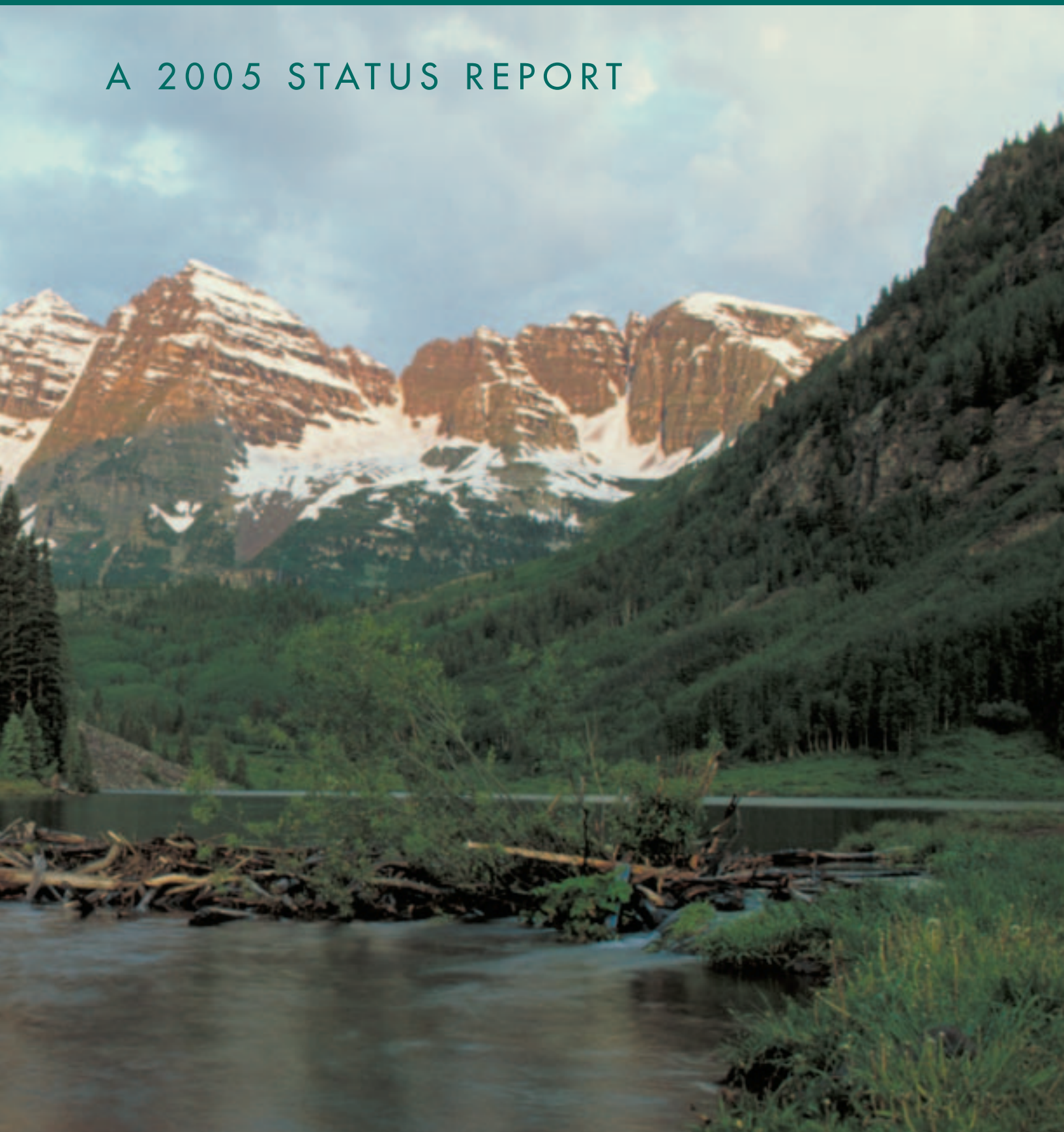
CHILD AND ADOLESCENT VIOLENCE IN COLORADO:

A 2005 STATUS REPORT



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Uncredited quotations in this report are from the statewide stakeholder survey. See chapter seven (pg. 25) for more information.

CHAPTER ONE

INTRODUCTION

In September 2004, the Centers for Disease Control and Prevention awarded the Colorado Department of Public Health and Environment a two-year grant to enhance child and adolescent health through violence prevention. The Injury, Suicide and Violence Prevention program and the Child, Adolescent and School Health program at the Colorado Department of Public Health and Environment, working in conjunction with the State Prevention Leadership Council, are coordinating the project. A Violence Prevention Advisory Group (VPAG), consisting of nationally known violence prevention experts, state agency leaders, and members of statewide prevention groups, was created to assist in the completion of a state assessment of child and adolescent violence and the development of a statewide strategic plan for violence prevention. The information included in the following pages is a report on the needs and available resources related to the reduction of child and adolescent violence in Colorado. This assessment will influence the creation of a strategic plan to address child and adolescent violence, which will be completed in the summer of 2006.

Children and adolescents ages 0–18 are the focus of this report. Child maltreatment, youth suicide, sexual violence, teen dating violence, school violence, bullying, and community violence are the types of violence assessed, and are discussed at the community, family, school, peer, and individual domains. Some key terms used throughout the assessment include:

- **Public Health Approach**—A practical, goal-oriented, and community-based approach to promoting and sustaining health. This approach seeks to identify risk and protective factors, determine when in the life course they typically occur and how they operate, and enable researchers to design preventive programs that are effective in reducing risk and promoting protection.[1]
- **Risk Factors**—Characteristics or situations that increase the probability that a child or adolescent will become a victim or perpetrator of violence.[2]
- **Protective Factors**—Characteristics or situation that mitigate the risk of a child or adolescent becoming a victim or perpetrator of violence.[3]
- **Shared Risk and Protective Factors**—Risk and/or protective factors that have an impact on more than one type of violence. For example, "family connectedness" is a shared protective factor for child maltreatment, suicide, sexual violence, and community violence.
- **Universal Prevention**—Approaches that serve an entire population who share a general risk.[4]
- **Selective Prevention**—Approaches that serve subsets of the population that are at an enhanced risk of youth violence, and are aimed at preventing the onset and reducing the risk of violence.[5]
- **Indicated Prevention**—Approaches that serve those who already demonstrate violent or seriously delinquent behavior.[6]

Chapter Two identifies and discusses risk and protective factors for child and adolescent violence, and discusses factors shared among different types of violence. Chapter Three provides current data about child and adolescent violence in Colorado, including pertinent resources for where the information can be accessed. Chapter Four reviews the Colorado Revised Statutes that include universal child and adolescent violence prevention policies, and discusses how legislation can influence youth violence at the state and local levels. Chapter Five highlights state-level programs for child and adolescent violence prevention, focusing on those that utilize a universal approach, and recognizes the many local programs currently working to reduce youth violence. Chapter Six discusses uniform minimum standards for effective prevention programming, and emphasizes the importance of using research-based designs. Chapter Seven presents the results of an online stakeholders survey regarding child and adolescent violence and violence prevention efforts statewide. Chapter Eight introduces steps toward integrated prevention efforts and discusses how the current assessment will influence the 2006 strategic plan.

The intent of an assessment of child and adolescent violence and violence prevention efforts in Colorado is to provide prevention researchers, educators, and practitioners with a resource for information. Ultimately, the lasting goal of this two-year project is to develop integrated strategies that are accepted and implemented statewide and impact all of the children and youth of Colorado, making the state a national leader in creative and effective approaches to child and adolescent violence prevention.

"Child and adolescent violence prevention is complex. It's important to look at the most factors possible to understand the entire problem and solutions."

— (From the statewide stakeholders survey)

CHAPTER TWO

RISK AND PROTECTIVE FACTORS FOR CHILD AND ADOLESCENT VIOLENCE

IN RECENT YEARS, the study of risk and protective factors has gained momentum as researchers incorporate the public health approach into the study of violence prevention. Historically, prevention practitioners evaluated the causes of violent behavior by looking at each type of violence individually, without evaluating how certain factors may impact multiple types of violence. In this chapter, we define risk and protective factors, evaluate how certain risk and protective factors are shared by various types of violence at different levels of influence (community, family, school, peer, and individual), discuss some of the gaps in current approaches to violence prevention, and suggest strategies to reduce and buffer risk and improve protection of children and adolescents.

Defining Risk and Protection

The concepts of risk and protection are integral to the public health approach of preventing violence among children and adolescents. Risk factors are those characteristics or situations that increase the probability that a child or adolescent will become a victim or perpetrator of violence, while protective factors mitigate the risks in the lives of children and adolescents.[7] Pioneering studies by Emmy Werner and Ruth Smith regarding the notion of resilience helped influence and create the language of protection in the study of risk and protective factors.

Prevention science research suggests that the most effective methods for promoting positive youth development and preventing problem behaviors involve addressing both risk and protective factors.[9] It is difficult to develop high levels of protection in the face of high levels of risk, suggesting that children who are exposed to very few protective factors may benefit not only from increased protective factors, but also from risk-reduction strategies.[10] According to the 2001 *Youth Violence: A Report of the Surgeon General*, most risk and protective factors result from social learning or the combination of social learning and biological factors.[11]

In 1996, David Hawkins and Richard F. Catalano at the University of Washington created the social development model after conducting more than thirty years of systematic reviews of experimental and longitudinal studies to identify risk and protective factors that predict child and adolescent behavior.[12] Hawkins and Catalano are pioneers in the study of risk and protection, and their research is widely cited in the study of youth violence and violence prevention. The social development model outlines how youth develop both problem and positive behaviors and describes the pathway to healthy behaviors.[13] For example, according to Hawkins and Catalano a factor such as early and persistent antisocial behavior is identified as a risk for substance abuse, delinquency, teen pregnancy, school dropout, and violence.[14]

Other studies of risk and protection do not necessarily meet the experimental and longitudinal design of the Hawkins and Catalano model, but have strong implications regarding the study of risk and protection for child

> *"There is some general acceptance that the process of resilience is what helps people sustain lives of health and hope, despite adversity. In general, individuals and families demonstrate resilience when they draw on inner strengths, skills and supports to keep adversity from derailing their lives."*[8]
>
> — From Emmy Werner and Ruth Smith's 2001 study of resilience, *Journeys from Childhood to Midlife: Risk, Resilience, and Recovery.* Ithaca, NY: Cornell University Press.

and adolescent behavior. In 2004, Michael Resnick and Peggy Mann Rinehart at the Center for Adolescent Health and Development at the University of Minnesota used data from The National Longitudinal Study of Adolescent Health to identify risk and protective factors relevant to adolescents involved in violent behavior.[15] Although their study does not investigate the specific types of violence presented in this status report, it is a detailed presentation of risk and protective factors associated with violent behavior. For example, Resnick and Rinehart identify family connectedness as a protective factor, suggesting that healthy family bonds are associated with youth who do not perpetrate violence.[16]

In 1996, Peter Benson and the Search Institute introduced the 40 Developmental Assets, which are building blocks of healthy development that help young people grow up healthy, caring, and responsible.[17] The 40 Developmental Assets includes external and internal influences in young peoples lives that, when present, serve to shape healthy, productive citizens. These assets are similar to the protective factors presented by Hawkins and Catalano, and Resnick and Rinehart, and emphasize positive youth development as a means to counter problem or violent behavior. For example, having a parent and/or other adult that models positive, responsible behavior is an external asset for positive youth development.[18]

This assessment includes factors from all of the researchers and sources mentioned above to illustrate the impact of risk and protection for Colorado youth as broadly as possible. Many of the factors will be relevant to the Violence Prevention Advisory Group's future strategic planning process.

Tables 2.1 and 2.2 on the following pages highlight the risk and protective factors related to child and adolescent violence from the studies conducted by Hawkins and Catalano, Resnick and Rinehart, the Surgeon General's report on youth violence, the Search Institute's 40 Developmental Assets, and the expertise of the members of the Violence Prevention Advisory Group. The 40 Developmental Assets are highlighted in Table 2.3. These national studies did not evaluate risk and protection based on all of the types of violence specified for the current project. However, they present the findings of the major research done to date regarding risk and protective factors related to violence among children and adolescents. The information is presented to provide an idea of the research that has been conducted to date, and to highlight some of the factors that may be presented and addressed in the Violence Prevention Advisory Group's future strategic planning.

"The large body of research on violence risk factors for adolescents is now being joined by a growing number of studies that identify the factors, experiences and events that protect against violence involvement. The dual strategy of reducing risk and enhancing protection provides a framework for those involved in programs, policies and practice, so that their priorities can reflect our understandings about what works to protect young people from harm."

— Michael Resnick and Peggy Mann Rinehart. Influencing Behavior: The Power of Protective Factors in Reducing Youth Violence. Center for Adolescent Health and Development, University of Minnesota. 200 Oak Street SE, Suite 260, Minneapolis, MN. 2004.

Table 2.1—Risk Factors for Child and Adolescent Violence

	Hawkins & Catalano[1]	Resnick & Rinehart[2]	Surgeon General's Report[3]	VPAG[4]
COMMUNITY:				
Availability of alcohol, tobacco, other drugs, and firearms	X		X	X
Laws and norms favorable toward drug use, firearms, & crime	X		X	X
Community disorganization	X		X	X
Economic deprivation	X			X
FAMILY:				
Family history of problem, or antisocial behavior	X		X	X
Parents w/ + attitude toward substance abuse & violence	X			X
Family conflict	X		X	X
Family management problems	X		X	X
Physical/sexual/emotional abuse			X	X
Low parental involvement			X	X
Family suicide attempt		X		X
Easy access to firearms (male)		X		X
Low socioeconomic status			X	X
SCHOOL:				
Academic failure beginning in late elementary school	X	X	X	X
Lack of commitment to school	X			X
Truancy or skipping school		X		X
Carrying weapon to school		X		
Being a victim of violence		X		X
PEER:				
Having friends w/ weak social ties			X	X
Having delinquent peers			X	X
Gang involvement	X		X	X
Friend who has attempted suicide		X		X
Friends who engage in problem behavior	X			X
INDIVIDUAL:				
Low IQ			X	
Early and persistent antisocial behavior	X		X	X
Rebelliousness	X			
Previous involvement w/ violence		X	X	X
History of victimization		X		X
Poor general health		X	X	X
History of treatment for emotional or mental problems		X	X	X
High levels of emotional distress		X		
Aggression (M)			X	X
Substance use		X	X	X
Gay, lesbian, bisexual, transgender				X

[1] Social Development Research Group—Definition of violence includes aggressive behavior and interpersonal violence by youth.

[2] Center for Adolescent Health and Development—Definition of violence includes interpersonal violence perpetration.

[3] U.S. Department of Health and Human Services—Definition of violence includes aggravated assault, robbery, rape, and homicide.

[4] Violence Prevention Advisory Group—Responses based on the expertise of the members of VPAG

Table 2.2—Protective Factors for Child and Adolescent Violence

	Hawkins & Catalano[5]	Resnick & Rinehart[6]	Surgeon General's Report[7]	VPAG[8]
COMMUNITY:				
Bonding w/ caring adults	X	X		X
Available resources and opportunities	X			X
Sense of safety		X		X
Healthy community norms & expectations	X			X
FAMILY:				
Parental monitoring			X	
Family connectedness/attachment	X	X	X	X
High educational expectations	X	X		
Share in regular activities with parents	X	X		X
Parent consistently home at optimum times		X		
SCHOOL:				
High academic achievement		X		X
Commitment/bonding to school	X	X	X	X
Clear rules for behavior	X			
PEER:				
Friends who participate in pro-social or conventional activities	X		X	X
INDIVIDUAL:				
High IQ	X		X	
Viewing problem behavior disapprovingly	X		X	X
Positive social orientation	X		X	X
Self-identified religiosity	X	X		X
Identity of perceived sanctions for wrongdoing	X		X	X
Emotional well being		X		X

[5] Social Development Research Group—Definition of violence includes aggressive behavior and interpersonal violence by youth.

[6] Center for Adolescent Health and Development—Definition of violence includes interpersonal violence perpetration.

[7] U.S. Department of Health and Human Services—Definition of violence includes aggravated assault, robbery, rape, and homicide.

[8] Violence Prevention Advisory Group—Responses based on the expertise of the members of VPAG

Shared Risk and Protective Factors

Shared risk and protective factors are those factors that impact more than one type of violence. The research on risk and protective factors for various types of violence reveals a level of consistency across all the forms of violence analyzed throughout this project: youth suicide, child maltreatment, school violence and bullying, community violence, sexual violence, and teen dating violence. Identifying the shared risk and protective factors among the different types of violence may better integrate child and adolescent violence prevention efforts throughout Colorado. It also may encourage communities and state agencies to address multiple types of violence, and to more efficiently use resources to implement broader prevention programs. These risk and protective factors will be presented in the context of community, family, school, peer, and individual domains.

Research has found that race and/or ethnicity has little influence on most risk and protective factors. For example, substance use is a risk factor for child and adolescent violence regardless of race or ethnicity. Likewise, family connectedness and/or attachment is a protective factor regardless of race or ethnicity.

Table 2.3—The Search Institute's 40 Developmental Assets[19]

EXTERNAL ASSETS

SUPPORT

1. **Family Support—**Family life provides high levels of love and support.
2. **Positive Family Communication**—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. **Other Adult Relationships**—Young person receives support from three or more non-parent adults.
4. **Caring Neighborhood**—Young person experiences caring neighbors.
5. **Caring School Climate**—School provides a caring, encouraging environment.
6. **Parent Involvement in Schooling**—Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT

7. **Community Values Youth**—Young person perceives that adults in the community value youth.
8. **Youth as Resources**—Young people are given useful roles in the community.
9. **Service to Others**—Young person serves in the community one hour or more per week.
10. **Safety**—Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES & EXPECTATION

11. **Family Boundaries**—Family has clear rules and consequences and monitors the young person's whereabouts.
12. **School Boundaries**—School provides clear rules and consequences.
13. **Neighborhood Boundaries**—Neighbors take responsibility for monitoring young people's behavior.
14. **Adult Role Models**—Parent(s) and other adults model positive, responsible behavior.
15. **Positive Peer Influence**—Young person's best friends model responsible behavior.
16. **High Expectations**—Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. **Creative Activities**—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. **Youth Programs**—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. **Religious Community**—Young person spends one or more hours per week in activities in a religious institution.
20. **Time at Home**—Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

COMMITMENT TO LEARNING

21. **Achievement Motivation**—Young person is motivated to do well in school.
22. **School Engagement**—Young person is actively engaged in learning.
23. **Homework**—Young person reports doing at least one hour of homework every school day.
24. **Bonding to School**—Young person cares about her or his school.
25. **Reading for Pleasure**—Young person reads for pleasure three or more hours per week.

POSITIVE VALUES

26. **Caring**—Young person places high value on helping other people.
27. **Equality and Social Justice**—Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity**—Young person acts on convictions and stands up for her or his beliefs.
29. **Honesty**—Young person "tells the truth even when it is not easy."
30. **Responsibility**—Young person accepts and takes personal responsibility.
31. **Restraint**—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. **Planning and Decision Making**—Young person knows how to plan ahead and make choices.
33. **Interpersonal Competence**—Young person has empathy, sensitivity, and friendship skills.
34. **Cultural Competence**—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance Skills**—Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful Conflict Resolution**—Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. **Personal Power**—Young person feels he or she has control over "things that happen to me."
38. **Self-Esteem**—Young person reports having a high self-esteem.
39. **Sense of Purpose**—Young person reports that "my life has a purpose."
40. **Positive View of Personal Fortune**—Young person is optimistic about her or his personal future.

Gender however, in certain instances, does influence risk and protection.[20] For example, aggression is a more significant risk factor for violent behavior for males than for females, while self-identified religiosity is a stronger protective factor for females than for males. Thus, gender variation will be noted where appropriate. Further, risk and protective factors have varying degrees of effect depending on the developmental stages of a child's or adolescent's life. For example, family relationships are more significant than peer relationships in childhood. Then, as children enter adolescence, peer and community factors increase in significance.

Community

Community risk factors for violence among children and adolescents include the availability of alcohol, drugs, and weapons; community laws and norms favorable toward drug use, weapon use, and criminal activity; and community disorganization and/or economic deprivation.[21]

Community factors that protect against child and adolescent violence include the presence of caring and supportive adults in the community; available opportunities within the community that offer healthy, safe, structured activities; and a sense of community safety and organization.[22]

Family

Factors present in a child or adolescent's home or family environment that increase the risk of violence include low family socioeconomic status; poverty; having parents with antisocial personality traits or parents who have tolerant views regarding the use of violence and/or substance abuse; having poor parent–child relationships; or having parents who are physically or emotionally abusive.[23] According to Resnick and Rinehart, other risk factors in a family setting include a suicide attempt by a family member and easy access to firearms in the home (males only).[24] A 2000 study from the Colorado Department of Public Health and Environment found that 67 percent of the adolescents who died by suicide used a firearm obtained from their home. Further, 72 percent of those that died by suicide in the study had access to a firearm in the home, while only 50 percent of subjects in a control group had access to a firearm in the home.[25]

Protective factors in the family environment include strong parental monitoring and expectations of success in school; strong family connectedness; and participating in regular shared activities with parents.[26] Further, Resnick and Rinehart identified the consistent presence of parents being home during at least one of the following times as protective: when children wake up in the morning, arrive home from school, during their evening meal, or at bedtime.[27]

School

Risk factors for violence at school include truancy; the presence of learning problems or disabilities; carrying a weapon to school; a perception of prejudice among students at school; and being a victim of violence at school.[28] A lack of commitment to school and academic failure beginning in late elementary school are also risk factors.[29]

Protective factors in the school environment include strong school connectedness, participation, and involvement; an atmosphere of caring and support from teachers and other adults within the school; high expectations for school achievement; and clear standards and rules for school behavior.[30] Maintaining a high grade point average is also a protective factor, particularly for females.[31]

Peer

Peer group risk factors that have been identified throughout the research include friends with weak social ties, delinquent peers, involvement in a gang,[32] and having a friend who has died by or attempted suicide.[33] Having friends with favorable attitudes toward problem behavior or who participate in problem behavior is a significant risk factor for children and adolescents to engage in violent behavior. Peer pressure, particularly in adolescence, is a very powerful influence in young people's lives. The Surgeon General's report on youth violence suggests that peers become more influential than parents in adolescence.[34] Negative or unhealthy peer relationships with power inequality and aggression are serious risks for violent behavior.

Protective factors related to peer relationships include having friends who engage in conventional behavior and participate in pro-social activities. Again, because peers heavily influence behavior, particularly in adolescence, strategies designed to improve protection and therefore reduce violence should address the development of positive, healthy peer relationships.

Individual

Risk factors for violence among children and adolescents at the individual level are often related to previous experience with violence, overall health status, and certain behavioral factors. According to Resnick and Rinehart, the strongest correlates for violence at the individual level are previous involvement in violent behavior and a history of being victimized by violence.[35] Risk factors related to health status are high levels of somatic complaints, poor general health, a history of being treated for emotional problems, low self-esteem (females only), and high levels of emotional distress.[36] Behavioral risk factors include early and persistent antisocial personality traits and behavior,[37] prior suicide attempt, aggression (males only),[38] and substance use.[39]

Factors at the individual level identified with a lower risk of violence among children and adolescents include having a high IQ; self-identified religiosity; and high self-esteem.[40] The 2001 Surgeon General's report also identified that viewing problem behavior disapprovingly and having a positive social orientation as protective factors at the individual level.[41]

Challenges in Current Research and Knowledge

Many of the risk and protective factors identified at the different categories of influence in a child or adolescent's life are shared factors among multiple types of violence. As noted, risk factors such as previous experience with and/or victimization from violence, emotional problems or distress, and substance use are shared among all types of child and adolescent violence. Likewise, protective factors such as parent–family connectedness, successful school performance, and positive relationships with other caring adults are shared among multiple types of violence.

Unfortunately, very few data exist in Colorado that measure risk and protection. However, in a 2002 Colorado Trust study, *Ask the Children: Youth and Violence, Colorado Students Speak Out for a More Civil Society,* 1,012 Colorado youth from 5th through 12th grade participated in a study to evaluate youth perspectives on violence and prevention. The representative Colorado sample is compared to a national sample of 1,001 students, and is stratified by school type (public, private, and parochial); grade coverage; rural, suburban, or urban setting; and region. The study notes that Colorado youth do not report more frequent violence than the national sample. The report highlights factors such as healthy, positive relationships with adults and peers; safety in schools, communities, and homes; and increased focus on strategies for coping with anger and anxiety, as factors that students identify as needing to be strengthened to help minimize violence.[42]

Using risk and protection to integrate services and save resources: "It is more than money. If we can stop the violence early, we can lessen the number of adult victims/perpetrators."

Because the Hawkins and Catalano study, the Resnick and Rinehart study, and the Surgeon General's report on youth violence use national, representative samples, we can compare their findings to children and adolescents in Colorado. However, Colorado could benefit from creating data sources that are state-specific in order to give researchers, practitioners, and others a greater understanding of the risk and protective factors most closely affecting the children and adolescents of Colorado.

Next Steps

Prevention practitioners will be able to implement integrated prevention efforts by incorporating shared risk and protection into the design of prevention programs. Given limited community and school resources and time to implement prevention or strength-building curricula, programming should be as integrative as possible to most effectively and efficiently reduce multiple types of child and adolescent violence.

Prevention activities that address multiple types of violence can be integrated by identifying shared risk and protective factors. The next step is to identify and recommend evidence-based programs and strategies that promote integration and mitigate risk by increasing protection for children and adolescents. Identifying programs and resources that strengthen families, enhance positive relationships with adults, encourage school and community connectedness, improve academic performance,[43] and emphasize positive, healthy peer relationships provides the opportunity to counter risk while increasing protection using positive, healthy, strength-building strategies.

CHAPTER THREE

DATA ON CHILD AND ADOLESCENT VIOLENCE

THIS CHAPTER PROVIDES A BROAD OVERVIEW of the Colorado-specific data currently available on various types of violence at different stages of child and adolescent development (ages 0–17). The descriptions below provide a brief glimpse of the problem and should not be considered as comprehensive. Because the data tend to be collected categorically, this overview is presented by type of violence, rather than by shared risk and protective factors or stage of child development. Following a brief description of what is known about each type of violence, some of the gaps in available data are identified. Suggestions for possible next steps are presented at the close of the chapter.

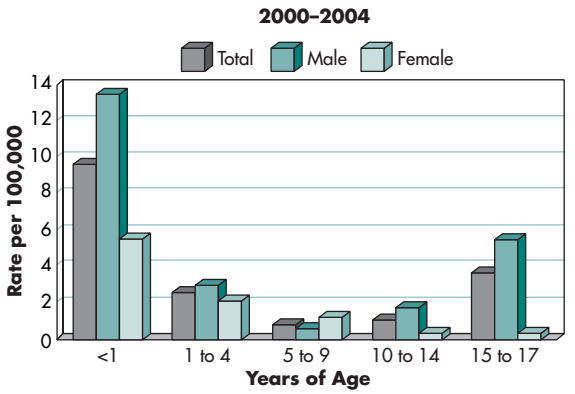
In reviewing the information provided, consideration should be given to the quality and limitations of the data. Information on child and adolescent violence is dependent upon the accuracy and completeness of reporting by victims and/or service providers. In most instances, the accuracy and completeness of reporting has not been assessed. It is likely that the numbers and rates presented in this chapter may be underestimates of the true number of occurrences.

Child Maltreatment

The Child Abuse Prevention and Treatment Act defines child maltreatment as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."[44]

Data are available in Colorado on childhood deaths and hospitalizations (serious physical harm). Based on data from 2000–2004, for children ages 0–17, homicide rates are highest for infants under the age of 1 (9.6 per 100,000), with rates being higher for boys (13.5 per 100,000) than girls (5.5 per 100,000).[45] Similarly, hospitalization rates for physical harm or abuse are higher for male infants under the age of 1 (93.3 per 100,000) than for other child/adolescent age groups.[46]

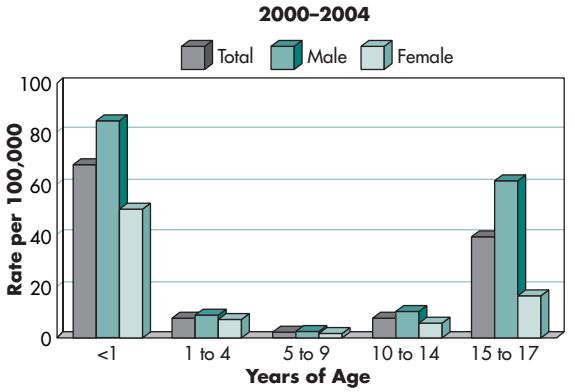
Colorado Homicide Death Rates by Age



Source: CoHID

Data from the Department of Human Services indicates that in 2002, investigations were conducted on 27,889 referrals of alleged child abuse and neglect. After investigation, there were 7,558 confirmed victims of child abuse and neglect, and of these, 77 percent were children under the age of 12.[47]

Colorado Hospitalization Rates Due to Assault by Age



Source: CO Hospital Association

Prior victimization, age, and male gender are risk factors for child maltreatment. Nationally, victims of prior abuse or neglect are twice as likely to be a victim of maltreatment than children with no history of prior abuse or neglect.[48] Children ages 0–3 and males of all ages have higher rates of victimization.

In 2003, 77 percent of Colorado perpetrators of child maltreatment were parents.[49] For adult perpetrators, risk factors for committing child maltreatment include poverty, a history of being a perpetrator of intimate partner or domestic violence, believing that aggression is justifiable, exposure to violence in the perpetrator's childhood, and substance abuse.[50]

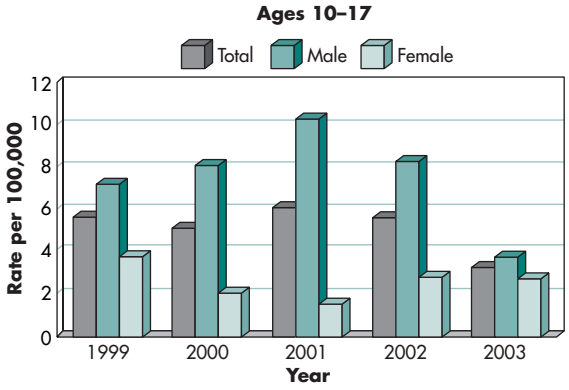
Although total numbers of reported abuse/neglect are available, there are significant gaps in the information collected. For example, race/ethnicity information is missing for 30 percent of hospital discharge records.[51] For perpetrators who are children or adolescents, no information is readily available on the perpetrator's age, gender, ethnicity, or relationship to the victim. Data on child and adolescent exposure to domestic violence are also not routinely captured.

Youth Suicide

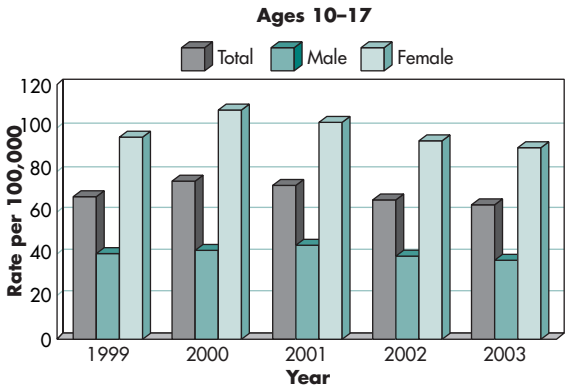
Suicide is the second leading cause of death for adolescents ages 10–17 in Colorado and the third leading cause of death for adolescents nationally.[52] The suicide rate for adolescent males in Colorado (7.8 per 100,000) is almost three times higher than for adolescent females (2.8 per 100,000).[53] Although rates vary by county, no county in Colorado has an adolescent suicide rate that is statistically higher or lower than the overall state rate.

While adolescent males have a higher suicide death rate, adolescent females have a higher rate of hospitalization for a suicide attempt. The hospitalization rate for adolescent females (100.9 per 100,000) is more than twice that of adolescent males (41.7 per 100,000).[54] The majority of hospitalized suicide attempts by adolescents involve drug overdose (82 percent).[55]

Colorado Suicide Death Rates by Sex



Hospitalization Rates Due to Suicide Attempt by Sex



National research indicates that for all ages, 90–95 percent of individuals who die by suicide have a mental illness, such as depression.[56] Depression in adolescence often manifests as "acting out." Truancy from school, declining school grades, poor behavior, violence, abuse of alcohol or other drugs, sleep disturbances, and changes in eating habits are all signs of depression and are risk factors for suicide.[57] National studies also show that gay, lesbian, bisexual youth, and youth questioning their sexual orientation are more likely to attempt suicide than their heterosexual peers. These adolescents may account for as much as 30 percent of youth suicides.[58] Other risk factors that have been linked to adolescent suicide include knowing someone who has died by or attempted suicide,[59] childhood abuse,[60] and impulsivity or aggression.[61]

Gaps in suicide data include the lack of a statewide database for treatment provided in emergency departments (visits that do not result in hospitalization). As mentioned above, race/ethnicity information is frequently missing from hospital discharge data. Psychological autopsy information, a process designed to assess a variety of factors including behavior, thoughts, feelings, and relationships of an individual who is deceased, would provide better understanding of the circumstances related to the suicide and help guide the development of appropriate prevention strategies.

Sexual Violence

Due to significant underreporting, sexual violence directed at children and adolescents is very difficult to assess. Children and adolescents who are victims of sexual violence may have difficulty reporting, since their understanding of inappropriate adult behavior may be lacking and they are most likely to be abused by someone they know (usually a male relative or acquaintance).[62] Few data sources on sexual violence involving children and adolescents are available in Colorado. According to the Colorado Health Information Dataset (CoHID), in 2003, there were 935 substantiated cases of child sexual abuse in Colorado, which represents approximately 11 percent of the total number of substantiated child maltreatment cases that year.[63]

National research on sexual violence suggests that children and adolescents victimized by sexual violence are at risk of experiencing psychological and behavioral problems, including guilt, fear, sexual dysfunction, withdrawal, school failure, and acting out.[64] Victims often are at risk for not only suffering immediate consequences of sexual violence, such as pregnancy or sexually transmitted disease, but long-term consequences, such as eating disorders, sexual dysfunction, sleep disturbances, and chronic headaches and fatigue.[65] Sexual abuse victimization is a shared risk factor for other types of violence including suicide, bullying and violence against others.

Children and adolescents can also be perpetrators of sexual violence. According to the Colorado Bureau of Investigation, the number of juvenile arrests for rape dropped from 235 in 1998 to 84 in 2003; however, the number of juvenile arrests for other sexual offenses (not defined) climbed from 278 to 386.[66]

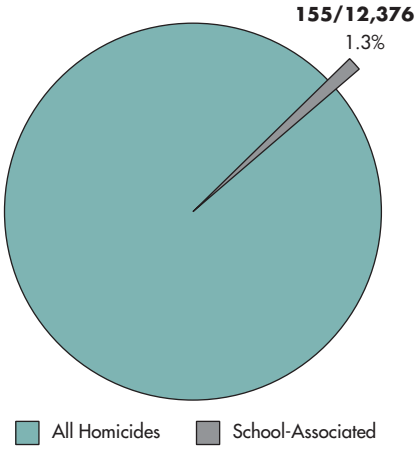
Teen dating violence, although not always sexual, is another relevant issue. The 2003 Colorado Youth Risk Behavior Survey conducted by the Colorado Department of Public Health and Environment found that, of the 757 9th through 12th graders who responded to the survey, 10.1 percent self-reported being hit, slapped or physically hurt intentionally by a boyfriend or girlfriend at some time in the prior 12 months. This compares to 8.9 percent reported nationally. Further, 7.7 percent of Colorado respondents reported being physically forced to have sexual intercourse, compared to 9 percent nationally.[67]

The greatest gap in data collection on sexual violence is the significant underreporting of sexual crimes. Of the crimes that are reported to the Colorado Bureau of Investigation, the reliability of the information is dependent upon the consistency and accuracy of local law enforcement reporting processes. The current Colorado sexual assault data do not include the gender, age, or race and ethnicity of juvenile perpetrators, and do not identify whether the crime resulted in conviction. Additionally, hospitalization and criminal data do not include information on teen dating violence.

School Violence

Safety in schools is a national concern. Recent school shootings, particularly the 1999 Columbine High School shooting in Littleton, Colorado, heightened the national emphasis on addressing violence, mental health, and bullying in America's schools. The 2002 study by The Colorado Trust cited earlier found that 47 percent of Colorado youth reported feeling very safe at school (compared to 39 percent nationally), while 42 percent felt somewhat safe, and 12 percent did not feel very safe at all.[68] Students reported being less concerned about extreme violence, such as the

Homicides Among School-Aged Children, 1994–1999



Source: CDC

events that occurred at Columbine, and more concerned about emotional violence and bullying, types of violence that do not fall under the definition of criminality. A report from the Centers for Disease Control and Prevention found that from 1994–1999 only 1.3 percent of all homicides among school-aged children happened at school or were school associated.[69] These data suggest that despite high profile tragedies such as Columbine, schools remain relatively safe, although bullying and emotional violence remain an issue.

The Center for the Study and Prevention of Violence at the University of Colorado at Boulder, uses the Olweus Bullying Prevention Program definition of bullying: "A student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students. Such negative actions include intentionally inflicting, or attempting to inflict injury or discomfort upon another … In order to be considered bullying, there should also be an imbalance in power or strength."[70] According to the U.S. Department of Health and Human Services' "Stop Bullying Now" campaign, bullying has historically been viewed as a rite of passage for school-aged children. Recent research, however, suggests that bullying can have significant immediate and long-term consequences for both perpetrators and victims. In some cases, individuals can become both a victim as well as a perpetrator of bullying.[71] Suicide, truancy, frequent fighting, vandalism, substance abuse, carrying a weapon, and dropping out of school are all correlated with bullying victimization.[72] Because of the association between bullying and other types of violence, addressing the issue of bullying might result in a reduction in other types of violent behavior.

Data on bullying are limited, with most information gleaned from self-report surveys. The bullying information in the 2002 Colorado Trust report indicates that younger children (5th through 8th graders) are more likely to be hit, shoved, kicked or tripped than older children. Older children (9th through 12th graders) are more likely to tease and gossip about one another.[73] Children and adolescents with positive parental, peer, and teacher relationships are less likely to experience victimization or perpetrate aggressive behavior.

In addition to addressing physical bullying, prevention strategies should address emotional bullying as well. Students participating in the 2002 Colorado Trust study reported that the best way to end youth violence was to end emotional violence such as teasing, gossiping, put-downs, bullying, meanness, insults, and making fun of classmates.[74]

With regard to other issues in the school environment, the Colorado Department of Education reported that in 2002–2003, the school suspension rate was 15.6 percent and the expulsion rate was 0.3 percent. Four percent of suspensions and 4 percent of expulsions were for assaults and/or fights, while 0.6 percent of suspensions and 17 percent of expulsions were for carrying dangerous weapons.[75] Determining whether students who are suspended or expelled for violence-related actions are at higher risk for violence perpetration or victimization has not been measured, leaving a significant gap in the current data.

"We still need local data on teen violence, including assaults, date rape and non-physical forms of abuse, including emotional, mental, and verbal."

Community Violence

Community violence is frequently viewed synonymously and stereotypically with gang violence and minority populations. In reality, social disorganization, characterized in part by poverty, high resident turnover, a lack of positive adult role models, and an elevated presence of crime and drugs is likely more associated with community violence than is race or ethnicity. Gangs, defined as a group of adolescents involved in delinquent activities, are present not only in urban communities, but in suburban and rural communities as well.[76]

From 1999–2002, the adolescent (ages 13–17) homicide rate in Colorado (4.1 per 100,000) was slightly lower than the national rate (4.52 per 100,000). Adolescent males account for 87 percent of the adolescent homicides in Colorado.[77] Adolescent males also have a higher rate of hospitalization for assault than adolescent females (47.6 per 100,000 and 13.9 per 100,000 respectively).[78]

According to the 2002 Colorado Trust report, 51 percent of Colorado youth reported feeling very safe from violence in their neighborhood, while 37 percent felt somewhat safe, and 12 percent did not feel very safe at all.[79]

Data on youth and community violence are limited in Colorado. For example, the Colorado Bureau of Investigation does not electronically report the age, gender, and ethnicity of perpetrators, and does not report convictions. Data are also limited on measures of community characteristics potentially related to violence such as socioeconomic status, neighborhood access to free and/or affordable resources, neighborhood stability, and support and funding for neighborhood schools.

Next Steps

Although some data on child and adolescent violence in Colorado are available to researchers, community members and prevention practitioners, significant gaps in the data exist. State, community and local agencies should strive to create more comprehensive and accurate data collection systems while building upon and improving the data collection and evaluation tools that currently exist. With enhanced data, researchers and others can identify shared risk and protective factors, to assist in identifying, developing, implementing and evaluating a more integrated approach to child and adolescent violence prevention.

CHAPTER FOUR

OVERVIEW OF COLORADO STATUTES ADDRESSING CHILD AND ADOLESCENT VIOLENCE

POLICIES AT THE FEDERAL, STATE AND COMMUNITY LEVELS have a significant impact on the development and institutionalization of child and adolescent violence prevention programs. For the purpose of the current assessment, the Colorado Revised Statutes are the focus. Time and resources do not allow for a full assessment of county and community policies. Rather, this assessment of Colorado's statutes provides communities with a better understanding of state statutes related to prevention, which may assist in guiding the assessment and development of local policies. This chapter reviews the Colorado Revised Statutes and identifies the statutes which address universal prevention, discusses whether current statutes reflect data trends and/or consider risk and protection, determines whether "model" policies exist as guides for current and future statutes, and identifies the gaps in Colorado's Revised Statutes in relation to child and adolescent violence.

Universal, selective, and indicated prevention and intervention programs designed to reduce violent youth behavior and strengthen positive youth development, are often dependent on the funding, resources, and organizations created through legislation. Policies that address and support child and adolescent violence prevention, some of which are described below, can be useful, to an integrated approach to reduce youth violence in Colorado.

Colorado Revised Statutes and Universal Prevention

By searching entire sections of statutes by key words and phrases, the Colorado Revised Statutes (CRS) generated a list of laws that relate to child and adolescent violence. Of those, 17 address universal prevention efforts or initiatives (see Appendix B). The majority of statutes address selective or indicated prevention and most address violence after a crime or incident of violence has occurred, including laws to protect children that are victims of child abuse, neglect and sexual violence.

In some cases, legislation is reactive. Laws are developed and signed into statute following a publicized incident of violence that results in public outcry for an immediate and effective response. An example of this type of legislation is the Colorado Bullying Prevention Law (2001), which was developed in response to the 1999 shootings at Columbine High School. The legislation amends the Colorado Safe Schools Act by requiring each school district to include a specific policy in the district conduct and discipline code concerning bullying prevention and education. The law also requires that the school's policy concerning bullying prevention and education, including information related to the development and implementation of any bullying prevention programs, be submitted annually to the Colorado Department of Education, and be available to the public.[80] Additionally, the statute mandates that each school district board of education adopt a mission statement for the school district, which includes creating a safe school plan in each public school within the district.[81] Thus, the law includes a universal prevention focus with non-mandated prevention and education practices, but was developed after an incident with national exposure

highlighted the need for schools to adopt bullying prevention practices. This is not to suggest that adopting policy in response to tragedy or rapid increases in violence trends is not effective long-term. However, data and resources on risk and protection may be useful to policy makers to develop and pass legislation prior to serious violent events.

The Tony Grampsas Youth Services program (CRS 25-20.5-201) was originally passed by legislation in 1994 in response to the 1993 "summer of violence." The Tony Grampsas Youth Services legislation funds services at the local level that are intended to decrease incidents of crime and violence among children and adolescents and/or prevent or reduce child abuse and neglect. Although funding was lost in 2002, it was reinstated in 2004 and $3,225,261 was granted to 115 local programs in 55 Colorado counties in September 2005.

Other statutes contributing to Colorado's efforts to promote universal prevention of child and adolescent violence include the Prevention, Intervention, and Treatment Services for Children and Youth (CRS 25-20.5), the Colorado Children's Trust Fund (CRS 19-3.5-104), the Office of Suicide Prevention (CRS 25-1.5-101), the establishment of programs providing family resource centers (CRS 26-18-101 through 104), alcohol and drug abuse and dependency prevention and education (CRS 25-1-203), and the Colorado Department of Education's Prevention Initiatives Unit (CRS 22-25-104.5).[82]

Creating Model Policy

Model policies should be focused on prevention and positive youth development. One challenge is that what may be considered a model approach for one issue may not work for another. However, it may be possible to create model policy for universal child and adolescent violence prevention that informs policy makers.

Colorado and many other states are implementing and assessing strategies and statutes that address school violence, particularly bullying. One organization, Bully Police USA, identifies states that have mandated some type of anti-bullying legislation, gives grades to each state, and provides a model for effective bullying legislation. Colorado is one of 18 states identified as having bullying legislation, and received a grade of "B."[83] Unfortunately, the Bully Police USA site does not provide evidence regarding the success of its model policy, primarily because no states currently meet all of the required elements. However, the model provides an example of characteristics that anti-bullying legislation should strive to achieve, including mandating evidence-based prevention programs. Currently, Colorado requires that all schools have an anti-bullying policy, and discretion is left to individual schools or school districts regarding the specific components of the policy.[84]

Another statute with characteristics of universal prevention came with the creation of Colorado's Office of Suicide Prevention in 2000 (CRS 25-1.5-101), one of the only state-housed offices in the United States that addresses suicide across the lifespan. Support for the legislation was generated by an enthusiastic Colorado state senator, the Governor's Office, and the executive director of the Colorado Department of Public Health and Environment, who called for a lead agency to leverage resources for organized and influential leadership for suicide prevention, and to foster collaborative partnerships statewide. The Office of Suicide Prevention, housed at the Colorado Department of Public Health and Environment, cannot be considered "model" because it is too early to measure its impact, but it exemplifies how the legislative process can be used to mandate and fund universal prevention efforts statewide, and it illustrates the importance of obtaining legislative support.

Risk and Protection in Statute Development

Colorado statutes that relate to children and adolescents address substance abuse, firearms, crime, gang involvement, child abuse and neglect, and sexual violence. Although sections of these statutes may reference prevention, most relate to mandated consequences for the violent behavior or perpetration.

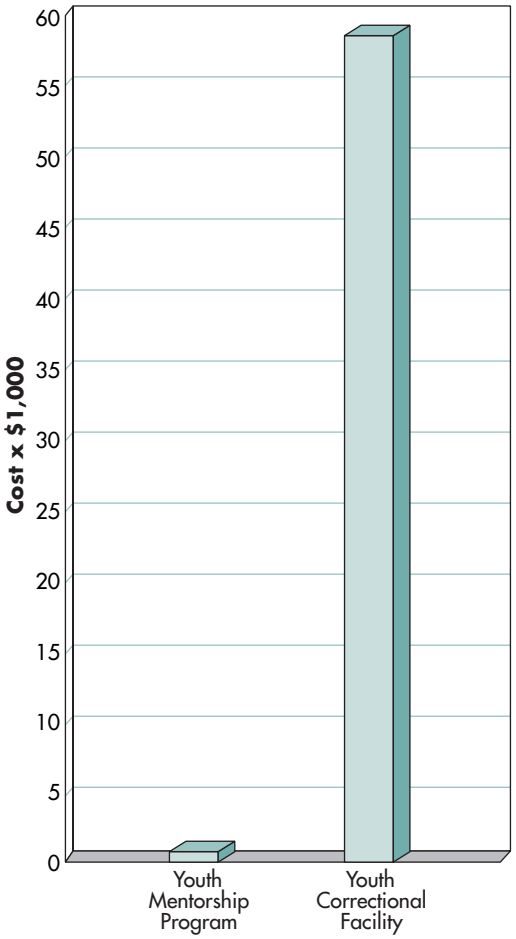
It may be just as necessary and effective to create policy that promotes protection and positive youth development. As support for the integration of methods that address shared risk and protection continues to grow, policies that support evidence-based programs that strengthen academic achievement and reduce suspensions and expulsions; strengthen family, school and community connectedness; increase mentoring programs; and strengthen positive social orientation may all be effective. Implementing evidence-based, strength-focused statutes may have a lasting impact on community and youth development throughout Colorado.

Challenges and Next Steps

Continued support for prevention initiatives and funding streams like the Tony Grampsas Youth Services and the Expelled and At Risk Student Services programs is critical. Youth violence prevention practitioners and researchers need to continue to pursue the input of health economists to highlight the long-term financial savings and advantages of successful universal prevention. For example, successfully mentoring a child, potentially resulting in the child avoiding criminal behavior and/or incarceration, is more cost-effective than using state dollars to house the child in a youth correctional facility: according to Big Brothers Big Sisters of Colorado, Inc. it costs approximately $1,200 to set up and maintain a successful youth and mentor relationship for one year,[85] and conversely, it costs approximately $58,560 to house a youth who has been fully committed to a youth correctional facility for one year.[86]

"Culturally appropriate interventions and prevention models should be mandatory."

Approximate cost to set up a youth/mentor relationship for one year compared to the cost to house a youth committed to a youth correctional facility for one year



Source: Big Brothers Big Sisters of Colorado

CHAPTER FIVE

OVERVIEW OF STATE-LEVEL PREVENTION PROGRAMS FOR CHILDREN AND ADOLESCENTS

In May 2000, the Colorado State Legislature passed House Bill 1342 (now CRS 25-20.5), approving legislation for strengthening collaborative partnerships across state departments. The purpose was to institute a more unified, effective and efficient approach to the delivery of state and federally funded prevention, intervention, and treatment services for children and youth in Colorado. Based on this legislation, the Colorado Department of Public Health and Environment produces an annual report of statewide programs. The 2003 report, *Prevention and Intervention Services for Children and Youth*, identified and summarized 43 statewide prevention and intervention programs operated or funded by the Colorado departments of Education, Human Services, Public Health and Environment, Public Safety, and Transportation.[87] A list of the 43 programs is in Appendix C.

There are over 1,200 prevention and intervention programs currently being implemented in communities throughout Colorado. The Violence Prevention Advisory Group reviewed only those prevention programs operated or funded by the five state agencies. Among the mandates of CRS 25-20.5-101-109 is the establishment of uniform minimum standards, best-practice approaches and program fidelity for all state-managed prevention, intervention and treatment services for children and youth.

In this chapter, there is a brief discussion of some of the 43 programs throughout Colorado administered by state agencies. Emphasis is placed on those that utilize a universal approach to child and adolescent violence prevention and emphasize shared risk and protective factors. The importance of local programs is also noted, followed by challenges faced by prevention programs and possible next steps for program success.

State-Managed and Funded Programs

Some of the prevention and intervention programs funded and/or managed by the five state agencies mentioned above do not directly relate to violence prevention, nor do they all utilize universal prevention strategies. Only programs that relate to universal child and adolescent violence prevention, or risk and protective factors related to child and adolescent violence (i.e., substance use) are reviewed.

Colorado Department of Education

The Colorado Department of Education manages ten prevention and intervention programs serving children and youth in Colorado. Programs such as Even Start Family Literacy and the Expelled and At-Risk Student Services incorporate a selective prevention approach and target at-risk youth. The Comprehensive School Health Program, Community Consolidated Child Care Pilots, and Safe and Drug Free Schools and Communities are examples of programs implementing a universal prevention approach. For example, the Comprehensive School Health Program provides three-year grants, technical assistance, and staff development to school districts across the state to implement a pre-K through 12th grade sequential health education program. Schools teach students skills regarding such topics as violence prevention, substance abuse, and bullying, while expanding or initiating plans for implementing evidence-based programs to address mental health, school climate, and parent involvement.

Colorado Department of Human Services

The Colorado Department of Human Services manages five prevention and intervention programs. Of these, one uses universal prevention strategies. The Substance Abuse Prevention Block Grant awards four-year grants to local agencies and non-profit organizations providing substance abuse prevention services

in their communities. The Alcohol and Drug Abuse Division's universal prevention goal is to develop, implement, maintain, and evaluate substance abuse prevention programs statewide. This includes reducing risk factors and increasing protective factors related to substance abuse at the community, family, school, peer, and individual levels. Evidence of program effectiveness is not yet available, but preliminary results are encouraging.

Colorado Department of Public Health and Environment

The Colorado Department of Public Health and Environment manages 22 prevention and intervention programs. Examples of programs that implement universal prevention approaches related to child and adolescent violence include the Colorado Children's Trust Fund; the Maternal and Child Health Program; the Sexual Assault Prevention Program; the Office of Suicide Prevention; and the Tony Grampsas Youth Services program.

In July 2005, the Colorado Children's Trust Fund granted 16 agencies in 25 counties funds to implement the Nurturing Parenting Program, an evidence-based child abuse and neglect program. The program targets some at-risk families, but is also available to all interested families within the funded communities. The program goals include helping parents develop a sense of empathy for their children, and providing them with alternatives to violence for disciplinary purposes.

The Sexual Assault Prevention Program provides funding for local sexual violence prevention efforts in schools and communities across Colorado. The program plans, coordinates, develops, and supports sexual violence prevention efforts statewide. The program also funds the Colorado Coalition Against Sexual Assault to provide resources and information on sexual violence prevention through social norms and social marketing campaigns.

The Office of Suicide Prevention addresses suicide and suicidal behavior among all ages, including adolescents, in order to reduce the suicide rate in Colorado. The Office is responsible for coordinating prevention and education services statewide, through public awareness, training, and community grant-making.

As mentioned in the previous chapter, the Tony Grampsas Youth Services program funds prevention and intervention services at the local level that are intended to decrease incidents of crime and violence among children and adolescents. Student dropout prevention, youth mentoring, and early childhood programs receive the majority of funds based on the requirements of the legislation.

Colorado Department of Public Safety

The Colorado Department of Public Safety manages two prevention and intervention programs: the Juvenile Justice and Delinquency Prevention Formula Grant Program and the Title V Incentive Grants for Local Delinquency Prevention. The Juvenile Justice and Delinquency Prevention Formula Grant funds a range of services based on system gaps and needs, including youth advocacy, mental health services, and mentoring. The Title V Incentive Grants fund local communities across the state engaged in a comprehensive planning process that includes data collection and analysis to identify and maximize protective factors. Mentoring programs, parenting skills training, and after school programs are funded as universal prevention services.

Colorado Department of Transportation

The Colorado Department of Transportation manages four prevention and intervention programs, most of which emphasize driver, bicycle, and pedestrian safety and injury reduction. The Impaired Driving Program advocates healthy choices and alternatives to drinking as strategies to reduce alcohol-related fatal crashes. Although not directly related to violence, alcohol prevention education fits well with more specific violence prevention objectives for reducing risk and increasing protection.

Local Programs

In addition to state administered programs, there are evidence-based, sustained, highly active local, community-based programs throughout the state. In fact, there are approximately 1,200 prevention and intervention service programs funded or managed by the state alone in local communities throughout Colorado,[88] and many more that are not state-managed or funded. Examples of successful local community programs include The Boys and Girls Clubs of America's SMART Moves program; sports and recreation programs such as Little League; faith-based programs at local churches; after school and tutoring programs that are privately funded; mentoring services; and school-based prevention curricula. Many local programs emphasize positive youth development, providing young people with the knowledge and skills to lead healthy and productive lives. The cognition and skills emphasized in these programs can act as protective factors, mitigating certain risks that may be present in a child or adolescent's life.

Local programs may receive funding from multiple sources, including private foundations, federal grants, and donations from community members. The Colorado Trust is a private grant-making foundation that operates independently of state and federal agencies, and which provides a great deal of funding for strength-based and positive youth development programs to communities throughout Colorado. In April 2005, The Colorado Trust announced that 45 grantees in 32 Colorado counties received funding for a three-year (2005–2008) Bullying Prevention Initiative. Each site received an average of $50,000 (of the $8.6 million grant) to implement bullying prevention programs. More information regarding programs in communities is available through local departments of health and/or local program providers.

Challenges and Next Steps

Local agencies and community members are challenged in knowing what child and adolescent programs are available to them. Due to the number of programs offered, duplication of services may also reflect inefficiency for communities. This suggests the importance of collaboration and integration among prevention providers to reduce the duplication of services and to increase program awareness among community members. Also, prevention programs generally rely on grants or other sources of funding to support implementation, which can make funding streams inconsistent and challenging to maintain, leading to effective programs being dropped due to a lack of funding. Finally, finding the most effective program is difficult because there are so many agencies marketing their programs to communities. With limited resources, communities may select programs based on the availability of grant dollars for a specific program rather than selecting a program that may be more effective for the target population, but does not have grant dollars attached to implementation.

Emphasis should be placed on identifying effective programming that addresses shared risk and protective factors for child and adolescent violence. Communities and state agencies need to collaborate in order to reduce the duplication of services, and therefore utilize limited resources more efficiently. It may be helpful to create a resource that lists all of the promising and/or effective available programs at the state and community level. The resource could provide communities with a description of each program, including the cost and time required to implement successfully, and identify programs as using primarily universal, selected, or indicated prevention approaches. Colorado has many excellent programs for children and adolescents, and community members need to be more aware of what resources and programs are available to them.

CHAPTER SIX

OVERVIEW OF UNIFORM MINIMUM STANDARDS AND BEST PRACTICES

COLORADO REVISED STATUTE 25-20.5 emphasizes coordinating and streamlining state processes related to prevention, intervention, and treatment services for children and youth. This work includes the mandatory development and adoption of Uniform Minimum Standards across disciplines, promotes best-practice approaches, and enhances the capacity of local providers to implement effective prevention, intervention, and treatment services for children and youth. The Prevention Leadership Council (the state interagency coordinating body), which evolved from Colorado Revised Statute 25-20.5, is optimistic that the standards will be adopted by many community agencies across the state as a means of addressing program effectiveness.

The Prevention Leadership Council's Uniform Minimum Standards are described in this chapter, followed by a discussion about why implementing research-based programs should be done with fidelity to the program model. Emphasis is placed on selecting prevention programs that are evaluated, proven effective, fit well with the population of children or adolescents served, and are sustainable.

Uniform Minimum Standards

As a result of the Prevention, Intervention, and Treatment Services for Children and Youth Act (CRS 25-20.5), the Prevention Leadership Council was created and has since negotiated Memoranda of Understanding with five state agencies that manage a variety of prevention and intervention programs for children and youth, fostering an environment of increased collaboration around prevention issues. The agencies are the Colorado Departments of Education, Human Services, Public Health and Environment, Public Safety, and Transportation. The Colorado Department of Law is a voluntary partner with a representative on the Prevention Leadership Council. One of the requirements of the legislation is the development and adoption of Uniform Minimum Standards for all state and federally funded prevention and intervention programs for children and adolescents, including all of the programs mentioned in the previous chapter. The Prevention Leadership Council formed a Uniform Minimum Standards Task Force to develop recommended standards. They identified eight areas considered critical to the development and implementation of effective programs (Box 6.1).

All of the programs operating at the five Colorado state agencies emphasize the eight Uniform Minimum Standards and strive to implement them in the programs that they and the funded communities implement. As the five state agencies making up the Prevention Leadership Council continue to include the requirement for meeting the Uniform Minimum Standards in requests for proposals and program quality improvement processes, it is the goal that other non-state funded, community-based programs will adopt these same standards in an effort to create shared understanding and consensus regarding the provision of effective prevention and intervention services. The Violence Prevention Advisory Group, working with the Prevention Leadership Council, will apply these same standards to any future strategic planning or implementation projects.

The Uniform Minimum Standards provide state and local programs a guide to enhance program success and consistency, and provide new programs with information regarding achieving early and lasting success. Grant applications, resource sharing, and collaboration will be improved if the Uniform Minimum Standards are universally accepted in Colorado, while the duplication of services and lack of evaluation standards should decrease. The Prevention Leadership

Box 6.1—Uniform Minimum Standards for Prevention and Early Intervention Programs

1. **Clear statement of problem/issue(s) to be addressed.** The program/project identifies the specific problem/issue(s) to be addressed, and describes a population or geographic area where the problem/issue exists. Estimates of the extent and nature of the problem in the population or geographic area to be served are based on relevant existing local, regional, state or national data (e.g., data from health, human services, education, law enforcement agencies, relevant studies or program data).
2. **Focus on contributing factors.** The program/project specifies risk factors known to contribute to the problem and/or protective factors known to prevent or reduce the problem/issue(s) identified; and focuses its resources on changing these risk and/or protective factors. If specific risk and protective factors related to the problem have not been identified in the literature, the program/project provides a clear rationale for the program focus, based on relevant prevention/intervention or child/youth development principles, theories or frameworks.
3. **Intended outcomes specified.** The program/project specifies one or more measurable outcomes it intends to achieve as a result of the prevention and intervention program/services to be provided. These intended outcomes are related to changing factors contributing to the problem, or factors contributing to the prevention or reduction of the problem. The intended outcomes specify the changes in knowledge, attitudes/beliefs, skills, behaviors, obstacles/enabling factors in the physical or social environment and/or changes in the physical or emotional health status, educational achievement or well-being of the individual, group or community being served.
4. **Evidence-based programs/services.** The program/project provides prevention or intervention services that have been previously implemented in one or more communities with demonstrated success in achieving the intended results, or that otherwise demonstrate a reasonable potential for success based on research, sound prevention/intervention principles or relevant theory.
5. **Services and target population specified.** The program/project specifies the amount and type of services to be provided, and the proposed number of individuals, groups or the target population that will receive or benefit from the various program activities/services.
6. **Evaluation.** (a) The program/project systematically documents and is able to provide data regarding services provided/activities carried out and the number of individuals, groups and/or target populations(s) receiving the services or benefiting from program activities; and (b) the program/project systematically documents changes occurring as a result of the program services and activities provided; and is able to provide evidence of progress in meeting one or more of its intended outcomes.
7. **Agency capacity.** (a) Staff carrying out the program/project are trained in the specific program, services or model that they will be implementing; or they have at least two years prior experience in the successful implementation of similar prevention or intervention programs, practices and/or policies; and (b) The agency maintains records of revenues and expenditures by funding source, and can produce verification of expenses upon request. An independent review of the fiscal records/practices is conducted periodically, but no less frequently than annually.
8. **Collaboration.** The program/project regularly exchanges information with other public, private non-profit prevention, intervention programs at the state, regional or local level (e.g. faith-based organizations, health, law enforcement, human services agencies, or other units of government) for the purposes of resource sharing, coordination of efforts, case management and to avoid duplication of services.

* Developed by the Colorado Prevention Leadership Council and adopted by the State Board of Health on 3/17/04.

Council intends to create Standards of Excellence to provide important guidelines for program assessment and to encourage ongoing quality improvement of prevention and intervention programs across the state.

Best Practices for Universal Child and Adolescent Violence Prevention

Best practices (often referred to as model or science-based) refer to programs and strategies that are known to be effective in multiple settings and replications, based on stringent and long-term evaluation. The 2001 Surgeon General's report on youth violence suggests that, "The scientific community agrees on three standards for evaluating effectiveness: rigorous experimental design, evidence of significant deterrent effects, and replication of these effects at multiple sites or in clinical trials."[89] The history of evaluating program effectiveness suggests that not all prevention programs are as effective as others, and in rare circumstances a program has been found to have a negative effect on its target population. However, the fact that a program is not identified as model or promising does not mean

it is not effective. In some cases it may mean only that the program has not yet been rigorously evaluated.[90]

Many community programs and/or agencies have a significant positive impact on the population served, but are in developmental stages. Best practice models can provide these programs with examples and strategies for achieving model or promising status and/or overall improved outcomes.

It is important that best and promising practice program criteria be defined and marketed to the public. Various federal, state, and private agencies across the country have created best practice lists, but the requirements for programs to rate as model or best practice varies by agency, often making it difficult for prevention practitioners to know which list is best suited for identifying proper programming.

Federally, the Substance Abuse and Mental Health Services Administration (SAMHSA) created a National Registry of Effective Programs and Practices (NREPP). The National Registry of Effective Programs and Practices identifies Model Programs, Promising Programs, and Effective Programs that are implemented and evaluated and are scientifically defensible.[91] SAMHSA also reviews model programs according to rigorous standards of research, using criteria that are recognized nationally.

Colorado is home to the Center for the Study and Prevention of Violence at the University of Colorado at Boulder. The Center's Blueprints for Violence Prevention project is a nationally known violence prevention initiative that identifies effective violence prevention programs based on a detailed and strict set of criteria. Eleven prevention and intervention model programs, called "Blueprints," are identified as being effective in reducing adolescent violent crime, delinquency, aggression, and substance use.[92] The Blueprints include evidence of deterrent effect with a strong research design, sustained effect, and multiple site replications.[93] Staff from the Center for the Study and Prevention of Violence serve on a federal committee charged with creating a national set of criteria for best practice programs and creating a best practice list. The intent of this committee is to provide a consistent and nationally recognized resource for prevention practitioners and program designers throughout the United States.

The Colorado Department of Public Health and Environment and the Prevention Leadership Council created a best practices web site as a resource for the state of Colorado (www.colorado.gov/bestpractices). The site aggregates information on best practices for prevention and intervention strategies and programs. The site includes research, reviews, and summaries of the current literature and web resources on best practices, and it provides visitors with a resource for locating the model programs identified by various agencies.[94]

Evidence-based programming is only one aspect of obtaining successful prevention results. Of equal importance is understanding and valuing program fidelity. Without program model fidelity, communities and/or local agencies implementing a particular program may not see the same results as the research suggests, or as those implementing with a high level of fidelity. If providers implement only segments of the program deemed necessary to them, or do not dedicate the necessary time preparing for and delivering program objectives, it is likely that outcomes will be negatively impacted. Having a "champion" within the community dedicated and enthusiastic about the program, and willing to organize and promote a successful implementation can have a lasting effect on program success.

It is also important that effective programs be institutionalized. Funding is often cut or unavailable for prevention programming. It is important that communities adopt programs that fit well within the community,

are cost-effective, and show positive outcomes. Community members and prevention practitioners become frustrated having to learn and adopt new programs on an inconsistent basis, meaning that sustaining successful programs will achieve increased outcomes and improve community support.

Challenges and Next Steps

Because a primary goal of the current project is to integrate strategies that emphasize shared risk and protective factors, it is imperative that evidence-based, best practice programs supporting this goal be identified. A long-term goal is to enhance or create effective and integrated approaches for addressing child and adolescent violence. Programs that focus on family functioning, comprehensive health, mental health, social skill building, and positive youth development are examples of programs that address multiple types of violence and need to be implemented more broadly statewide. The development of Uniform Minimum Standards is a step in the right direction. It is important now that agencies throughout the state apply the standards to their programs and activities.

"Culturally appropriate interventions and prevention strategies must be utilized to reach youth. Community building should be at the core of this work, especially with youth of color and immigrant youth."

Available resources for universal approaches to child and adolescent violence prevention are limited. Colorado is fortunate to have some outstanding funding sources for universal prevention, like The Colorado Trust (privately funded) and the Tony Grampsas Youth Services program (state funded). Many communities and programs are faced with eliminating prevention services due to a shortage of funding and/or a lack of institutionalization. For example, in 2005, the Tony Grampsas Youth Services Program received grant requests of more than $12 million in program support, and had only $3.2 million to distribute.

Because of these challenges, it becomes even more important for communities and state agencies to spend limited resources efficiently. The ultimate goal must be to implement and to fund programs that have a measurable, long-term, and evidence-based impact on the population of children and adolescents being served. Because time and resources are limited in communities, schools, and state agencies, it is relevant that integrated best practice approaches be developed to address shared risk and protective factors and multiple types of child and adolescent violence.

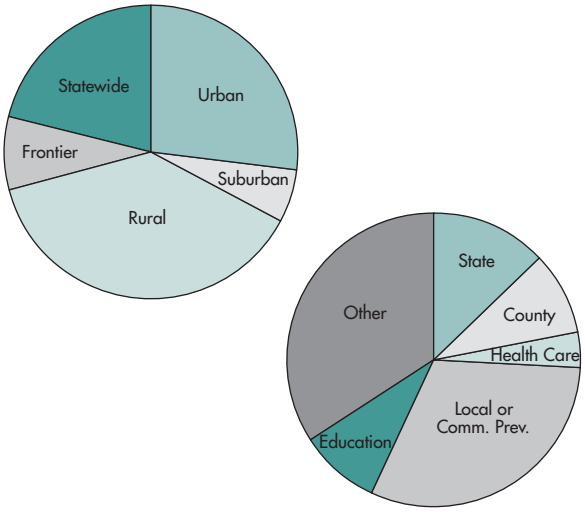
CHAPTER SEVEN

NEEDS AND READINESS—RESULTS FROM A STATEWIDE STAKEHOLDERS SURVEY

SEVENTY-EIGHT STATEWIDE STAKEHOLDERS completed an online survey designed to gather information regarding the status of child and adolescent violence and violence prevention within their community. The survey was designed and disseminated using Zoomerang, a global online survey software.[95] The survey collected information regarding the primary prevention gaps and needs of each respondent's organization and/or community, and asked them to prioritize possible prevention strategies. Stakeholders were candid in their responses and provided a great deal of relevant information that will help inform the direction of the 2006 strategic plan for child and adolescent violence prevention.

The respondents represent diverse agencies and demographics across Colorado. The rural and frontier response is particularly significant (46 percent of total). Respondents work for state agencies (13 percent); county agencies (9 percent); health care providers (4 percent); local or community prevention agencies (31 percent); education (9 percent); and, other (34 percent). Examples of "other" include advocacy group members, a local school board member, community mental health workers, a domestic violence program, a faith-based non-profit, a prevention coalition, a federal public health agency, a family resource center, and a university administrator. Stakeholders represent urban communities (27 percent); suburban communities (6 percent); rural communities (38 percent); frontier communities (8 percent); and statewide providers (21 percent). All racial and ethnic groups within the state are served by the agencies that stakeholders represent, and half of the respondents suggest that 50 percent or more of the children and youth that their agency serves live below the poverty line or are Free and Reduced Lunch recipients. Thus, the survey appears fairly representative of the state and the responding stakeholders appear very qualified to provide meaningful responses.

Stakeholders by Community and Organization Type



Risk and Protective Factors

Emphasizing risk and protective factors, particularly those shared by multiple types of child and adolescent violence, is central to this two-year planning project. The Centers for Disease Control and Prevention and the Violence Prevention Advisory Group are striving to identify shared risk and protective factors as a means to create more integrated child and adolescent violence prevention strategies. Those that completed the stakeholder survey agree that understanding and emphasizing risk and protective factors are important. Sixty-two percent of respondents suggest that they "always" or "often" utilize shared risk and protective factors in planning and implementing child and adolescent violence prevention strategies. Seventy-four percent "strongly agree" or "agree" that utilizing shared risk and protective factors and integrated prevention strategies is important to their agency as a means to save time and resources. Finally, 78 percent "strongly agree" or "agree" that the risk and protective factors identified in Chapter Two are consistent with what they see in their community.

Data

Seventy percent of the stakeholders responding to the survey "strongly agree" or "agree" that the data presented in Chapter Three are consistent with what they see in their community.

Colorado Revised Statutes

Only 66 percent of respondents suggest that they are aware of existing statutes that emphasize child and adolescent violence prevention. Of those, 41 percent do not believe that statutes emphasizing child and adolescent violence prevention are being adopted and implemented in their community.

Prevention Programs

Sixty-four percent of the stakeholders are aware of the child and adolescent violence prevention programs in their community that receive funding from the state. Unfortunately, 63 percent speculate that community members are not aware of the programs available to them within the community, suggesting that there is opportunity to create and/or improve marketing and public awareness regarding available prevention programs.

With increasing national emphasis for communities to implement evidence-based programs, it is encouraging to note that 86 percent of the stakeholders suggest that the programs offered through their agency are designed and implemented based on current and relevant research.

Strategic Priorities

Respondents were asked to identify eight child and adolescent violence prevention strategies that were most significant to them and/or their organization and community. Fourteen strategies were listed (Table 7.1), with the following five identified most often:

1. Provide more funding to communities for violence prevention (86 percent).
2. Provide more funding and technical assistance for evaluating the effectiveness of community programming (71 percent).
3. Create more programs that are strength-based or focus more on protective factors (69 percent).
4. Provide training and technical assistance to communities related to evidence-based programs and practices (68 percent).
5. Provide information on evidence-based programs and practices for violence prevention (66 percent).

"For the most part, I think the schools and other agencies which serve families and youth implement what they can, but low budgets make some state mandates quite difficult to follow through with in a small, rural community."

Table 7.1—List of possible strategies related to child and adolescent violence prevention. Stakeholders were asked to identify their top eight. The percentage that identified each is in parenthesis.

- Provide more funding to communities for violence prevention (86 percent).
- Provide training and technical assistance for evaluating the effectiveness of community programming (71 percent).
- Create more programs that are strength-based or focus more on protective factors (69 percent).
- Provide training and technical assistance to communities related to evidence-based programs and practices (68 percent).
- Provide information on evidence-based programs and practices for violence prevention (66 percent).
- Provide training and technical assistance to communities related to community mobilization to involve all key stakeholders in child and adolescent violence prevention (58 percent).
- Assure that local data are consistent and available (53 percent).
- Collect and disseminate information on effective local violence prevention policies (53 percent).
- Assist local communities with collecting, analyzing an interpreting data (53 percent).
- Create prevention information and programs that are more culturally relevant (52 percent).
- Develop a statewide system for collecting risk factor and protective factor data (40 percent).
- Support local systems for collecting risk factor and protective factor data (39 percent).
- Develop a stronger statewide data collection system (32 percent).
- Create new statutes related to violence prevention (19 percent).

It is not surprising that respondents identified the need for greater funding as their top priority. However, it is encouraging that 69 percent of respondents are interested in programs that include strength-based components and emphasize the development and enhancement of protective factors. It is also encouraging that respondents are interested in obtaining more information, training, and technical assistance regarding evidence-based programs and practices for violence prevention.

Several stakeholders commented on the importance of creating culturally appropriate prevention models that recognize the significance of indicators such as racism and poverty, and concentrate on meeting the needs of underserved populations. The notion of community building as being integral to successful prevention was also emphasized, highlighting the need to reach youth beyond just the individual and family levels, and to expand the reach of prevention-focused programming to include community building, pride, and awareness.

Challenges and Next Steps

With only 78 responses, it is impossible to suggest that the above survey results are representative of all child and adolescent violence prevention agencies and practitioners in Colorado. However, because agency and demographic representation is so diverse, and because stakeholders from rural communities responded so strongly, the information is important and can help generate ideas for strategic planning among the members of the Violence Prevention Advisory Group. It is encouraging to confirm that the priorities of this two-year project are in line with the priorities of those who responded to the stakeholder survey. The strategies considered most important by respondents will help guide the development of a statewide strategic plan to address child and adolescent violence and violence prevention.

CHAPTER EIGHT

CONCLUSION—STEPS TOWARD INTEGRATED PREVENTION EFFORTS

THE STATE OF COLORADO has spent a great deal of time and resources on child and adolescent violence prevention over the years, and has developed and implemented many successful programs, statutes, and data sources that continue to impact all types of child and adolescent violence throughout the state. Now, and in the future, it is important that existing methods be expanded and improved. Through the current funding from the Centers for Disease Control and Prevention, Colorado has a unique opportunity to develop strategies and make recommendations that will enhance child and adolescent violence prevention in Colorado.

Taking steps toward integrated prevention efforts will enable the state, local communities, and prevention practitioners to collaborate more effectively, reduce duplicated services, and implement programs that emphasize shared risk and protective factors that impact multiple types of violence. Identifying shared risk and protective factors for multiple types of violence is important to the success of integrated prevention efforts. Likewise, data sources must be available to the public, interpreted accurately, and representative of the entire state. Implementing and sustaining any proposed strategies will require policy and financial support. Finally, effective programming that addresses shared risk and protective factors should be identified and implemented with fidelity, with state and local agencies adhering to Uniform Minimum Standards.

The stakeholders survey confirms that prevention experts and practitioners across the state are emphasizing risk and protective factors and evidence-based programming in their efforts to reduce child and adolescent violence. Results also confirm that funding remains the top priority for local communities, and suggests that communities are interested in learning more about strength-based programs and positive youth development.

A statewide strategic plan for reducing child and adolescent violence and enhancing universal prevention approaches will be disseminated in September 2006 by the Colorado Department of Public Health and Environment and the Violence Prevention Advisory Group. Ultimately, the goal of this two-year planning project is to create a realistic, manageable, and economical strategy to reduce incidents of child and adolescent violence victimization and perpetration and to improve the health and well being of Colorado's young people.

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APPENDIX A

DATA SOURCES FOR CHILD AND ADOLESCENT VIOLENCE

National Violent Death Reporting System (NVDRS)
- Maintained by the Colorado Department of Public Health and Environment (CDPHE)
- Statewide data
- January 2004 to present

Vital Records/Death Certificates
- CDPHE/Colorado Health Information Dataset (CoHID)
- Statewide
- 1990–2003

Hospitalization discharge data
- CDPHE
- All acute care hospitals in Colorado
- 1996 to present

Colorado Trauma Registry Case Abstracts
- CDPHE
- Statewide
- 1997 to present

Traumatic Brain Injury (TBI) Surveillance System
- CDPHE
- Statewide
- 1991 to present

Youth Risk Behavior Survey
- Colorado Department of Education (2003), OMNI Research Institute (2005)
- Representative sample ('05 only) of Colorado public high school students
- 2003 and 2005

Colorado Client Assessment Record
- Colorado Division of Mental Health Services
- Statewide
- 1997 to present

Child Fatality Review
- CDPHE
- Statewide
- 1990–1993 (ages 0–16), 1993–1999 (ages 0–17), 2005—one year pilot for national database

Sexual Assault
- CDPHE
- Statewide rape crisis centers
- 2000–2003

Child Protective Services
- Colorado Department of Health and Human Services/Child and Family Services Review
- Statewide
- 2002—Compared child safety and maltreatment in Colorado to national standards

Child Welfare Services
- Child Welfare Services
- Statewide
- 1999 to present

National Child Abuse and neglect Data System (NCANDS)
- Cornell University
- National
- 1998–1999

National Crime Victimization Survey
- Bureau of Justice
- National
- 1973 to present

Child Trends Data Bank
- Child Trends
- National
- August 2003

National Archive of Criminal Justice Data (NACJD)
- NACJD
- National
- 1926 to present

Preventing Youth Handgun Violence: A National Study with Trends and Patterns for the State of Colorado (1999)
- Colorado Trust, Center for the Study and Prevention of Violence, OMNI Research
- Statewide
- 1995–2002

Denver Youth Survey
- Center for the Study and Prevention of Violence
- Denver
- 1986 to present

Neighborhood Facts Data Book/Resource and Risk Factors
- Piton Foundation
- Denver Neighborhoods
- 2000–2004

APPENDIX B

COLORADO REVISED STATUTES UNIVERSAL PREVENTION STATUTES

STATUTE MAIN TITLE HEADINGS:

19—Children's Code

22—Education

25—Health

26—Human Services Code

STATUTES RELATING TO OR INVOLVING UNIVERSAL PREVENTION

19-3.5-102. Legislative declaration. (Promoting prevention and education programs that are designed to lessen the occurrence and reoccurrence of child abuse and neglect and to reduce the need for state intervention in child abuse and neglect prevention and education).

19-3.5-104. Colorado children's trust fund board—creation—members.

22-25-104.5. Law-related education program—creation. (Colorado dept. of education prevention initiatives unit. Promoting behavior which will reduce the incidence of gang or other antisocial behavior and substance abuse by students in the public schools through education)

22-32-109. Safe School Act. (Every district has a policy and procedures for bullying prevention.)

22-32-109.1. Board of education—specific powers and duties—safe school plan (bullying policy and safe school requirements. Each school district board of education shall adopt a mission statement for the school district, which shall include making safety a priority in each public school within the district)

25-1-203. Grants for public programs. (Education and counseling regarding the use and abuse of alcohol and drugs; programs for prevention of alcohol and drug abuse)

25-1-1100.2. Legislative declaration. (drug abuse and drug dependency prevention, education, and treatment programs).

25-1.5-101. Powers and duties of the department. The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section: To act as the coordinator for suicide prevention programs.

25-3.5-802. Legislative declaration (tobacco use prevention and education)

25-3.5-804. Tobacco education, prevention, and cessation programs—grants. (Provide funding for community-based and statewide tobacco education programs designed to reduce initiation of tobacco use by children and youth, promote cessation of tobacco use among youth and adults, and reduce exposure to second-hand smoke.

25-20.5. Prevention, Intervention, and Treatment Services for Children and Youth—The state operates or state agencies provide funding for a wide variety of prevention, intervention, and treatment programs designed to assist children and youth in achieving an education, in making informed choices about their heath and well-being, in avoiding the juvenile and criminal justice systems, and, generally, in becoming healthy, law-abiding, contributing members of society.

25-20.5-201. Tony Grampsas youth services program—creation—standards—applications. (TGYS fits in all four domains based on the type of programs funded and resources provided. Both primary and secondary prevention programs included)

25-20.5-202. Tony Grampsas youth services board—members—duties—student dropout prevention and intervention fund—creation.

25-20.5-204. Colorado student dropout prevention and intervention program.

26-18-101. Legislative Declaration (Establishing programs to provide family resource centers).

26-18-102. Definitions (of family resource center information).

26-18-104. Program created. (Family resource center program at CDPHE)

APPENDIX C

COLORADO STATE AND FEDERALLY FUNDED OR MANAGED PREVENTION AND INTERVENTION PROGRAMS FOR CHILDREN AND YOUTH 2003–2004

DEPARTMENT OF EDUCATION

Center for At-Risk Education

- Even Start Family Literacy

Prevention Initiatives

- Colorado Preschool Program
- Expelled and At-Risk Student Services
- Community Consolidated Child Care Pilots
- HIV/AIDS Prevention Education
- Comprehensive School Health
- Education of Homeless Children/Youth
- Improving Health, Education and Well-Being
- Out-of-School-Time Care
- Safe and Drug Free Schools and Communities

DEPARTMENT OF HUMAN SERVICES

Alcohol and Drug Abuse Division

- Driving Under the Influence (DUI) LEAF
- Substance Abuse Prevention Block Grant

Children's Mental Health

- Kid Connects

Division of Child Welfare

- Promoting Safe and Stable Families
- School Readiness

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Disease Control and Environmental Epidemiology

- Sexually Transmitted Disease Prevention

Prevention Services Division

- Abstinence Education Programs
- Child and Adult Care Food Program
- Colorado Children's Trust Fund
- Community Interventions to Reduce Motor Vehicle Injuries
- Family Resource Centers
- Health Care Program for Children with Special Needs
- Healthy Childcare
- Maternal and Child Health Block Grant
- Nurse Home Visitor Program
- Office of Homeless Youth (funding discontinued 6/03)
- Oral Health
- School Based Health Centers
- Sexual Assault Prevention Programs
- STEPP: Community Programs to Reduce Tobacco Use
- STEPP: Collegiate Tobacco Prevention Initiative
- STEPP: Get REAL!
- STEPP: K–12 Tobacco Prevention Initiative
- STEPP: Youth Access/Merchant Compliance SYNAR Program
- STEPP: Youth Smoking Cessation Project
- Suicide Prevention
- Women, Infants and Children (WIC) Supplemental Food Program
- Youth Mentoring (funding discontinued 6/03)
- Youth Services—Federal Tax Relief Reconciliation

DEPARTMENT OF PUBLIC SAFETY

Division of Criminal Justice

- Juvenile Justice/Delinquency Prevention Formula Grants
- Title V Juvenile Delinquency Prevention Incentive Grants

DEPARTMENT OF TRANSPORTATION

Office of Safety and Engineering

- Impaired Driving/Substance Abuse Prevention/Underage Drinking Prevention Programs
- Bicycle and Pedestrian Safety Program
- Occupant Protection Program
- Young Drivers Program

Colorado Department of Public Health and Environment

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