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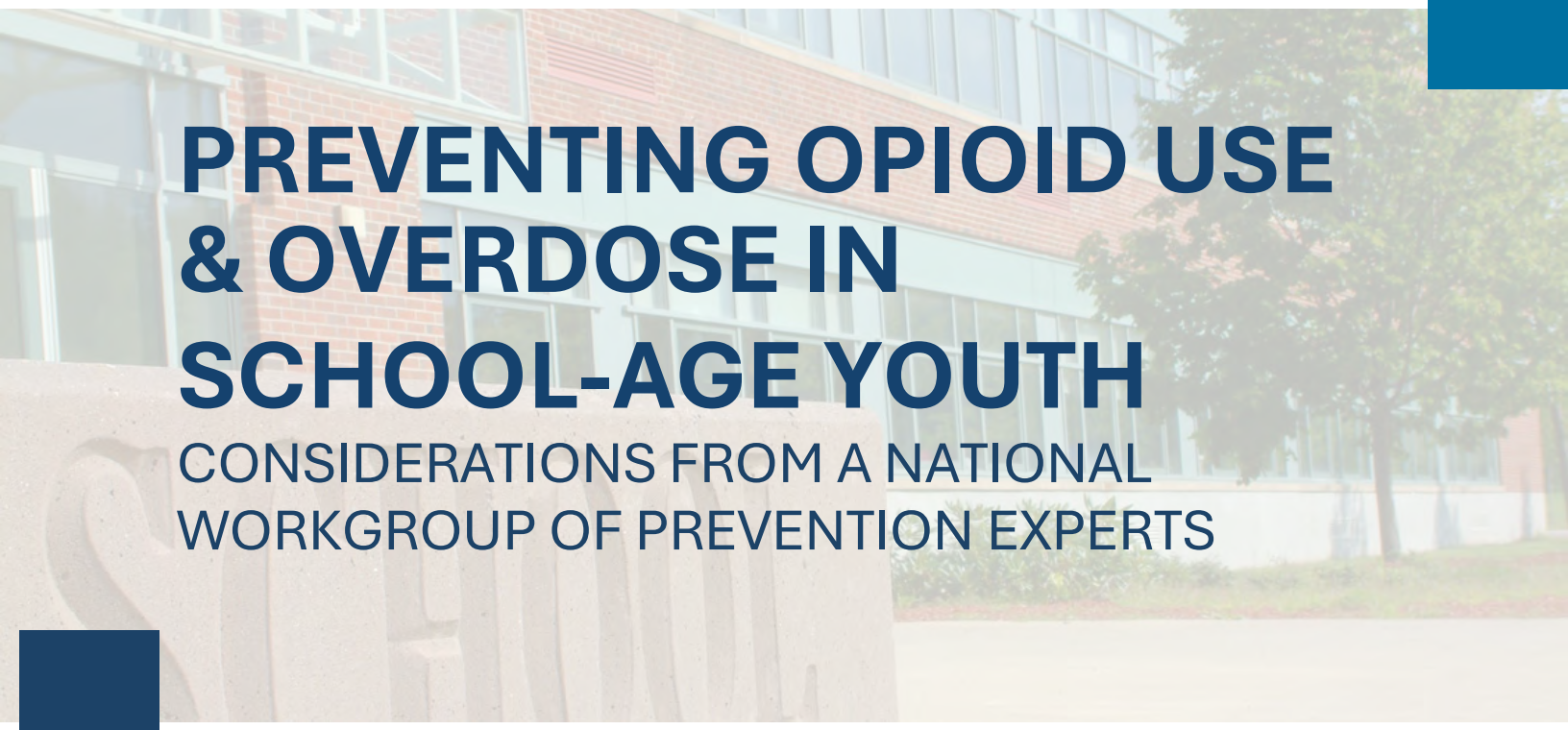

PREVENTING OPIOID USE & OVERDOSE IN SCHOOL-AGE YOUTH

CONSIDERATIONS FROM A NATIONAL WORKGROUP OF PREVENTION EXPERTS

Prepared For:
HIDTA Communities

Prepared By:
Youth Opioid Prevention Workgroup

PURPOSE

The purpose of this resource is to offer considerations for educators, school administrators, law enforcement, parents, policymakers, and other community partners on engaging with schools to help prevent youth from using and overdosing on opioids, including fentanyl. Considerations are based on the best available evidence regarding what works and what does not work in preventing substance use among school-age youth.

ACKNOWLEDGEMENTS

In response to multiple technical assistance requests received by ADAPT asking for guidance on how to integrate fentanyl education and naloxone training into schools according to the best available evidence, ADAPT commissioned a **Youth Opioid Prevention Workgroup** in the summer of 2024 to review the science and offer considerations for how schools and their community partners can achieve this for the purpose of preventing opioid use in school-aged youth.

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INTRODUCTION

Opioid prevention through the lens of what works and what does not work in preventing substance use among school-age youth

For many years, the risk of dying from an opioid (morphine, codeine, oxycodone, hydrocodone, heroin) overdose was primarily seen as a risk to middle-aged white males. With the advent of inexpensive synthetic opioids, such as fentanyl, overdoses in school-age youth have been increasing dramatically. While the majority of funding in this crisis has been allocated to treatment, policymakers and practitioners have called for prevention efforts to be directed to school-age youth.

The purpose of this resource is to offer considerations for educators, school administrators, law enforcement, parents, policymakers, and other community partners on engaging with schools to help prevent youth from using and overdosing on opioids, including fentanyl. Considerations are based on the best available evidence regarding what works and what does not work in preventing substance use among school-age youth. Schools are an attractive and effective venue for prevention interventions. Quite simply, schools are where one finds the vast majority of teens. Educators are charged with caring for and nurturing the students in their building. Additionally, the primary purpose of schools is educating youth, and a significant component of effective prevention includes education. Thus, teachers, counselors, coaches, and nurses employed in schools have essential roles in supporting prevention programming.

For decades, prevention scientists and program developers have focused on developing substance use curricula and other school-based programs and strategies aimed at delaying the onset of substance use and mitigating any harm that could result from use. In dealing with the crisis of opioid/fentanyl overdoses, we can draw upon the vast literature and lived and living experiences of trained professionals who have identified effective as well as ineffective prevention strategies. Sharing the expertise from decades of research and experience is the foundation of this resource. It is important to note that no materials or strategies have been evaluated rigorously that specifically target the prevention of opioid use or overdoses. This resource provides direction based on measures that have been effective in delaying onset and reducing the harm of using other substances such as tobacco, alcohol, marijuana, and other drugs.

An essential component of any school-based prevention strategy is a positive school climate. Students' everyday interactions with the adults in their building form the base for other prevention activities. An intervention will not be as effective when students experience bullying, inconsistent routines, anger, unsupportive discourse, or intimidation from adults. A protective climate in the school is the foundation for all prevention work, including secondary and tertiary strategies, which address emerging or existing substance use and associated consequences. The possibility for the best possible outcomes occurs when all members of the school community have a positive view of their school and feel protected and cared for. The adults in the school, especially leadership, are responsible for creating and maintaining such a prevention-focused environment.

This resource may appeal to people with a range of experiences:

- For the reader who has little experience or contact with school-based prevention, this resource can offer an overview of effective prevention.
- For the reader with experience working with schools in prevention, this resource can provide the most current information and serve as a refresher.
- For the reader who has worked frequently with schools in evidence-based prevention, this resource can serve as a blueprint for expanding substance use prevention to include opioid/fentanyl prevention.

CURRENT DATA REGARDING USE AND OVERDOSE

Over 90,000 people died from opioid overdose in 2020. The U.S. had a 31% increase from 2019, indicating the opioid epidemic remains a grave public health issue affecting our nation. [1] The current opioid epidemic and overdose deaths resemble a three-phase process. Initially, fatalities from prescription opioids, including natural and semi-synthetic types, began to climb in 1999 and reached their highest point in 2017. This also correlated with a notable rise in heroin overdoses starting around 2010, which also reached the highest point in 2017. Since 2014, there has been a sharp and ongoing rise in overdoses linked to synthetic opioids, particularly fentanyl.

Several factors drive the opioid epidemic among youth. [2] The youth opioid crisis is closely associated with the improper use of prescription opioids, characterized by taking medication in ways or doses not prescribed or without a doctor's prescription. While opioid misuse and dependence are highest among young adults who are between 18 and 25 years old, a recent analysis of data from the Monitoring the Future [3] showed that 31% of high school seniors misuse prescription drugs. Even legitimate use of prescription opioids before high school graduation was found to be independently associated with a 33% increase in the risk of future opioid misuse after high school.

The diversion of prescription opioids is a significant problem because youth are subjected to peer and social pressures to share their prescription opioids for nonmedical use. Recent studies show that 14%–35% of high school students divert their prescription opioids. Elevated rates of misuse are especially troubling, given that individuals who misuse prescription opioids are more prone to transitioning to heroin and fentanyl use.

While most youth do not use substances, illegal drug use has become a lethal problem among students, and fentanyl was responsible for making up over 77% of all overdose deaths among adolescents in 2021. According to research by Friedman et al. using a CDC database, among teenagers aged 14-18, there was a staggering 169% increase in mortality associated with fentanyl and other illicit synthetic opioids from 2019 to 2020 (from 1.21 to 3.26 per 100,000), followed by a 30% rise from 2020 to 2021 (from 3.26 to 4.23 per 100,000). [4]

This rise is particularly concerning given the decline in adolescent drug use rates overall from 30.4% in 2020 to 18.7% in 2021, suggesting that the highly potent and often unrecognized presence of fentanyl in counterfeit pills may be a key factor. The rate of overdose deaths linked to counterfeit pill use has more than doubled from 2019 to 2021. Illicitly manufactured fentanyl and synthetic opioids are progressively contaminating the illegal drug supply. Those who succumbed to these counterfeit pills were generally younger and more likely to have a history of prescription medication misuse compared to individuals who died from other drug overdoses. These behaviors have resulted in more than 6,000 deaths among youth and young adults (ages 15-24) in 2021. Illicit drug producers often mix fentanyl with other substances, like methamphetamine, to enhance the potency and effects of their products. However, fentanyl tends to clump together, resulting in uneven distribution within a batch of pills and dangerously high levels of fentanyl in some pills. Even if users are aware that their pills are contaminated, the unpredictable amount of fentanyl in each pill significantly increases the risk of overdose.

A broader issue of growing racial and ethnic disparities potentially contributes to patterns of overdose deaths among adolescents, warranting deeper investigation and targeted intervention. American Indian and Alaska Native adolescents experienced the highest overdose death rates (11.79 per 100,000) in 2020, a trend that mirrors the high rates observed among adults in these groups. In contrast, while Latinx adolescents also have high overdose rates (6.98 per 100,000), these are notably higher compared to Latinx adults. [4]

Therefore, the current epidemiological data underscores a critical need for targeted harm-reduction strategies, including education about the dangers of misuse and diversion of prescription drugs, fentanyl use, and counterfeit drugs, as well as broader access to life-saving interventions like naloxone.

WHAT WORKS IN SCHOOL-BASED FENTANYL AND OTHER DRUG PREVENTION

Whatever your level of experience in the field of substance abuse prevention, it is important to understand that not all prevention strategies are effective or even helpful. Many of the most common strategies being used by well-meaning parents and caregivers, schools, and communities have been shown by careful research to be ineffective or even to cause harm by unintentionally reinforcing and promoting pro-use attitudes, behaviors, and norms. **The use of approaches, curricula, and policies with demonstrated effectiveness is required to safeguard the health of students from the effects of alcohol, tobacco, and other drugs, including fentanyl and opioids. In other words, fentanyl education should be aligned with the best available evidence for educating youth on any substance to prevent use.** (Additional considerations related to fentanyl and the outcome of overdose can be found on page 12 in the section on harm reduction.)

Past research has identified the characteristics of effective substance use prevention programs for youth.[5,6] These include: (1) going beyond merely raising awareness about the risks associated with substance use by focusing on building specific skills that empower youth to make healthy choices; (2) equip youth with competencies in life skills like self-management, interpersonal, assertive communication, and responsible decision-making [7] (3) offer a sufficient dose to create changes on substance use behaviors; (4) increase youth perceptions of risk and perceptions of anti-substance use norms, and (5) incorporate interactive and engaging delivery methods.

Effective programs, curricula, and approaches incorporate the following core elements:

- **Development of personal and social skills**: This includes decision-making, stress management, identifying risk situations, goal-setting, and resisting peer pressure. [5]
- **Interactive and engaging methods:** Utilizing interactive techniques like role-playing, group discussions, and peer-led activities helps maintain student engagement and facilitates deeper understanding and retention of prevention messages.[8,9]
- **A comprehensive approach:** Programs that integrate multiple components—such as classroom instruction, family involvement, and community engagement—provide a more holistic strategy that reinforces positive behavior changes.[10]
- **Developmentally appropriate content:** Tailoring content to the age and cognitive abilities of students ensures relevance and effectiveness. [12] (Educating on the specifics of any substance is typically not introduced until middle school.)
- **Ongoing support and follow-up:** Including booster sessions and periodic evaluations helps sustain the effectiveness of the prevention efforts over time. [13]

What Works

- Drug resistance skills training
- Social norms change
- Peer education

What Does Not Work

- Informational approaches
- Awareness raising
- Bio-medical approaches
- Guest speakers/assemblies
- Scare tactics
- Dramatizations
- Affective approaches

The available evidence indicates that the following programmatic characteristics are associated with positive psycho-social and behavioral outcomes related to substance use prevention. [14]

- **Uses interactive teaching methods** (e.g., role plays)
- **Is delivered through a series of structured sessions or lessons** at least once a week and providing booster sessions in the following years
- **Is delivered by trained facilitators**, particularly those with formal academic training and credentials/licensure in health education and promotion
- **Provides an opportunity for youth to learn and practice various personal and social skills**, including goal setting, decision making, recognizing and managing risk situations, assertive communication and resistance skills, and coping skills
- **Impacts perceptions of risk associated with substance use**, including immediate consequences on peer and family relationships and personal aspirations
- **Dispels misconceptions regarding the normative nature and expectations linked to substance use**

EVIDENCE-BASED PROGRAMS, CURRICULA, & APPROACHES

With the current opioid addiction and overdose crisis, many states are ramping up treatment and harm-reduction services to mitigate the negative consequences associated with drug use. What is also needed, however, is prevention!

Over the past 30 years, prevention research has shown that systematically addressing the root causes of behavioral problems among vulnerable populations and promoting protective and supportive environments will steadily divert trajectories away from substance use disorders, which could include opioid use disorders, later in life. The same risk and protective factors in child and adolescent families, schools, peer groups, and neighborhoods that affect smoking, alcohol use, and cannabis use are also predictive of advancing opioid use. [15] Therefore, the use of evidence-based programs to address those factors known to affect the determinants of alcohol, tobacco, and other drug use is likely to reduce the likelihood that school-age youth will initiate or continue to use opioids or fentanyl. However, the evidence base regarding the effectiveness of such approaches, specifically on adolescent fentanyl use, is lacking and deserves further attention.

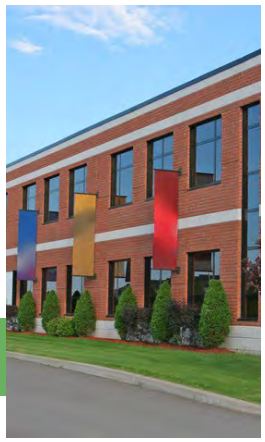
Research on periods of vulnerability during youth development and the kinds of social and environmental factors that increase risks associated with substance use have led to the design and testing of numerous evidence-based prevention programs that have been shown to reduce risk factors as well as increase protective factors that affect drug use. These evidence-based programs have multiple benefits – with some showing decreased or delayed drug experimentation in adolescence and young adulthood. Policymakers and school administrators should advocate for the implementation of those curricula and programs known to be effective in reducing substance use among school-age youth. These prevention programs also could abate lifelong harms from substance use disorders – including opioids.

For this reason, states and schools should implement programs demonstrated by research to work. Blueprints for Healthy Youth Development is a free online registry designed to help decision-makers find evidence-based programs. [16] Prevention programs listed on the Blueprints registry have been shown through rigorous research to improve child development, support families, and enhance school experiences. [17] These programs are developmentally appropriate, and many have been shown to either prevent the initiation of substance use or escalation of use.

Blueprints-certified programs can be effectively scaled when integrated into a comprehensive service delivery system based on an assessment of need, delivered at the community level, and supported by a monitoring and evaluation data infrastructure. Scaling of evidence-based programs is also part of a comprehensive national strategy to prevent opioid use disorder launched by the National Prevention Science Coalition to Improve Lives. [15]

The Appendix of this document contains a matrix listing 15 programs designed for children and youth backed by solid evidence of effectiveness in preventing the onset of problem behaviors associated with substance use and two frameworks that can be used to scale these programs. Most programs are school-based, meaning they can be implemented during the regular school day. Each program name within the matrix is hyperlinked to a Fact Sheet listed on the Blueprints website, where you can find more program information, such as costs and materials to assist with dissemination.

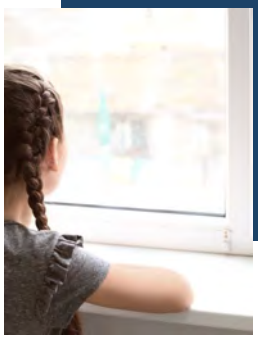
IMPLEMENTATION CONSIDERATIONS FOR SCHOOLS & POLICYMAKERS



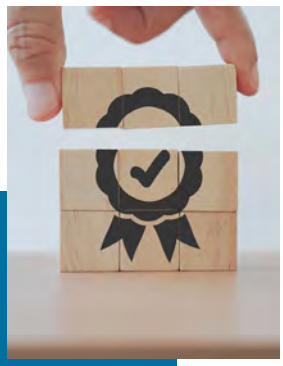
1. PREVENTION IS AN ORGANIZATIONAL EFFORT.

To influence prevention efforts, individuals from across the school and community must work together to impact change. One way to affect change is to increase levels of health literacy. The World Health Organization has recognized that health literacy "represents the personal knowledge and competencies which accumulate through daily activities, social interactions and across generations. Personal knowledge and competencies are mediated by the organizational structures and availability of resources which enable people to access, understand, appraise, and use information and services in ways which promote and maintain good health and wellbeing for themselves and those around them." [18] Therefore, when designing educational experiences for young people, there must be both a recognition of how social interactions and generational factors affect one's likelihood of using opioids, along with the need to teach the specific knowledge and skills that affect substance use and/or seeking treatment or support once using.

2. HEALTH BEHAVIORS INTERSECT - FENTANYL USE IS NOT AN ISOLATED OCCURENCE.



While fentanyl and other opioid use is an important topic to address, educational approaches must also recognize that the use of fentanyl and other opioids is rarely isolated to one specific behavior. In fact, of those who use, many also report health risks related to mental health, sexual behavior, delinquency, violence, and academic underachievement. [19] Because this is true, educational efforts must include strategies to address the intersection of why use occurs and how use can both complicate and be complicated by other health risks. Educational approaches can allow students to investigate and begin to address some of the root causes of use, along with designing intervention strategies that help students recovering from use re-enter classroom experiences in ways that help them succeed.



3. DEDICATED INSTRUCTIONAL TIME SUPPORTS SKILL DEVELOPMENT AND KNOWLEDGE ACQUISITION.

While prevention efforts aim to help young people develop the ability to avoid substance use, this can only be accomplished when they are given dedicated time (ideally as a part of a required health education course) to learn the skills that help them to be healthy. Grounding educational efforts in the Characteristics of Effective Health Education [20] supports teaching students the National Health Education Standards. [21] An emphasis on skill development to prevent fentanyl use serves as the context for how students can apply these skills in relevant and meaningful ways. This allows them to directly apply their learning in ways that will benefit them outside of the classroom. Standards can be found on the following page.

NATIONAL HEALTH EDUCATION STANDARDS [21]

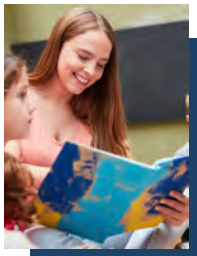
Standard	Rationale
1 Use functional health information to support health and well-being of self and others.	The acquisition and application of functional health information provides a foundation for promoting health and well-being. This standard includes essential concepts based on established theories and models of health behavior and health promotion. It focuses not only on risk factors, but also on protective factors that can support health and wellness. Concepts reflected in this standard include health literacy, health promotion, health equity, social determinants of health, well-being, and health outcomes within individual, interpersonal, community, societal, and environmental contexts. Functional information can be applied to health-related skills, such as analyzing influences, accessing resources, interpersonal communication, decision-making, goal setting, engaging in health practices and behaviors, and advocacy.
2 Analyze influences that affect the health and well-being of self and others.	Health and well-being are affected by many diverse influences within individual, interpersonal, community, societal, and environmental contexts. This standard focuses on identifying and evaluating internal and external factors influencing health practices and behaviors. Influences on health and well-being may include but are not limited to: personal values and beliefs, perceived social norms, family, peers, schools, communities, culture, media and technology, policies, and the environment. This standard recognizes that the factors affecting health behaviors and outcomes, such as social determinants of health, are complex and impact people and communities differently. It also supports the individual's ability to identify and use skills to recognize the types of influences, analyze the role of influences across a variety of wellness dimensions, and manage influences on health and well-being in digital and in-person settings. This skill contributes to a better understanding of the connections between individual health, community health, and health equity, which can strengthen use of other health skills, such as accessing information and advocacy.
3 Access valid and reliable resources to support the health and well-being of self and others.	Access to valid and reliable health information, products, services, and other resources is essential to promoting health and well-being, and preventing, detecting, managing, and treating health issues and conditions. Access to valid and reliable information, products, services, and other resources promotes health and well-being in individual, interpersonal, community, societal, and environmental contexts. This standard focuses on identifying, accessing, and evaluating valid and reliable resources, including managing misinformation and disinformation, within digital and in-person settings. Media and technology play a significant and increasing role in the way individuals learn about and connect with ourselves, others, and the world. This standard engages students in critical thinking around media messages and resources, including how they are accessed, evaluated, and used to support health and well-being.
4 Use interpersonal communication skills to support the health and well-being of self and others.	Effective communication promotes health and well-being in individual, interpersonal, community, societal, and environmental contexts. This standard focuses on expressive and receptive communication in digital and in-person settings. Combined with perspective-taking, communication skills help to recognize and strengthen interpersonal interactions, create and maintain relationships, express and interpret messages, and manage conflict. Developing communication skills helps individuals to see how they communicate and the ways in which their communication affects those around them.

NATIONAL HEALTH EDUCATION STANDARDS (cont.)[21]

Standard	Rationale
5 Use a decision-making process to support the health and well-being of self and others.	Effective decision-making is needed to identify, adopt, and maintain health-promoting behaviors. This standard includes skills and steps integral to the process of effective decision-making to support health and well-being. The decision-making process enables collaboration to improve quality of life within individual, interpersonal, community, societal, and environmental contexts.
6 Use a goal-setting process to support the health and well-being of self and others.	Goal-setting is a process to support short- and long-term health and well-being goals. In addition to achieving a goal, a goal-setting process includes using practices, habits, and routines in daily life. This standard includes the processes needed to plan, reach, and reflect on health goals. Setting goals is a flexible process and considers personal and social factors affecting health and well-being. Goal-setting supports aspirations and future planning for health and well-being within individual, interpersonal, community, societal, and environmental contexts.
7 Demonstrate practices and behaviors to support the health and well-being of self and others.	Developing health practices and behaviors can promote health and well-being over the lifespan and reduce risk to self and others. Practicing health behaviors is critical to incorporating health-promoting habits and routines into all dimensions of wellness. Due to the increasing influence of technology, it is crucial to develop and apply practices and behaviors that support media balance and digital wellness. This standard promotes individual and collective responsibility by encouraging the exploration and practice of skills and processes that support health and well-being in individual, interpersonal, community, societal, and environmental contexts.
8 Advocate to promote the health and well-being of self and others.	Advocacy skills are critical for promoting health and well-being within individual, interpersonal, community, societal, and environmental contexts. This standard helps learners develop and apply skills and strategies to increase agency and advocacy for self and others. Practicing advocacy helps students be informed, civic-minded members of their community who are inclusive of individual, cultural, historical, and other differences.

IMPLEMENTATION CONSIDERATIONS FOR SCHOOLS & POLICYMAKERS (cont.)

4. TRAINED AND/OR LICENSED EDUCATORS IMPLEMENTING CURRICULA



Implementing fentanyl and opioid prevention education in schools can be the responsibility of many invested parties. However, training and licensed educators (e.g., health teachers) are essential core parts of the implementation strategy. While others may enhance implementation efforts by providing support, resources, or additional information, this should supplement classroom instruction from trained and licensed educators interacting with students through regular classes such as a health class.

5. ADAPTATIONS TO CURRICULA OR PROGRAMS

Commercially available curriculum exists on various topics, including general substance use prevention. There are a limited number of curricula that specifically or solely target fentanyl or opioid prevention. As such, adaptations may need to be made to the pre-designed curriculum to include a greater emphasis on fentanyl and opioid prevention. While some adaptations will not fundamentally alter the intention of the curriculum, other modifications can cause the curriculum to be no longer valid or effective and may even be counterproductive. We recommend consulting the manual and/or the developer(s) of the curriculum or program to ensure you include core concepts and elements and that the changes you make are consistent with the prevention strategy.

- **Green Light Adaptations** – These adaptations include modifying scenarios to represent a population, making an activity more interactive, using updated statistics, or modifying language to be culturally inclusive.
- **Yellow Light Adaptations** – These are adaptations that should be considered with caution as they can potentially limit a learner's learning or ability to use the lesson in their life. Examples include modifying lesson order, replacing learning activities with a different activity, and using a program in a different setting or with a different population than the original target audience.
- **Red Light Adaptations** – are adaptations that fundamentally alter a curriculum and eliminate or significantly reduce time and learning opportunities. Examples include eliminating time for students to practice skills learned, changing interactive activities to a lecture, removing or shortening lessons, and removing opportunities for personalization.

6. ADDRESS UPSTREAM FACTORS THROUGH POLICY AND PRACTICE.

Although having the knowledge and skill to address an issue is necessary, it is also necessary to recognize that more than educational approaches alone will be needed to solve this problem. Schools must address additional factors that affect one's ability to remain free from fentanyl and other opioid use. Therefore, in the design of educational materials, it is necessary to understand how social determinants of health can affect a person's ability to gain health literacy skills and how sociocultural factors can affect the ability of individuals to apply the skills in ways that align with prevention efforts. [22] As described in Health People 2030, social determinants of health include economic stability, educational access and quality, health care access and quality, neighborhood and built environment, and social and community context. [23]

When planning educational approaches, schools and communities can use their knowledge of sociocultural factors to design learning experiences that help students consider the role of social determinants on opioid use while also developing the agency to navigate the complex landscape of their health and well-being. Similarly, students can learn about laws (e.g., Good Samaritan Law, impaired driving) and policies (e.g., sports participation, disciplinary policies) that may affect how and when they act in various situations.

HARM REDUCTION STRATEGIES TO REDUCE FENTANYL AND OPIOID OVERDOSE

One might hope that prevention strategies would negate the need for secondary or tertiary strategies to deal with opioid misuse, especially those involving fentanyl. However, it is naïve to assume that the opioid epidemic, as it has been publicly termed, will be eliminated in the near, perhaps even distant future. Yet, most schools in the United States offer drug education programs that adhere to abstinence-only principles. While it is important to empower students to make healthier choices, we should recognize that some teens will try drugs. Efforts to address their needs are called "harm reduction strategies" that recognize that opioid/fentanyl misuse exists and the consequences must be ameliorated. This section focuses on school policies regarding opioid response, naloxone dissemination, and treatment. Harm reduction consists of strategies designed to minimize the medical and social impacts of substance use, using patient-centered methods that are practical, nonjudgmental, and nonpunitive. **While the knowledge, attitudes, and skills needed to prevent the USE of any substance, including fentanyl, are the same regardless of substance, additional fentanyl harm reduction strategies in schools can aim to prevent OVERDOSE and promote SAFETY among students and staff** through the following components:

OVERDOSE RECOGNITION & RESPONSE TRAINING	**Naloxone Availability and Access:** Ensure naloxone is available on school premises, including in nurse's offices, with trained staff members, and during school-sponsored functions. **Overdose Recognition and Response Training:** Train school staff, including teachers, coaches, and security personnel, as well as students and parents, on how to recognize the signs of an overdose and respond appropriately, including the use of naloxone. Training of students can begin as early as late middle school or high school. Consider risk levels and developmental factors in determining the best time to begin and supporting evidence for the selected training strategy.
PEER SUPPORT & STIGMA REDUCTION	**Peer Support Programs:** Develop peer support networks where students can receive guidance and support from their peers on substance use issues by involving people with lived experience in leadership roles and the prevention, treatment, and recovery services, thereby allowing them to serve as role models for peers, demonstrating what meaningful change can look like. **Stigma Reduction:** Reduce stigma and discrimination associated with substance use, its co-occurring mental disorders, and social consequences. This also includes trauma-responsive approaches to support students in learning and re-entry, if applicable.
SAFE SPACES & OPEN COMMUNICATION	**Safe Spaces for Discussion:** Create non-judgmental environments where students feel safe discussing substance use issues and seeking help. **Open Communication Channels:** Encourage open communication between students, staff, and parents/caregivers about the dangers of fentanyl and the risk of experimentation.
PARTNERSHIPS WITH COMMUNITY ORGANIZATIONS	**Collaborate with Local Health Agencies:** Work with local health departments, harm reduction organizations, and other community partners to provide resources, training, and support to the school community. **Referral Networks:** Establish referral pathways to local health services, substance use treatment and recovery programs, treatment of infectious diseases such as HIV and viral hepatitis, and harm reduction resources for students in need.
POLICY DEVELOPMENT & IMPLEMENTATION	**Substance Use Policies:** Develop clear policies on substance use prevention, intervention, and response, including protocols for handling suspected overdoses. **Harm Reduction Focus:** Ensure policies are supportive and focus on harm reduction rather than punitive measures to encourage students to seek help without fear of punishment.
PARENT & CAREGIVER ENGAGEMENT	**Parent Education:** Provide parents and caregivers with information on the risks of fentanyl, signs of drug use, and how to talk to their children about drugs. **Resource Sharing:** Share resources with families on supporting their children, including information about naloxone and harm reduction strategies.

These strategies aim to equip the school community with the knowledge, tools, and support needed to prevent fentanyl overdoses and promote overall student health and safety.

SCHOOL POLICIES REGARDING OPIOID RESPONSE

In an era that is often referred to as an "opioid epidemic," schools are frequently adopting policies specifically related to opioids and, more specifically, may reference fentanyl. It is recommended that these policies address the emergency administration of an opioid antidote to a student, staff member, or other person who is experiencing an opioid overdose. The policy should acknowledge that schools are required to comply with statewide laws, carefully noting relevant statutes, including those covering "Good Samaritan" provisions that protect those seeking to administer help. Recommended provisions include:

- The school maintains an unlocked and easily accessible supply of opioid antidotes (i.e., naloxone) that are accessible during regular school hours, during school-sponsored functions on school grounds, or those adjacent to the school building. It may also make naloxone accessible during school-sponsored functions off school venues.
- Designate the school nurse and/or another employee to be trained in opioid antidotes using an evidence-based practice. The policy should explicitly permit the school nurse or designated trained employees to administer an opioid antidote to any person whom the nurse or the trained designated employee, in good faith, believes is experiencing an opioid overdose. The policy should specifically immunize these people and others who administer antidotes (e.g., not be subject to any criminal or civil liability or any disciplinary action for administering or permitting the administration of the opioid antidote in accordance).
- That an overdose victim be transported to a hospital emergency room by emergency medical responders after the administration of an opioid antidote, even if the person's symptoms appear to have resolved.
- Procedures should be in place to refer an overdose survivor to follow-up care.

Findings from our review of resource lines for naloxone stocking, training, and administration in 50 states can be found in the table below. Compared with an ONDCP report from 2022, this shows an improvement because only 30 states had statutory language for access to naloxone in schools in 2022.

Naloxone Standing Order or Statute Available Online	Specific Naloxone Resource Lines for Schools Available Online	# of States	States
Yes	Yes	25	AL*, AK, AZ, AR, CO, CT, FL, IL, IN, ME, MN, MO*, NE, NJ, NY, OH, OR, PA, RI, SD, TX, VT, VA, WA, WI
	No	20	CA, GA, HI, IA, KS, KY, LA, MD, MA, MI, MT, NV, NM, NC, OK, SC, TN, UT, WV, WY
No	No	5	DE, ID, MS, NH, ND

* Schools are not specifically mentioned in the naloxone standing order or statute

NALOXONE DISSEMINATION

The development of naloxone to reverse opioid overdoses promised to be a highly effective secondary prevention or harm reduction strategy. The drug is administered in injection formulas, auto-injectors, and nasal sprays, with the latter typically used by lay citizens and the former two forms by people in emergency management (e.g., EMS, police, fire, ER). As of June 2023, the last reported date, in California alone, more than 2.6 million naloxone kits had been administered, resulting in over 180,000 overdose reversals, according to reports. Research suggests that making naloxone widely available has been an effective strategy, saving thousands of lives. **Youth overdose prevention efforts in schools may focus on increasing the availability of naloxone and increasing the number of staff that carry and are trained to deploy naloxone both through school district policy and training. School-based prevention programs for older youth may also consider addressing overdoses as an outcome of opioid use and include basic naloxone training.**

However, like many medical advances, the role of social and behavioral science in the process needs to be more effectively managed. If one positive emerged out of COVID-19 and HPV vaccines, it should be the awareness that creating *vaccines* does not ensure *vaccination* or *uptake*. Jayawardene, Hecht, and colleagues reviewed over 100 naloxone training programs and found very few with credible evidence of efficacy. [24] To date, only three programs could be identified with even promising evidence of efficacy. The others tend to be long and/or in-person, requiring resources that are often not available, and most rely on merely providing information about opioids and overdoses. Programs with at least some evidence supporting efficacy beyond increases in knowledge include:

Developing the Opioid Rapid Response System™ for Lay Citizen Response to the Opioid Overdose Crisis: a Randomized Controlled Trial

GetNaloxoneNow
Save a Life

NATIONAL HARM REDUCTION COALITION

- The **Opioid Rapid Response System**, developed by Hecht, Jayawardene and colleagues, is a brief, online program that has demonstrated effects on efficacy, concerns, and opioid scene management in a randomized controlled trial.
- The website **GetNaloxoneNow.org** was developed by Simmons and colleagues. In a randomized controlled trial, the program demonstrated effects on knowledge and skills to intervene successfully and increased confidence in the ability to intervene successfully.
- The **Drug Overdose Prevention and Education (DOPE) Project**, developed by Enteen and colleagues, is the most extensive single-city naloxone distribution program in the country and provides correlational evidence linking participation to overdose reversals. However, the program was not tested in a randomized clinical trial.

The development and dissemination of evidence-based programs appear inhibited by the mistaken belief that naloxone, particularly the intranasal form, is easy to administer. Some programs merely use the analogy to allergy nasal sprays. However, one internal report following up on a naloxone training program built on the SAMSHA model reported confidence levels in the mid-30% among EMS, police, fire, and lay citizens. Naloxone distribution without the attendant practical training is a much less cost-effective strategy that utilizes evidence-based programs.

TREATMENT

Harm reduction incorporates a range of strategies that may serve as a pathway to evidence-based health and social services, such as treatment and recovery programs. The final part of the harm reduction section is treatment and recovery. **Referrals to effective treatment programs are essential to "close the loop" if prevention, described in the previous section, and policies failed to prevent misuse of opioids such as fentanyl.** It is recommended that school policies mandate referrals if opioid misuse is suspected and confirmed. In addition, naloxone training programs can provide referral sources since someone emerging from a potentially fatal overdose might be receptive (i.e., it is a teachable moment). Note that this is not always the case; some emerge from overdose reversal angered that their high has also been terminated. However, the programs described above provide trainees with local referrals for treatment that they can provide if appropriate.

The next question concerns the type of treatment that is most likely to be effective. Wakeman and colleagues conducted a large-scale comparative effectiveness study among over 40,00 adults with opioid use disorder. [25] Of the six treatment approaches that were examined over 1-year post-discharge, overdose or other acute opioid use was only reduced by treatments with buprenorphine or methadone. The National Institute on Drug Abuse website, however, recommends a broader range of solutions that include methadone and buprenorphine, but also naltrexone. [26] The website claims that all three treatments can reduce opioid use and opioid use disorder-related symptoms, as well reducing the risk of infectious disease transmission or associated criminal behaviors. Finally, Fairley et al. and colleagues found that the most cost-effective solutions combine these medications with contingency management, overdose education, and naloxone distribution. [27]

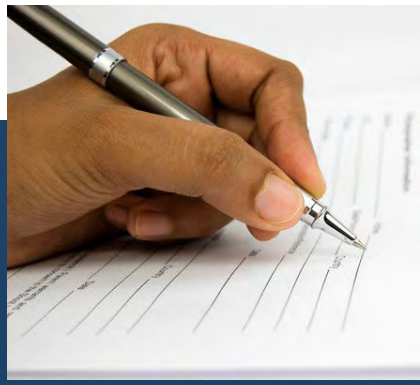
Like all medical interventions, compliance with treatment regimens is a significant inhibitor of treatment success. There exist racial/ethnic barriers to accessing and completing treatment, often related to the distance needed to travel to sites. Fewer treatment options are available in poorer communities, particularly those dispensing medications. That said, research shows that including medication results in higher retention than with non-pharmacotherapy.

Opioid use disorder treatment and recovery services in schools can be designed as specialized programs to address the unique challenges associated with fentanyl use among students. These services can aim to provide early intervention, treatment, and ongoing support in a school setting to help students recover and prevent overdoses. On the next page, a few critical school-based and fentanyl-specific treatment and recovery services in addition to those mentioned previously in this resource are described.

TREATMENT (cont.)

Screening, Brief Intervention, & Referral to Treatment (SBIRT)	Medications for Opioid Use Disorders (MOUD)	Counseling & Mental Health Support	School-based Health Centers (SBCHs)
Screening for Opioid Use Routine screenings to identify students who may be using fentanyl or other opioids.	**MOUD Referrals** Facilitating access to medications for opioid use disorders (MOUD) options, such as buprenorphine or methadone, can help manage opioid dependence. While MOUD are usually not provided directly in schools, school counselors or social workers can assist in coordinating these services with local providers.	**Individual and Group Counseling** Licensed counselors can provide one-on-one or group counseling to address the underlying issues related to fentanyl use, such as trauma, mental health conditions, or peer pressure.	**Integrated Care** SBHCs may offer integrated services that include screenings, counseling, and referrals tailored explicitly for students at risk of or currently using fentanyl.
Brief Interventions Short, evidence-based interventions to raise awareness, provide education on the dangers of fentanyl, and motivate students to seek help.		**Crisis Intervention** Immediate support for students experiencing a crisis related to fentanyl use or overdose.	**On-site Support** Providing on-site mental health services and case management to ensure students receive continuous support within the school environment.
Referral to Treatment If a student requires more intensive support, they are referred to external treatment providers specializing in opioid use disorder.	**MOUD Coordination** Working with healthcare providers to ensure continuity of care for students receiving MOUD, including supporting adherence to medication regimens.		

These services help create a comprehensive approach to addressing fentanyl use among students, focusing on prevention, early intervention, and ongoing support to foster recovery and well-being within the school environment.



APPENDIX

MATRIX OF BEST AVAILABLE EVIDENCE

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
MODEL+			
Program: LifeSkills Training (LST) **Website:** https://www.lifeskillstraining.com **Description:** A classroom-based program designed to prevent teenage drug and alcohol use, tobacco use, violence, and other risk behaviors. **Strategy Type:** School-based curriculum **Setting:** Schools **Age:** Early Adolescence (12-14) - Middle School **Length:** 30 sessions taught over 3 years	Personal self-management skills, social skills, information and resistance skills specifically related to substance use	Study 1: 52% male and 91% White Study 2: 51% male; 39% Black, 33% Hispanic, 10% White, 6% Asian, 2% Native American, and 10% other Study 3: 53% male and 96% White	• Reduced cigarette smoking at posttest, cigarette smoking and marijuana use at the 3-year follow-up, polydrug use at the 6.5-year follow-up • Reduced delinquency at posttest, frequent fighting at posttest
MODEL			
Program: Blues Program **Website:** https://bluesprogram.org **Description:** A school-based group intervention that aims to reduce negative cognition and increase engagement in pleasant activities to prevent the onset and persistence of depression in high school students exhibiting depressive symptoms. **Strategy Type:** School-based curriculum **Setting:** Schools **Age:** Late Adolescence (15-18) – High School **Length:** 6 weekly one-hour group sessions and home practice assignments.	Building group rapport, cognitive restructuring techniques, and developing response plans to future life stressors	Study 1: 72% White Study 2: 70% female, 46% White and 33% Hispanic	• Reduced depressive symptoms at posttest; lower rates of major depression onset at six-month, one-year and two-year follow-up • Reduced substance use through two years • Improved social adjustment at six-month follow-up • Greater social support from friends
Program: Positive Action **Website:** https://www.positiveaction.net **Description:** A school-based program designed to increase positive behavior and improve social and emotional learning (SEL) and school climate. **Strategy Type:** School-based curriculum **Setting:** Schools **Age:** Late Childhood (5-11) - K/Elementary; Early Adolescence (12-14) - Middle School **Length:** 30 sessions taught over 3 years	Self-concept, positive actions of your body and mind, managing yourself responsibly, treating others the way you like to be treated, telling yourself the truth, and improving yourself continually	Study 1: Schools were 50% male, 50% female; 15% White, 12% Asian American, 2% Black, .03% Native American or American Indian or Alaska Native, 32% Native Hawaiian or Pacific Islander, 24% Multi-ethnic, 13% other Study 2: 53% Black, 32% Hispanic, 10% White, and 7% Asian or Asian American	• Reduced: Substance use, bullying and violence at grades 5-8 • Lower: Depression and anxiety at grade 8 • Reduced: School-level disciplinary referrals and suspensions at grade 8 • Improved: Reading test scores at grade 8.

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
MODEL			
Program: Project Towards No Drug Abuse **Website:** tnd.usc.edu **Description:** A classroom-based prevention program that aims to prevent teen drinking, smoking, marijuana and drug use. **Strategy Type:** School-based curriculum **Setting:** Schools **Age:** Late Adolescence (15-18) – High School **Length:** 40-minute interactive sessions taught by teachers or health educators over a 3-week period	Motivation factors (i.e., students' attitudes, believes, expectations, and desires regarding drug use); skills (effective communication, social self-control, and coping skills); and decision-making (i.e., how to make decisions that lead to health-promoting behaviors)	Study 1: 37% White, 46% Hispanic, 4% Asian American, 8% Black, 3% Native American, and 2% other Study 2: 34% White, 38% Hispanic, 26% Black, and 2% other Study 3: 27% white students, 50% Latino students, 10% African American students, and 13% "other" Study 4: 18.2% white, 62.1% Hispanic, 8.4% Asian, 8.1% African American, and 3.2% other ethnicity	• Reduced hard drug use prevalence rates at one-year, two-to-three-year, and four-to-five-year follow-ups • Reduced alcohol use prevalence at one-year follow-up among those using alcohol at baseline • Reduced 30-day tobacco and hard drug use at two-year follow-up
PROMISING			
Program: Big Brothers Big Sisters of America **Website:** http://www.bbbs.org/ **Description:** A community mentoring program which matches a volunteer adult mentor to a child or adolescent to delay or reduce antisocial behaviors; improve academic success, attitudes and behaviors, peer and family relationships; strengthen self-concept; and provide cultural enrichment. **Strategy Type:** Mentoring – Tutoring **Setting:** Community **Age:** Late Childhood (5-11) – K/Elementary; Early Adolescence (12-14) – Middle School; Late Adolescence (15-18) – High School **Length:** Dyads meet 3-5 hours/week for 12 months	Trusting relationships by matching youth with a mentor (match is monitored and supervised by a staff member). Goal setting identified from an extensive case manager interview with parent or guardian and youth. Goals relate to school attendance and academic performance, relationships with other youth and siblings, learning new skills or developing a hobby. Goals are updated by the case manager as progress is made and circumstances change over time.	60% male, 40% female; 45% White, 55% minoritized youth (with the minoritized youth listed as 71% Black, 18% Hispanic, 5% biracial, 3% Native American, and 3% other racial/ethnic groups)	• Reduced initiation of illicit drug use (posttest) • Reduced times hitting someone (posttest) • Improved school attendance, overall parental relationship (e.g., less lying to parents, higher parental trust), competency for schoolwork (posttest)
Program: Coping Power **Website:** www.copingpower.com **Description:** A group intervention designed to reduce aggressive attitudes and behaviors and prevent substance abuse among youth. **Strategy Type:** School-based Curriculum **Setting:** School **Age:** Late Childhood (5-11) – K/Elementary; Early Adolescence (12-14) – Middle School **Length:** 16-month program with 22 sessions in 5th grade and 12 sessions in 6th grade for youth, and half hour individual sessions once every two months Parents attend11 & 5 group sessions during 5th/6th yrs	Problem-solving and conflict management, coping mechanisms, positive social supports, and social skill development (youth). Skills to manage stress, identify disruptive child behaviors, effectively discipline/reward children, establish effective communication structures, and manage child behavior outside of the home (parent).	100% male; 47% Black and 53% White	• Reduced delinquent behavior, substance use (posttest) • Improved behavior at school (posttest)

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
PROMISING			
Program: Cooperative Learning **Contact:** Mark J. Van Ryzin, Ph.D. Research Professor at University of Oregon (markv@uoregon.edu) Research Scientist at Oregon Research Institute (markv@ori.org) **Description:** A school-based intervention designed to provide youth with positive peer relationships that can promote positive behaviors, prevent bullying and victimization, and reduce emotional (mental health) problems and risky behaviors such as alcohol use. **Strategy Type:** School (Individual Strategies) **Setting:** School **Age:** Early Adolescence (12-14) – Middle School **Length:** Ongoing	Cooperative learning approach (reciprocal teaching, peer tutoring, jigsaw, and other methods where peers work together to maximize one another's learning)	48% female; 76% White; 14% Hispanic-Latino, 4% multiracial, 4% American Indian or Alaska Native	• Reduced rates of alcohol use (posttest) • Reduced rates of emotional problems, bullying (posttest) • Improved rates of relatedness (or close relationships with peers), prosocial behavior (posttest)
Program: Familias Unidas **Website:** www.familias-unidas.info **Description:** A multilevel family-based intervention to empower Hispanic immigrant parents to build a strong parent-support network and help their adolescent children respond effectively to the risks of substance use and unsafe sexual behavior. **Strategy Type:** Family-based intervention **Setting:** Community **Age:** Early Adolescence (12-14) – Middle School; Late Adolescence (15-18) – High School **Length:** 9 weekly 2-hour sessions; 4 to 10 1-hour family visits year and five sessions during the 6th grade year	Builds a strong parent-support network to increase knowledge of culturally relevant parenting, strengthen parenting skills, and applying skills in activities designed to help their adolescents respond effectively to the risks of substance use and unsafe sexual behaviors. Emphasis on the importance of cultural pride and identity for resilience and positive self-image to help mitigate the impact of discrimination	64% boys, 35% girls; 100% Latino or Hispanic; 56% of adolescents were born in the U.S, with immigrant adolescents born in Honduras (27%), Cuba (20%), and Nicaragua (16%)	• Reduced substance use at 30 months post baseline • Improved family functioning (e.g., parent-adolescent communication, positive parenting, and parental monitoring of peers)
Program: Guiding Good Choices **Website:** communitiesthatcare.net/programs/ggc/ **Description:** A family training program that aims to enhance parenting behaviors and skills and effective child management behaviors and parent-child interactions and bonding, teach children skills to resist peer influence, & reduce adolescent problem behavior. **Strategy Type:** Family-based program **Setting:** Schools, Community **Age:** Early Adolescence (12-14) – Middle School **Length:** 5 total sessions, 1 per week lasting 2 hours each	Peer resistance skills, identification of risk factors for adolescent substance abuse and a strategy to enhance protective family processes; development of effective parenting practices, particularly regarding substance use and family conflict management and use of family meetings as a vehicle for improving family management and positive child development	51% female, 48% male; 97% White	• Lower alcohol initiation and frequency of past month drinking (among users), reduced growth of alcohol use at the 3.5-year follow-up (ages 12-15 ½) & tobacco use over time; reduced alcohol & polysubstance use • Reduced general delinquency over time • Reduced depressions

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
PROMISING			
Program: KEEP SAFE **Contact:** Patricia Chamberlain Oregon Social Learning Center 10 Shelton McMurphey Boulevard Eugene, OR 97401-4928 **Description:** A group-based intervention, facilitated by paraprofessionals, for youth in foster care as they transition to middle school. The program aims to prevent internalizing and externalizing problems that may lead to more serious longer-term outcomes such as delinquency, substance use, and high-risk sexual behavior. **Strategy Type:** Skills Training **Setting:** Social Services **Age:** Early Adolescence (12-14) – Middle School **Length:** 6 sessions (twice weekly for 3 weeks in summer). Ongoing training and support are provided to foster parents (group-based) and youth (one-on-one sessions) once a week for two hours during the first year of middle school	Youth: setting goals, establishing positive relationships with peers and adults, building confidence, and developing decision-making. Problem-solving skills and opportunities are also provided so they can practice positive behaviors Foster parents: maintaining stability in the home, preparing the youth for middle school, and developing behavioral reinforcement techniques and realistic expectations	100% female; 63% White, 10% Latino, 9% African American, 4% Native American, and 14% multiracial	• Reduced substance use 2 years post-intervention • Reduced internalizing and externalizing problem behaviors at six months • Reduced health- risking sexual behavior at 36 months beyond baseline (2 years post-intervention) • Improved prosocial behavior 6-months and 12-months post intervention • Placement stability at the 12-month posttest
Program: RealTeen **Contact**: Traci Schwinn School of Social Work Columbia University 1255 Amsterdam Avenue New York, NY 10027 Email: tms40@columbia.edu Phone: 917-763-3786 **Description:** An internet-based, gender-specific program designed to reduce substance use among early adolescent girls by improving social and drug refusal skills. **Strategy Type:** Skills Training **Setting:** Online intervention **Age:** Early Adolescence (12-14) – Middle School **Length:** 9 twenty-minute sessions and a secure website, which offers a homepage with a variety of content, including feeds from the latest entertainment sites, online polls, beauty tips, and a quote of the day	Geared to females to improve skills specific to drug use. Content includes goal setting, decision making and problem solving, puberty, self-esteem and body image, coping, drug knowledge, norms and social influences, refusal skills, and a review	100% female; 63% White, 17% Black, and 15% Latino.	• Reduced cigarette use at posttest and 1-, 2-, and 3-year follow-up, and e-cigarette use at 3-year follow-up • Reduced binge drinking at 1-year follow-up. • Reduced marijuana use at 2-year follow-up • Reduced “other” drug use (cocaine, club drugs) at 20 year follow-up

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
PROMISING			
Program: SPORT Prevention Plus Wellness **Website:** https://preventionpluswellness.com **Description:** A health promotion program that highlights the positive image benefits of an active lifestyle to reduce the use of alcohol, tobacco and drug use by high school students in addition to improving their overall physical health. **Strategy Type:** Brief intervention **Setting:** School **Age:** Late Adolescence (15-18) – High School **Length:** 1 session brief intervention	Health behavior screen, one-on-one consultation, a take home fitness prescription recommending the youth to set health-related goals	56% female, 44% male; 51% White, 22% Black, 28% other	• Reduced alcohol consumption, initiation, alcohol use risk, and drug use behaviors (30-day cigarette frequency) three months post-intervention • Increased exercise habits at posttest
Program: Strengthening Families 10-14 **Website:** www.extension.iastate.edu/sfp **Description:** A group parenting and youth skills program that aims to help parents/caregivers learn nurturing skills that support their children, teaches parents/caregivers how to discipline and guide their youth effectively, gives youth a healthy future orientation and an increased appreciation of their parents/caregivers, and teachers youth skills for dealing with stress and peer pressure. **Strategy Type:** Family-based intervention **Setting:** Community **Age** Late Childhood (5-11) – K/Elementary; Early Adolescence (12-14) – Middle School **Length:** Weekly 2 hour sessions for 7 total sessions	Caregivers: Enhance parenting skills and promote effective parenting styles; Youth: Build life skills and foster positive attitudes Family: Strengthen family bonds, promote positive communication, and enhance joint problem-solving	51% female, 49% male; 98% Caucasian	• Reduced rates of initiation in each of the three alcohol ever-use measures at the one- and two-year follow-ups • Reduced transitions to substance use at the two-year follow-up
Program: Strong African American Families Program **Website:** www.cfr.uga.edu **Description:** A culturally tailored, family-centered program designed for Black families in rural communities to build on strengths of African American culture to prevent substance abuse and other behaviors among youth by strengthening positive family interactions, enhancing caregivers' efforts to help youth reach positive goals and prepare for teen years. **Strategy Type:** Family-based intervention **Setting:** Community **Age:** Late Childhood (5-11) – K/Elementary; Early Adolescence (12-14) – Middle School **Length:** 7 weeks, 2 hours per week	Caregivers: Enhance parenting skills, strengthen relationship with child Youth: Promote competence to avoid risky behavior, set goals for the future, and strengthen relationship with caregiver Family: Strengthen family bonds and communication, understand importance of family values, and develop strategies for addressing experiences of racism and discrimination	Study 1: 54% female, 46% male; 100% Black Study 2: 53% female, 47% male; 100% Black	• Reduced levels of youth risk behaviors (at posttest) • Fewer "new alcohol users" and slower growth in alcohol use at long-term follow up

PROGRAM & DESCRIPTION	MAJOR COMPONENTS	STUDIED POPULATIONS	OUTCOMES
PROMISING			
Program: Strong African American Families – Teen (SAAF-T) **Website:** www.cfr.uga.edu **Description:** A group-based adaptation of the SAAF parenting program designed for families with you ages 14-16. SAAF-T aims to build on the strengths of African American families to prevention substance use and other risky youth behaviors. **Strategy Type:** Family-based intervention **Setting:** Community **Age:** Late Adolescence (15-18) – High School **Length:** 5 sessions lasting 2 hours each	Caregivers/Family: Strengthening parental monitoring and involvement, communicating with youth about substance use, engaging in cooperative problem-solving, and developing resilience against negative experiences Youth: Goal setting and attainment, resistance of involvement in risky behaviors, strategies for addressing experiences of racism and discrimination; acceptance of parental influences	56% female, 44% male; 100% Black	• Reduced substance use, alcohol use, and substance use problems (at posttest) • Reduced conduct problems (at posttest) • Reduced depression rates (at posttest) • Reduced frequency of unprotected sex (at posttest)
FRAMEWORKS			
Program: PROSPER **Website:** http://www.prosper.ppsi.iastate.edu/ **Description:** A prevention delivery system that fosters implementation of evidence-based youth and family interventions through completion of ongoing needs assessments, monitoring of implementation quality and partnership functions, an evaluation of intervention outcomes. **Strategy Type:** Prevention Framework **Setting:** Schools, Community **Age:** Early Adolescence (12-14) – Middle School **Length:** Ongoing	School-community-university partnership that fosters implementation of evidence-based youth and family interventions, ongoing needs assessments, monitoring of implementation quality and partnership functions, and evaluation of intervention outcomes	51% female, 49% male; 85% White, 5% Hispanic, 3% Black	• Reduced rates of lifetime use of gateway drugs and illicit drugs • Reduced conduct problem behavior index (scale included items such as stealing, truancy, aggression) at posttest, 1-year, 2-year, 3-year, and 5-year follow-up
Program: Communities That Care (CTC) **Website:** https://www.communitiesthatcare.net **Description:** A system for reducing levels of delinquency and substance use through the selection and use of effective preventive interventions tailored to a community's specific profile of risk and protection. **Strategy Type:** Prevention Framework **Setting:** Schools, Community **Age:** Late Childhood (5-11) – K/Elementary; Early Adolescence (12-14) - Middle School; Late Adolescence (15-18) – High School **Length:** Ongoing	Strategic Community Plan: identification of youth risk factors, protective factors and problem behaviors Community Readiness Assessment: community training, assessments of existing community resources Community Action Plan: training and implementation of prevention interventions	70% White, 9% Native American, 4% Black, 20% Hispanic	• Reduced rates of delinquent behavior in grades 5-7 • Reduced alcohol, cigarette and smokeless tobacco initiation in grades 5 to 8 • Reduced tobacco use in past 30 days, binge drinking in past 2 weeks, & delinquent behaviors in past year in grades 8 & 10

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ADAPT

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Cultivating Prevention

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