



Making the Wise Investment

Statewide Needs Assessment of Primary Prevention
for Substance Abuse (SNAPS) Final Report

FEBRUARY 2018

About the Colorado Health Institute

The Colorado Health Institute, which conducted this needs assessment, is a nonprofit and independent health policy research organization that is a trusted source of objective health policy information, data and analysis for the state's health care leaders. The Colorado Health Institute is primarily funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

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EXECUTIVE SUMMARY

The spotlight is shining as never before on the growing problem of substance abuse, both in Colorado and across the nation.

Colorado's drug overdose death rate has doubled since 1999, driven in large part by opioids. That year, Colorado lost 108 people to an overdose involving some type of opioid – either a prescription pain reliever or heroin. In 2016, it was 504 people.¹

These statistics — along with equally alarming data about misuse of alcohol, marijuana, cocaine, and other illicit drugs, across all demographics and in all corners of the state — underlie the urgency to provide treatment for those already misusing substances.

Equally urgent is the need to prevent substance use in the first place so that Coloradans, particularly children and youth, have the opportunity to live healthy, substance-free lives.

Evidence shows that investing in substance use prevention has positive returns, both on the personal level and the community level. Preventing substance misuse and abuse will offer brighter futures for Coloradans and result in more resilient communities and a stronger economy.

Colorado is fortunate to have several funders and hundreds of programs that are working to promote substance use primary prevention. The Colorado Department of Human Services, Office of Behavioral Health (OBH) is one of the state's main funders of these efforts, work made possible with funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Yet some needs are going unmet, and funders are duplicating a number of efforts. OBH retained

the Colorado Health Institute (CHI) to conduct a statewide needs assessment of substance use primary prevention. The goal of the assessment is to help OBH and other statewide funders better use their resources to strengthen Colorado's substance use prevention programming.

This Statewide Needs Assessment of Primary Prevention for Substance Abuse (SNAPS) reveals that:

- **Colorado's communities** need help supporting kids both in school and in their families.
- **Local substance use prevention providers** need access to effective programs at the right time and the necessary training to deliver those programs.
- **Statewide substance use primary prevention funders** need to strengthen their coordination of existing efforts to reduce overlap and address unfunded needs.

There is an appetite to change how funders work together and to increase access to evidence-based programs and practices (EBPs) in prevention. OBH is taking this opportunity to bring together state-level actors and community experts to address prevention needs and to streamline existing efforts.

What CHI Found

CHI undertook a comprehensive study of Colorado's primary prevention landscape between June and December 2017 using several methods.

CHI, in partnership with OBH, convened an advisory group of statewide prevention funders and experts, conducted a survey of OBH's grantees, and analyzed existing prevention efforts. CHI staff convened 16 forums across Colorado to understand community needs, meeting with more than 200 people, including families, community prevention program administrators and experts.

CHI documented the many efforts that are already underway to keep youth healthy and to prevent early substance use. Dedicated community prevention practitioners are delivering hundreds of programs targeted to youth, their families and their communities.

For example, programs like LifeSkills Training are helping teens avoid substance use; approaches like Strengthening Families are promoting positive family relationships; and initiatives like Communities That Care are building substance use prevention coalitions at the community level.

CHI also created a first-of-its-kind financial map to trace the money that is funding primary prevention programs in the state. The map shows that \$32 million from federal and state sources is being administered by the state's main prevention funders — the Colorado Department of Human Services (CDHS) through its Office of Behavioral Health and Office of Children, Youth and Families (OCYF); the Colorado Department of Public Health and the Environment (CDPHE); and the Colorado Attorney General's Office.

While these resources for prevention programming are significant, the financial mapping also serves to reveal the need to better coordinate efforts among these funders.

Bottom line: The state has opportunities — and an urgent need — to strengthen its efforts on behalf of communities, prevention experts and their programs, and the statewide funding system. These are the primary findings from CHI's needs assessment.

Communities Need Help Supporting Youth Both in School and at Home.

Communities need prevention efforts that engage the whole family and change the way that community members view substance use. That “whole family” approach is in line with the “2Gen” work adopted by many funders, nonprofit organizations and state agencies in Colorado, including CDHS.

Many community members lamented that drug and alcohol use are increasingly being treated like a normal part of youth's lives. To counteract this troubling cultural shift, they called for increased focus on population-level programs known as environmental approaches. Examples of these approaches could include modifying local alcohol or tobacco practices by limiting hours of sale or store density, promoting anti-drug use policies in schools, changing social norms and undertaking marketing campaigns.

Community members also told us that parents often feel helpless to support their children because they don't know which prevention programs are available locally. And they said that it's important to understand the context of each community. Barriers such as program fees, lack of transportation, or even unsafe streets — whether from crime or low walkability — can prevent youth from joining after-school activities designed to reduce their risk for substance use.

The quantitative data reveal Colorado's highest areas of needs both geographically and by age. South central Colorado — Pueblo, Custer, Fremont and Lake counties — stands out across many indicators, including high rates of drug and alcohol use, easy access to substances, low protective factors such as having an adult to talk to, and high risk factors such as school dropout rates.

Young people moving between life stages have special needs for prevention, according to CHI's research. For example, young adults between the ages of 18 and 25 are the heaviest substance users. And survey data suggest that eighth, ninth and 10th graders are most likely to start using substances, providing an opportunity for early prevention efforts.



Local Substance Use Prevention Experts Need Access to the Right Programs at the Right Time and the Necessary Training to Deliver Those Programs.

Local substance use prevention program administrators need better coordination among funders, a greater choice of programs appropriate for their communities, and help sustaining their programs.

Participants in every community prevention program focus group called for increased coordination among funders. Many prevention program administrators are funded by three or more statewide actors, resulting in more staff time going towards multiple evaluation requirements and grant progress reports.

Community prevention program administrators said they needed more culturally appropriate EBP options. Though they recognize the importance of implementing evidence-based substance use prevention efforts, they said appropriate EBPs are often too costly, not available in different languages or are a poor fit with a region's culture.

As a result, many local prevention program administrators significantly adapt EBPs from their original design — such as changing the materials used or number of sessions provided. Some of these adaptations may be necessary to make the approach more culturally appropriate or suitable for a target community. But if they compromise the core components of the program, adaptations can make the prevention approach less effective.

Home-grown programs — even successful ones — can be difficult to classify as EBPs. The process is expensive and requires long-term evaluation and assessments in peer-reviewed journals to be designated as evidence-based.

Substance use community prevention administrators also said they need technical assistance for program planning, especially when it comes to sustaining their efforts. OBH grantees responding to CHI's survey ranked sustainability as their main organizational need.

Statewide Funders Need to Better Coordinate Efforts to Reduce Overlap While Addressing Gaps in Funding.

Many statewide substance use prevention funders expressed the need to better coordinate and align their efforts. The focus groups of community prevention program administrators reached the same conclusion, which was backed up by CHI's financial mapping exercise.

CHI identified eight funding streams, with significant overlaps in the types of substance use prevention services funded and populations served. For example, most substance use primary prevention funding (79 percent) goes to universal strategies — those for entire schools or communities — rather than to at-risk groups or individuals. And more than two thirds of funds (67 percent) go to youth-focused programs rather than to strategies for caregivers or whole families.

But even though their dollars are going to similar programs and people, statewide substance use prevention funders don't consistently coordinate their funding efforts and reporting requirements. CHI identified 11 counties where four or more funding streams are providing money for substance use prevention programs. But six counties — Baca, Custer, Jackson, Kiowa, Prowers and Rio Blanco — will not receive any substance abuse primary prevention money in fiscal year 2017-18 beyond statewide program funding.

CHI's Recommendations to Address the Needs

CHI will partner with the SNAPS advisory group in January and February 2018 to craft a strategic planning framework for OBH based on the findings from this needs assessment. This assessment makes the following recommendations to discuss during that process:

Address Community-Level Prevention Needs.

Invest in family-oriented prevention as well as environmental — or systemic — approaches. OBH and its partner statewide funders should increase investments in substance use prevention programs that support both young people and adults in their lives — from parents to grandparents to neighbors. In addition to addressing prevention needs at the individual, school, family and community levels, communities can also undertake environmental strategies, or policies and public relations campaigns to combat the normalization of drug and alcohol use. For example, resources directed at policy change can reduce availability and advertising of substances, and messaging campaigns can change the way young people and their families use and talk about substances.

Better align substance use prevention funding with need. OBH and its funding partners can design their funding allocation methodology to better address high-need regions and populations. One approach might be to allocate more funding to areas identified in this needs assessment such as Pueblo and the Upper Arkansas Valley or to “transition age” youth like the 18- to-25-year-old population.

Address Local Substance Use Prevention Provider Needs.

Support the adoption of evidence-based approaches. Equip local program administrators with more EBP choices. Substance use prevention funders should maintain or boost technical assistance to help grantees select EBPs or adapt EBPs for their communities. Strategies could include connecting grantees with EBPs that are age-appropriate and culturally relevant, as well as training and coalition development assistance. Another long-term strategy could be to evaluate existing community-based substance use prevention programs to ensure they are evidence-based.



Align reporting requirements from statewide prevention funders. To the extent that it's possible, help community prevention providers work efficiently by aligning the requirements to apply for grants and comply with reporting requirements. For example, state agency prevention funders could collaborate to develop a common grant reporting form.

Address Statewide Systemic Overlap and Gaps in Substance Use Prevention.

Strengthen coordination of statewide primary prevention efforts. Colorado needs strong leadership to better align ongoing efforts. A coordinated system will require collecting and sharing consistent funding information, aligning leadership through a prevention funder council, and coordinating and consolidating funding streams to consistently address service and population needs. OBH's 2018 strategic planning process offers one opportunity to do this. But meaningful change will be possible only if OBH's efforts are coordinated with other key prevention funders, including CDPHE and OCYF.

Introduction

Policymakers and the general public increasingly are paying attention to behavioral health and substance use, and for good reason: The use of opioids and methamphetamines is rising, along with the number of overdose deaths in Colorado and nationally. Alcohol remains the substance of choice for Colorado youth, with almost three of five reporting drinking in 2015. And Colorado ranks in the top 20 percent nationally for cocaine, marijuana, alcohol and opioid use — the only state in the heaviest use category for all four substances by residents 12 and older.

Substance use prevention presents a clear opportunity to address these challenges far upstream, before any treatment is needed. Primary prevention helps people — often youth, but also adults — develop skills to avoid substance use and misuse. Successful programs can help people avoid damaging their personal lives and health, as well as prevent the larger societal costs of substance abuse.

Colorado's Office of Behavioral Health (OBH) is assessing the prevention landscape as it looks forward to developing its strategic plan in 2018. OBH retained the Colorado Health Institute (CHI) to conduct a needs assessment of substance use prevention programming between June 2017 and February 2018.

CHI began this work with a simple question: What do communities, local prevention experts and statewide prevention funders need to strengthen Colorado's efforts in primary prevention of substance use?

This assessment — and answers to that question — are designed to help OBH and its partners better use their resources to strengthen Colorado's substance use prevention programming. OBH will use the results to inform its strategic planning process in 2018.

To complete the assessment, CHI and OBH established and facilitated an advisory group, conducted statewide community forums, gathered and analyzed a broad range of data on substance use in Colorado, and mapped prevention funding streams to better understand where the prevention money is coming from — and where it's going.

This project's next step is to work with the SNAPS advisory group by February 2018 to prioritize needs and recommendations to take forward into the strategic planning process. Then, CHI will produce a strategic plan outline, including potential evaluation measures, baseline values and recommended workgroups.

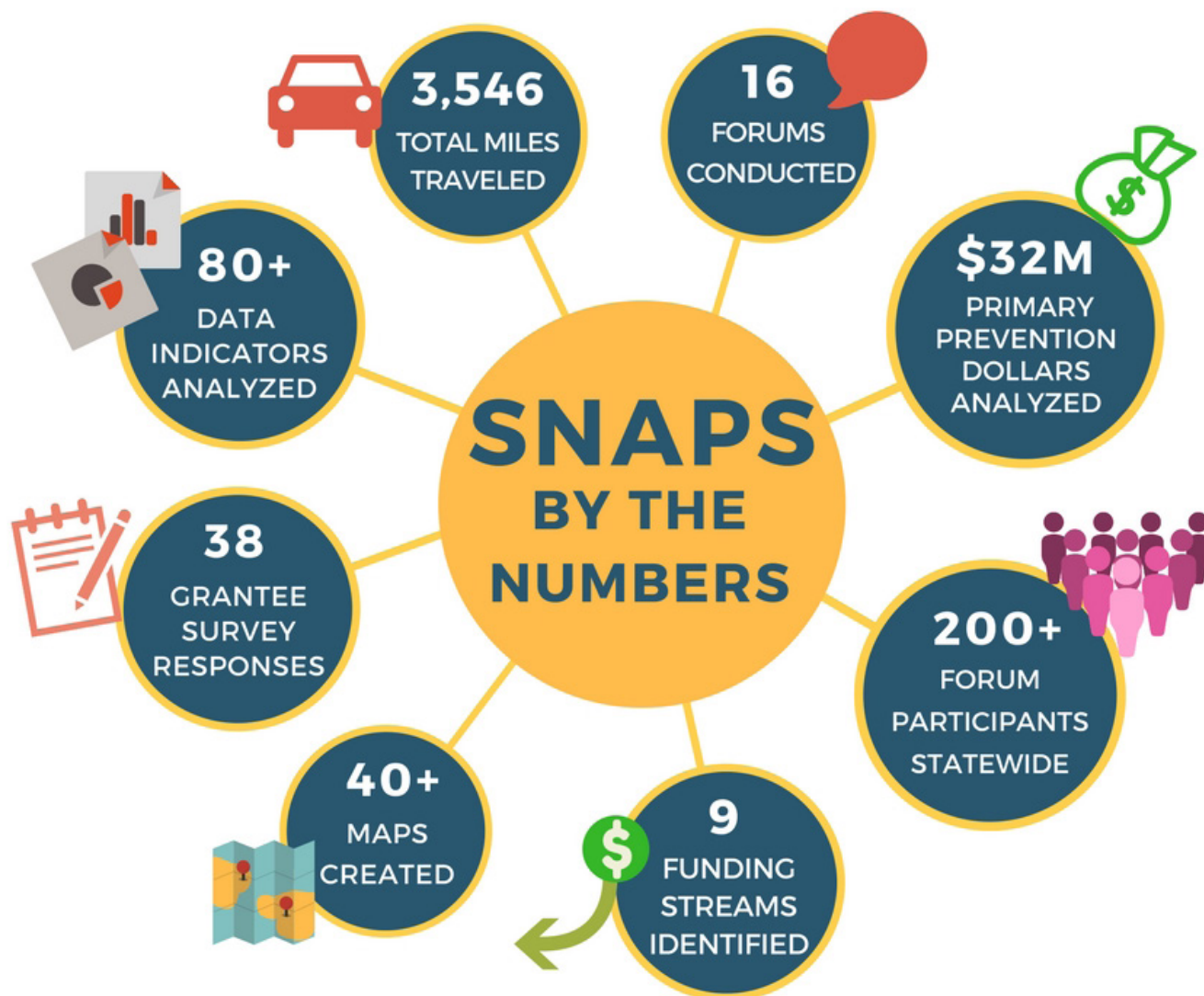
Conducting the Research

CHI traveled more than 3,500 miles, talked with more than 200 Coloradans, analyzed more than 90 indicators of substance use and related factors, surveyed 38 of OBH's grantee program administrators, and tracked more than \$32 million in primary prevention funds through a series of interviews and reviews of budget documents.

The needs assessment has two goals: to identify gaps in funding and areas of overlap with other state agencies and funders and to assess the adoption of evidence-based programs and practices (EBPs) and recommend ways to increase their use.

To achieve these goals, CHI:

- **Conducted** a literature review to identify data sources and successful primary prevention efforts for substance use;
- **Established** and facilitated an advisory group of state agencies, funders and prevention experts;
- **Planned, conducted and analyzed** results of 16 community and expert forums across the state;
- **Surveyed** OBH's grantees to learn what is working and what should change;
- **Examined** other funding for primary prevention of substance use, looking for gaps and areas of overlap;
- **Analyzed** a broad variety of prioritized data sets on substance use and abuse, crime, demographics, and risk and protective factors.



Best Practices in Prevention: The Evidence on What's Working

We know a lot more about the primary prevention of substance use than we did 30 years ago. The thinking has changed — shifting from scare tactics and required drug testing to strengthening protective factors and reducing risk factors.





This first section examines the evidence behind primary prevention and how program managers can select the most effective interventions for their communities.

Primary prevention is a public health approach to help communities avoid substance abuse and many related behavioral health problems such as depression, violence and teen pregnancy.

Primary prevention should happen before a behavioral health problem arises — like being diagnosed with a substance use disorder. It includes evidence-based programs, policies and strategies that address contextual factors, such as community and family connectedness, school participation and social skills. Those factors are known as risk and protective factors and they can predict health behaviors.

Prevention planners use a framework known as the socioecological model to help organize these complex factors. The model classifies these factors across four levels — individual, school, family and community — so that prevention planners can target their efforts to specific factors at different levels. For example, an individual-level approach might include school-based programs to help kids improve their relationship skills, or a community-level approach could change local policies to increase alcohol taxes in an attempt to discourage drinking. (See Figure X – Examples of Risk and Protective...)

FIGURE 1. Examples of Risk and Protective Factors Across the Socioecological Model.²

Risk Factors Risk factors increase the likelihood young people will develop health and social problems.	Domain	Protective Factors Protective factors help buffer young people with high levels of risk factors from developing health and social problems.
<ul style="list-style-type: none"> • Sensation seeking • Impulsiveness • Early initiation of problem behavior • Interaction with friends involved in problem behavior 		<ul style="list-style-type: none"> • Social skills • Emotional control • Interaction with prosocial peers
<ul style="list-style-type: none"> • Low academic achievement • Low commitment to school • Bullying 		<ul style="list-style-type: none"> • Opportunities for prosocial school involvement • Recognition of that school involvement
<ul style="list-style-type: none"> • Family conflict • Family history of antisocial behavior • Favorable parental attitudes to the problem behavior 		<ul style="list-style-type: none"> • Attachment and bonding to family • Opportunities for prosocial involvement in the family • Recognition of family involvement
<ul style="list-style-type: none"> • Perceived availability of drugs • Community transitions and mobility • Laws and norms favorable to drug use • Economic disadvantage 		<ul style="list-style-type: none"> • Opportunities for prosocial community involvement • Recognition of community involvement • Exposure to evidence-based prevention approaches

Decades of prevention science have identified those contextual factors and the prevention efforts that work best to address them.³ This is known as a shared risk and protective factor approach to prevention. These factors are consistent across races and cultures. They are considered “shared” because long-term studies have shown that they can reliably predict multiple health behaviors, not just substance use. (See Figure X – Risk Factors for Behavioral Health Problems in Young People).

Research provides insight into what works and what doesn’t in primary prevention. Effective prevention approaches share some main characteristics, which are detailed in Figure X – Characteristics of Effective Primary Prevention Approaches.⁵

Community groups or coalitions use planning frameworks such as the Substance Abuse and Mental

Health Services Administration’s (SAMHSA) Strategic Prevention Framework to determine which approach addresses their community’s needs (See Figure X – SAMHSA’s Strategic Prevention Framework). This type of planning process helps community members begin with a clear understanding of local needs – such as substances that present the biggest problems and the populations that are most in need – before selecting and implementing a prevention approach.

Primary prevention usually targets young people rather than adults. That’s because behavioral health problems in childhood and adolescence can have a big impact on health later in life. And research demonstrates that prevention and early intervention are more effective than later interventions.

Primary prevention differs from secondary and tertiary intervention. Primary prevention efforts aim to reduce

FIGURE 2. Risk Factors for Behavioral Health Problems in Young People.⁴

Risk For Health and Behavioral Problems	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression & Anxiety
Peer/Individual						
Early and Persistent Antisocial Behavior	●	●	●	●	●	●
Rebelliousness	●	●		●	●	
Gang Involvement	●	●			●	
Friends Who Engage in the Problem Behavior	●	●	●	●	●	
Early Initiation of the Problem Behavior	●	●	●	●	●	
Constitutional Factors	●	●			●	.
School						
Academic Failure Beginning in Late Elementary School	●	●	●	●	●	.
Lack of Commitment to School	●	●	●	●	●	
Family						
Family History of the Problem Behavior	●	●	●	●	●	●
Family Management Problems	●	●	●	●	●	●
Family Conflict	●	●	●	●	●	●
Favorable Parental Attitudes and Involvement in the Problem Behavior	●	●			●	
Community						
Availability of Drugs	●				●	
Availability of Firearms		●			●	
Community Laws and Norms Favorable toward Drug Use, Firearms and Crime	●	●			●	
Media Portrayals of the Behavior	●				●	
Transition and Mobility	●	●		●		●
Low Neighborhood Attachment and Community Disorganization	●	●			●	
Extreme Economic Deprivation	●	●	●	●	●	

new cases of substance use while secondary and tertiary prevention try to reduce prevalence, or the total number of people abusing substances. (See Figure X – Primary Prevention’s Place in the Continuum of Prevention Efforts.)










Examples of these prevention effort levels include:

- **Primary prevention:** Training offered to all students in a school to help them better manage their emotions.
- **Secondary prevention:** A primary care provider conducts Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify at-risk patients and connect them to substance use counseling.
- **Tertiary prevention:** An injecting drug user receives access to a clean needle exchange program to avoid transmission of blood-borne diseases.

Primary, secondary and tertiary prevention are important, research-based upstream tools to avoid behavioral health problems. But downstream approaches are critical components as well. When it comes to substance abuse, prevention is one part of the continuum of care. (See Figure X – Substance Use Care Continuum).

For example, after-school programs can help build social skills and prepare all students for a lifetime of health. But for those who need additional help — such as kids whose parents abuse drugs or those who are already addicted to substances — targeted prevention, treatment and recovery programs are required.

Figure 3. Characteristics of Effective Primary Prevention Approaches

	Comprehensive	Curriculum addresses multiple domains (family, peers, community).
	Use varied teaching method	Diverse strategies focus on increasing awareness, understanding, the problem behaviors and building skills.
	Offers sufficient dosage	Programs are not just offered once. Follow-up is included.
	Theory-driven	Programs are supported by empirical research.
	Builds positive relationships	Programs provide exposure to adults and peers.
	Appropriately timed	Programs are initiated early to match the development stage of participants.
	Culturally relevant	Programs integrate the community and cultural norms of the participants in planning and implementation.
	Evaluation-driven	Programs have clear goals and objectives to track them.
	Offers well-trained staff	Program staff are trained in the program, but also in cultural competency and to address any language barriers.

What Does It Mean to be Called an Evidence-Based Program?

Prevention experts and funders seek EBPs for primary prevention of behavioral health problems like substance use. EBPs have a proven track record, and their use can help avoid wasting time and money on approaches that may not be effective. However, it's a challenge to identify the EBPs that will be most effective for a community. And that's important to Colorado's prevention program administrators, because they're having trouble finding EBPs that fit their populations.

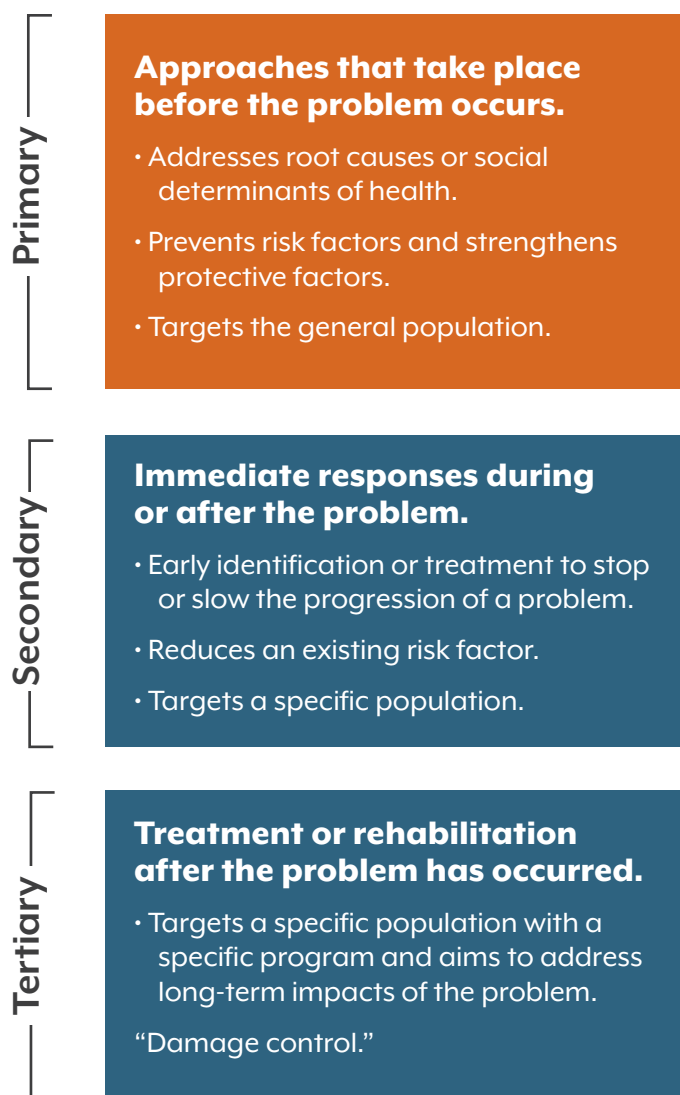
EBPs can be difficult to judge because there are gradations of evidential strength. The strength of the evidence depends on four factors:⁷

- Rigor of the evaluation design. Did evaluators ask the right questions in their study?

Figure 4. SAMHSA's Strategic Prevention Framework



Figure 5: Primary Prevention's Place in the Continuum of Prevention Efforts



- Rigor of methods used to collect and analyze data. Are the tracked metrics the right ones?
- Magnitude and consistency of interventions on targeted outcomes. Are the same effects seen every time?
- Generalizability of the findings to other populations and settings. Will the program work elsewhere?

But those criteria are not always easy to discern.

Some programs are reviewed, rated using a combination of the criteria, and then added to national evidence-based strategy registries such as the Blueprints for Healthy Youth Development. Program administrators can search the online registries and select a program that fits their community. However, there is no unified registry, and different registries use different criteria.

There are other ways of selecting evidence-based programs if an appropriate registry-rated program doesn't exist. For example, some programs report positive results but are not yet rated by a registry. But staying on top of those results can be a full-time job for local prevention staff. This situation can result in communities using programs that lack an evidence basis. For example, evidence now shows that once-popular programs such as D.A.R.E. and Scared Straight are ineffective.

There are many roads leading to an evidence-based designation. SAMHSA outlines ways to identify an evidence-based intervention appropriate for a community's needs (See Figure X).

Figure 6. The Substance Use Care Continuum.⁶

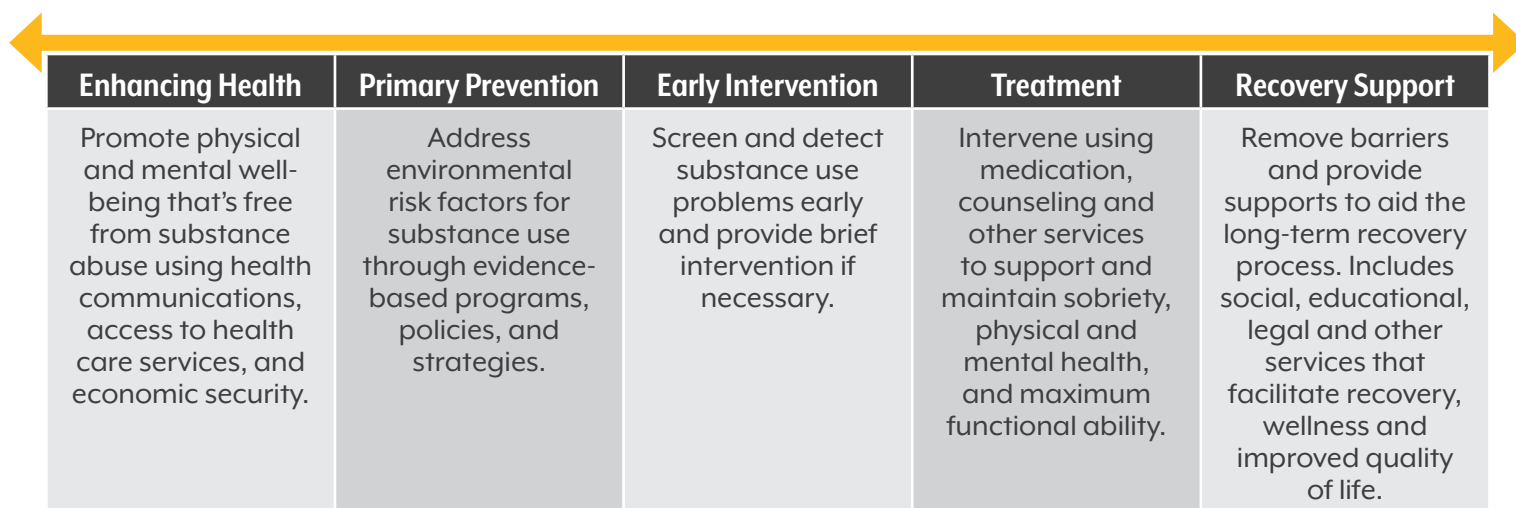


FIGURE 7. SAMHSA Recommendations for Selecting EBPs

SAMHSA's Recommended EBP Selection Strategies	What is it?	Benefits	Challenges
National Registries of Programs	Lists like NREPP, Blueprints for Healthy Youth Development, and others offer program resources for prevention administrators	One-stop-shop for program descriptions and evidence basis	Limited in the programs included; evidence grading is inconsistent
Peer-Reviewed Journals	Programs may be evaluated and published in peer-reviewed journals	Includes details like program developer's contact information	Time-consuming and challenging for program administrators
Other Methods	Book chapters, academic papers and other resources	Offers additional options for program administrators	Leaves significant responsibility to program administrators to assess the evidence

Using National Registries

National registries provide a one-stop shop for concise program descriptions and evidence ratings. But they include a limited number and type of interventions, and evaluation of the evidence is inconsistent across registries.

Registries like SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) or the Blueprints for Healthy Youth Development Registry review and rate programs using the agencies' own scoring. But those ratings differ from one registry to another. As a result, a single program may get a different rating across all the registries. For example, one popular prevention program called Project Toward No Drug Use (TND) has three different rankings in three different registries.

These examples show how the different rating criteria get confusing:

- Coalition for Evidence-Based Policy rates programs as "top tier" or "near top tier."⁸
- Blueprints for Healthy Youth Development rates programs as "Model +", "Model" or "Promising."⁹
- Office of Juvenile Justice and Delinquency Prevention Model Programs (OJJDP) rates programs as "effective," "promising" or "ineffective."¹⁰

Using Peer-Reviewed Journals

The academic literature offers another option for program administrators who may not find an appropriate intervention on a national registry. They can review journals like "Prevention Science" or the "Journal of Adolescent Health" to find detailed information on a program's design, limitations, and researchers' contact information. But it's time-consuming and challenging for program administrators to pore over the literature and assess whether a given approach is backed by evidence.

Using Other Methods

Program planners may look to book chapters, evaluation reports or academic papers to help them select an intervention outside of federal registries and peer-reviewed literature. But this method requires prevention planners to assess available research, and it may be difficult to prove to potential funders that they've made a good choice.

It's a challenge to identify prevention programs that work for all communities — or even just for one. The task for prevention funders and administrators is to find programs that work best for the community and that are also backed with strong evidence.

SNAPSHOTS

Analyzing the Data: Substance Use in Colorado

Substance use is a significant problem for Colorado.

As part of this assessment, CHI analyzed data from 30 sources related to alcohol, marijuana, tobacco, prescription and nonprescription opioids (heroin), illicit substances like cocaine, methamphetamines, and ecstasy, and nonmedical use of prescription drugs. CHI also analyzed related risk and protective factor data such as dropout rates and youth reporting poor mental health.

To better understand Colorado's substance use prevention needs, CHI analyzed trends in substance use, including changes over time, as well as geographic and demographic differences. We analyzed data on perceived ease of accessing substances, the availability of substances, the perception of whether substances are harmful, overdose death rates and a number of related risk factors.

CHI then analyzed the data related to each substance, paying attention to how each substance is used by the state's youth — including middle and high schoolers (about 11- to 18-year-olds) to paint a picture of the substance use landscape in Colorado.

CHI highlighted the most relevant data for each substance and created full-page infographics that are titled "SNAPshots." As the name suggests, each page provides a "snapshot" of youth substance use in Colorado. Each infographic provides an overview of regions and populations in need of primary prevention, given trends in usage, access to

substances, the perception of risk, and consequences of substance use. In addition to highlighting five categories of substances, CHI also created an infographic of risk factors and protective factors throughout the state. (See pages X through X.)

In one of the most telling statistics, Colorado ranks in the top 20 percent nationally for rates of using cocaine, marijuana, alcohol and opioids. It is the only state in the heaviest use category for all four substances by residents 12 and older.¹¹

When we analyze that measure by age groups, it's Colorado's adults over 18 — not teens — who are driving the high across-the-board levels of substance use. When it comes to Colorado youth, their current substance use is on par with national averages for marijuana, alcohol, illicit drugs, tobacco and opioids. It's clear that Colorado faces a challenge in stopping substance use in youth before they become adults.

Alcohol is the substance most often used by Colorado youth, with 59 percent reporting having tried alcohol in the Healthy Kids Colorado 2015 survey. Marijuana comes in second at 38 percent, followed by tobacco (cigarettes) at 20 percent, nonmedical use of prescription drugs at 14 percent, inhalants, cocaine and ecstasy at 6 percent each and meth and heroin at 2 percent. (See Figure X.)

A significant change in alcohol use by Colorado's youth is evident over the past decade. While alcohol continues to be the substance of choice, the percentage who say they are current drinkers has

FIGURE 8. Substances Most Commonly Used by Colorado Youth

Percentage of Colorado Youth Who Report Ever Using a Substance, Healthy Kids Colorado Survey, 2015

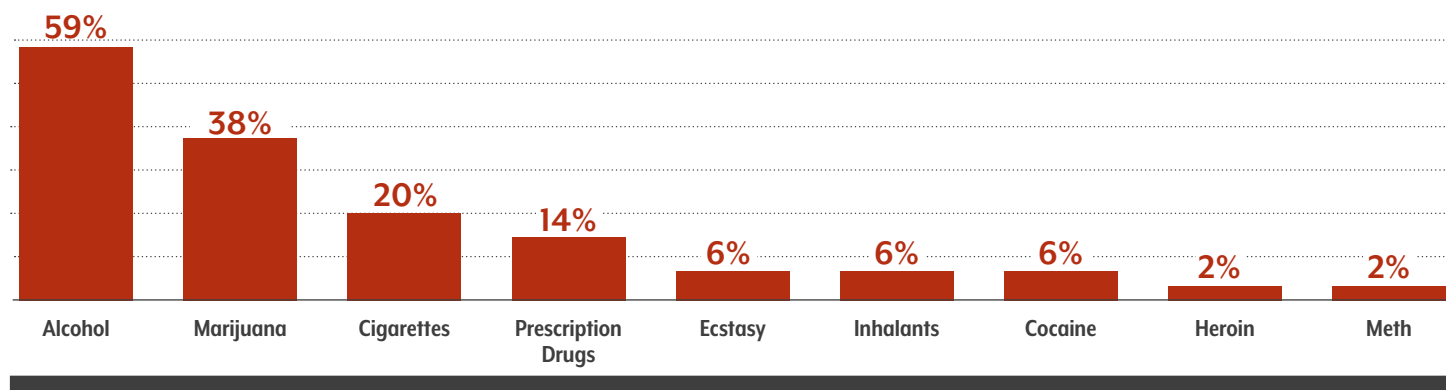
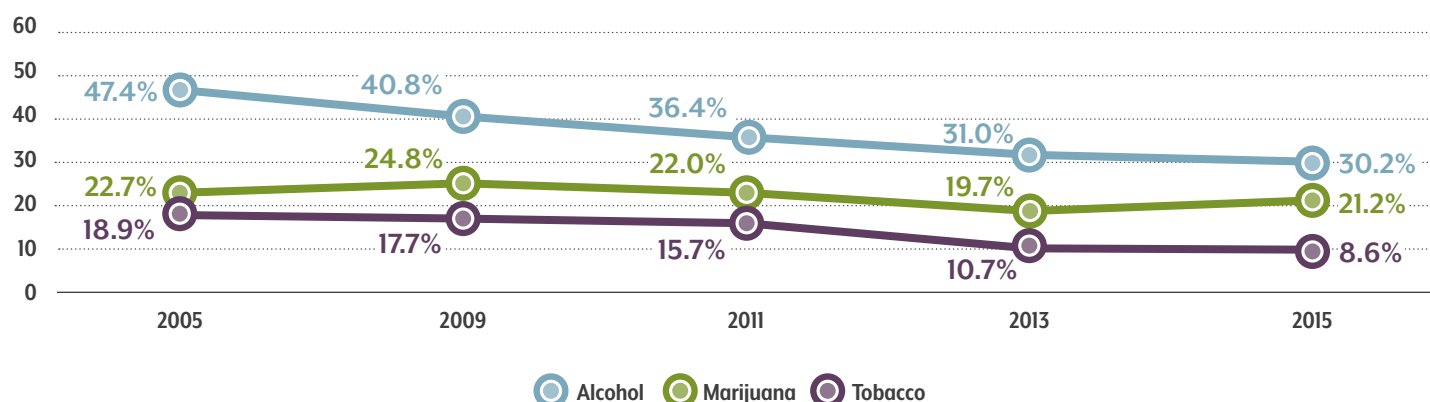


Figure 9. Most Commonly Used Substances in Colorado Youth, 2005-2015



dropped from 47.4 percent in 2005 to 30.2 percent in 2015. (See Figure X.)

With some regional variation, statewide marijuana use by Colorado youth has stayed flat over the past decade, hovering around 20 percent. And tobacco use is far less popular, falling from 18.9 percent in 2005 to 8.6 percent in 2015.

Highlights from the SNAPShots for each substance show that:

Alcohol: About one of three Colorado high school students (30.2 percent) reports currently drinking alcohol, similar to the national average of 32.8 percent. And nearly three of five (59.2 percent) report having at least one drink of alcohol during their life.

Marijuana: Even though Colorado began legal retail sales of marijuana to adults in 2014, Colorado's youth aren't using marijuana at higher rates, with insignificant change between 2013 and 2015. The story varies by region and grade, but youth marijuana use overall is on par with U.S. averages. One of five Colorado high schoolers say they use marijuana regularly. Still, the data show a definite swing in the percentage of Colorado youth who don't think marijuana is harmful. In 2013, 54 percent of young people thought regular use of marijuana would be harmful, but that rate fell by six percentage points to 48 percent in 2015.

Tobacco: The decline in smoking by Colorado's youth is a public health success story. From 2005 to 2015, cigarette smoking decreased from 18.9 percent

to 8.6 percent, similar to the national trend, which decreased from 23.0 percent to 10.8 percent.

Illicit Drugs: Colorado youth are using cocaine, methamphetamines, ecstasy and other illicit drugs at about the same rate as their peers nationally. There was little change in usage for these substances between 2013 and 2015. Meanwhile, one of seven (13.7 percent) report using prescription drugs like Oxycontin, Xanax or Adderall without a prescription. One of four (25.0 percent) say they think prescription drugs would be easy to get without a prescription if they wanted.

Heroin and Opiates: For Coloradans ages 12 and above, prescription opioid use and overdose deaths are leveling off, while heroin use and related overdose deaths are heading higher. These troubling trends are driven by adults. Only two percent of high school students report ever using heroin, in line with national averages. Pueblo County and Denver have the highest rates.

Risk Factors and Protective Factors: Pueblo County and the Upper Arkansas Valley counties of Fremont, Custer, Chaffee and Lake consistently stand out for risk factors that predict future substance abuse. Youth in these areas report the lowest levels of teacher encouragement and having an adult to go to if they have a problem — both protective factors. These regions also had the worst scores on risk factors, including youth reporting high rates of feeling sad or hopeless, high dropout rates for school, and high rates of youth who have difficulty with their emotions.



SNAPSHOT

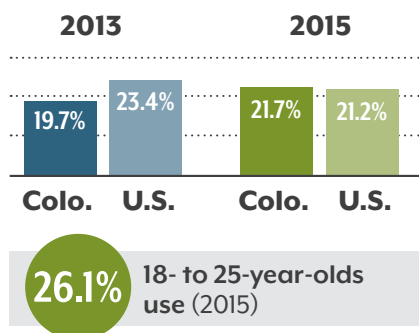
MARIJUANA

Colorado's first-in-the-nation retail marijuana shops opened for business on January 1, 2014. Today, nearly four years later, 509 retail stores dot the state.

Tax and fee collections are on track for a record-setting year. And more states are following Colorado's lead on legalization. The challenge for parents and policymakers — ensure that more Colorado youth don't start using marijuana.

Rate of Marijuana Use: Staying Steady

One of five middle school and high school students report currently using marijuana, a rate that didn't change from 2013 to 2015.



Access

Top Five Colorado Counties: Rate of recreational and medical marijuana shops.

State average: 12.7 per 100,000

1. **Costilla** 118.6 (4 shops)
2. **Gunnison** 110.3 (11 shops)
3. **Pitkin** 107.2 (16 shops)
4. **Routt** 66.4 (4 shops)
5. **La Plata** 37.0 (12 shops)

(Note: Excludes counties with 0, 1 or 2 shops)

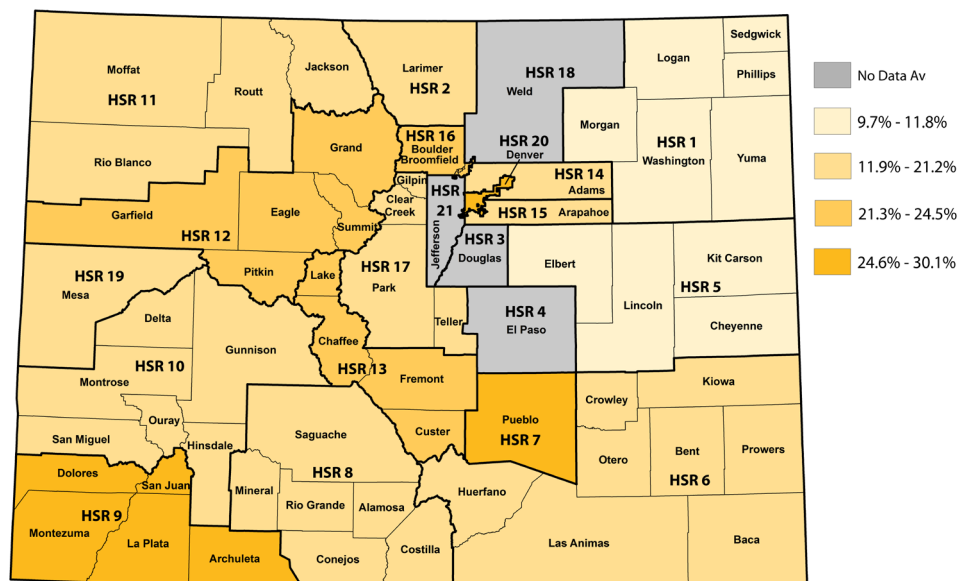
Nearly 6 of 10

high school students reported it was sort of easy/very easy to get marijuana.

Colorado Youth: Who's Most Likely to Use Marijuana?

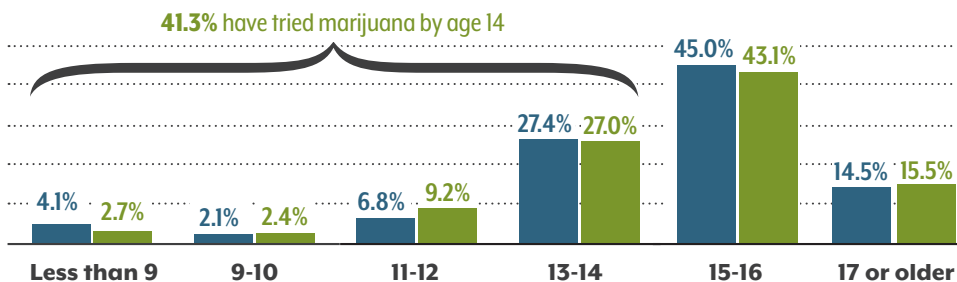
High school students on the Western Slope and in southwest Colorado had higher rates of use than those on the Eastern Plains. **Pueblo County** has the state's highest rate — 30.1 percent.

Percentage of High Schoolers Who Have Used Marijuana at Least Once in the Past 30 Days



First Use of Marijuana: Nearly Half by Age 14

More than 40 percent of high school seniors who say they have ever used marijuana had tried it by the age of 14. ■ 2013 ■ 2015



Marijuana at Home

8 Percent

of adults with children under 15 had marijuana products in or around their home.



16,000 Homes

Had children under 15 with possible exposure to secondhand marijuana smoke or vapor.

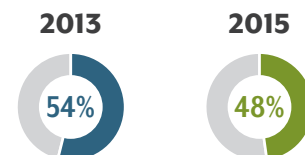


6 Percent

New mothers who used marijuana during pregnancy.

Perception of Risk

Percentage of kids who think regular use is risky:



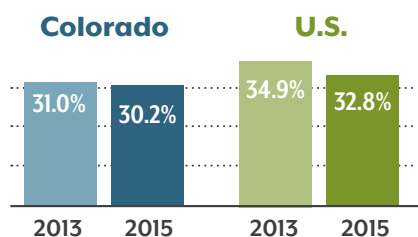


ALCOHOL

Colorado high schoolers use alcohol at a higher rate than any other substance. Nearly six of 10 (59 percent) report ever trying alcohol, closely mirroring the national rate. Alcohol is also the easiest substance for Colorado youth to obtain.

Rate of Alcohol Use:

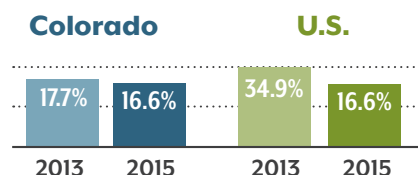
One of three high school students report currently drinking alcohol, a rate that didn't change from 2013 to 2015. Colorado youth are near the national average.



68.0% 18- to 25-year-olds use (2015)

Binge Drinking:

One of six high school students report binge drinking in the last 30 days.



Access:
58.6 Percent

Nearly three of five high schoolers believe it is easy to get alcohol if they wanted.

18.2 Percent

Nearly one of five report trying alcohol before age 13.

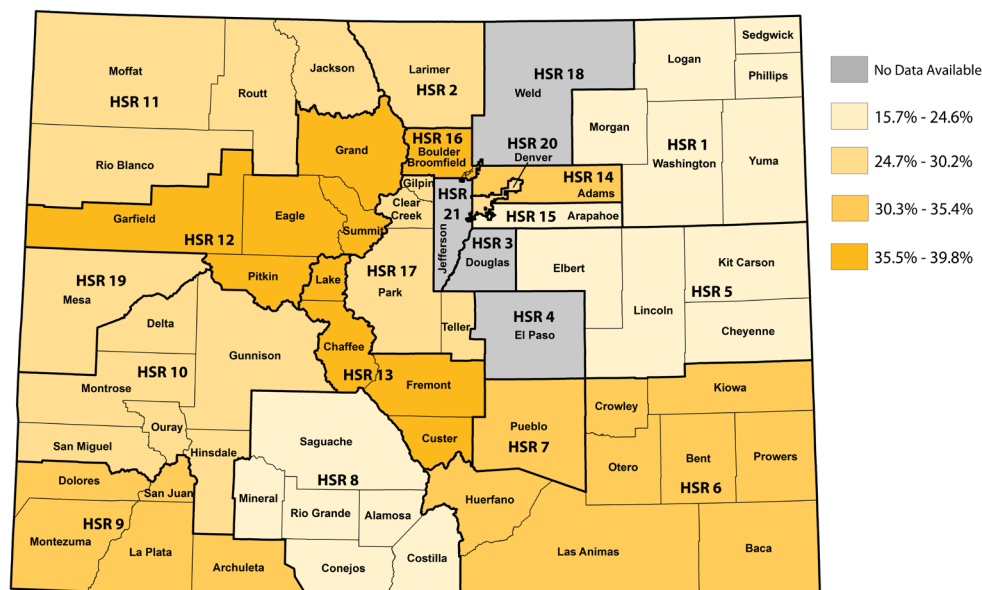
1,623

liquor stores in Colorado
(28.7 per 100,000 residents)

Colorado Youth: Who's Most Likely to Use Alcohol?

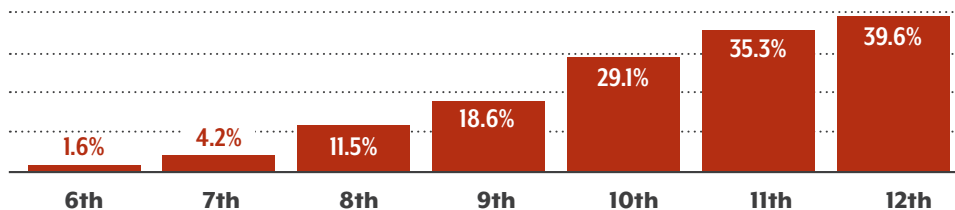
Four of 10 (40 percent) high school students in the Interstate 70 mountain counties of Eagle, Garfield, Grand, Pitkin and Summit say they've had at least one drink in the past month, the state's highest rate of alcohol use. The second highest rate is reported by high schoolers in the counties of Boulder and Broomfield at 38 percent.

Percentage of High Schoolers Who Drank At Least Once in the Past 30 Days



Current Alcohol Use by Grade: Two of Five Seniors Regularly Drink

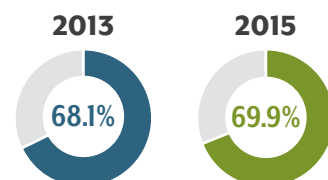
Current alcohol use steadily increases by grade, with an apparent jump between 8th and 10th grade.



Perception of Risk

Seven of 10 (69.9 percent) high schoolers believe that regularly drinking alcohol is risky to their health compared with 48.8 percent when it comes to marijuana. But even though high school students think it's riskier to drink alcohol than smoke marijuana, they still drink at a much higher rate.

Believe regular alcohol consumption risks harm to themselves





SNAPSHOT

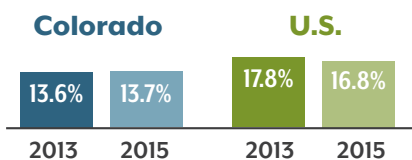
ILLICIT SUBSTANCES

Colorado is about average nationally when it comes to the use of cocaine, methamphetamines, ecstasy, prescription drugs and other illicit substances by high schoolers. Still, some regions of the state are seeing significantly higher rates of high school use. And, disturbingly, overdose deaths are rising among all ages.

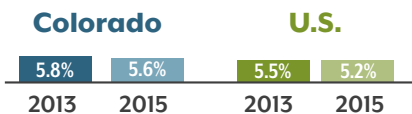
Rate of Illicit Substance Use: Little Change From 2013 To 2015

Illicit drug use is on par with the national averages. Nonmedical prescription drugs are the illicit substance the state's high schoolers are most likely to use, with nearly one of seven reporting use at least once in their lives.

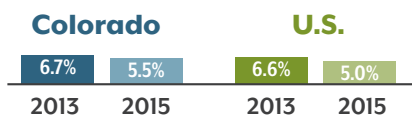
Nonmedical Use of Prescription Drugs



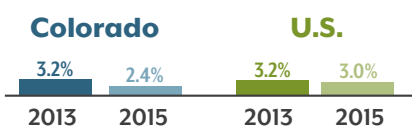
Cocaine



Ecstasy



Methamphetamines

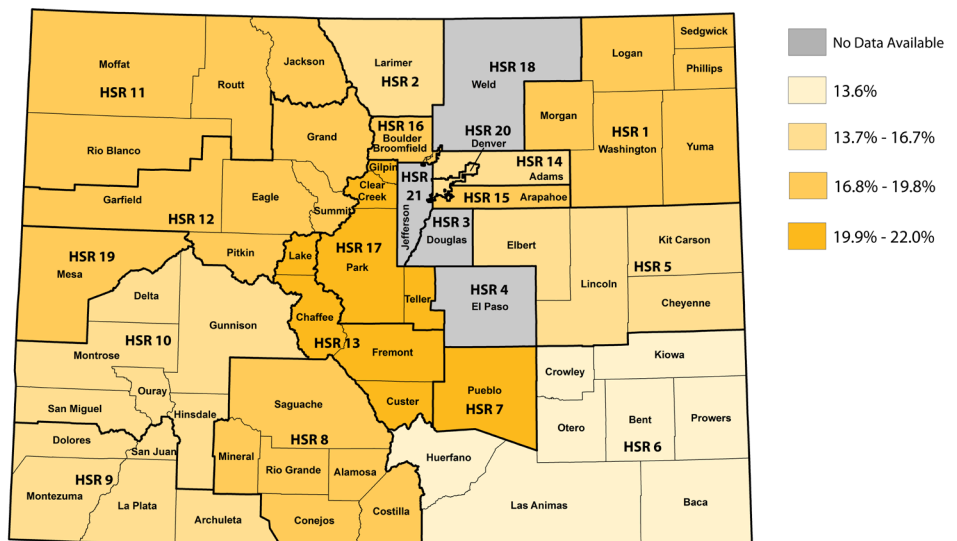


Pueblo and the Upper Arkansas Valley counties of **Fremont, Custer, Chaffee** and **Lake** were in the highest quartile for cocaine, meth, ecstasy and prescription pills.

Youth Access to Drugs: Bigger Problem in Some Regions

The question: How easy is it to get cocaine, LSD, methamphetamines and other illicit drugs? The answer: It's easiest for high schoolers in the Upper Arkansas Valley counties of Custer, Fremont, Chaffee, Park, Lake, Clear Creek and Gilpin. One of five high schoolers there report that it's easy to obtain illicit drugs. Students there also report the state's the highest use of illicit drugs.

Percentage of Students Who Feel it Would Be Sort of Easy or Very Easy to Get Drugs Like Cocaine, LSD, Amphetamines If They Wanted

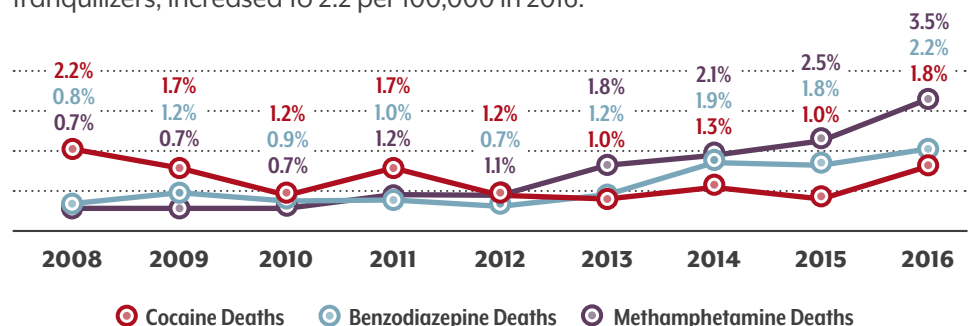


High school students report it would be easy to get ...

25.5% Prescription drugs without a prescription **17.3%** drugs like cocaine, LSD and amphetamines

Illicit Drug Overdose Rates, per 100,000 (All Ages)

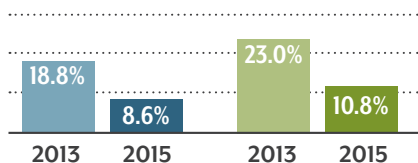
Among illicit drugs, methamphetamines contribute to Colorado's highest overdose rate for all ages. The rate increased fivefold between 2010 and 2016 to 3.5 per 100,000 residents. The overdose death rate for benzodiazepines, or tranquilizers, increased to 2.2 per 100,000 in 2016.



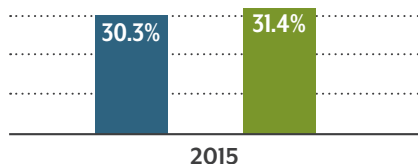
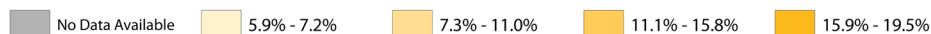


The earlier someone starts smoking cigarettes, the less likely they are to quit. In Colorado, 8.6 percent of high school students smoke cigarettes, slightly lower than the rate of 10.8 percent. The good news is Colorado's rate is less than half of what it was 10 years ago. At nearly one of three (30.3 percent) of Colorado high schoolers say they currently use tobacco, either cigarettes, electronic cigarettes, cigars or smokeless tobacco.

U.S.



U.S.

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71.3%
of high school students
in the Upper Arkansas
Valley say it's easy to
get cigarettes

Lake

Chaffee

Fremont

Custer



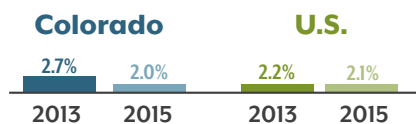
SNAPSHOT

OPIOIDS

The rate of heroin use among high schoolers remains at a steady two percent — on par with the national average. But expanding the age group to include all Coloradans, beginning with 12-year-olds, reveals that the rate of heroin use is increasing rapidly while the rate of prescription opioid use has leveled off. The same trends are seen in overdose death rates. Heroin overdose death rates are skyrocketing in Colorado even as prescription opioid death rates level off, perhaps a sign of progress in the battle against the misuse of prescription drugs.

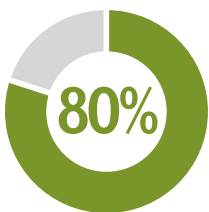
Rate of Youth Heroin Use:

Two percent of high school students in Colorado report using heroin at least once — a slight decrease from 2013. Pueblo leads the state at 6.3 percent with Denver second at 4.8 percent, both higher than the state average.



Heroin Use Rising, Prescription Opioid Use Steady:

The rate of heroin use among Coloradans 12 and older quintupled from 20 per 100,000 Coloradans in 2003 to 100 per 100,000 Coloradans in 2014. However, the rate of prescription opioid use (pain relievers) has stayed relatively steady since 2007 at about 450 per 100,000 Coloradans in 2014.



of heroin users reportedly started their opioid use with prescription pain relievers.

Fentanyl Overdose Rate:

Fentanyl-related overdose deaths shot up ninefold between 1999 and 2016. Nearly 50 Coloradans died from overdosing on fentanyl in 2016

1999: **0.1 per 100,000**

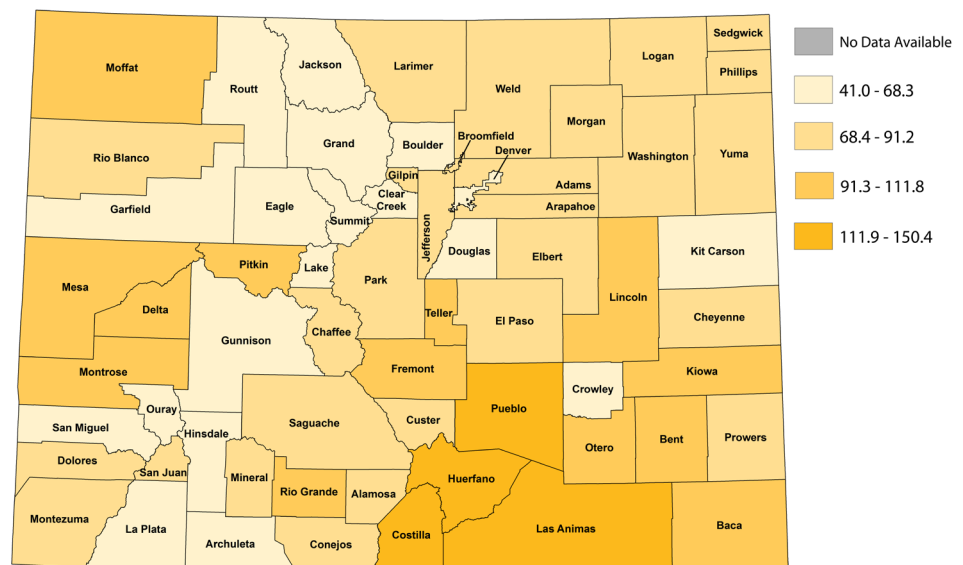
2016: **0.9 per 100,000**

Access to Prescription Opioids:

Prescribing Rates Highest in Southeast Colorado, Pueblo.

Colorado averages 76.2 opioid prescriptions for each 100 Coloradans. Counties in southeastern Colorado including Costilla, Huerfano, Las Animas, Pueblo and Otero all have opioid prescribing rates of more than 111 prescriptions per 100 people. Costilla County recorded 150 prescriptions per 100 residents, nearly double the state average.

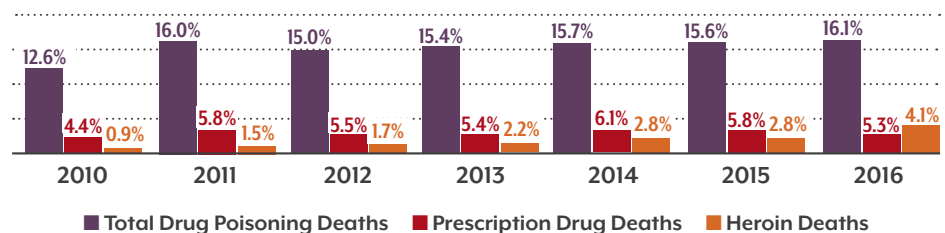
Rate of Opioid Prescriptions Per 100 Colorado Residents, 2016



Heroin Overdose Deaths Climbing, Prescription Opioid Deaths Leveling Off

Colorado has seen a slight downtick in the rate of prescription opioid-related overdose deaths, which stood at 5.3 deaths per 100,000 in 2016. However, the rate of heroin overdose deaths is on the rise — more than quadrupling between 2010 and 2016, when they reached 4.1 per 100,000. Heroin overdose deaths account for 25 percent of all drug poisoning deaths in 2016, up from 18 percent in 2015.

Opioid Overdose Death Rates per 100,000





SNAPSHOT

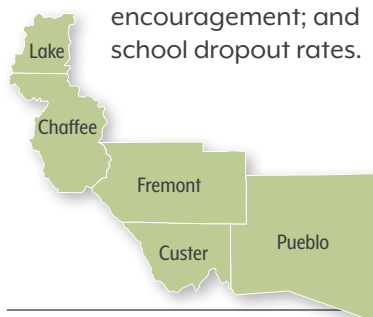
RISK FACTORS FOR SUBSTANCE USE

A person's risk of substance use can be influenced by many factors, including levels of social and emotional support, environmental surroundings, and mental health.

Studies show that youth with serious emotional problems are more likely to use substances and become dependent on them. Youth who lack supervision and supportive adults in their life also are more likely to use substances. These data help to illustrate the differences in risk factors across Colorado that may influence susceptibility to substance use among youth.

High-Need Areas

Pueblo County and the Upper Arkansas Valley counties rank among the state's worst regions for youth reporting difficulty with emotions; feeling sad or hopeless; having an adult to talk to; teacher encouragement; and school dropout rates.



Dropout Rates

Students who have dropped out of school have an elevated risk of substance use. Lake and Fremont counties, both in the Upper Arkansas Valley, share the state's highest dropout rate of 3.3 percent for students of any age.

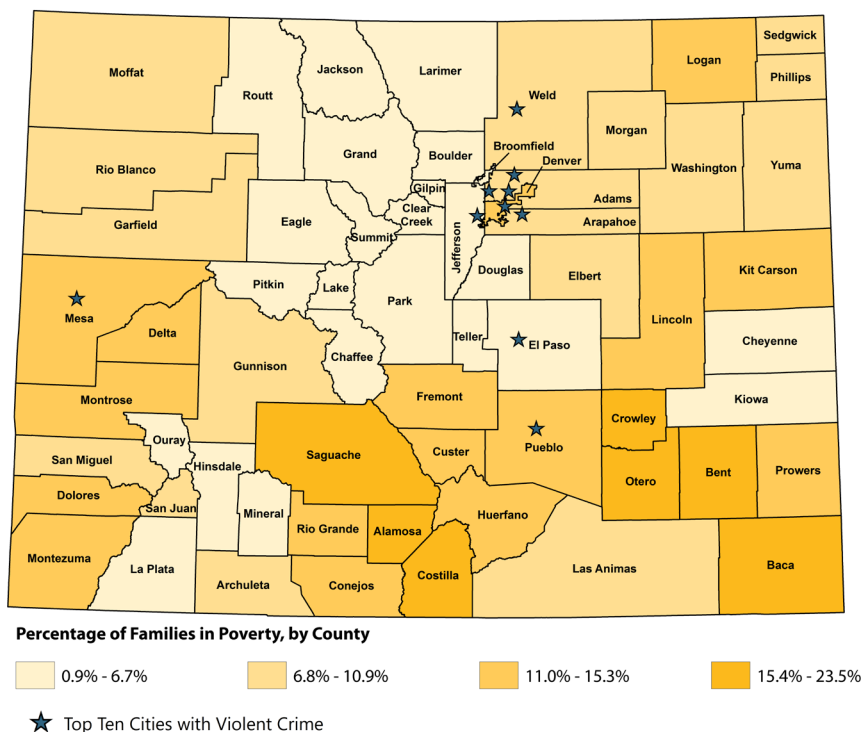
State average: 2.3 percent

1. **Lake** 3.3 percent
2. **Fremont** 3.3 percent
3. **San Juan** 3.2 percent
4. **Montezuma** 2.9 percent
5. **Saguache** 2.8 percent

Poverty and Violent Crime

Studies show that poverty and violent crime are associated with higher rates of substance use. Studies also show that impoverished neighborhoods tend to have higher rates of violent crime. Counties in the southeast area of the state have the highest percentage of households under the federal poverty level. In Crowley County, for example, nearly one of four households (23.5 percent) is in poverty. That's more than twice the state average of 11 percent. Violent crime, meanwhile, is highest in the city of Pueblo, with 9.8 violent crimes per 1,000 people, more than double the state average of 4.4 per 1,000. Denver comes in second with 6.6 violent crimes per 1,000 people. Six of the cities with the highest violent crime rates are in the Denver Metro Area.

Poverty and Violent Crime: Southeast Counties Highest Poverty – Pueblo, Denver Metro Area Highest in Crime

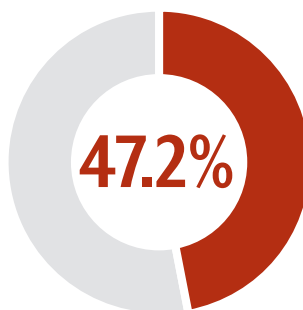


Social and Emotional Support

Nearly two out of five

Pueblo County high school students lack a supportive adult to go to with a serious problem.

Having a supportive adult and a supportive school and home environment can reduce the risk of substance use for adolescents.



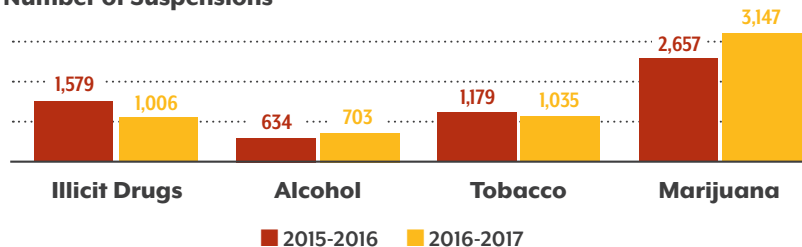
Less than half of students in Pueblo County think their teachers encourage and care about them. Similarly, the number for the Upper Arkansas Valley is 53.5 percent.

Both are below the state average of 60.9 percent.

K-12 Drug, Alcohol, Marijuana and Tobacco Suspensions

In the 2016-2017 school year, marijuana was the substance that resulted in the most suspensions at 3,147 — a noticeable increase from the previous year. Alcohol- and tobacco-related suspensions remained steady, while illicit drugs (other than marijuana) saw a decline from 1,579 suspensions to 1,006.

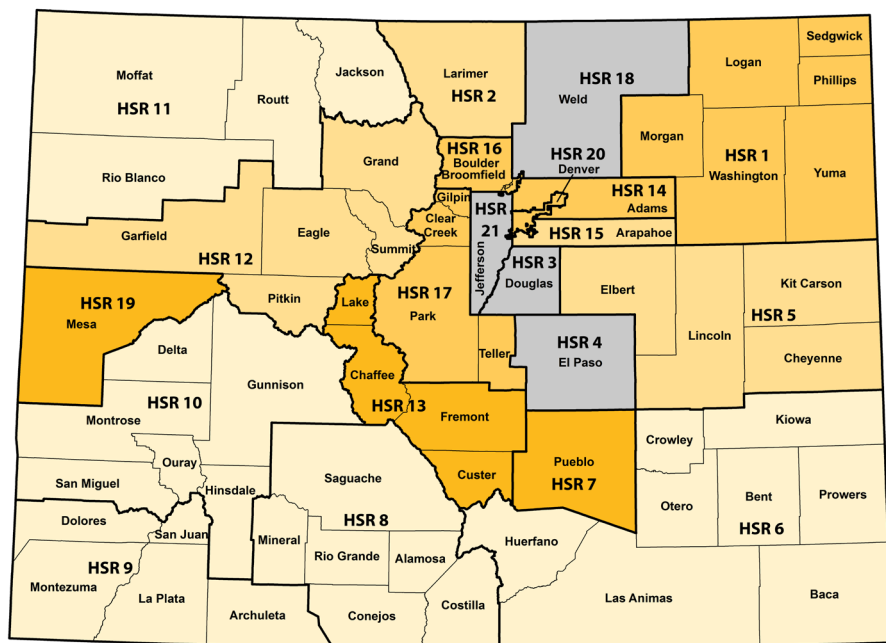
Number of Suspensions



Mental Health

Students who suffer from mental health issues are at greater risk for substance use. Mesa and Pueblo counties, along with counties in the southeast corner and the Upper Arkansas Valley, report the highest rates of children with emotional difficulties and high school students who were sad or hopeless for at least two weeks in a row in the past year.

High Schoolers Who Felt Sad or Hopeless Almost Every Day for Two Weeks or More in a Row



Highest Rates in the State

HSR 19 (Mesa)

37.8%

HSR7 (Pueblo)

34.5%

HSR 13 (Lake, Fremont, Chaffee, Custer)

34.2%

Statewide

29.5%

Difficulty with Emotions

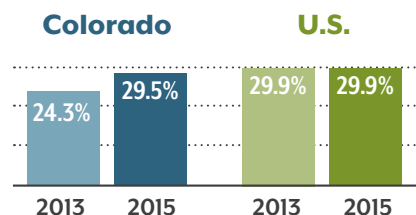


Nearly one of three

youth between ages one and 14 in Southeast Colorado counties have difficulties with emotions, concentration, or getting along with other people (31.7 percent). Those in the Upper Arkansas Valley rank second at about one of four (23.9 percent.) The statewide number is one of five (19.2 percent).

More Youth Reporting Symptoms of Depression

The percentage of students who reported that they felt sad or hopeless every day for two weeks or more in the last year increased by about five percentage points to 29.5 percent in 2015 from 24.3 percent in 2013. This compares with the national rate, which stayed the same between 2013 and 2015 at 29.9 percent.



About four of 10 (37.8 percent) high school students in Mesa County say they felt sad or hopeless every day for two weeks or more, the state's highest rate. The next highest rates are reported by high schoolers in Pueblo County (34.5 percent) and the Upper Arkansas Valley (34.2 percent).

Colorado's Substance Use Primary Prevention Landscape

Approaches to Substance Use Primary Prevention

We now consider the day-to-day work of substance abuse primary prevention in Colorado, including the content of these programs, their policies and approaches, and their funding.

CHI identified eight separate substance use-specific primary prevention funding streams that are active either statewide or in 58 of Colorado's 64 counties. The largest, at \$9.8 million, is the

Colorado Department of Human Services' (CDHS) Tony Grampsas program, named for a longtime state legislator from Evergreen who championed education and children's issues.

This funding supports prevention efforts that promote healthy behaviors in youth, teach parenting skills, offer after-school activities, and involve young people in positive development activities such as art or outdoor pursuits. These dollars also make possible other prevention activities such as social marketing, local policy change and general information dissemination.

Many Colorado programs are nationally recognized and evidence-based. Figure X shows examples of programs funded by the Office of Behavioral Health, listed alphabetically.

FIGURE 10. Evidence-Based Primary Prevention Programs Funded by the Colorado Office of Behavioral Health: Examples Across the Socioecological Model



Primary Prevention Funding in Colorado: A Financial Map

More than \$32 million will flow into Colorado substance use primary prevention programs during fiscal year 2017-18, according to a financial mapping analysis conducted by CHI.

The money will come from both the federal government and the state government. Colorado, however, is the source of most of the funding — nearly \$25 million. And the Colorado Marijuana Tax Cash Fund, created when retail marijuana sales became legal in 2014, contributes the largest share of the state portion. Marijuana taxes dramatically changed the funding landscape in Colorado. Before 2014, federal funding was the largest source of prevention money.

Of the state's 64 counties, 58 will receive funding specifically targeted to primary prevention of substance abuse. Only Baca, Custer, Jackson, Kiowa, Prowers and Rio Blanco counties will not receive any substance abuse primary prevention money beyond funding for statewide programs.

CHI's financial mapping shows how much money is going to substance use primary prevention programs in Colorado and where it is coming from. CHI analysts collected the data by interviewing a wide range of funders, poring through annual budgets and gathering data from other sources.

While it could be argued that many programs targeting Colorado youth contribute to their substance-free well-being, CHI narrowed the focus of the financial mapping as much as possible. We decided not to include primary prevention that isn't specific to substance use, provider education or health promotion campaigns, among other activities. For example, the Office of Children, Youth and Families' (OCYF) Core Services program was excluded because it is not substance-use specific, even though it promotes healthy families and could deter youth from drinking, smoking or using drugs. More detail on our methodology is described in Appendix 1: Financial Mapping Methods.

Mapping the \$32 million in substance abuse primary prevention funding shows that:

- CDHS — which houses OBH and OCYF — is the state's leading primary prevention player, managing \$17.2 million, or 53 percent of the total funds.
- The Tony Grampsas Youth Services Program receives \$9.9 million of those dollars, making it the state's largest funding stream. It is managed by the department's Office of Children, Youth and Families.



- The department’s Office of Behavioral Health administers another \$7.4 million in state and federal funds. Less than 10 percent of that money comes from the state while the rest comes from the federal government.
- The Colorado Department of Public Health and Environment (CDPHE) manages \$14.1 million, or 43 percent, of statewide funding.
 - Communities That Care is one of the state’s largest single primary prevention programs with a \$9.4 million budget. Now running in 42 counties, it helps communities build a coalition that selects and implements evidence-based prevention programs.
 - Marijuana education campaigns receive about \$4.7 million. One example is the Good To Know program, which provides information on Colorado’s marijuana laws and safe adult use.
- Most funding is state-sourced. But about \$7.7 million comes from the federal government and flows to local programs through the state Office of Behavioral Health and Drug-Free Communities grants.
- Most primary prevention funding in Colorado, nearly \$26 million, or 79 percent, goes to universal approaches serving entire schools or communities rather than to services for at-risk groups or individuals. (See Figure X: Primary Prevention Funding by Program and Target Audience).
- About two thirds of Colorado’s primary prevention efforts (68 percent) are for youth.

Prevention programs target populations by how “at risk” they are for a behavioral health problem, such as substance use.¹² Programs can be universal, selective or indicated, depending on how narrow a population they target. (See Figure X). Universal programs are available to everyone in the program’s area. Selective programs are aimed at people exposed to

risk factors. Indicated programs are tailored for those who have shown signs of problem behaviors. Based on data provided from interviewees and CHI’s analysis of programs, Colorado’s spending is heavily weighted toward universal programs.

The financial mapping reveals a great deal of programmatic overlap. Each program operates independently, with funding often coming from several sources or administered by different offices. For example, CHI identified 11 counties where four or more funding streams are providing money for programs. (See Map X).

This array of funding is contributing to confusion among grantees and extra administrative work that could instead be focused on prevention. Multiple funding streams can be a burden. Reporting requirements are different across all funding streams, often because of federal requirements. Local organizations must devote substantial resources to grant-required progress reports.

At the program level, the financial mapping and grantee surveys show that coalition-building and educational efforts receive the most funding. Coalition-building includes different approaches such as the Communities That Care planning meetings and the Strategic Prevention Framework planning approach. Education programs offer activities like classroom or small-group sessions and family management lessons. Less funding goes to environmental strategies such as modifying views about drugs, alcohol and tobacco, or to local policy change.

About 68 percent of Colorado’s primary prevention dollars are targeted directly to youth. About a quarter (23 percent) focus on both youth and their families, and the rest target just families (see Figure X: Primary Prevention Spending by Youth and Family Focus).

FIGURE 11. Primary Prevention Funding by Program and Target Audience

Funding for Primary Prevention of Substance Abuse	Universal	Selective	Indicated
Total	\$25.7 million	\$5.9 million	\$0.9 million
	79 percent	18 percent	3 percent

MAP 1: Number of Substance Abuse Primary Prevention Funding Streams In Each County (2017-18)

Map includes only county-specific funding.²

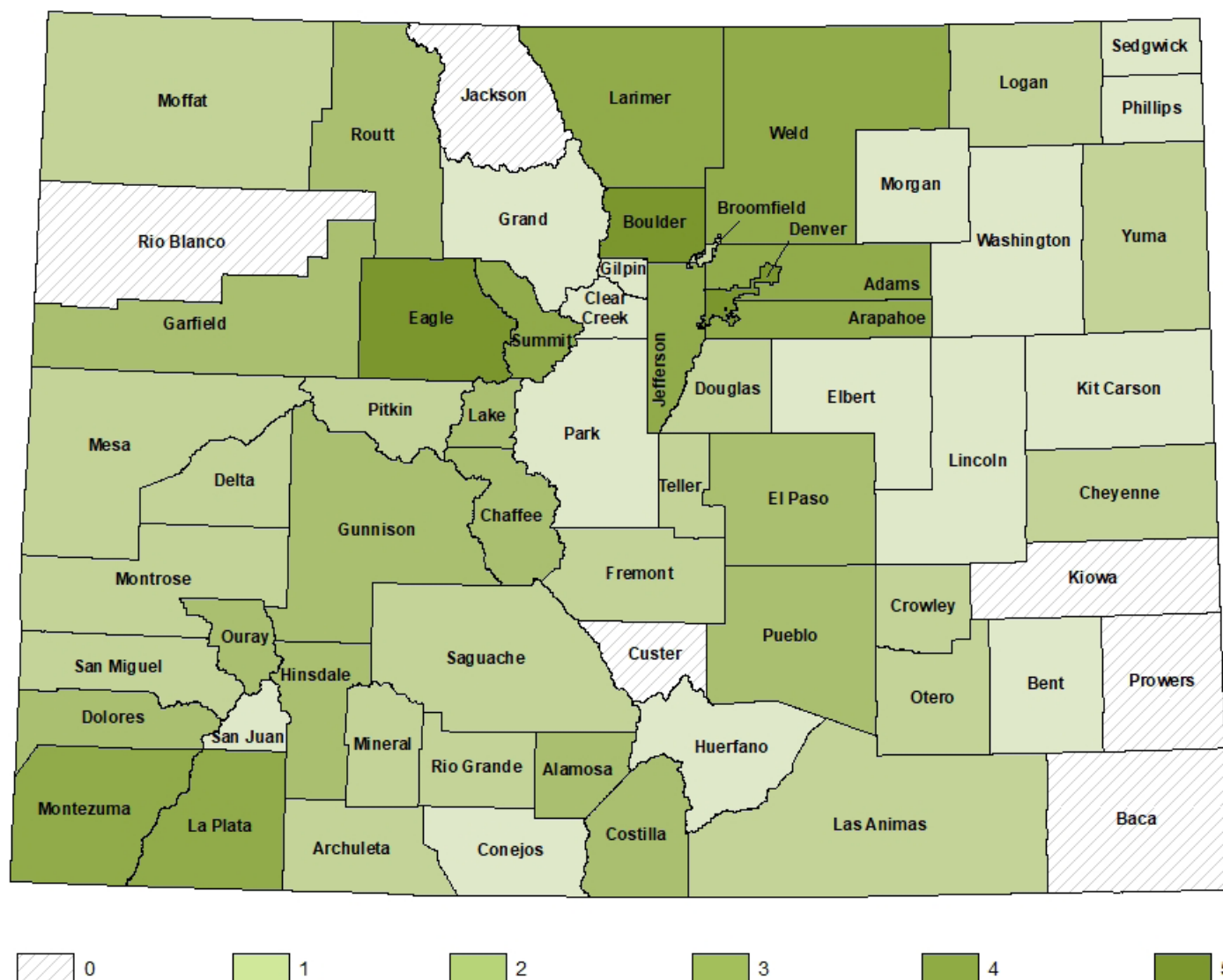
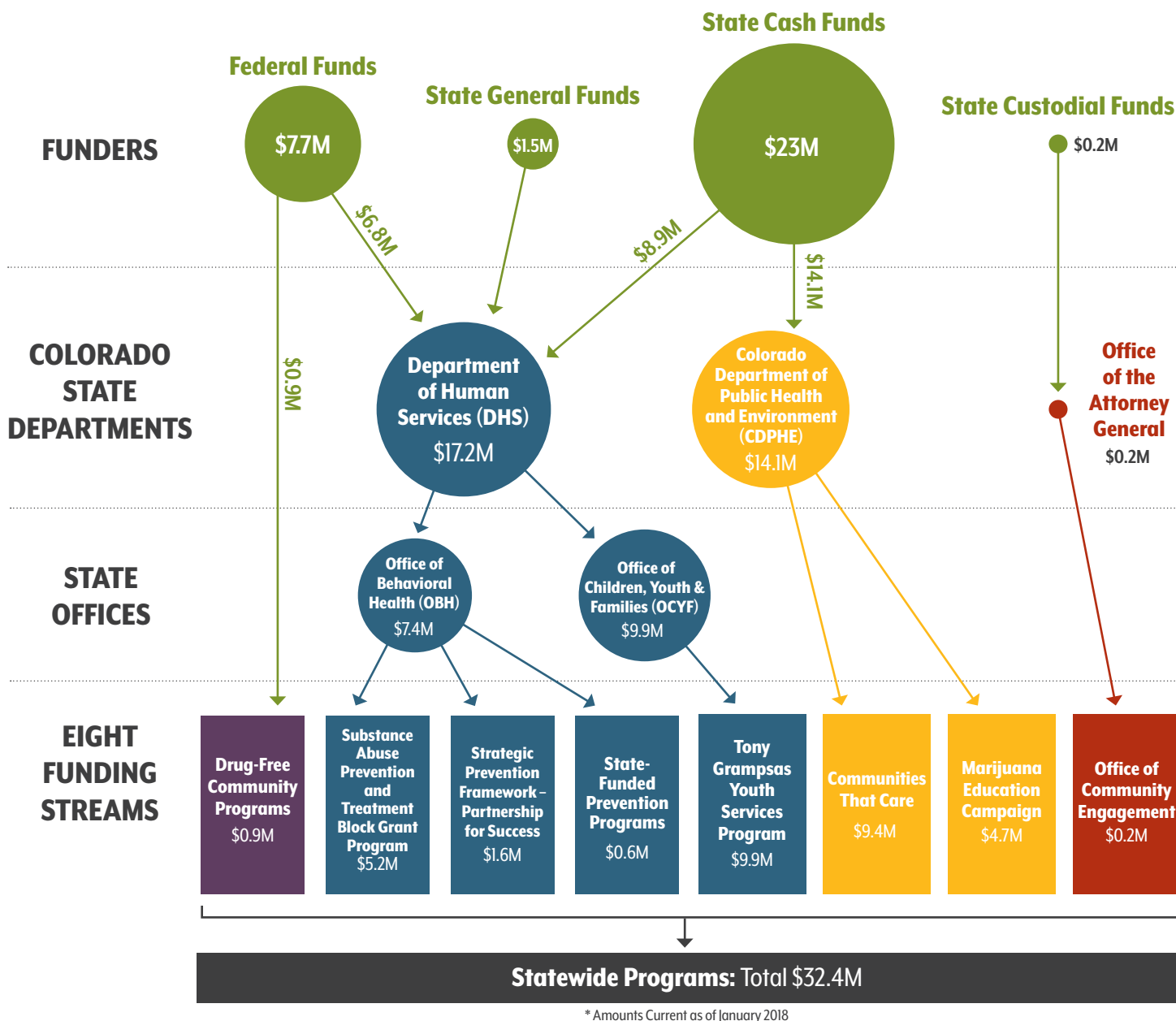


FIGURE 12. Primary Prevention Spending by Youth and Family Focus

	Youth-Focused	Youth and Family	Family-Focused
Primary Prevention for Substance Abuse Program Funding	67 percent (\$21.8 million)	23 percent (\$7.4 million)	10 percent (\$3.1 million)
Example Programs	<ul style="list-style-type: none"> Boys and Girls Clubs Big Brothers Big Sisters 	<ul style="list-style-type: none"> Communities That Care Other coalition-building efforts 	<ul style="list-style-type: none"> Parent Possible Active Parenting of Teens

FIGURE 13. Substance Use Primary Prevention Funding in Colorado: A Financial Map



How to Read the Primary Prevention Financial Mapping Flow Chart

Top Level: Funding comes from four sources: the federal government; the state's General Fund, which is supported by tax revenue; state cash funds, which come from user fees, marijuana taxes and other revenues; and a separate custodial fund established from a pharmaceutical lawsuit settlement that is managed by the state's Office of the Attorney General.

Middle Two Levels: The Colorado Department of Human Services (CDHS) administers federal funds, state General Funds and several state cash funds. Two CDHS agencies — the Office of Behavioral Health (OBH) and the Office of Children, Youth and Families (OCYF) — are responsible for distributing that money. The agency does manage some marijuana tax money, but only through OCYF's Tony Grampas program. CDPHE administers money from the state Marijuana Tax Cash Fund. The Colorado Attorney General provides support through its custodial funds.

Bottom Level: Eight funding streams provide money for the hundreds of prevention program administrators across the state. This level shows the eight funding streams and the source of their funding. All streams are administered by the state except the Drug-Free Communities Support Program which is run by the federal Office of National Drug Control Policy (See Figure X: Summary of Funding Streams and Administrators.)

Identifying Colorado's Substance Use Primary Prevention Needs

Despite more than \$32 million in funding, Colorado's prevention landscape has room to improve. The SNAPS project undertook extensive efforts, including both qualitative and quantitative analysis, to identify the most significant needs:

- **Community and prevention program expert input.** CHI recorded the experiences of more than 200 Coloradans across the state representing more than 100 organizations and communities. We facilitated two types of forums in each of the six OBH prevention regions followed by four statewide virtual forums. Community conversations included parents, teens, school staff and other community members. Focus groups collected input from prevention experts and program providers. We analyzed these findings by coding our results and conducting frequency analyses using the qualitative data analysis platform Dedoose.¹³
- **Grantee survey results.** CHI surveyed OBH's grantees to learn how program administrators select and implement programs, as well as what they perceived as needs and priorities to strengthen prevention efforts. We deployed a 20-question online survey in October and November 2017 to the 50 grant programs funded by OBH. We received 38 responses from 29 unique grantees, a 58 percent return rate.

- **Quantitative data.** CHI analyzed more than 80 indicators from more than 30 data sets, including sources like the Healthy Kids Colorado Survey and the Child Health Survey, the Pregnancy Risk Assessment Monitoring System, the Prescription Drug Monitoring Program (PDMP) and others.
- **Financial mapping analysis.** CHI identified eight unique funding streams for primary prevention services targeted to substance abuse, totaling more than \$32 million, from state and federal sources. We collected these data by reviewing budget documents and by conducting interviews and email exchanges with more than 30 people in 20 state agencies and organizations. We characterized funding by the target audience using the Institute of Medicine's (IOM) designations of "universal," "selective" or "indicated" strategies, and whether the programs primarily targeted youth, family or both.

This work allowed CHI to identify Colorado's critical needs in primary prevention efforts. This section explores the needs in two ways. It includes a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the current system. And it takes a deeper look through the lenses of communities, expert prevention stakeholders and statewide funders.

FIGURE 14. SWOT Analysis of Colorado's Efforts Toward Primary Prevention of Substance Use

Strengths

- Commitment of state prevention program administrators
- Many prevention programs in place and working for youth
- Use of evidence in selecting programs

Weaknesses

- Insufficient EBP choices that are age- and culturally appropriate
- No consistent data set to track EBP adoption and gaps

Opportunities

- Support community prevention program administrators (sustainability planning, program training and identifying appropriate EBPs)
- Address service needs and geographic needs
- Better coordinate funding

Threats

- Potential funding changes at state or federal level
- Underlying social issues such as poverty will weaken prevention efforts

SWOT Analysis of Colorado's Substance Use Primary Prevention Landscape

Colorado benefits from more than \$32 million in funding and an overall commitment to using evidence-informed strategies. However, there are opportunities to better coordinate efforts and support program administrators. This analysis identifies the strengths, weaknesses, opportunities and threats of the current substance abuse primary prevention system (See Figure X).

Strengths

Colorado's main strength stems from the commitment of its state agencies and the federal government to funding primary prevention.

More than \$32 million support programs at the state level and in 58 counties to provide family-based programming, mentorship, community-driven prevention programs and extracurricular activities that offer alternatives to youth substance use. Participants in statewide forums reiterated this strength.

Program administrators report using evidence-based programs or practices. Survey results from OBH's grantees provide an illustration. More than half of OBH's grantees responding (57 percent) said they chose their prevention approach based on significant risk and protective factor research, and more than two thirds (69 percent) reported using national registries to do that. Just one of seven (14 percent) said they built their program from the ground up. And most grantees are talking frequently with the developers of their programs — a quarter (25 percent) reported annual discussions and half (50 percent) reported talking with the developers at least quarterly.

Weaknesses

Program administrators participating in the statewide forums do not feel they have adequate EBP options that will work well in their communities. Resistance from teachers, facilitators and students is a challenge. According to survey responses from OBH's grantees, most use nationally recognized EBPs (40 percent). But many also adapt programs significantly (29 percent) such as changing the materials used or number of sessions provided. Some

take another approach altogether (31 percent).

Also, Colorado has no consistent data to analyze EBP adoption rates across all its primary prevention programs. This makes it labor-intensive to understand which grantees need assistance in selecting and implementing EBP programs.

Opportunities

Opportunities exist to strengthen Colorado's prevention efforts. Communities could use regionally targeted investments in efforts that change perceptions of drugs and alcohol for teens and their families. Grantees could use help strengthening their organizations' sustainability, getting training on program implementation and identifying the right EBP.

Threats

Colorado has problems with overlapping funding and a lack of coordination among statewide funders. This systemic confusion is most likely weakening prevention efforts. Prevention program experts said funding is inconsistent and reporting is burdensome.

Community members also cited underlying social factors, such as poverty, housing shortages and transportation difficulties, as threats to current prevention efforts. These factors keep kids from accessing prevention programs, after-school activities.

Community, Program and Statewide Prevention Needs

Now we will take a deeper look at Colorado's substance use primary prevention system through three lenses: community needs, local prevention program administrator needs, and statewide funder needs.

1. Colorado's community members need help supporting youth both in school and in their families.
2. Local substance use prevention administrators need access to effective programs at the right time and the necessary training to deliver those programs.
3. Statewide prevention funders need a systematic way to coordinate existing efforts, reduce overlap and address unfunded needs.

1. What Colorado's Communities Need

Communities need substance use prevention programs that target the regions and populations most at risk, along with services that are consistent and multigenerational. These strategies, known as the “2Gen” approach, already inform many statewide agency efforts to support families. Learn more in figure X – Colorado's 2Gen Approach.

Community members also called for more environmental strategies — meaning approaches that change policies and social norms to reduce substance use and its related harms.

Services for Families and Changing Community Norms

Prevention services need to be consistent, standardized and focused on youth and their families. Community members say they need:

- Programs for all parents, as opposed to targeted parent groups.
- Multigenerational approaches that incorporate parents, other family members and teens.
- Continuous, standardized education across multiple ages.
- Programs that are selected in partnership with the community.
- Environmental approaches — programs, policies or strategies that seek to change norms and perceptions of substance use.

Almost a third (32 percent) of Colorado's total substance use primary prevention funding is directed at families or both youth and families. Even so, this was the number one need identified across all statewide forums, suggesting that families may not be aware of existing programs or there are not enough available.



(Programs) should be integrated into existing subjects rather than something additive.”

– Aurora expert focus group participant



Used to be a big deal to smoke marijuana, now it's a big deal to BINGE smoke”

– Steamboat community member

“(Substance use is) normalized, out of control.”

– Pueblo expert focus group participant

Community members and local program administrators feel that programs need to focus on systemic issues like policy change and perceptions of substance use. Policy changes or social norms campaigns are known as environmental approaches. They were identified by more than a third of OBH's grantee survey respondents (39 percent) as the biggest primary prevention gap in their community. Examples of these approaches include modifying alcohol or tobacco practices, promoting drug use policies in schools, changing views on alcohol and drug use, and undertaking marketing campaigns.¹⁴

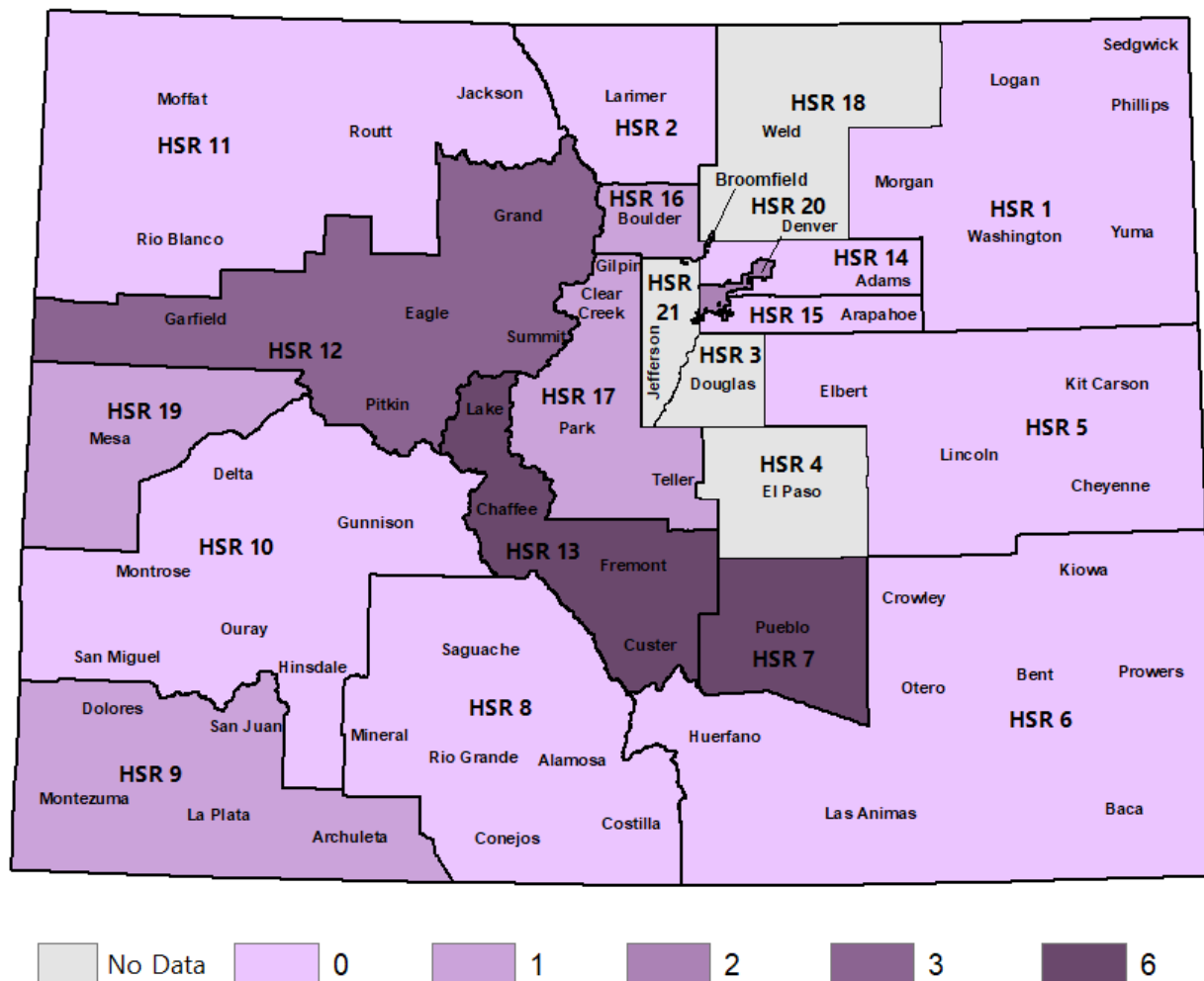
Environmental approaches can change the way people talk about and perceive the use of substances, which leads to reduced use. For example, large numbers of youth in Pueblo and the Upper Arkansas Valley think many substances are not harmful. Youth in these regions also use more substances than anywhere else in the state. In terms of marijuana, youth in Pueblo are almost half as likely as other Coloradans to say they think that pot is harmful (See Map X). These areas may be ripe for implementing environmental strategies to change social norms and perceptions around substance use.

Better Communication and Access to Prevention Resources

Community members need to know what programs are available. Many parents said they don't know how to support their kids or where to turn for help. Parents at our forums asked for a centralized place to find prevention resources such as after-school programs and parent education.

MAP 2. Regions Where Youth Substance Use is Highest

Number of times a region ranked in the top quartile for youth use of eight substances: alcohol, marijuana, heroin, ecstasy, meth, prescription medication, cocaine and tobacco



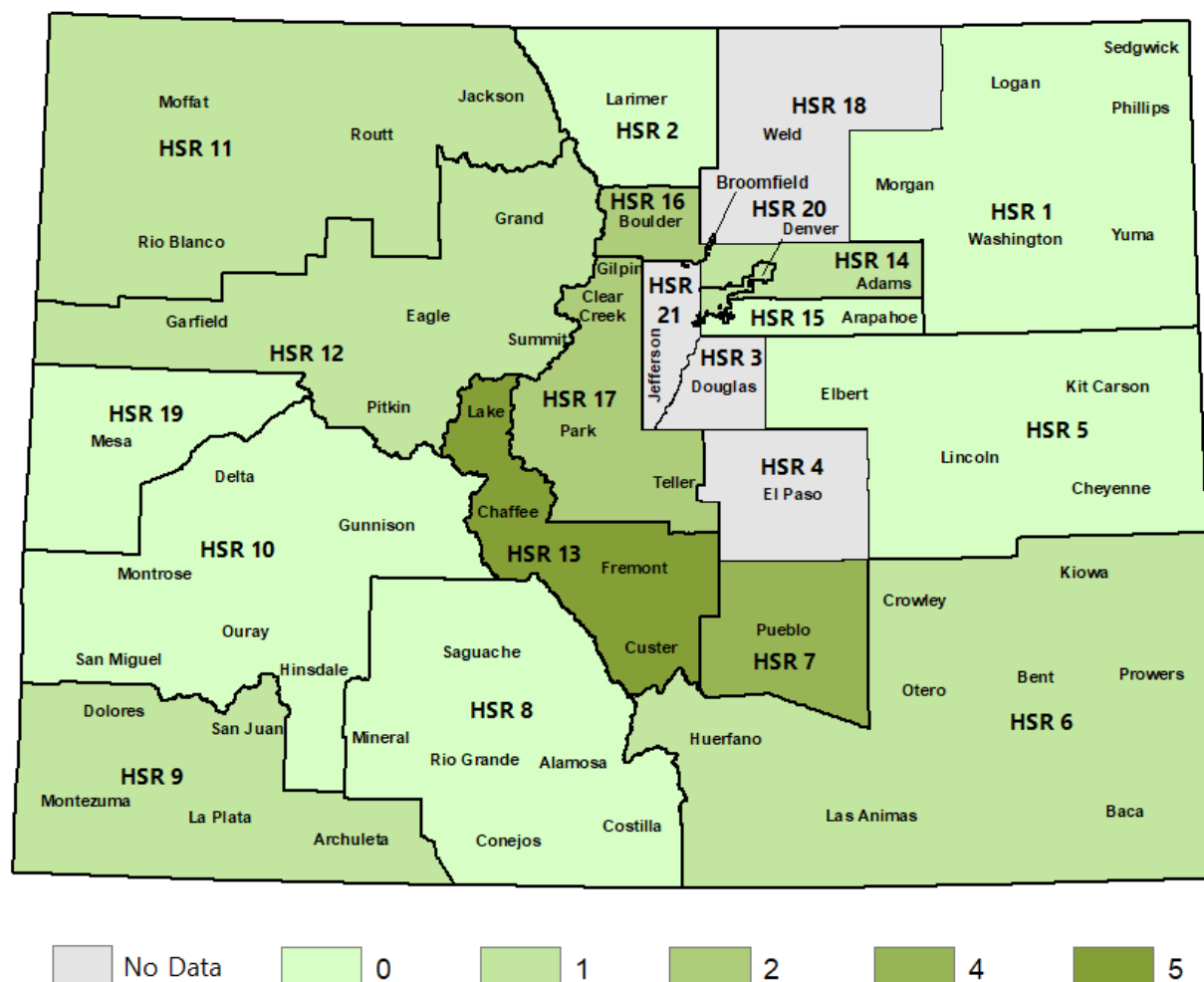
Colorado's 2Gen Approach

A 2Gen, or two-generation, approach is a collection of strategies to address poverty by focusing on the needs of both children and their caregivers.

A well-known example of the approach is Head Start,¹⁵ a national early education program promoting school readiness and comprehensive child development. While providing early learning opportunities for children, the program also supports parents working toward financial security. Leaders from Colorado's state and county governments, nonprofits, and the philanthropic community have embraced 2Gen as a core element of successful programs such as the Jefferson County Prosperity Project,¹⁶ the Valley Settlement Project,¹⁷ and multiple initiatives by the Colorado Department of Human Services.¹⁸

MAP 3. Regions Where Youth Access to Substances is Easiest

Number of times a region ranked in the state's top quartile for perceived ease of access to five substances: marijuana, alcohol, prescription medication, tobacco and illicit drugs



*Parents are calling
because their kid is using.
Do I call the police? Are they
better off in jail? Who can help
me, not just my kid?"*

—School administrator participant in Pueblo community forum

High-Need Areas

Pueblo County and the Upper Arkansas Valley consistently rank as most in need of prevention efforts. These places could benefit from greater future investment given their high rates of substance use, despite prevention efforts:

- Youth in these two regions rank among the state's heaviest users of six of eight substances analyzed — alcohol, marijuana, heroin, ecstasy, meth, prescription medication, cocaine and tobacco. (See Map X.)
- Substances are easy to obtain in these regions. Youth in the Upper Arkansas reported some of the most concerning scores in the state in terms of ease of access to marijuana, alcohol, prescription medication, tobacco and illicit drugs. Pueblo County also ranked high for four of these five substances — all except tobacco.
- The regions also rank among the state's worst regions for four out of five risk factors — difficulty with emotions, feeling sad or hopeless, having an adult to talk to, teacher encouragement, and school dropout rates. (See Maps X, X and X.)

MAP 4. Regions with Lowest Scores on Risk Factors

Number of times a region ranked in the state's worst quartile for five risk factors: school dropout rates, difficulty with emotions, feeling sad or hopeless, having an adult to talk to, and teacher encouragement

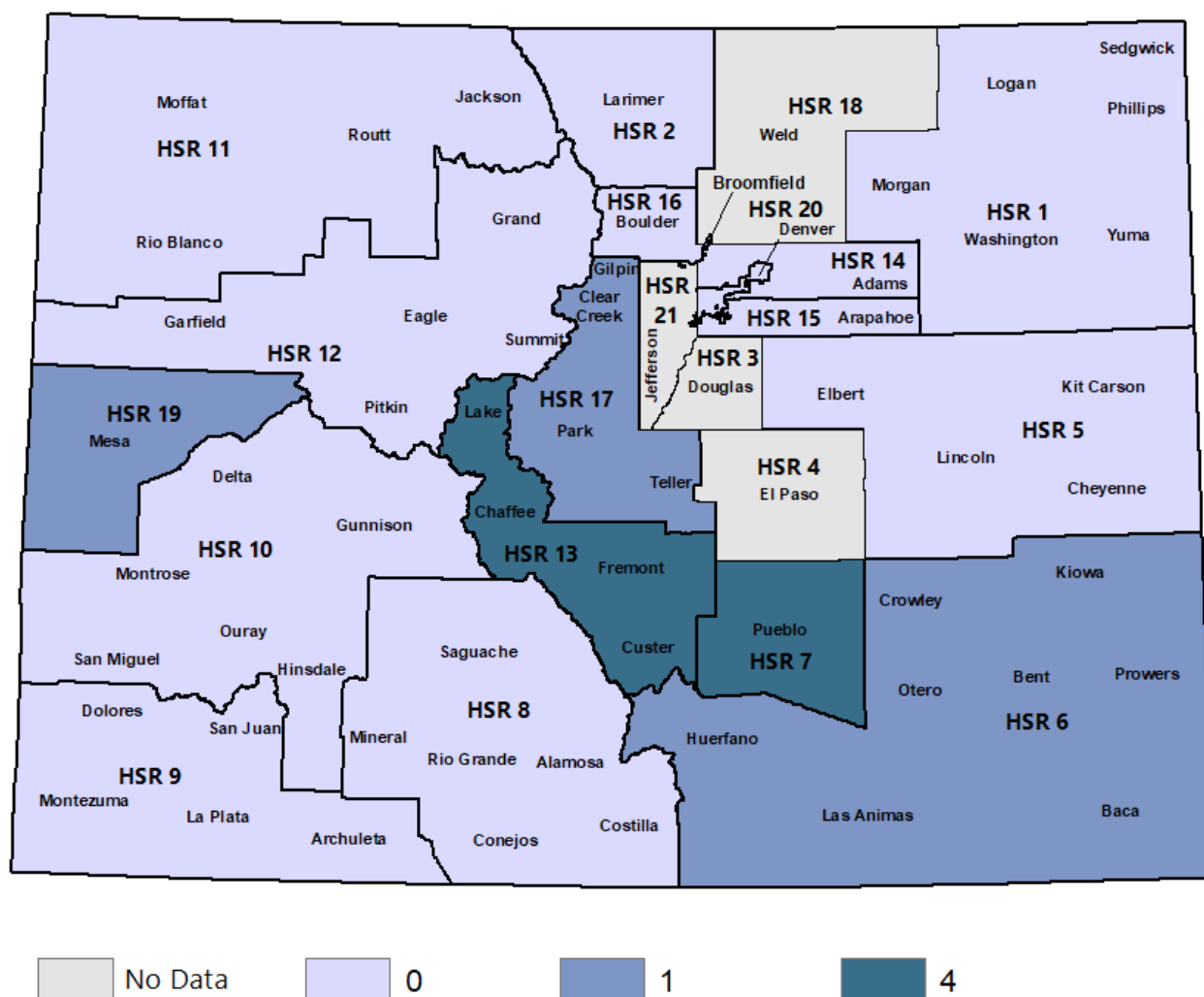
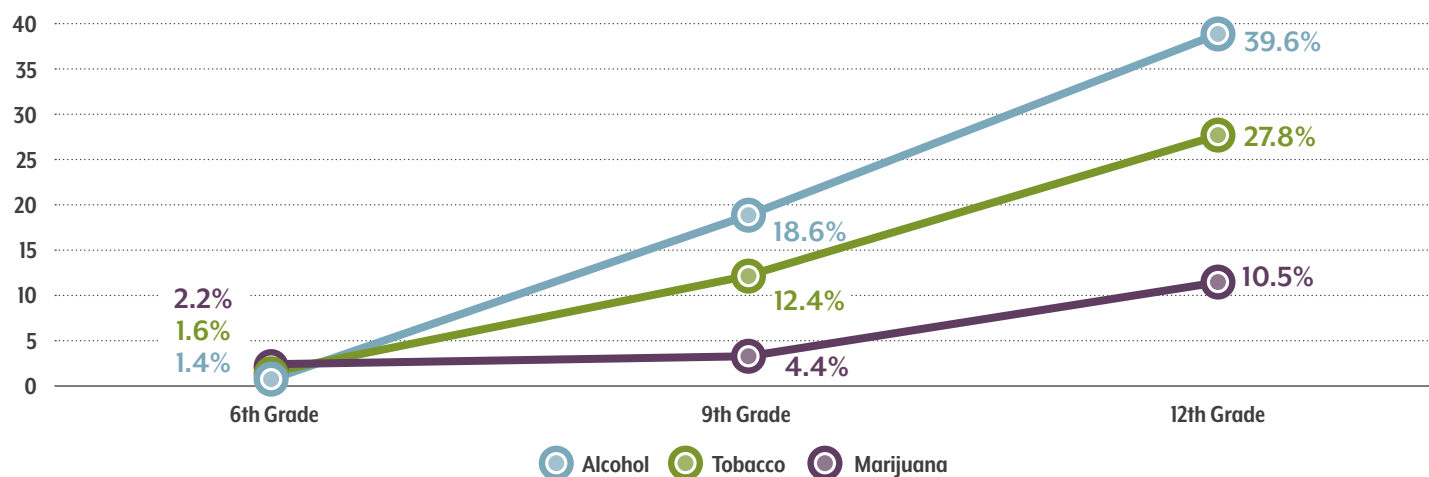


FIGURE 15: Biggest Jump in Substance Use Rates Happens Between Middle and High School



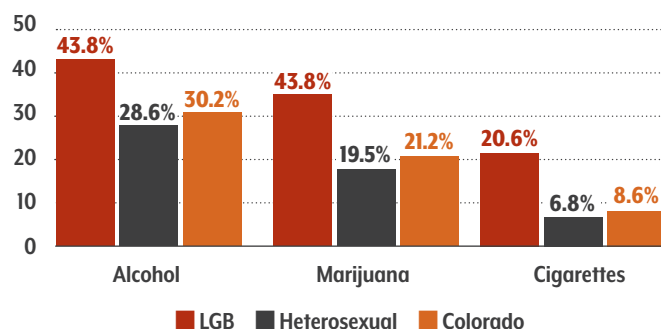
Substance Use Prevention Planning for Populations in Need

Some populations experience higher rates of substance use, and that's important to know when planning primary prevention programs. But the differences can vary across substances and by population.

For example, lesbian, gay and bisexual (LGB) high school students in Colorado report higher use of alcohol, marijuana and cigarettes than heterosexual students. LGB students smoke cigarettes at a rate of 20.6 percent—three times higher than heterosexual students at 6.8 percent and more than double the state average of 8.6 percent.

Substance use rates can also vary by race and ethnicity, but the story isn't consistent. For example, 23.6 percent of Hispanic high school students report using marijuana regularly compared with 19.5 percent of white students. However, for regular cigarette use, the two groups report the same rate of 8.3 percent.

Figure 16. Current Substance Use by Sexual Orientation



Though disparities remain in substance use, there are limitations to planning targeted prevention programs. And it's important to recognize that many underlying social and economic factors contribute to substance use disparities—including education, income and discrimination.

High-Risk Populations

Age groups in transition from one life stage to another need the most attention. Coloradans between the ages of 18 and 25 are the heaviest substance users.¹⁹ Forum participants said this is the toughest group to reach with prevention efforts. Illicit drug use is especially high in this age group among those with high school degrees or less.²⁰

Another group that needs attention is eighth, ninth and 10th graders. Survey data suggest that youth start using substances in middle and high school. The biggest jump in substance use rates happens at this time. This age group may present the greatest opportunity for successful prevention efforts. (See Figure X – Biggest Jump in Substance Use Rates.)

2. What Local Prevention Programs Need

CHI convened expert focus groups to hear from the front lines of substance use prevention. These experts include people working in schools, clinics, after-school programs and extracurricular youth activities. These community prevention program administrators identified several needs, including

better coordination among funders, a greater choice of programs appropriate for their communities, and help in sustaining their programs.

Local prevention program administrators said they need:

Better Funder Coordination

This topic came up at every expert focus group across the state, and a survey of OBH's grantees revealed similar calls for better statewide coordination. Programs in almost all of Colorado's counties receive funding from more than one source, and some places are dealing with four or more funders. That overlap means grantees spend more time and resources on multiple evaluation requirements, grant progress reports and other administrative activities.

More Choices of Programs

Prevention experts also called for greater choices of age-appropriate and culturally appropriate EBPs that fit their communities. Many prevention experts adapt EBPs to make them relevant to youth and families. Others choose approaches that resonate with participants but may not be based in clear evidence. More than half (59 percent) of OBH's grantees



We are struggling with the short list of approved prevention curricula. We have tried several curricula, some work, some don't. Resistance to a few of them has been high, not only from the students, but also the teachers and facilitators. Trying a new one this year for 7th grade, trusting it will be great."

– OBH grantee survey respondent

responding to CHI's survey reported adapting their evidence-based program significantly from the original design. They also want more environmental prevention strategies, such as local policy changes to increase the alcohol tax.

Increased Technical Assistance

Prevention experts said they need help in program planning, especially when it comes to sustaining their efforts. A third of OBH's grantees responding to CHI's survey (29 percent) ranked sustainability planning as their main organizational need, and half ranked "increased continuity of funding" as top need from funders. Grantees also said they would benefit from streamlined funding applications, funding streams and reporting requirements.

FIGURE 17. Shared Needs Across Community Members and Expert Stakeholders



COMMUNITY FORUMS

Multiyear programs for kids and their parents.

Programs that are selected and implemented in partnership with the community.



SHARED NEEDS

Family-focused environmental programs

Addresses social determinants of health

Mental Health and trauma-informed prevention

Communication of available resources



EXPERT STAKEHOLDER FOCUS GROUPS

Better coordination of funders

More choices of programs appropriate for their community

Help to sustain prevention programs

Family-focused programs that change social norms. These programs would serve whole families and would be selected and implemented in partnership with community members.

Social determinants of health. Social factors can be barriers to prevention programming. A lack of transportation, unsafe neighborhoods, poor housing, long drive times, and limited income make it difficult to afford uniforms or equipment for after-school activities.

Mental health and trauma-informed prevention. Several forum participants said substance users are taking drugs or drinking alcohol to deal with an underlying issue, such as poor mental health or the effects of adverse childhood experiences. Treatment for these conditions should be an integral component of prevention efforts.

Better communication. Communication about available resources and specific programs could be improved to families, to communities, to programs, and at the state level. Community program administrators were interested in learning about other programs in their community and across the state. Parents wanted information about local programs to help their kids.

Common Themes Across Community Conversations and Expert Focus Groups

Across all forums, both community members and expert stakeholders agreed on several common recommended areas to focus prevention efforts. (See Figure X.)

Grantees also need support getting the best training in delivering EBPs. A third of OBH's grantees (31 percent) reported that only some of their staff had been trained in the selected EBP. Of those staff that were trained, only half were trained by a program developer or certified trainer. And 30 percent of responding grantees said the trainings were only somewhat useful.

3. What Statewide Funders and Coordinators Need

Many statewide funders expressed the need to better coordinate and align their efforts in primary prevention of substance abuse. CHI's financial map and focus groups of community prevention program administrators reached the same conclusion.

CHI identified eight funding streams with significant overlaps in the types of substance use prevention services funded, the populations served and the regions they cover.

In terms of target audiences, most primary prevention funding (79 percent) in Colorado goes to universal strategies — those for entire schools or communities — rather than to services for high-need groups or individuals. All eight identified primary prevention funding streams support universal strategies.

Similarly, more than two thirds of funds (68 percent) go to youth-focused programs, rather than strategies for caregivers or whole families. Seven of the eight identified funding streams support those programs.

But even though their dollars are going to similar programs and people, statewide substance use prevention funders don't consistently coordinate their funding efforts and reporting requirements. CHI identified 11 counties where four or more funding streams are providing money for substance use prevention programs. But six counties — Baca, Custer, Jackson, Kiowa, Prowers and Rio Blanco — will not receive any substance abuse primary prevention money in fiscal year 2017-18 beyond statewide program funding.

Voices of Colorado's Young People

Getting young people into our statewide forums was a challenge. We knew that even when they showed up, they might not feel free to participate alongside their parents, community leaders and local prevention program administrators. So, we took a different approach. We tapped one of our youngest analysts to conduct two key informant interviews with youth leaders. He also talked with 10 youth under age 18 from a health-specific council of students convened by CDPHE called the Youth Partnership for Health. This approach brought in youth voices from Weld County, Cheyenne County, Denver, Pueblo, Aurora and other parts of the state.

Information gathered from these youth-focused efforts did not significantly differ from the findings we collected from community members and stakeholders. Young people said prevention should focus on:

- Intergenerational programs.
- Substance use disorder treatment for parents as prevention for their kids.
- Programs that are academic in nature — not scare tactics or information without the science to back it up.
- Mental health support to address underlying pain and stress that substances users are “treating.”
- Approaches that do not assign blame for substance use.

Young people also said they believe the Healthy Kids Colorado Survey under-reports substance use in Colorado.

The multiplicity of funding streams can burden grantees with reporting requirements that vary from one funder to another. The lack of a standardized method for grantees to access funding and report their results represents a gap in the system, because hours and dollars that grantees spend on grant-related administrative tasks cannot be spent on prevention work.

Recommendations for Making the Wise Investment

This needs assessment presents real opportunities for OBH and other statewide primary prevention funders. As OBH pursues its strategic planning process in 2018, it should consider convening its fellow statewide prevention funders to help focus Colorado's collective investments on addressing the greatest needs:

- **Address community needs.** Target investments to multigenerational and environmental approaches that help Coloradans who are most in need.
- **Address local prevention program administrator needs.** Provide technical assistance to community substance use prevention program administrators to select the best evidence-based programs and sustain them, and to evaluate existing prevention approaches.
- **Address statewide systemic needs.** Foster strong leadership by aligning prevention priorities, sharing funding information and consistently coordinating what's funded.

Addressing Community Needs

This report makes the following recommendations to address substance use primary prevention needs in Colorado's communities:

Invest in Family-Oriented Prevention and Environmental Approaches

OBH and its statewide substance use prevention funder partners can support communities by making prevention programs available that support both young people and the adults in their lives, from parents to grandparents to neighbors. OBH also can help change the normalization of substance use by targeting investments to local policy change and messaging campaigns. Policy change can reduce availability and advertising of substances, and messaging campaigns can change the way young people and their families use and talk about substances.

Explore Ways to Better Align Funding with Need

By setting a strategic direction for its primary prevention efforts, OBH can design a funding allocation methodology to achieve that strategy. One approach might be to allocate funds to high-need areas such as Pueblo and the Upper Arkansas Valley, or to "transition age" youth like the 18- to-25-year-old population.

Addressing Local Programmatic Needs

These recommendations address shortcomings identified by substance use prevention program administrators:

Support Adoption of Evidence-Based Prevention Programs and Approaches

OBH should maintain or boost its technical assistance for grantees to increase EBP adoption. Strategies could include connecting grantees with relevant EBP choices, required trainings, coalition development assistance, and evaluation of existing programs to ensure they are evidence-based. OBH and other funders will need to be flexible in helping community prevention program administrators select and adapt programs. Colorado's communities are unique, so one short list of EBP options on a federal registry won't work everywhere.

Increased technical assistance would help grantees to:

- **Select programs.** Grantees need support to find and adapt EBPs that are culturally appropriate and age appropriate.
- **Evaluate existing prevention programs.** Many grantees use programs that may not be considered evidence-based because they are not on a national registry. OBH could help establish criteria to evaluate programs to ensure they work, are sustainable and are cost-effective. They could also focus additional resources on evaluation of existing programs.

- **Sustain their programs.** In the survey, OBH's grantees said their top priority is securing assistance for sustainability planning, community readiness assessments and strategic planning.

Align Reporting Requirements from Funders

Many primary prevention programs are funded by more than two state funders and federal grants. To the extent that it's possible, aligning the requirements to apply for grants and comply with reporting requirements would lessen the burden on grantees and increase the efficiency of funding. For example, the state agencies that provide funding could collaborate to develop a common grant reporting form.

Addressing Statewide Systemic Needs

The final set of recommendations addresses systemic needs in statewide prevention funding:

Better Coordinate Statewide Primary Prevention Efforts

OBH and leadership from the Department of Human Services should work with their peer statewide primary prevention funders on a continuous basis to coordinate primary prevention funding. A coordinated system will require:

- **Collecting and sharing consistent information.** Statewide funders need to collect and publicly share information on their prevention efforts and programs. Community members and stakeholders want a centralized place to access programs. Operating a clearinghouse will require ongoing maintenance and consistent tracking of programs and funding.
- **Aligning leadership.** Funders have not consistently coordinated their priorities, reporting requirements and allocation methodologies. This will require strategic thinking in 2018, and OBH can be a leader in the effort. An initial idea is to revitalize a prevention funder leadership council that was active in the past. If state agencies strengthen the way they track and share their primary prevention funding efforts with other funders, they could take an important step toward aligning Colorado's various funding streams.

- **Coordinating and consolidating.** Multiple state actors administer more than \$32 million in prevention funding for communities, but the funding streams are not clearly delineated by their focus — either geographically, strategically, or by service or population targets. This lack of coordination and clarity presents an opportunity for OBH to make clear its funding priorities and the distinct role they play in Colorado's prevention landscape, or to consolidate its funding with other agencies that pursue similar goals.

Conclusion

Substance use affects the lives of thousands of Coloradans every day. Significant prevention efforts are underway — more than \$32 million goes to programs supporting communities, families and young people across the state. That work and the people who do that work are critical to building resilient youth in Colorado.

However, challenges remain. CHI identified opportunities to help communities address substance use locally, address local prevention program administrator needs in selecting and implementing programs, and close gaps in how those programs are funded.

This needs assessment marks the beginning of OBH's 2018 strategic planning process. But it also marks a potential change in the way Colorado thinks about addressing substance abuse across the state.

Primary prevention — and the evidence behind it — offers an opportunity to move the state's investments upstream. If the investments are made effectively,

Appendix 1. SNAPShots Methods

Data on substance use, access, perception of risk, overdose deaths, crime, and risk factors were gathered from a variety of state and national sources to inform each of the SNAPShots infographic summaries in this report. Data were selected based on relevance to substance use primary prevention, trendability, youth populations, sub-state geographic reporting, and ability to cross tabulate by demographics.

These are the data sources for the SNAPShots. Included are the year(s) used, a description of the source and link to the data, where applicable, and the data indicators used.

1. AMERICAN COMMUNITY SURVEY (ACS), UNITED STATES CENSUS BUREAU, 2015

The U.S. Census Bureau collects data nationally for the ACS annually, capturing demographic information such as race, education, poverty and income at the county level.

<https://www.census.gov/programs-surveys/acs/>

Risk Factors SNAPShot

- **Percentage of Households under the Federal Poverty Level.** The percentage of households reporting annual incomes under the federal poverty level by county in Colorado in 2015.

2. COLORADO BUREAU OF INVESTIGATION (CBI), 2016

The annual Crime in Colorado report is a compilation of crime statistics submitted to the CBI by Colorado law enforcement agencies through the national Uniform Crime Reporting (UCR) Program. Included in this report are data on violent crime by city in Colorado.

<https://www.colorado.gov/pacific/cbi/crime-colorado>

Risk Factors SNAPShot

- **Violent Crime Rates by City.** The number of violent crimes for Colorado's 39 most populous cities reporting these numbers. The number of crimes were recalculated to a rate of violent crime per 1,000 people per city for 2016.

3. COLORADO DEPARTMENT OF EDUCATION, 2015-2016, 2016-2017

The Colorado Education Statistics portal provides data on dropouts, graduation rates, suspensions/expulsions and more for Colorado students grades K-12. These data are reported by school district.

<https://www.cde.state.co.us/cdereval/>

Risk Factors SNAPShot

- **Drug, Alcohol, Marijuana and Tobacco Suspensions.** The number of suspensions related to drug, alcohol, marijuana and tobacco violations among Colorado students grades K-12 for the 2015-2016 and 2016-2017 school years. A substance violation is defined as the use, possession or sale of drugs, alcohol or tobacco on school grounds or at school events.
- **Dropout Rates.** The percentage of dropouts reported per school district in Colorado in the 2015-2016 school year. These data were recalculated by county.

4. COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT (CDPHE), 1999-2016

CDPHE provides overdose death data by request for many substances. These data are collected continuously with rates calculated annually.

Illicit Substances SNAPShot

- **Illicit Drug Overdose Death Rates.** Overdose death rates due to benzodiazepines, methamphetamines and cocaine from 2008 to 2016 among Coloradans of all ages. Rates were calculated per 100,000 Coloradans.

Opioids SNAPShot

- **Fentanyl Overdose Death Rates.** Overdose death rate due to fentanyl from 1999 to 2016 among Coloradans of all ages. Rates were calculated per 100,000 Coloradans.
- **Opioid Overdose Death Rates.** Overdose death rates include total drug poisoning deaths (all substances), prescription drug deaths and heroin deaths from 2010 to 2016 among Coloradans of all ages. Rates were calculated per 100,000 Coloradans.

5. COLORADO DEPARTMENT OF REVENUE, MARIJUANA ENFORCEMENT DIVISION, 2017

The Marijuana Enforcement Division updates current medical and recreational marijuana licenses monthly. <https://www.colorado.gov/pacific/enforcement/statistics-and-resources>

Marijuana SNAPShot

- **Number of Medical and Recreational Marijuana Licenses in Colorado.** The number of licenses were calculated at a rate per 100,000 Coloradans by county.

6. COLORADO CHILD HEALTH SURVEY (CHS), 2015

CHS administrators use the Behavioral Risk Factor Surveillance System (BRFSS) to identify households with children ages 1 to 14 years old. Parents complete the CHS on a variety of topics, including their child's exposure to substances.

<https://www.colorado.gov/pacific/cdphe/behaviorsurvey>

Marijuana SNAPShot

- **Percentage of Adults with Children Under 15 With Marijuana Products in or Around Their Home.** The percentage of Colorado adults surveyed with children ages 1 to 14 years old who report having marijuana products in or around their homes.
- **Number of Homes with Children Under 15 With Possible Exposure to Secondhand Marijuana Smoke or Vapor.** Among Colorado adults surveyed who have children ages 1 to 14 years old, the number of homes with possible exposure to secondhand marijuana smoke or vapor.

Risk Factors SNAPShot

- **Percentage of Adults with Children Under 15 Who Report Their Child Has Difficulty with Emotions.** Among Colorado adults surveyed with children ages 1 to 14 years old, the percentage who report their children have difficulty with emotions, concentration and getting along with other people.

7. HEALTHY KIDS COLORADO SURVEY (HKCS), 2005, 2013, 2015

HKCS collects health information every odd year from Colorado public school students in middle and high school. Questions address a variety of health-related topics, such as exercise and diet, as well as substance use, ease of access to substances, perception of harm from use of alcohol, marijuana, tobacco, illicit substances such as cocaine and ecstasy, and opioids like heroin. HKCS also collects data on several risk and protective factors, such as having a supportive adult and teacher encouragement, as well as mental health measures. The survey data are reported by Health Statistics Region and are disaggregated by grade, age, gender, race/ethnicity, and sexual orientation.

<https://www.colorado.gov/pacific/cdphe/hkcs>

Alcohol SNAPShot

- **Current Alcohol Use.** Percentage of high school students who had at least one drink of alcohol on one or more of the past 30 days.
- **Current Binge Drinking.** Percentage of high school students who had five or more drinks of alcohol within a couple of hours on one or more of the past 30 days
- **Ease of Access to Alcohol.** Percentage of students who feel it would be sort of easy or very easy to get alcohol if they wanted.
- **Perception of Risking Harm to Themselves from Alcohol.** Percentage of high school students who think people who have one or two drinks nearly every day have moderate/great risk of harming themselves.
- **Trying Alcohol Before Age 13.** Percentage of high school students who had their first drink of alcohol other than a few sips before age 13.

Illicit Substances SNAPShot

- **Ease of Access to Illicit Substances.** Percentage of students who feel it would be sort of easy or very easy to get drugs like cocaine, LSD, or amphetamines if they wanted.
- **Ease of Access to Prescription Drugs without a Prescription.** Percentage of students who think it is sort of easy or very easy to get prescription drugs without a prescription.

- **Ever Used Cocaine.** Percentage of high school students who used cocaine one or more times during their life.
- **Ever Used Ecstasy.** Percentage of high school students who used ecstasy one or more times during their life.
- **Ever Used Methamphetamine.** Percentage of high school students who used methamphetamines one or more times during their life.
- **Ever Used Nonmedical Prescription Drugs.** Percentage of high school students who used prescription drugs without a doctor's prescription one or more times during their life.

Marijuana SNAPShot

- **Current Marijuana Use.** Percentage of high school students who used marijuana one or more times during the past 30 days.
- **Ease of Access to Marijuana.** Percentage of students who think it is sort of easy or very easy to get marijuana if they wanted.
- **First Use of Marijuana.** Percentage of high school students reporting age of first use of marijuana.
- **Perception of Risking Harm to Themselves from Alcohol.** Percentage of students who think people who use marijuana regularly have moderate/great risk of harming themselves.

Opioids SNAPShot

- **Heroin Ever Use.** Percentage of high school students who used heroin one or more times during their life.

Risk Factors SNAPShot

- **Feeling Sad or Hopeless.** Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.
- **Supportive Adult to Go to With a Serious Problem.** Percentage of high school students who have an adult to go to for help with a serious problem.
- **Teacher Encouragement.** Percentage of students who strongly agree or agree that teachers care about them and encourage them.

Tobacco SNAPShot

- **Any Tobacco Use.** Percentage of students who smoked cigarettes, smoked cigars, used chewing tobacco, or used an e-vapor product on one or more of past 30 days.
- **Current Cigarette Use.** Percentage of high school students who smoked cigarettes one or more times during the past 30 days.
- **Ease of Access to Cigarettes.** Percentage of students who feel it would be sort of easy or very easy to get cigarettes if they wanted.
- **Perception of Risking Harm to Themselves from Smoking Cigarettes.** Percentage of students who think people who smoke one or more packs of cigarettes per day have a moderate/great risk of harming themselves.

8. NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH), 2013-2015

This nationwide annual survey uses online interviews to collect substance use data on tobacco, alcohol, illicit drugs, and marijuana as well as many mental health indicators.

<https://www.samhsa.gov/data/population-data-nsduh/reports>

Alcohol SNAPShot

- **Percentage of 18- to 25-year-olds in Colorado who report current alcohol use.** Among Coloradans ages 18 to 25, the percentage who report having an alcoholic drink one or more times in the last month in 2015.

Marijuana SNAPShot

- **Percentage of 18- to 25-year-olds in Colorado who report current marijuana use.** Among Coloradans ages 18 to 25, the percentage who report having smoked marijuana one or more times in the last month in 2015.

Opioids SNAPShot

- **Past Year Abuse or Dependence on Prescription Opioids or Heroin, 2003-2014.** Substance Abuse Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality calculated these annual averaged rates for heroin use based on state surveys from the National Survey on Drug Use and Health (NSDUH). Abuse

and dependence for Coloradans 12 and older were measured in terms of state percentages and rates per thousand. Annual averages were based on 2003-2006, 2007-2010, and 2011-2014. Rates were originally per 1,000 residents, recalculated per 100,000.

9. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP), 2016

The PDMP is a tool available through the Department of Regulatory Agencies for prescribers and dispensers. This system of monitoring prescription drugs collects data on prescribing rates for a variety of substances by county annually.

<https://www.colorado.gov/dora-pdmp>

Opioids SNAPShot

- **Rate of Opioid Prescriptions Per 100 Colorado Residents.** The number of prescriptions dispensed for opioids for every county, calculated at a rate per 100 Colorado residents.

10. PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS), 2014

PRAMS is designed to identify and monitor behaviors and experiences of women before, during and after pregnancy. Information is collected by surveying a sample of women who have recently given birth. The survey includes a variety of substance use-related questions. These data are reported every other year and can be combined at the Health Statistics Region geographic level.

<https://www.colorado.gov/pacific/cdphe/pregnancysurvey>

Marijuana SNAPShot

- **Percentage of New Mothers Who Reported Using Marijuana During Their Pregnancy.** Percent of new mothers in Colorado who reported using marijuana or hashish at any time during pregnancy.

11. Youth Risk Behavior Surveillance System (YRBSS), 2013, 2015

Nationwide biennial school-based survey that collects health risk behavior and substance use data on tobacco, alcohol, illicit drugs and marijuana. Data are collected on middle school through high school students.

<https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>

Alcohol SNAPShot

- **Current Alcohol Use.** Percentage of high school students nationally who had at least one drink of alcohol on one or more of the past 30 days.
- **Current Binge Drinking.** Percentage of high school students nationally who had five or more drinks of alcohol in a row within a couple of hours on one or more of the past 30 days.

Illicit Substances SNAPShot

- **Ever Used Cocaine.** Percentage of high school students nationally who used cocaine one or more times during their life.
- **Ever Used Ecstasy.** Percentage of high school students nationally who used ecstasy one or more times during their life.
- **Ever Used Methamphetamine.** Percentage of high school students nationally who used methamphetamines one or more times during their life.
- **Ever Used Nonmedical Prescription Drugs.** Percentage of high school students nationally who used prescription drugs without a doctor's prescription one or more times during their life.

Marijuana SNAPShot

- **Current Marijuana Use.** Percentage of high school students nationally who used marijuana one or more times during the past 30 days.

Opioids SNAPShot

- **Heroin Ever Use.** Percentage of high school students nationally who used heroin one or more times during their life.

Tobacco SNAPShot

- **Any Tobacco Use.** Percentage of high school students nationally who smoked cigarettes, smoked cigars, used chewing tobacco, or used an e-vapor product on one or more of past 30 days.
- **Current Cigarette Use.** Percentage of high school students nationally who smoked cigarettes one or more times during the past 30 days.

Appendix 2. Financial Mapping Methods

Substance use primary prevention programs and their associated funding were identified through a series of interviews and budgetary documents.

Spending was also identified as following a “universal,” “selective” or “indicated” strategy, based on the Institute of Medicine (IOM)’s classifications for prevention. Universal strategies target whole populations with the aim of preventing or delaying substance use. Selective strategies target groups that are identified to be at higher risk for substance use. Indicated strategies target individuals who are beginning to show early signs of substance use risk, but do not yet meet criteria for a substance use disorder diagnosis.

Programs were further classified as targeting youth, families or both. This targeting was based on the initial point of intervention, even though all programs may impact youth and/or their families. For example, a program that works directly with families to prepare children for school would be identified as a “family” program, even though the child is the eventual beneficiary of these services.

Below is additional information about sources and assumptions for each funding stream, and notes on funding that was excluded from this analysis.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT (CDPHE)

MARIJUANA MEDIA CAMPAIGN

- Dollar amount based “Marijuana Education Campaign” financing in the 2017-18 Long Appropriations Bill.
- Assumed media campaign funding was education campaign funding in long bill, except for the Latino Outreach and Positive Youth Development funding described below.
- Source is Marijuana Tax Cash Fund.
- Because the effort is mass media, assumed all funding goes to universal prevention targeted at both youth and families.

POSITIVE YOUTH DEVELOPMENT

- Dollar amount provided by CDPHE.

- Source is Marijuana Tax Cash Fund.
- Based on program description provided by CDPHE; assumed all funding goes to universal prevention targeted at youth.

LATINO OUTREACH

- County-level dollar amounts provided by CDPHE.
- Source is Marijuana Tax Cash Fund.
- Based on program description provided by CDPHE; assumed all funding goes to universal prevention targeted at youth and families.

COMMUNITIES THAT CARE

- County-level dollar amounts provided by CDPHE.
- Source is Marijuana Tax Cash Fund.
- Assumed all funding goes to universal prevention targeted at youth based on description of CTC program on national website.

EXCLUSIONS

State Innovation Model (SIM) grants were excluded. So were chronic disease tobacco funds. According to the long bill, CDPHE gets about \$22 million for tobacco efforts, but it is not able to estimate how much of this goes to primary prevention.

DEPARTMENT OF HUMAN SERVICES – OFFICE OF BEHAVIORAL HEALTH (OBH)

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT PROGRAMS

- Dollar amounts statewide and by county based on data provided by OBH.
- For county programs, IOM classifications were based on the grantee’s reported list of strategies reported using the Colorado Prevention System platform. CHI assumed that strategies used within a program were approximately equal to funding splits — for example, if a grantee had one “universal” strategy and three “indicated” strategies, CHI assumed 25 percent of its funding went to universal efforts and 75 percent to indicated.

- For statewide programs, the county-level funding distribution was applied to prorate those dollars across counties and IOM classification.
- Grantees using strategies of “parenting and family management” were considered to be family-targeted. One example is Peer Assistance Services aimed at parents, caregivers and working adults. The rest were assumed to have a youth focus. Programs supporting both family and youth strategies, like the OMNI Institute’s statewide evaluation work, are considered “both.”

STRATEGIC PREVENTION FRAMEWORK – PARTNERSHIP FOR SUCCESS

- Dollar amounts based on Strategic Prevention Framework-Partnership for Success grant amounts provided by OBH.
- Source is the federal SAMHSA Strategic Prevention Framework Grant.
- Assumed equal allocation to all counties participating in this grant based on the equal allocation of county-specific funds reported by OBH.
- Based on SAMHSA grant description; assumed all programs to be universal and youth-targeted.

STATE-FUNDED PREVENTION PROGRAMS

- Dollar amounts based on “prevention program” funding line in the 2017-18 Long Appropriations Bill and from OBH.
- Sources are state General Fund, Adolescent Substance Abuse and Treatment Cash Fund, Persistent Drunk Driver (PDD) Cash Fund, Law Enforcement Assistance Fund (LEAF) Cash Fund, and Cigarette, Tobacco Product, and Nicotine Product Use by Minors Prevention Cash Fund.
- Based on the PDD and LEAF fund descriptions, assumed funding from PDD Cash Fund was used for indicated efforts targeting both youth and families; LEAF Cash Fund was used for universal efforts targeted at both youth and families.
- For all other funds, CHI applied the same funding split by IOM classification that was used by OBH’s Substance Abuse Prevention and Treatment Block Grant grantees. All funds were assumed to target both youth and families.

DEPARTMENT OF HUMAN SERVICES – OFFICE OF CHILDREN, YOUTH AND FAMILIES (OCYF)

TONY GRAMPSAS

- Dollar amount and allocations by funding source based on 2017-2018 Long Appropriations Bill.
- Allocations by program based on Tony Grampsas grantee data on OBH website.
- Within a program that serves multiple counties, CHI assumed the county expenditures could be calculated based on the share of the 0- to 25-year-old population in each county, based on estimates from the state demography office.
- Sources are Youth Services Program Cash Fund, Marijuana Tax Cash Fund and the state General Fund.
- CHI classified each Tony Grampsas program by its IOM classification based on the description. If the program included elements of more than one strategy, CHI assumed equal spending between these classification types (e.g., a program using both universal and selective approaches was assumed to be 50 percent universal and 50 percent selective. A program using all three approaches was assumed to be 33.3 percent universal, 33.3 percent selective and 33.3 percent indicated).
- Programs were also assumed to be targeting youth, family or both based on the descriptions.

EXCLUSIONS

DHS OCYF core services were not included. While they are aimed at creating healthy families, they were not explicit to the goal of avoiding substance use.

DIRECT COMMUNITY GRANTS

ONDCP DRUG-FREE COMMUNITIES

- Dollar amounts by program and county based on SAMHSA website. Source is ONDCP Drug-Free Communities Grants from SAMHSA.
- For programs using more than one strategy, CHI assumed equal spending between these strategies (e.g., a program using both universal and selective approaches was assumed to be 50 percent universal and 50 percent selective. A program using all three approaches was assumed to be 33.3 percent universal, 33.3 percent selective and 33.3 percent indicated).

- Assumed all programming followed this even split and served youth only, with two exceptions. The Gunnison Substance Abuse Prevention Project was assumed to target both youth and families and not include any indicated approaches, based on website description. The Weld County Prevention Partners Community Coalition was assumed to be fully selective as it is also part of the strategic prevention framework.

OFFICE OF THE ATTORNEY GENERAL

OFFICE OF COMMUNITY ENGAGEMENT

Dollar amount for Rise Above funding through attorney general's office based on data provided by the office. Source is the Attorney General's Custodial Funds. Assumed to be fully universal and youth-targeted.

EXCLUSIONS

Based on interviews and research, these entities

were excluded from the analysis since they were not considered to be doing primary prevention that is specific to substance use.

- Philanthropic organizations (Colorado Health Foundation, others)
- Colorado Department of Education
- CDHS Office of Early Childhood
- Colorado Consortium for Prescription Drug Abuse
- Division of Criminal Justice
- Denver Juvenile Court
- Colorado Department of Public Safety
- Colorado Behavioral Health Care Council
- Colorado Department of Health Care Policy and Financing
- School-based health centers

Appendix 3.

Funding Streams by County and Statewide

	Tony Grampsas	Communities That Care	Substance Abuse Prevention and Treatment Block Grant Programs	Strategic Prevention Framework	Marijuana Education Campaign	Office of Community Engagement	ONDCP Drug-Free Communities	Prevention Programs
Statewide								
Adams								
Alamosa								
Arapahoe								
Archuleta								
Baca								
Bent								
Boulder								
Broomfield								
Chaffee								
Cheyenne								
Clear Creek								
Conejos								
Costilla								
Crowley								
Custer								
Delta								
Denver								
Dolores								
Douglas								
Eagle								
El Paso								
Elbert								
Fremont								
Garfield								
Gilpin								
Grand								
Gunnison								
Hinsdale								
Huerfano								
Jackson								

	Tony Grampsas	Communities That Care	Substance Abuse Prevention and Treatment Block Grant Programs	Strategic Prevention Framework	Marijuana Education Campaign	Office of Community Engagement	ONDCP Drug-Free Communities	Prevention Programs
Jefferson								
Kiowa								
Kit Carson								
La Plata								
Lake								
Larimer								
Las Animas								
Lincoln								
Logan								
Mesa								
Mineral								
Moffat								
Montezuma								
Montrose								
Morgan								
Otero								
Ouray								
Park								
Phillips								
Pitkin								
Prowers								
Pueblo								
Rio Blanco								
Rio Grande								
Routt								
Saguache								
San Juan								
San Miguel								
Sedgwick								
Summit								
Teller								
Washington								
Weld								
Yuma								

Appendix 4. Statewide Forum Participants

We are grateful to the families, local prevention program administrators and other community members across Colorado who participated in CHI's 16 forums held in October 2017. Over 200 people made time in their schedules, contributions to this report and for the work they do on a daily basis:

October 2: Durango

- Adeline Bryant, Durango School District
- Allison Duran, Montezuma County Public Health Department
- Alyssa Maynard, Collaborative Management Program
- Amanda Rydiger, Fort Lewis College
- Ashley Wagle, Archuleta School District
- Becky Joyce, San Juan County Public Health and Silverton Public Schools
- Bobbi Lock, Montezuma County Public Health Department
- Brad Dodd, Member of the Public
- Bruce LeClaire, Southern Ute Indian Tribe
- Christine Schler, Mercy Regional Medical Center
- Eileen Wasserbach, Southern Ute Community Action Programs
- Joyce Fontana, Member of the Public
- Kendra Gallegos Reichle, Fort Lewis College
- Laura Warner, San Juan Basin Public Health
- Mary Dengler-Frey, Southwestern Colorado Area Health Education Center
- Pat Senecal, Celebrating Healthy Communities
- Peter Tregillus, Southern Ute Community Action Programs
- Ron Tyner, TuerEx
- Ruth Rydiger, Member of the Public
- Sandy Lane, Archuleta School District
- Scott Smith, La Plata Youth Services/CMP
- Stephanie Allred, Axis Health System

October 9: Aurora

- Aleah Horstman, Arapahoe House
- Alexis Ritvo, UCD/UCHealth Addiction Psychiatry
- Annie Klein, Peer Assistance Services
- Benita Martin, Denver District Attorney's Office Diversion
- Bonnie Wright, Telligen
- Carolyn Swenson, Peer Assistance Services
- Deb Federspiel, Children's Hospital Colorado
- Delwin Maben, City of Centennial

- Eddy Costa, CIVHC
- Elizabeth Pace, Peer Assistance Services
- Eric Sigel, Children's Hospital Colorado
- Erin Flynn, Colorado Department of Public Health and Environment
- Franklin Erickson, Young People in Recovery
- Gina Olberding, Colorado Consortium for Prescription Drug Abuse Prevention
- Halle Drestow, Member of the Public
- Harlan Austin, CEMP
- Heidi Letko, CPHP
- Jenna Glover, Children's Hospital Colorado
- Jennifer Place, CeDAR/UCHealth
- JK Costello, Steadman Group
- Laura Don, Tri-County Health Department
- Lauren Reedy, Jefferson Center for Mental Health
- Marc Garstka, Aurora Strong Resilience Center
- Marcia Ko, Ameritox, LLC
- Matt Hess, Colorado Area Health Education Center
- Meghan Prentiss, Tri-County Health Department
- Molly Ryan-Kills Enemy, Member of the Public
- Nikki Hyde, Tri-County Health Department
- Philippe Marquis, National Institute for Change
- Rachel Uslan, Aurora Mental Health Center
- Steve Martinez, Tri-County Health Department
- Yajaira Johnson-Esparza, Salud Family Health Centers

October 11: Pueblo

- Angela Garcia, Boys and Girls Club
- Aubree Adams, Moms Strong
- Cheryl Reid, Crossroads
- Dawn Okeefe, University of Colorado Hospital and Colorado State University
- Eric Pearson, ReSADA
- Jenny Case, Pueblo City-County Health Department
- Jessica Thurman, HTF and DSS
- Judy Solano, Southern Colorado Harm Reduction Association
- Kim Whittington, Pueblo City-County Health Department

- Leo Ybarra, Pueblo City-County Health Department
- Lexie Ellis, Pueblo City-County Health Department
- Libby Stuyt, CMHIP - Circle
- Michael Bayer, Pueblo City Schools
- Mike Nerenberg, Pueblo City-County Health Department, SCHRA
- Mike Orrill, Chaffee County Public Health
- Patrick Hatchett, Catholic Charities
- Rapunzel Fuller, Pueblo County D.S.J.
- Terry Krow, Integrated Community Health Partners (IHP)
- Tina Gage, Integrated Community Health Partners (IHP)
- Valerie Baughman, Parkview Medical Center

October 12: Greeley

- Aubrie Hartnell, Team Wellness & Prevention
- Cheslie Covey, Larimer County Health Department
- Christa Timmerman, Larimer County Health Department
- Christy Weeks, Community Grief Center
- Colt Smith, iThrive
- Daniel Shaw, North Range Behavioral Health
- Dawn Williams, UCHHealth CAC & MTC
- Elissa Unger, Colorado Access
- Emily Garner, UCHHealth ER
- Jeff Appleman, Centennial Area Health Education Center
- Jim Riesberg, North Range Behavioral Health
- John Cordova, North Range Behavioral Health - Weld County Prevention Partners
- Karen Randinitis, Larimer County Health Department, Communities That Care
- Katherine Chu, Larimer County Health Department
- Kelly Slade, North Range Behavioral Health
- Kendall Alexander, North Range Behavioral Health
- Laurie Walker, University of Northern Colorado, School of Nursing
- Margie Gomez, SB44
- Melissa Jensen, Community Grief Center
- Monica Mika, Centennial Area Health Education Center

October 12: Colorado Springs

- Ashley Hill, Central Colorado Area Health Education Center
- Cari Davis, Colorado Springs Health Foundation
- Carliss M. Hamerzell, Communities That Care

- Cindy Mouser, O.R.Y. (Older Women Reaching Back for the Younger Women)
- Darlene Brace, SCHN
- Darlyn Miller, Community Health Partnership
- Doris Ralston, Colorado Springs Osteopathic Foundation
- Jennifer Place, CeDAR/UCHealth
- Jessica Curry, SCHN
- Julie Thompson, OMNI Institute
- Juliette Cutillo, School District 8
- Kristina Fortenberry, Community Health Partnership
- Lisa Bell, O.R.Y. (Older Women Reaching Back for the Younger Women)
- Mary Steiner, Community Health Partnership
- Russell Himmelberger, Fort Carson Army Substance Abuse Program
- Shirley Rhodus, El Paso County Public Health
- Taryn Bailey, El Paso County Public Health
- Terri Ridgeway, Aspent Pointe
- Traci Jewett, Advocate
- Velda Baker, Penrose St. Francis
- Yaritza Trevino, El Paso County Public Health

October 17 & 18: Virtual Forums

- Adam Musielewicz, Team Wellness & Prevention
- Angie Trelstad, Aspen Mine Center
- Ann Sherman, Member of Public
- Anna Marie Neal, Member of Public
- Ann-Marie Peterson, Member of Public
- Ashley Hill, Regional Health Connector
- Brigitte Strawmatt, Right of Passage
- Cara Cheevers, One Colorado
- Charity Neal, Northwest Colorado Health
- Chris Lopez, Boys and Girls Club of the San Luis Valley
- Christina Abel, Member of Public
- Christine Gill, Member of Public
- Christine O'Neill, Mental Health Partners
- Cindy Morris, Member of Public
- Claire Lara, Boys and Girls Club of the San Luis Valley
- Clarissa Woodworth, Member of Public
- Danielle Culp, HCPF
- David Arnold, Coalition of Colorado Campus Alcohol and Drug Educators (CADE)
- Dawn Nannini, Team Wellness & Prevention
- Debbie Barry, Las Animas-Huerfano Counties District Health Department

- Dee Kessler, Regional Health Connector
- Denise Gutierrez, Aspen Mine Center
- Donna Golden, Chaffee County Colorado Community Response
- Emily Brown, Member of Public
- Gretchen Russo, CDHS
- Heidi Troxell, Member of Public
- Helen Harris, El Paso County Public Health Epidemiologist
- Jacky Noden, Boys & Girls Clubs of Metro Denver
- Jade Woodard, Illuminate Colorado
- Jane Squires, Member of Public
- Jena Finch, Lake County Build a Generation
- Jillian Adams, Illuminate Colorado
- Jenna Quigley, Colorado Judicial Branch
- Johanna Bernholtz, Gunnison Valley Mentors
- Kari Commerford, GCSAPP
- Katelyn O'Grady, Poudre School District
- Kent MacLennan, Rise Above Colorado
- Kerri Quinlan, Lake Country School District
- Kimberly Bryant, SLV Public Health Partnership
- Lauren Harrington, Poudre School District
- Lauren Kiel, Poudre School District
- Laurie Blackwell, Summit County
- Laurie Jevons, NASPA
- Lee Scriggins, Boulder County
- Leslie Beckstrom, Weld County Department of Public Health and Environment
- Lisa Laake, Larimer County Department of Public Health and Environment
- Lisa Thomason, Voyager Youth Program
- Lori Hammer, Partners for HOPE Center
- Madeline Morrissey, RMC Health
- Maggie Moorland Loggains, Peer Assistance Services
- Mallori Gariner, San Luis Valley Health
- Mary-Claire Geiss, City of Fort Collins Restorative Justice Services
- Megan McKinley Dziekan, Member of Public
- Michel Holien, Denver Public Schools
- Mikayla Curtis, Eagle River Youth Coalition
- Robin Albert, Summit County Youth and Family Services
- Sarah Provino, OMNI Institute
- Shanna Farmer, Catholic Charities
- Shannon Allen, Rocky Mountain Prevention Research Center

- Ted Borden, Aspen Mine Center
- Yen Nguyen, Mile High Behavioral Healthcare

October 19: Steamboat Springs

- Amy Goodwin, Yampa Valley Medical Center Pain Management
- Bobby Jones, Boys and Girls Club
- Brian Hoza, Hayden Schools & DMS
- Brian Smith, Steamboat Mountain School
- Dana Duran, Boys and Girls Club
- David Schramm, SK8 Church/The Foundry
- Gail Cape, RN BSN
- Gail Smith, United Methodist Church
- Garrett Wiggins, Routt County Sheriff
- Henry Howard, Northwest Colorado Community Health Partnership (Music With Vision)
- Jack Dugwyler, Middle Park High School, Celebrate Recovery Grand County
- Julia Luciano, Partners in Routt County
- Kate Nowak, Routt County United Way
- Keagan Scronek, Northwest Colorado Community Health Partnership
- Ken Davis, Northwest Colorado Community Health Partnership
- Kristin Bantle, De-Escalation Nation
- Lauren Vanderhurk, Rocky Mountain Youth Corps
- Lindsey Simbeye, Grand Futures
- Mark Andersen, Yampa Valley Community Foundation
- Megan Geraets, Northwest Colorado Community Health Partnership
- Mel Stewart, Steamboat Fire
- Michelle McNamara, Member of Public
- Ralph Maher, Oak Creek Police
- Sarah Bartels, SK8 Church
- Sarah Valentino, Northwest Colorado Community Health Partnership
- Shelby Dewolfe, School District
- Stephanie Monahan, Northwest Colorado Community Health Partnership
- Susan Petersen, Communities That Care
- Susan Petersen, Communities That Care
- Susie Coleman, ISST Family Services, Northwest Colorado Health
- Tom Gangel, Mind Springs Health
- Tracey Fortson, Yampa Valley Medical Center
- Wes Hunter, Yampa Valley Medical Center

Endnotes

- ¹ Opioid-related overdose deaths, 1999-2016. Data provided by Colorado Department of Public Health and Environment (CDPHE).
- ² Communities That Care. "Risk and Protective Factors." <http://www.communitiesthatcare.org.au/how-it-works/risk-and-protective-factors>
- ³ Surgeon General's Report on Alcohol, Drug and Health. 2016
- ⁴ Centers for Disease Control and Prevention, Prevention Institute. "Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence." July 2014. https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf
- ⁵ Nation M, Crusto C, Wandersman A, Kumpfer K, Seybolt D, Morrissey-Kane E and Davino K. "What Works In Prevention: Principles of Effective Prevention Programs." American Psychologist. June/July 2003. http://www.ncdsv.org/images/AmPsy_WhatWorksInPrevention_6-7-2003.pdf
- ⁶ Surgeon General's Report on Alcohol, Drug and Health. 2016
- ⁷ SAMHSA. "Identifying and Selecting Evidence-Based Interventions." 2009. <https://store.samhsa.gov/shin/content//SMA09-4205/SMA09-4205.pdf>
- ⁸ Coalition for Evidence-Based Policy, "Social Programs that Work." <http://evidencebasedprograms.org/> Accessed November 2017.
- ⁹ Blueprints for Healthy Youth Development. <http://www.blueprintsprograms.com/> Accessed November 2017.
- ¹⁰ Office of Juvenile Justice and Delinquency Prevention, "Model Programs Guide." <https://www.ojjdp.gov/mpg/> Accessed November 2017.
- ¹¹ National Survey on Drug Use and Health (NSDUH), 2015
- ¹² "Risk and Protective Factors." Center for Application of Prevention Technologies: SAMHSA. Accessed November 9, 2017. <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors#universal-prevention-interventions>
- ¹³ A pre- and post survey of forum attendees did not reveal significant differences between what participants thought before the forums versus afterwards. The survey results were similar to what we heard at the forums.
- ¹⁴ "Prevention Approaches." Substance Abuse and Mental Health Services Administration (SAMHSA), Center for the Application of Prevention Technologies (CAPT). <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-approaches>
- ¹⁵ National Head Start Association. <https://www.nhsa.org/>
- ¹⁶ "Jeffco Prosperity Partners." Jefferson County Colorado Human Services. <https://www.jeffco.us/2716/Jeffco-Prosperity-Partners>
- ¹⁷ Valley Settlement. <http://www.valleysettlement.org/home/>
- ¹⁸ "The Two-Generation (2Gen) Approach." Colorado Department of Human Services. <https://www.colorado.gov/pacific/cdhs/two-generation-approach>
- ¹⁹ SAMHSA NSDUH (2016) (both state and national)
- ²⁰ SAMHSA. "CAPT Tips and Tools: Reaching and Engaging 'Non-college' Young Adults in Prevention Efforts." February 2015. <https://www.samhsa.gov/capt/sites/default/files/resources/reaching-noncollege-young-adults.pdf>
- ²¹ Institute of Medicine (IOM) Program Classifications for Prevention. October 2014. http://dpbh.nv.gov/uploadedFiles/mhnhgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf
- ²² Senate Bill 17-254. 2017-18 Long Appropriations Bill. Part XVI Department of Public Health and Environment. https://leg.colorado.gov/sites/default/files/documents/2017A/bills/2017a_pubhea_act.pdf
- ²³ Senate Bill 17-254. 2017-18 Long Appropriations Bill. Part VII Department of Human Services. https://leg.colorado.gov/sites/default/files/documents/2017A/bills/2017a_hum_act.pdf

Notes

Notes



The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

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