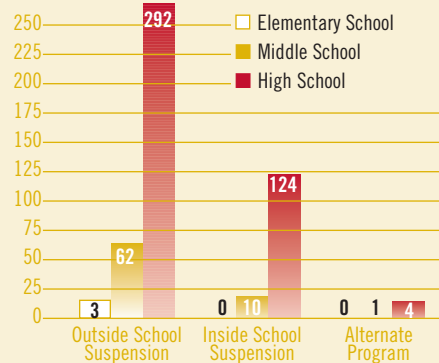
GRAPH 3: Percent of students who smoked cigarettes on 20 or more of the past 30 days, 2001–2005 (YRBS).



GRAPH 4: Percent of students who smoked cigarettes on school property one or more times in the past 30 days, 2001–2005 (YRBS).



GRAPH 5: Number of tobacco use or possession related suspensions statewide, 2004–2005 (SALT).



WHAT SCHOOLS AND DISTRICTS CAN DO TO PREVENT AND REDUCE STUDENTS' TOBACCO USE

Schools can adopt several policies, programs, and norms to help prevent and reduce students' tobacco use.

Discussion Questions

District and school leaders can use the following questions to start a conversation in the school community about ways to keep students tobacco free.

1. How do students' overall tobacco use rates in our school or district compare to the rest of the state?
2. How do these rates compare with what we as administrators, teachers, nurses, and student assistance counselors see in the student body?
3. Is tobacco a key discipline or attendance issue in our school or district?
4. How strong are our tobacco use policies? Are these policies properly implemented, enforced, and communicated to the school community?
5. How can we better educate our students and staff on tobacco use, prevention, and cessation?
6. Do we take part in tobacco events, such as Kick Butts Day or the Great American Smokeout?
7. How can we improve our tobacco cessation services to students and staff?
8. How can we better educate families about tobacco use and inform them about community resources around prevention and cessation?
9. What are our goals around tobacco use and how can we achieve them?

Best Practices

Below is a list of best practices—policies, activities, or programs to reduce tobacco use—that other schools have implemented successfully.

- » Develop and implement a tobacco-free school environment policy that bans all forms of tobacco use by students, staff, contract workers, and visitors in school buildings, on school grounds, in school vehicles, and at off-site school events, applicable 24 hours a day.
- » Enforce the tobacco-free school policy consistently.
- » Communicate the tobacco-free school policy to students, families, staff, and visitors through a variety of means, including handbooks, newsletters, and signs.
- » Make information about tobacco cessation available to students and staff in each building in the school district.
- » Implement planned, sequential, skill-based, and evidence-based tobacco prevention education in all grades.
- » Offer tobacco cessation programs to students and staff on a voluntary basis via the 1-800-TryToStop quitline or the www.trytostop.org interactive website.
- » Work with your school's student assistance counselor. Counselors have resources on tobacco prevention, intervention, and cessation strategies.

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For additional ideas, visit www.thriveri.org/issues/tobacco.html#bestpractices.
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INJURY



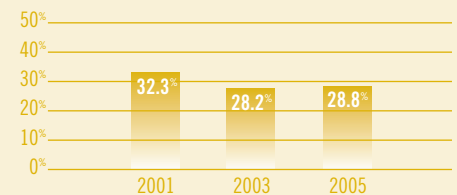
Injury is the leading cause of death for Rhode Islanders between 1–44 years old. Youth, particularly male youth, are at risk for injury or death from incidents, such as motor vehicle crashes, suicide and suicide attempts, homicide, assaults, and falls. For students, injuries can contribute to absenteeism, decrease academic performance, and lead to long-term disabilities and health problems.

According to 2005 Youth Risk Behavior Survey (YRBS) data, measures of injury prevention have not changed significantly in the past two years. While the new data do not indicate increasing trends in injury, violence, or mental health problems, they show a lack of recent progress. The percentages of students who in the past thirty days rode in a car with

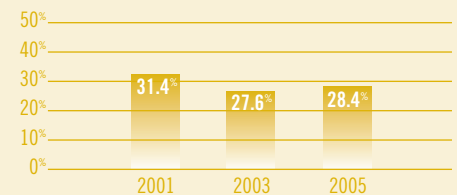
a driver who had been drinking and who were in physical fights during the past year increased slightly (see Graphs 1 and 2). The percentage of students who seriously considered attempting suicide during the past year remained about the same (see Graph 3).

Results from the 2005–2006 School Accountability for Learning and Teaching (SALT) survey provide insights to injury prevention based on Rhode Island students' experiences and perceptions of safety (see Graph 4). Rates of fear of violence, experience of violence, and feelings of safety in school vary among elementary, middle, and high school students. The percentages are higher of students who fear being hurt or bothered at school and who report feeling less safe at school than in the previous year, than are reports of actual experiences of violence. These data suggest that the effects of injury, such as from violence, reach beyond the students who are directly affected. It is important for students to be *and* feel safe in school.

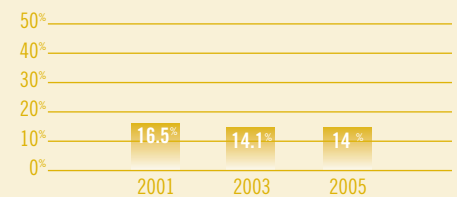
GRAPH 1: Percent of students in the past 30 days who rode in a car with a driver who had been drinking, 2001–2005 (YRBS).



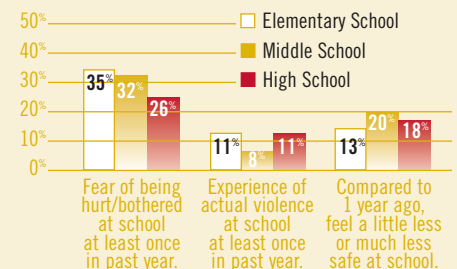
GRAPH 2: Percent of students who were in a physical fight during the past 12 months, 2001–2005 (YRBS).



GRAPH 3: Percent of students who seriously considered attempting suicide in the past 12 months, 2001–2005 (YRBS).



GRAPH 4: Rhode Island students' ratings of school safety, 2005–2006 (SALT).



WHAT SCHOOLS AND DISTRICTS CAN DO TO HELP PREVENT INJURY

Schools can use various approaches to help reduce the risk of injury and resulting health and academic consequences for their students.

Discussion Questions

District and school leaders can use the following questions to start a conversation in the school community about ways to prevent injury among their student population.

1. How do students' overall rates for injury, violence, and suicide attempts in our school or district compare to the rest of the state?
2. How do these rates compare with what we as administrators, teachers, and nurses see in the student body?
3. Is maintaining a safe physical environment an issue in our school or district?
4. Is violence a big discipline issue in our school or district?
5. How can we improve our behavioral health services for students?
6. How can we improve active supervision to promote safety in our school or district?
7. Do injury and violence interfere with attendance and students' ability to learn?
8. Do we have a written crisis response plan?
9. What are our goals around injury prevention and how can we achieve them?

Best Practices

Below is a list of model Rhode Island programs that schools can both learn from and implement to reduce risk behaviors that may lead to injury.

- » *The Student Assistance Program (SAP)* is a statewide school-based program that addresses risk factors for injury and violence with Masters-level counselors who provide a range of prevention and early intervention services.
- » *Westerly's Integrated Social Services Program* is a Child Opportunity Zone program that provides students and families with health, education, and community services in order to create a safe and nurturing environment conducive to learning.
- » *Life Skills Training (LST)* is an elementary and middle school program that seeks to modify major social and psychological factors that promote the initiation and early use of substances.
- » *Multisystemic Therapy (MST)* is a family-oriented, home-based program that targets chronically violent, substance-abusing juvenile offenders to promote positive social behavior and decrease antisocial behavior, including substance use.
- » *Strengthening Families Program I (SFP-I)* involves elementary school-aged children (6–12 years old) and their families in family skills training sessions. SFP-I uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems.
- » Put protocols in place that ensure every student is connected with a caring school adult mentor.

Recently passed legislation in Rhode Island:

Increased penalties for refusing to submit to a Breathalyzer test, and required annual reports from the Attorney General to identify cases involving impaired and drunk driving and Breathalyzer refusals.

Penalties to deter adults who knowingly provide alcohol to minors.

Enhancement to graduated driver licensing law, limiting cell phone use by youth less than 18 years while driving.

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For more information on model programs, visit www.colorado.edu/cspv/blueprints or www.modelprograms.samhsa.gov.
www.thriveri.org