



# Health Policy Brief

Connections between education and health

4

## School-based drug and violence prevention and mental health promotion

### Overview

HPIO's *Connections between education and health* series describes policy opportunities with the potential to improve both health and education outcomes. This fourth and final brief in the series describes:

- Evidence-based approaches implemented in K-12 schools to promote drug-free living, safety, healthy relationships, mental wellbeing and academic achievement among children
- The extent to which Ohio is implementing these approaches
- Policy options to improve education and health outcomes through school-based prevention

### The importance of prevention

With one of the highest drug overdose death rates in the country, Ohio has been particularly hard hit by the opiate crisis.<sup>1</sup> As thousands of Ohioans struggle to recover from addiction, policymakers are increasingly aware of the importance of stopping addiction before it starts. In addition, as the prescription opioid epidemic shifts towards use of other drugs (heroin, fentanyl, methamphetamine and cocaine), many policymakers recognize the need for a comprehensive approach to prevent all forms of substance use disorder across the life span.

School-based drug prevention is an effective way to address these concerns. Most children spend an average of six hours a day, five days a week in school, making it an ideal setting to promote healthy behaviors and personal resilience.

Many approaches that are effective in preventing drug use also improve other outcomes of interest to policymakers and educators, such as:

- Increased on-task behavior, school engagement and high school graduation
- Decreased school behavior problems and disciplinary problems
- Decreased depression, anxiety and suicide
- Decreased school violence and bullying

**K-12 prevention approaches with improved education and health outcomes**

Mental, emotional and behavioral problems	Alcohol, tobacco and other drug use	Violence and bullying
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### Additional HPIO education and health publications

This is the final policy brief in HPIO's four-part series describing the connections between education and health:

- **Policy brief No. 1** presents the relationship between education and health and describes factors impacting this relationship (Released: January 2017)
- **Policy brief No. 2** explores the provision of health services in schools (Released: July 2017)
- **Policy brief No. 3** describes early learning policies and programs including early childhood education, home visiting and social-emotional development (Released: October 2017)

For additional information on topics covered in this brief, see:

- [Intersections between Education and Health](#) online resource page
- [Addiction Evidence Project](#) webpage and [Addiction Overview](#) brief

Children who are most at risk for addiction are also at risk for school failure, mental illness and violence. Factors such as exposure to trauma, adverse childhood experiences (ACEs) and harmful community conditions are often at the root of many of these challenges.<sup>2</sup>

This brief focuses on policies and programs that support foundational protective factors for children, such as health literacy, impulse control, communication skills, school engagement and opportunities for positive social involvement, including:

- Prevention education
- Social-emotional learning and positive behavior programs
- School climate improvement initiatives

While these strategies are already being implemented in some Ohio communities, more can be done to deploy them in a widespread way that protects all Ohio children from future addiction, violence and mental illness.

## Scope of the problem

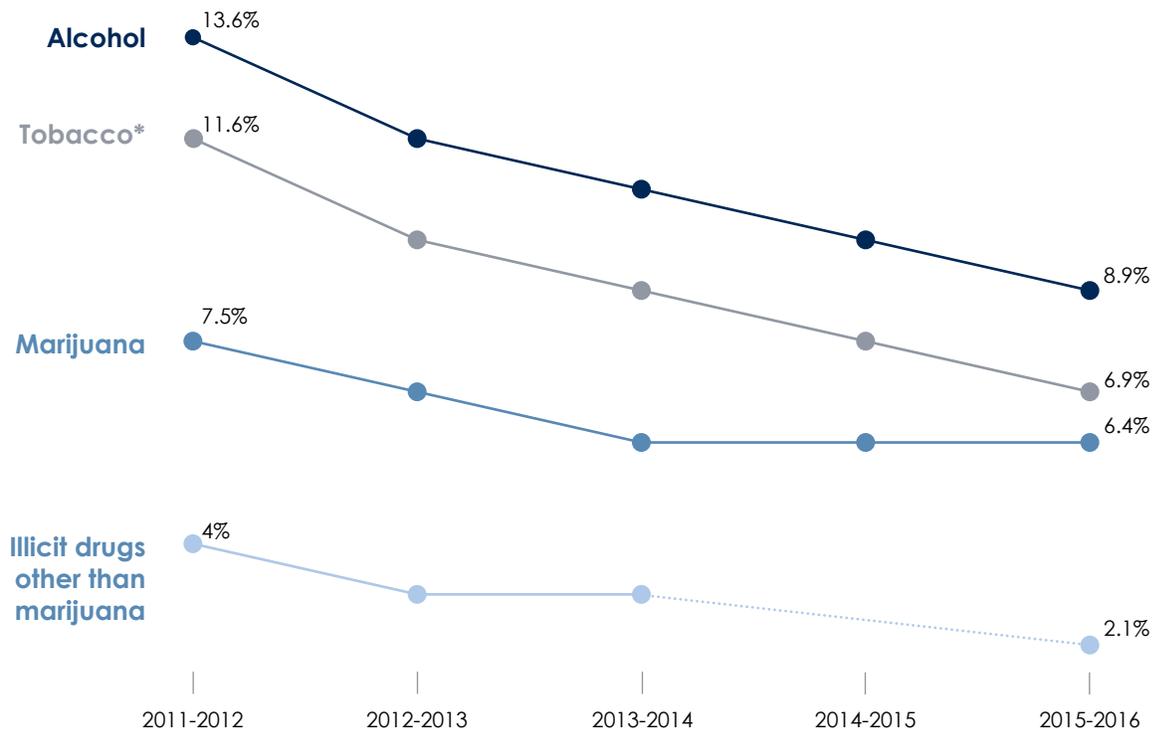
### Alcohol, tobacco and other drug use among adolescents

There is strong evidence that adolescence is a critical risk period for addiction. Addictive drugs are particularly harmful to the adolescent brain because it is still developing. Adults who began using alcohol or other drugs during adolescence are at greater risk of developing addiction than those who started at a later age.<sup>3</sup>

Adolescents typically begin by experimenting with legal substances, such as alcohol and cigarettes.<sup>4</sup> The average age at first use of these substances is about seven years younger than the average age of initiation for illegal drugs such as heroin and methamphetamine.<sup>5</sup>

Prevalence of adolescent alcohol and tobacco use within the past month have declined in recent years, while marijuana use has stayed about the same (see figure 1). E-cigarettes are now more commonly used by teens than cigarettes or other traditional tobacco products.<sup>6</sup> This is a concern because there is evidence that e-cigarette use increases risk of ever using traditional cigarettes among youth and young adults.<sup>7</sup>

Figure 1. Substance use in the past month among Ohio youth (ages 12-17)

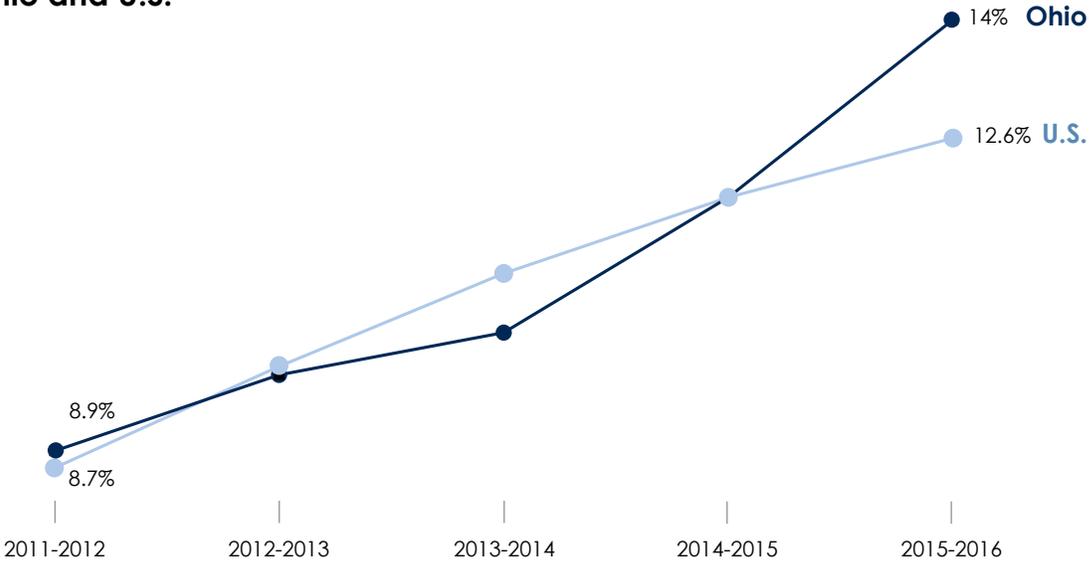


\*Includes cigarettes, smokeless tobacco, cigars and pipe tobacco. Does not include e-cigarettes.

**Note:** 2014-2015 data on illicit drug use other than marijuana is unavailable.

**Source:** National Survey on Drug Use and Health: Model-Based Prevalence Estimates

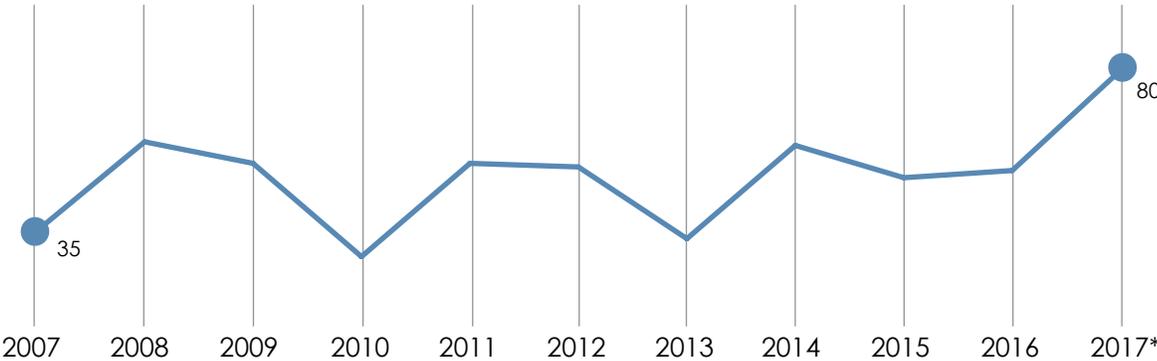
Figure 2. Major depressive episode in the past year, youth (ages 12-17), Ohio and U.S.



**Note:** Major depressive episode is defined as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

**Source:** National Survey on Drug Use and Health: Model-Based Prevalence Estimates

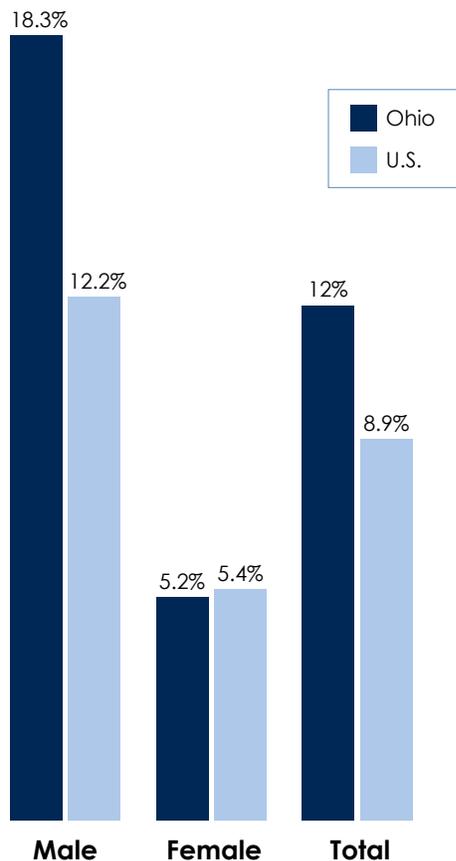
Figure 3. Suicide death count for Ohio children (ages 8-17), 2007-2017\*



\*2017 data is preliminary

**Source:** Ohio Department of Health (ODH), Bureau of Vital Statistics. Compiled by HPIO staff using the ODH Public Health Data Warehouse. Accessed July 27, 2018

Figure 4. **ADHD or ADD prevalence among Ohio children (ages 3-17), by sex (2016)**



**Note:** Includes children for whom a parent responded yes to two questions: "Has a doctor or other healthcare provider ever told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is ADD or ADHD?" and "Does this child currently have the condition?"

**Source:** 2016 National Survey of Children's Health

### Mental, emotional and behavioral problems among children

Mental, emotional and behavioral disorders among children include conduct disorder, attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD), anxiety and depression.<sup>8</sup> Researchers estimate that roughly 20 percent of young people have been diagnosed with one or more of these conditions<sup>9</sup> and there are large disparities by race, ethnicity, gender, disability status and geography.

Depression and suicide have both increased in Ohio in recent years. The percent of Ohio adolescents who experienced a major

depressive episode within the past year increased from 9 to 14 percent from 2011-2012 to 2015-2016 (see figure 2). The number of suicide deaths for Ohio children more than doubled from 2007 to 2017 (see figure 3).

ADHD/ADD prevalence is higher in Ohio compared to the U.S. and varies substantially by gender. In 2016, 18 percent of Ohio boys were diagnosed with ADHD or ADD, compared to only 5 percent of Ohio girls (see figure 4).

### Behavior problems in schools

Behavior problems are a significant challenge for educators. Concerns about discipline issues are a major cause of job dissatisfaction among teachers who leave the profession.<sup>10</sup>

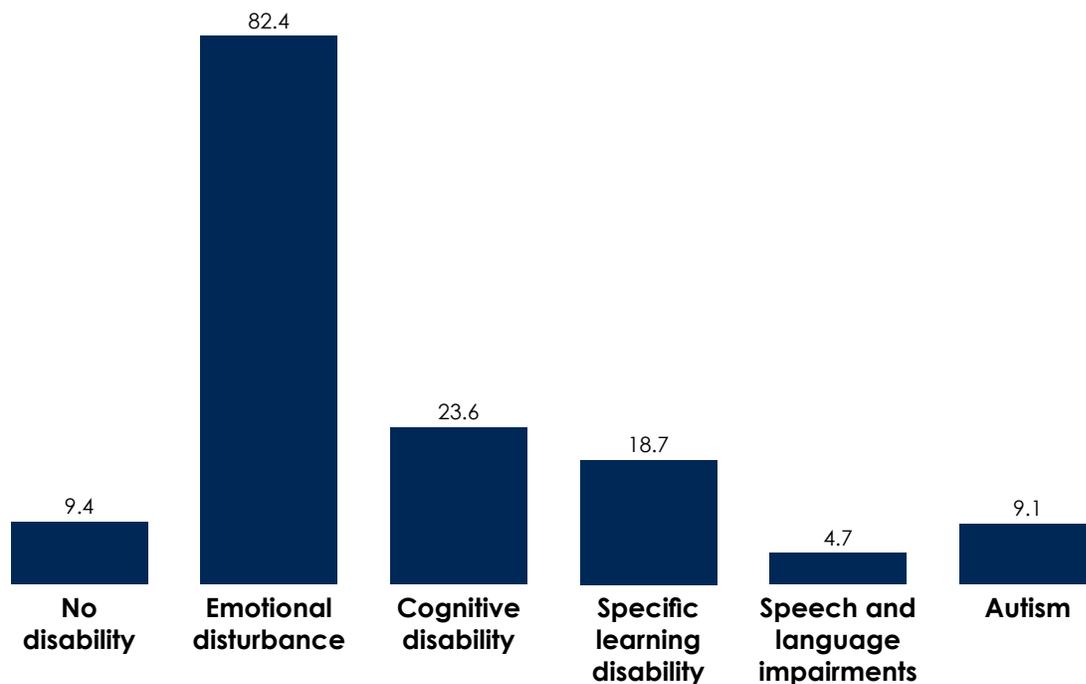
Children with mental, emotional and behavioral disorders often have difficulty staying on task at school and are more likely to be disciplined. For example, students with an emotional disturbance were much more likely than non-disabled students to have an out-of-school suspension in 2016-2017 (see figure 5). See the HPIO fact sheet on [Suspensions and Expulsions Among Young Children](#) for additional data on high rates of out-of-school suspensions for students who are economically disadvantaged, black and male.

### Violence

Children and adolescents are affected by several forms of violence, including child abuse (physical, sexual and emotional), neighborhood violence, dating violence, school violence and bullying. Different forms of violence often share the same root causes.<sup>11</sup> Research has found that a child who has a history of bullying others is also more likely to perpetrate other forms of anti-social behavior, aggression and violence, and children who consider their school to be unsafe are more likely to engage in violent behavior.<sup>12</sup> Violence experienced in childhood has negative health consequences across the lifespan, including heart disease, mental health problems and addiction.<sup>13</sup>

This policy brief focuses on strategies that prevent violence perpetrated by youth toward other youth, particularly school violence and bullying. However, efforts to improve education and health outcomes for children should also take into consideration other types of violence that children may have witnessed, experienced or perpetrated. Social-emotional

Figure 5. **Out-of-school suspensions per 100 Ohio students, by disability status (2016-2017 school year)**



**Note:** Rates are calculated by dividing the total number of out-of-school suspensions received by students of a certain category in all grade levels by the total number of enrolled students in that category. This number is then multiplied by 100. This can include multiple suspensions for a single student.

**Source:** Ohio Department of Education interactive report card data

learning and school climate improvements, in particular, may help children who have experienced trauma.<sup>14</sup> See the [CDC's Violence Prevention webpage](#) for more information.

### School violence and bullying

School violence is defined as youth violence that occurs on school property or on a student's way to or from school or a school-sponsored event.<sup>15</sup>

In 2013, almost 10 percent of black high school students and 4 percent of white students in Ohio reported that they did not go to school one or more days because they felt unsafe at school or on their way to school (see figure 6).

Bullying is one of the most common forms of school violence and involves intentional, aggressive behavior among school-aged children that is "carried out repeatedly and involves an imbalance of power, either actual or perceived, between the victim and the bully."<sup>16</sup> There are three types of bullying:

- **Verbal bullying** – saying or writing mean things about another person

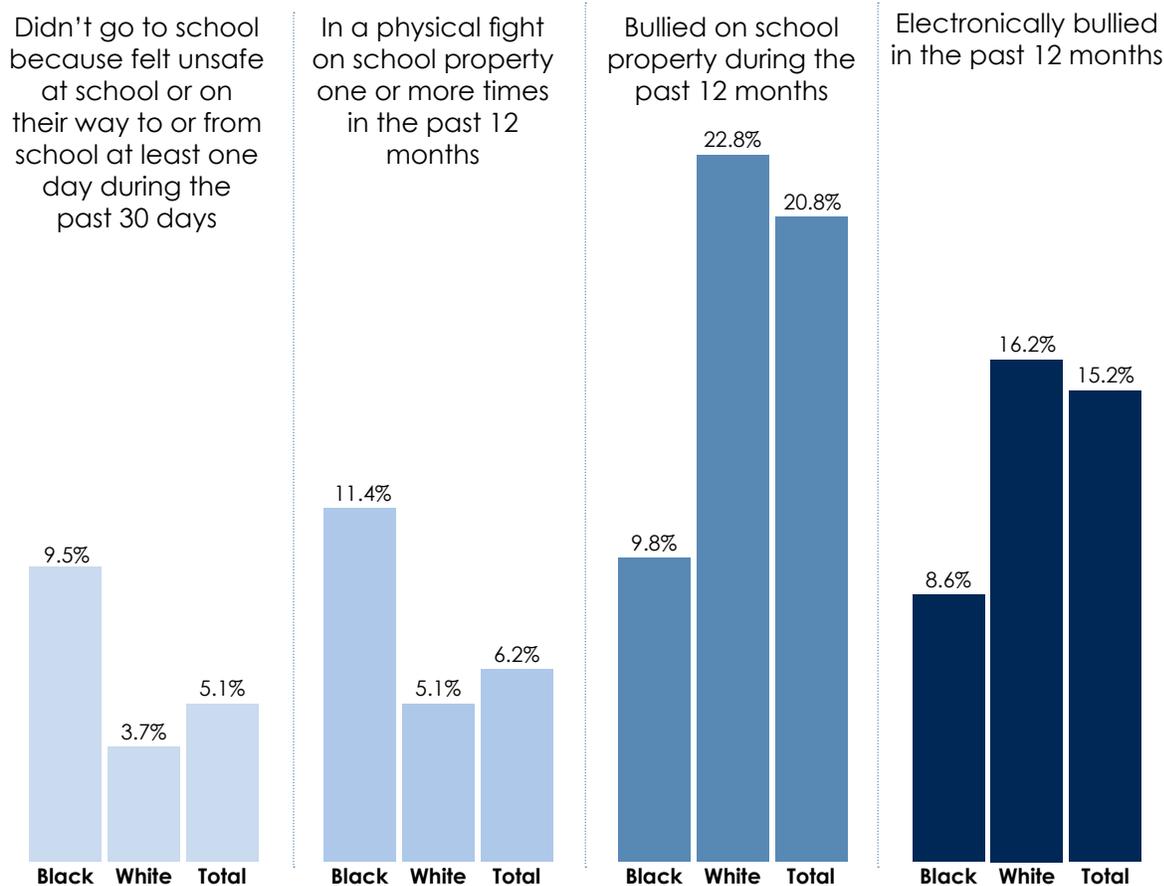
- **Social bullying** – damaging someone's reputation or relationships
- **Physical bullying** – hurting a person's body or possessions<sup>17</sup>

Cyberbullying refers to any type of bullying that is performed via electronic means.<sup>18</sup>

Being a victim of bullying is associated with an increased risk of depression and anxiety, health complaints (e.g., headaches, stomach aches, sleeping problems), self-harm, suicidal thoughts and lower academic achievement. These risks tend to increase as a child experiences more bullying and can last into adulthood.<sup>19</sup>

Children who bully others also experience negative outcomes. Into adulthood, they are more likely to engage in criminal activity or violent or risky behaviors. For example, they are more likely to abuse alcohol and other drugs, engage in early sexual activity, have criminal convictions, drop out of school and be abusive toward romantic partners.<sup>20</sup>

**Figure 6. School violence and bullying among Ohio high school students, by race (2013)**



Source: 2013 Youth Risk Behavior Survey

In 2013, almost 21 percent of Ohio 9th-12th grade students reported being bullied on school property within the previous year, and 15 percent reported being electronically bullied (i.e., cyberbullied).<sup>21</sup> White students were more likely to experience bullying than black students (see figure 6).

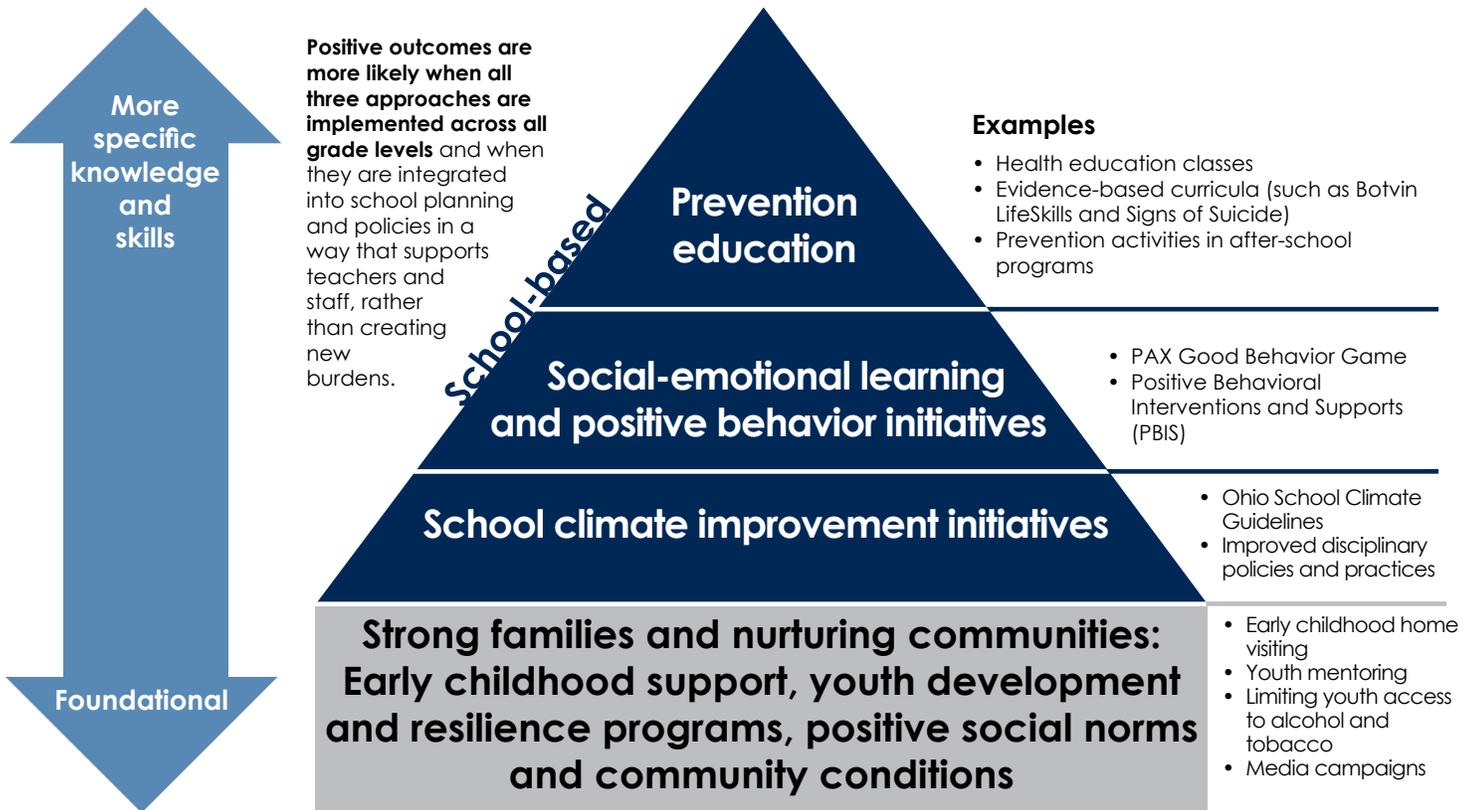
### Evidence-based strategies

There are many policies and programs that effectively prevent drug use and violence and promote mental wellbeing and positive behavior. Strong families, nurturing communities and positive social norms provide the foundation for healthy youth. Approaches such as parenting education, early childhood home visiting, youth mentoring and local prevention coalitions are critically important for drug and violence prevention and mental health promotion.

This brief focuses on the three types of K-12 school-based prevention approaches shown in figure 7: prevention education; social-emotional learning and positive behavior initiatives; and school climate improvement initiatives.

Prevention education addresses topic-specific knowledge and skills. For example, drug prevention curricula like Keepin' it REAL, Botvin LifeSkills Training and the HOPE curriculum are designed to reduce use of tobacco, alcohol, opiates and other drugs. Social-emotional learning and school climate improvement initiatives, on the other hand, are more foundational and affect a wide range of health and education outcomes. The PAX Good Behavior Game (GBG), for example, is a classroom behavioral management program that improves impulse control and on-task behavior in the short term. Researchers have

Figure 7. Evidence-based approach to universal K-12 drug and violence prevention and mental health promotion



also found that PAX GBG leads to reduced drug use and mental health benefits in the long term.<sup>22</sup> Efforts to create a positive school climate can lead to improved educational achievement, as well as fewer disciplinary problems and less violence and bullying among students.

The next section describes each of these school-based approaches and the extent to which they are being implemented in Ohio.

### Prevention education

Prevention education provides information and activities designed to affect critical skills, such as decision-making, refusal skills and critical analysis.<sup>23</sup> Prevention education can be delivered as part of a health education class, or as part of a broader school or community-based prevention program. K-12 school-based prevention education is most commonly delivered by:

- A health education teacher as part of a health class
- A teacher of another subject, referred

### Universal prevention

Universal prevention activities are directed at an entire population and are likely to provide some benefit to all. School-based prevention programs implemented with all students in a school building or grade level are examples of universal prevention.

Many universal prevention activities, such as the PAX Good Behavior Game or Second Step, have low per-person costs when compared to more intensive services such as one-on-one mental health counseling.<sup>24</sup>

### School-based mental health services

Some students need additional services beyond universal prevention. More targeted, early intervention and treatment services, such as individual or group counseling, can be provided to those students exhibiting signs and symptoms of mental health conditions. Additional information on school-based mental health programs can be found in HPIO's [Connections between Education and Health No. 2: Health Services in Schools](#)

to as cross-curricular education (such as learning about mental health within the context of an English class or addiction brain science in a biology class)

- Other school staff, such as a school nurse
- A prevention professional from a community-based organization

### Health education

School health education classes taught by a licensed health education teacher are an important component of prevention education. Health education refers to a series of planned learning experiences<sup>25</sup> that provide the opportunity for students to acquire knowledge and develop skills needed to make healthy decisions. The primary objectives of health education are to improve health literacy, reduce risky health behaviors and promote adoption and maintenance of healthy behaviors throughout the lifetime.

Efforts to establish healthy behaviors in young people are more effective, and tend to be easier, than efforts to change unhealthy behaviors that are already established in adults.<sup>26</sup>

**Health education standards.** Health education standards are a useful tool for helping schools to develop or select their health education curriculum. Standards outline what a student should know and be able to do at each grade

### Health literacy

Health literacy is defined as: “The capacity of an individual to obtain, interpret and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.”<sup>27</sup> Health literacy skills include the ability to:

- Access and use valid sources of health information, products and services
- Make healthy decisions
- Successfully navigate the healthcare system<sup>28</sup>

Limited health literacy is associated with poor health outcomes, such as difficulty managing chronic conditions.<sup>29</sup> Researchers find that health education in schools is the most effective way to improve health literacy.<sup>30</sup>

level, while leaving the development and evaluation of specific curricula to teachers and other local specialists. Standards are different than a curriculum, which refers to the detailed plan for day-to-day teaching. A curriculum outlines what will be taught and how it will be taught, with the goal of students mastering the standards.

### National Health Education Standards

National health education standards (NHES) were first developed by the Joint Committee on National Health Education Standards in 1995 and have since been reviewed and revised.<sup>31</sup> These standards do not address specific health education content areas. Instead, they provide a framework for selecting or developing a curriculum, allowing for specific content and concepts to be included as appropriate for local needs. The NHES outline expectations of what students should know and be able to do by grades 2, 5, 8 and 12,<sup>32</sup> and reflect a research-informed focus on skills.

#### Students will:

1. Comprehend concepts related to health promotion and disease prevention to enhance health
2. Analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors
3. Demonstrate the ability to access valid information and products and services to enhance health
4. Demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks
5. Demonstrate the ability to use decision-making skills to enhance health
6. Demonstrate the ability to use goal-setting skills to enhance health
7. Demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks
8. Demonstrate the ability to advocate for personal, family, and community health<sup>33</sup>

### **Evidence-based prevention education**

**curricula.** Some schools draw upon standards and other guidance to develop their own curricula, while others select and implement existing curricula. The following evidence registries summarize research findings on the effectiveness of prevention education curricula and related programs:

- **Office of Juvenile Justice and Delinquency Prevention Model Programs Guide** (U.S. Department of Justice)
- **Washington State Institute for Public Policy benefit-cost results**
- **Blueprints for Healthy Youth Development** (University of Colorado)

### **Other prevention education programs**

K-12 prevention education activities also include prevention programs implemented as part of before or after-school programs, school-wide campaigns and peer-led prevention.

### **Ohio status: Health education**

Ohio is the only state without health education standards.<sup>34</sup> Senate Bill 287 (Sykes) of the 132nd General Assembly seeks to require the State Board of Education to develop and adopt health education standards for grades K-12. As of the release of this publication, the bill had

received one hearing in the Senate Education Committee.

Ohio students are required to complete one-half unit of health education to graduate from high school. The content of this education is partially dictated by a series of state laws that require school districts to teach students about several specific topics:

- The nutritive value of foods, including natural and organically produced foods, the relation of nutrition to health and the use and effects of food additives
- The harmful effects of and legal restrictions against the use of drugs, alcoholic beverages and tobacco
- Prescription opioid abuse prevention with an emphasis on the prescription drug epidemic and the connection between prescription opioid abuse and addiction to other drugs
- Venereal disease (commonly known as sexually transmitted infections)<sup>35</sup>
- Personal safety and assault prevention (in grades K-6)
- Dating violence prevention (in grades 7-12)
- Anatomical gifts<sup>36</sup>

## **School wellness**

In addition to the mental health and safety outcomes discussed in this policy brief, school wellness programs can also include activities designed to promote:

- Physical activity
- Healthy eating
- Adequate sleep
- Reproductive health

Research finds that physical activity, nutrition and sleep can affect mental health and academic outcomes. Sleep problems, for example, are a risk factor for depression and anxiety,<sup>37</sup> and lack of physical activity can contribute to classroom behavior problems and poor academic performance.<sup>38</sup> Strategies such as later school start times and Safe Routes to School, therefore, can achieve multiple positive outcomes for children.

### **Local school wellness policies**

Federal legislation<sup>39</sup> requires all schools that participate in the National School Lunch

Program and/or School Breakfast Program to develop a local school wellness policy. Parents and community partners are involved in development of the local policy, which must address nutrition and physical activity. Assessments on implementation of the wellness policy are required every three years and must be shared with the public.<sup>40</sup> The Ohio Department of Education (ODE) reviews local wellness policies during administrative reviews.<sup>41</sup>

### **Whole School, Whole Community, Whole Child**

The Whole School, Whole Community, Whole Child model provides school leaders with a comprehensive approach for addressing health-related barriers to learning. The framework includes several wellness-related components, including health education, physical education and physical activity, nutrition environment and services and social and emotional climate. For more information, see **HPIO Connections between Education and Health No. 2: Health Services in Schools.**

### Ohio status: Other prevention education programs

Several state agencies (the Departments of Education, Health and Mental Health and Addiction Services), the Attorney General's Office and the State Board of Education are all involved in planning and supporting various K-12 prevention education activities. See figure 9 on page 14 for a list of these activities. Community partners are often critical to this work at the local level, including local prevention coalitions, mentoring programs, law enforcement partnerships and youth-led prevention groups.

### Social-emotional learning and positive behavior initiatives

#### Social-emotional learning

Educators increasingly recognize the non-academic, intrapersonal and interpersonal capabilities that are necessary for a student to be successful in school and in life. These skills foster mental wellness, build self-esteem, help children learn to effectively manage peer pressure, make responsible decisions and control impulsivity. The process through which students build these skills is commonly referred to as social-emotional learning.

The five core competencies developed through social-emotional learning are:

- **Self-awareness** – Ability to accurately recognize one's own emotions and thoughts and how they influence behavior
- **Self-management** – Ability to successfully manage and regulate emotions, thoughts and behaviors
- **Responsible decision-making** – Ability to make constructive choices about behavior and social interactions based on ethical standards, safety concerns and social norms
- **Relationships skills** – Ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups
- **Social awareness** – Ability to see the perspectives of and empathize with others, including those from diverse backgrounds and cultures<sup>42</sup>

Strong research evidence has found school-based social-emotional instruction to have the following benefits:

- Increased academic achievement
- Increased high school graduation
- Improved social-emotional skills
- Increased school engagement
- Increased self-confidence
- Improved mental health
- Improved youth behavior<sup>43</sup>

Research has demonstrated the effectiveness of a number of school-based social-emotional learning programs such as [Second Step, Promoting Alternative Thinking Strategies \(PATHS\)](#),<sup>44</sup> [Caring School Community](#) and [Too Good For Violence](#).<sup>45</sup>

The following evidence registries summarize research findings on the effectiveness of social-emotional learning programs:

- [CASEL Guide](#) – Collaborative for Academic, Social and Emotional Learning (CASEL) produces a Preschool and Elementary edition and a Middle and High School edition
- [Washington State Institute for Public Policy benefit-cost results](#)
- [Blueprints for Healthy Youth Development](#) (University of Colorado)

#### Positive behavior initiatives

PBIS (Positive Behavioral Interventions and Supports) is a comprehensive, proactive approach to improving academic and social outcomes for all students, while preventing problem behaviors. It is a decision-making framework for selecting, organizing and implementing evidence-informed behavioral supports and interventions in a school community. See [HPIO's fact sheet on PBIS](#) for more information.

PBIS has three tiers of interventions. The first tier includes universal strategies which aim to impact all students. The PAX Good Behavior Game (GBG) is an example of a Tier 1 strategy. It is an evidence-based classroom behavioral management program that uses a classroom-wide game format with teams and rewards for minimizing aggressive, disruptive and noncompliant behaviors. Research has identified mental health benefits and reductions in substance use and behavioral problems among students who have participated in the game.<sup>46</sup>

### Ohio status: Social-emotional learning

**Ohio's Strategic Plan for Education: 2019-2024** was released in June 2018. The vision of the plan is that each student is challenged, prepared and empowered for his or her future by way of excellent education. The plan identified social-emotional learning as one of four equal learning domains that contribute to holistic success of each Ohio child.<sup>47</sup>

Ohio is one of at least 11 states (including Connecticut, Idaho, Illinois, Kansas, Massachusetts, Maine, Pennsylvania, Vermont, Washington and West Virginia) that has specific social-emotional learning standards.<sup>48</sup> Currently, Ohio's standards are for birth through third grade, but ODE commissioned an advisory group to work on extending them through grade 12.

### Ohio status: Positive behavior initiatives

Ohio schools are required to implement PBIS. The ODE **State Support Teams** and **Ohio PBIS Network** offer resources, technical assistance and training services to assist schools with PBIS implementation. The Ohio PBIS Network was awarded federal grants to assist in expanding PBIS and mental health support efforts in schools. Although school districts are required to use PBIS, ODE does not currently track the number of districts implementing it.

The recently-passed SAFE Act will add several more requirements related to PBIS including annual progress reports and inclusion in teacher preparation programs. See the description on page 13.

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) received two years of federal funding, beginning in 2017, from the 21st Century Cures Act to implement training and technical assistance to expand and enhance use of PAX GBG in Ohio schools. The funding will allow 1,000 new teachers to be trained on the program, and another 2,000 teachers already familiar with the program will receive booster training.<sup>49</sup>

### School climate improvement initiatives

School climate is a broad, multifaceted concept that involves many aspects of a student's educational experience.<sup>50</sup> It is often described as the "quality and character" of school life, and refers to the norms, values and expectations that make students feel supported both academically and emotionally. The climate of a school can largely be determined by how people feel when they first walk into the school. A school with a positive climate is likely to feel safe and welcoming.<sup>51</sup>

The U.S. Department of Education's Safe and Supportive Schools model of school climate outlines the important elements of a positive school climate, as identified by national experts (see figure 8)<sup>52</sup>:

- **Engagement:** The formation of strong, positive relationships across the school community which foster respect, trust and support among all students, teachers, administrators, staff, families and even the broader community. It also refers to the extent to which students are engaged in learning and school activities.  
*Example: Every student is connected to a caring and responsible adult in the school*<sup>53</sup>
- **Safety:** Ensuring students feel physically and emotionally safe in school. This includes safety from violence, harassment, bullying and substance use.  
*Example: Train staff and students in bullying and harassment prevention and ensure that a mechanism is in place for students to report bullying behavior*<sup>54</sup>
- **Environment:** The physical, academic and disciplinary environment of the school. A positive school climate normally includes a school building that is clean and well-maintained, an environment that supports and promotes learning and student wellness, and disciplinary policies that are fair, clear and consistently applied.  
*Example: Maintain school grounds, buildings and busses with plenty of light and color to create a pleasant working and learning environment*<sup>55</sup>

Figure 8. **Safe and Supportive Schools Model for school climate**



**Source:** National Center for Safe and Supportive Learning Environments, U.S. Department of Education

**Benefits of a positive school climate**

There are numerous benefits associated with a positive school climate for students, teachers and the entire school community. A positive school climate improves educational outcomes and promotes positive youth development. Benefits identified through research include:

- Fewer disciplinary problems
- Less aggressive and violent behavior, including less bullying and harassment
- Increased teacher retention and job satisfaction
- Fewer school absences
- Greater student academic motivation and engagement
- Improved academic achievement, including higher test scores, rates of grade promotion and high school graduation rates<sup>56</sup>
- Improved student health, especially mental health (including improved self-esteem and lower rates of anxiety, depression and other psychiatric problems)<sup>57</sup>
- Less alcohol and drug use<sup>58</sup>

The safe and supportive environment of the school can serve as a safe haven for students living in challenging home and community environments.<sup>59</sup>

**Resources and strategies for improving school climate**

Various resources exist to help schools improve school climate, including the [National School](#)

[Climate Standards](#), developed by the National School Climate Council, and the [Ohio School Climate Guidelines](#).

Using a school climate survey to assess the feelings and perceptions of students, parents and school personnel regarding engagement, relationships, safety and the external environment is a valuable step. The [PRIDE Surveys](#) and the [OHYES! Survey](#) are examples of commonly used, reliable and valid assessments. Through reviewing results of these assessments, in addition to data on student achievement, attendance and disciplinary incidents, schools can identify specific needs, set goals and track progress toward improvement.<sup>60</sup>

There are a wide variety of evidence-based strategies to improve school climate. For example, the Olweus Bullying Prevention Program is a school-wide program for students ages 5-15. It includes assessing bullying at the school, training all staff on bullying and its effects, establishing and consistently enforcing bullying rules and policies and having regular discussions about bullying, peer relationships and other social and emotional issues with students.<sup>61</sup>

Implementing trauma-sensitive practices in a school is another strategy that can especially improve outcomes for students who have experienced trauma. Examples

include predictable routines, teachers using a harmonica rather than loud hand clapping to get students' attention and timeout rooms or comfort zones for students needing to calm down.

### **Ohio status: School climate improvement initiatives**

In Ohio's Strategic Plan for Education, "student supports and school climate and culture" was recognized as a key element of an education experience.<sup>62</sup> Ohio has school climate guidelines that offer a framework for schools to use to create and maintain positive learning environments. ODE is currently in the process of updating the guidelines. Schools can also use the [Ohio Improvement Process](#) when undertaking school improvement efforts.

The federal Every Student Succeeds Act (ESSA) requires states to choose a nonacademic accountability measure of school quality or student success. In its 2017 state plan, Ohio chose to measure chronic absenteeism. In addition, ODE will convene a workgroup to explore supplemental measures which may include a school culture index and/or a measure of well-rounded education.<sup>63</sup>

Ohio law ([ORC 3313.666](#)) requires each school district to establish a policy prohibiting harassment, intimidation and bullying. This policy is to be developed in partnership with parents, school employees, school volunteers, students and community members. A [model policy](#) was developed by the State Board of Education, as required by Ohio law. Additionally, ODE and several other state agencies formed the [Ohio Anti-Harassment, Intimidation and Bullying Initiative](#) to offer professional development and resources related to the model policy and other best practices for creating a safe and supportive learning environment.

The SAFE Act, sponsored by Senators Lehner and Manning, was passed by the Ohio General Assembly in June 2018. The law will gradually reduce out-of-school suspensions and expulsions by the 2021-2022 school year for students in pre-K through third grade for non-violent behavior, except in limited circumstances. Out-of-school suspensions will

still be permitted for student actions posing a physical threat to teachers or other students, as required by federal law. Schools will be required to assist the disciplined student's parent or guardian with finding mental health services when a need is identified, whenever possible.

The law also requires:

- School districts to report out-of-school suspension and expulsion data to ODE and submit annual PBIS progress reports
- Teacher preparation programs (for grades pre-K-5) to include a course on positive classroom behavior management principles that covers PBIS and social-emotional development
- School districts to provide professional development in PBIS to certain teachers and administrators
- ODE to develop a report including out-of-school suspension and expulsion data for school years 2018-2019 through 2021-2022 and best practices for PBIS implementation

The legislation appropriates \$2 million for competitive grants for elementary schools to implement PBIS and/or evidence- or research-based social and emotional learning initiatives.

Other legislation to address bullying is currently pending (e.g., HB 360 and SB 197).

Figure 9. **Examples of current K-12 drug and violence prevention and mental health promotion activities in Ohio**

	Policy, program or initiative
Statutory requirements for health education	Students are required to have one-half unit (60 hours) of health education to graduate. There are no standards or accountability metrics.
	Schools are required to teach students about the nutritive value of food, harmful effects of drugs, opioid abuse, venereal disease, personal safety, dating violence and anatomical gifts.
Prevention education curricula and programs	Health and Opioid-Abuse Prevention Education (HOPE) curriculum (developed to help schools meet the opioid education mandate)
	In some school districts, drug and violence prevention education programs are implemented by external partners, such as D.A.R.E. officers, ADAMH board-funded organizations, local health departments, etc. Some organizations use evidence-based curricula (such as LifeSkills, Project Alert or Keepin' it REAL, Safe Dates, SOS, etc.), while others may develop their own programs.
Ohio Department of Mental Health and Addiction Services (OhioMHAS)	Start Talking! campaign
	PAX Good Behavior Game training for teachers, supported by a federal grant
	Support for local prevention coalitions and the Ohio Youth-Led Prevention Network
Ohio Department of Health (ODH)	Adolescent Health Partnership (statewide collaborative with strategic plan), staff support provided by ODH
	2017-2019 State Health Improvement Plan (includes school-based drug and violence prevention strategies)
Ohio Department of Education (ODE)	Healthy Schools and Communities Resource Team
	Ohio Interagency Council for Youth
	PBIS Network
	Ohio's Strategic Plan for Education: 2019-2024 includes social-emotional learning as one of four learning domains and identifies "student supports and school climate and culture" as a key element of an education experience
	Social-emotional learning standards
	School climate guidelines
Attorney General's Office	Ohio Joint Study Committee on Drug Use Prevention Education (released 2017 report and 2018 resource guide)
	Grants to local law enforcement agencies to support D.A.R.E.
State Board of Education (BOE)	Social and Emotional Learning Advisory Group/Behavioral Health Wellness Advisory Committee
Statutory requirements related to positive behavior and school climate	School districts are required to implement PBIS on a system-wide basis ( <a href="#">OAC 3301-35-15</a> )
	Schools are required to provide in-service training for school personnel in the areas of school safety, violence, substance abuse, suicide, teen dating violence, child abuse, human trafficking and the anti-harassment, intimidation and bullying policy ( <a href="#">ORC 3319.073</a> )
School-based surveys of drug use, school climate and related topics	Youth Risk Behavior Survey (YRBS), supported by ODH and CDC
	Ohio Healthy Youth Environments Survey (OHYES!), supported by OMHAS, ODH and ODE
	Other school-based surveys selected by individual school buildings or districts, such as PRIDE Survey, Dayton Area Drug Survey, Search Institute Developmental Assets Profile, etc.

## Policy options for enhancing school-based prevention

### State agencies and policymakers

#### Comprehensive approach

1. Ensure that any requirements for schools regarding drug prevention education take a comprehensive approach that includes all types of substances (e.g., opioids, methamphetamines, cocaine, alcohol, tobacco, e-cigarettes, marijuana, etc.).
2. Support comprehensive, age-appropriate health education for grades K-12 by requiring ODE to develop health education standards and/or to disseminate model curricula, with a focus on age-appropriate skill development.

#### Financing

3. Explore development of an addiction prevention wellness trust funded by future potential legal settlement proceeds. A portion of these funds could be dedicated to support school district implementation of K-12 prevention activities.
4. Explore opportunities to finance prevention and behavioral health early intervention services through private health insurance and Medicaid.

#### Coordination

5. ODE, OhioMHAS, ODH, the Ohio Attorney General and the BOE can work together to:
  - a. Strengthen communication and joint planning so that local school districts receive consistent and coordinated support from the state regarding prevention activities.
  - b. Monitor the extent to which evidence-based prevention activities are being implemented in Ohio's K-12 schools.
  - c. Ensure that valid and reliable state-wide data on adolescent alcohol, tobacco, e-cigarette and other drug use is available by supporting consistent use of one school-based survey (such as the YRBS or the OHYES!).
6. ODE, OhioMHAS and ODH can work together to expand and support professional development and cross-system collaboration with prevention specialists to ensure understanding and use of evidence-based prevention approaches.

#### Monitoring and evaluation

7. Monitor implementation of the newly-passed SAFE Act (PBIS progress reports; limits on suspensions and expulsions) and HB 367 (opioid education requirement), assess whether intended outcomes have been achieved and revise school requirements and supports as needed to improve effectiveness.
8. Evaluate the effectiveness of the HOPE Curriculum and support ongoing dissemination and teacher training if it is found to be effective.

### Schools and school partners (including Educational Service Centers)

#### Build upon existing resources

1. Implement cross-curricular prevention education (combine relevant content of two or more subject areas, such as violence prevention and English Language Arts, or drug prevention and science).
2. Adopt and fully implement a comprehensive 100 percent tobacco-free school policy that includes all e-cigarette products, such as the model policy provided by ODH.
3. Make use of the following free prevention resources:
  - a. [Ohio Attorney General's Drug Use Prevention Resource Guide](#)
  - b. [HOPE curriculum](#)
  - c. [Ohio Adolescent Health Partnership](#)
  - d. [Ohio Tobacco-Free School Toolkit and Model Policy](#)
  - e. [Ohio PBIS Network](#)
  - f. [Ohio school climate guidelines](#)
  - g. Online evidence registries to identify effective prevention curricula and programs ([OJJDP Model Programs Guide](#), [Blueprints for Healthy Youth Development](#), [WSIPP Benefit Cost Results](#), [CASEL Guide](#))

#### Coordination

4. Encourage broad participation of community partners (such as ADAMH boards, community behavioral health organizations, domestic violence prevention organizations, law enforcement agencies, local health departments, mentoring programs and prevention coalitions) in school improvement planning.

#### Staffing

5. Employ a school health coordinator to oversee the delivery of health-related programs and services in the district.
6. Employ a licensed health education teacher and provide opportunities for ongoing professional development, including information about evidence-based drug, alcohol and violence prevention.

#### Monitoring and evaluation

7. Implement the SAFE Act by accurately tracking and reporting suspensions, expulsions and PBIS activities, and by providing teachers with professional development on positive classroom behavior management.
8. Document and evaluate prevention education programs, PBIS, social-emotional learning programs and school climate improvement initiatives.

## Authors

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