

WASHINGTON'S STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM

Program Manual

**June 2012 updated
April 2006 1st publication**

Prepared for:

Office of Superintendent of Public Instruction

Prepared by:

Dixie Grunenfelder, Program Supervisor
Student Assistance/Dropout Prevention Superintendent of Public Instruction

Mona Johnson, MA, CPP, CDP
Mona Johnson & Company, Training and
Consultation Services

Michelle M. Maike, MA
Maike & Associates
Evaluation, Research, & Planning

Kristin Schutte, Director
Olympic Educational Service District 114
Student Services Center Director

Funding for the update of this manual was made possible in part by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) (#1U79SP018669-01). The views expressed in this manual do not necessarily reflect the official policies of SAMHSA, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Table of Contents

Identification of Program Contacts

Introduction

- Program Manual Overview
- Background and Significance
- Theoretical Foundation
- Effective Program Characteristics
 - Continuum of Services
 - Suggested Areas of Focus
 - Barriers to Effective Programming
 - Summary
- Washington State's Model
 - Program History
 - Program Outcomes
 - Legislative Directive
- Organization of the Manual
- Additional Resources
 - What Are Risk Factors and Protective Factors
 - Risk and Protective Factor Framework
 - Sources of Prevention Research

Section 1: Implementation of Effective Student Assistance Programs

- Student Assistance Programs
 - Service Delivery Models
 - Staffing Models
 - Roles within the SAPISP Model
- Prevention Strategies
- Distribution of Targeted Students & Program Services
- Program Logic Model
- Required Components of an Effective SAP Program
- Suggested Program Operations Cultural Competence
- Additional Resources
 - Guidelines for a Student Support Component

Section 2: School Board Policy

- Safe and Drug-Free Schools & Communities Act
- Putting Policy into Action
- Suggested Program Operations
- Sample Policies
- Need to include HIB related to GLBTQ

Section 3: Staff Development

- The Importance of Staff Development
 - Staff Development for School Faculty
 - Staff Development for SAS
 - Staff development for Community Partners/Key stakeholders
- Suggested Program Operations
- Competency Rubric Assessment Tool
- Suggested Ethical Guidelines & Standards of Practice
- Washington State’s Unprofessional Conduct Regulation

Section 4: Program Awareness

- Purpose of Program Awareness
 - Social Marketing
 - Awareness Events
- Suggested Program Operations
- Additional Resources
 - Sample Classroom Presentation Format
 - Technical Assistance Bulletin: You Can Avoid Common Errors

Section 5: Internal Referral Process

- Introduction
- Early Identification
 - Substance Abuse Indicators
 - Referral Sources
- Suggested Program Operations
- Screening/Pre-Assessment Process
 - Step One – Gather Supporting Data
 - Step Two – Build Rapport
 - Step Three – Identify Risks and Needs
 - Assessing Risk and Protective Factors
 - Alcohol, Tobacco, and Other Drug Use Screening
 - Stages and/or Continuum of Adolescent Substance Use
 - Step Four – Intervention and Other Support Services
 - SAPISP Decision Tree for Services
- Understanding Confidentiality in SAPISP Programs
 - Confidentiality Regulation 42 CFR Part 2
 - Confidentiality: Questions and Answers
 - Suggested SAS Protocol for Releasing Confidential Information
- Sample Forms for Compliance with Confidentiality Regulations
- Record Keeping
- Sample SAPISP Data Collection and Other Forms
- Suggested Guidelines in Responding to Disciplinary Referrals
- Additional Resources
 - Strength-base student interview

Addiction continuum and Indicators
Recent research on Brain
Cultural sensitivity and linguistics

Section 6: Consideration for Vulnerable Populations

Mental Health Military Families
Children from substance Abusing Parents Gay, Lesbian, Transgender, and Questioning Native American
Additional Resources
 Suicide Suggested Protocol for SAS and Warning Signs
 Adverse Childhood Experiences
 Common Mental Health (serious emotional disturbances) and school- based strategies.

Section 7: Student Assistance Team: Problem Solving and Case Management

Introduction
Establishing A Student Assistance Team
 How Do Teams Function?
Suggested Program Operations
SAT Member Tasks
 Pre-Meeting Tasks
 Team Meeting
 Documentation
Team Maintenance
Case Management
 Monitoring the Student's Progress
Additional Resources
Sample Forms
Practice Notes: Managing Care, Not Cases

Section 8: Educational Student Support Groups

Introduction
Implementing Support Groups in the School Setting
Support Groups are Efficient
 Support Groups are Developmentally Appropriate
 Support Groups are Effective at Changing Alcohol/Drug-Specific Behavior
 Support Group Composition
 SAP Support Group Limitations
Washington State's SAPISP Support Group Offerings
 Group Logistics
 Group Preparation and Set Up
 Education Support Groups vs. Therapy Groups
 Critical Educational Support Group Components
 Group Formation
 Stages of Change

- Positive Solution Focuses/Strength-based strategies
- Standard Support Groups
 - At Risk/Social Skills Group (Primary Group #1)
 - Intervention Group (Primary Group #2)
 - Affected Others Group (Primary Group #3)
 - Recovery Support Group (Primary Group #4)
- Sample Forms

Section 9: Cooperation & Collaboration with Community Agencies and Resources

- Introduction
- Who Should Be Involved?
 - Benefits of Collaboration
 - Components of Successful Collaborations
 - Strategies to Minimize Barriers
- Cooperation and Collaboration Across the State
 - Examples of State-wide Collaboration Efforts
 - Examples of Local Level Collaboration Efforts
- Suggested Program Operations
 - SAS's Role in Working with Community Agencies and Resources
- Additional Resources
 - What Are School-Community Partnerships

Section 10: Program Evaluation

- Why Evaluate
- Washington's SAPISP Program
- State Goal
- State Objectives
- Statewide Evaluation Efforts
- Suggested Program Operations
- Data Collection Activities
- Data Collection Manual
- Additional Resources
- Designing and Doing Outcomes Evaluation

Identification of Program Contacts

ESD 101

Astri Zidack, Director
4202 Regal St., Spokane, WA 99223
Phone: (509) 789-3585
azidack@esd101.net

ESD 105

Ann Allen, Prevention/Intervention Program
Coordinator
33 S. Second Ave.
Yakima, WA 98902
Phone: (509) 454-3107
anna@esd105.org

ESD 112

Sandy Mathewson, Director
2500 NE 65th Ave.
Vancouver, WA 98661
Phone: (360) 750-7500 ext. 262
sandy.mathewson@esd112.org

ESD 113

Erin Rife, Program Administrator
6005 Tye Drive SW
Tumwater, WA 98512
Phone: (360) 339-8101
eriffe@esd113.org

ESD 114

Kristin Schutte, Director
105 National Ave. NE
Bremerton, WA 98312
Phone: (360) 405-5833
schutte@oesd.wednet.edu

ESD 121

Kim Beeson, Prevention Center Director
800 Oakesdale Ave.
Renton, WA 98057
Phone: 1-800-664-4549
kbeeson@psed.org

ESD 123

Diane Shepherd, Safe and Drug-Free
Schools Administrator
3918 W. Court St
Pasco, WA 99301
Phone: (509) 544-5761
dshepherd@esd123.org

ESD 171

Michael Lynch, Managing Director
PO Box 1847
Wenatchee, WA 98807
Phone: (509) 665-2631
mikel@ncesd.org

ESD 189

Maurene Stanton
1601 R Ave.
Anacortes, WA 98221
Phone: (360) 299-4010
mstanton@esd189.org

Glossary of Terms

ACoA: Adult Children of Alcoholics

At Risk: Factors that increase the chances of youth developing health and behavior problems are called risk factors. Individuals, families and communities who possess these factors are considered at risk. Those that possess several are considered high risk.

AOD: Alcohol or other drugs.

ATOD: Alcohol, tobacco, and other drugs.

Becca Bill: Primarily concerned with truant and runaway students.

BH: Behavioral health; mental health including substance abuse; As a general concept, behavioral health is the reciprocal relationship between human behavior and the well-being of the body, mind, and spirit, whether considered individually or as an integrated whole.

CADCA: Community Anti-Drug Coalitions of America

CAPT: Centers for the Application of Prevention Technologies (a program of CSAP)

CASA: Center on Addiction and Substance Abuse

CDC: Centers for Disease Control and Prevention (an agency of DHHS)

Cessation: Most commonly used in conjunction with tobacco. Cessation is a term referring to activities which hold the goal of helping a tobacco user quit. Whether cessation is an intervention or treatment is currently controversial as it has implications with regards to service and funding responsibilities.

Character Education: Teaching strategies intended to instill core values such as responsibility, hard work, honesty, kindness, integrity, respect, and perseverance.

CMHS: Child Mental Health Specialist. Mental health professional with specialized knowledge and experience serving children

COSAP: Children of Substance Abusing Parents (including alcohol) . More commonly referred to as "affected others" children who are affected by the alcohol and/or other drug abuse of another.

Confidentiality: Schools, treatment, and mental health all uphold the confidentiality rights of clients, though may operate on different definitions.

CORE/CARE Team: Group of school building staff that meet regularly to develop and review strategies for assisting individual students.

CSAP: Center for Substance Abuse Prevention.

CSAT: Center for Substance Abuse Treatment.

DAWN: Drug Abuse Warning Network.

DASA: Division of Alcohol and Substance Abuse, Olympia, WA.

DBHR: Division of Behavioral Health and Recovery; In July 2009 the WA State Department of Social and Health Services Division of Alcohol and Substance Abuse and the Mental Health Division merged to become the Division of Behavioral Health and Recovery to both assess and treat patients with co-occurring mental health and substance use disorders.

Developmentally Appropriate: Most program and curricula target specific age and developmental stages. Considered are readability, attention span, interests and academic abilities of each age and grade level.

DFSCA: Title IV Drug-Free School and Community Act enacted by Congress in 1987; changed in 1995 to include safety issues. U.S. Department of Education administers and annually distributes funds to states based primarily on the number of school aged youth. Through FY 2011 states received funds through two avenues: 1. State educational agencies (OSPI), 80 percent of total (30 percent of this is required to target 30 percent of high need districts) and 2. Governor's Offices or agencies designated by the Governor.

DHHS: Department of Health and Human Services

DoEd: Department of Education

DUI: Driving Under the Influence

DWI: Driving While Intoxicated

Early Intervention: A process for recognizing warning signs that individuals are at risk for mental health/substance abuse problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.

Environmental Factors: Environmental factors are external or perceived to be external to an individual but that may nonetheless affect his or her behavior. At a narrow level these factors relate to an individual's family setting and relationships. At the broader level, these refer to social norms and expectations as well as policies and their implementation.

ESD: Educational Service District. There are nine ESDs in Washington State. They are regional educational agencies serving school districts and state-approved private schools. ESDs function primarily as support agencies and deliver educational services that can be performed more effectively or economically on a regional basis.

ESEA: Elementary and Secondary Education Act, also known as No Child Left Behind.

Evaluation: Evaluation is a process that helps prevention practitioners discover and objectively measure the strengths and weaknesses of their activities so ~~that~~ they can make continuous improvements over time. Time spent on evaluation is well spent because it allows groups to use money and other resources more efficiently in the future. Also, evaluation does not have to be expensive or complicated to be useful. Some evaluations can be done at little or no cost, and some can be completed by persons who are not professional evaluators. Local colleges and universities can be sources of professional evaluation support by persons working on degrees in sociology, educational psychology, social work, biostatistics, public health, and other areas.

FAS/FAE: Fetal Alcohol Syndrome, Fetal Alcohol Effected.

FERPA: Family Educational Rights and Privacy Act. Assures the following rights to parents and students who are 18 years and older, or enrolled in postsecondary education:

- The right to inspect and review the student's education record.
- The right to exercise limited control over other people's access to the student's education record.
- The right to seek to correct the student's education record in a hearing if necessary.
- The right to report violations of the FERPA to the Department of Education.
- The right to be informed about FERPA rights. Adopted in 1980, revised in 1996.

GLEs: Grade Level Expectations. Standards and benchmarks established by subject by which students demonstrate knowledge.

Indicated: Program strategies designed to address the needs of those students who are showing early danger signs, such as failing grades, and alcohol, tobacco and other drug (ATOD) use and to target them with highly individualized and intensive services. Indicated intervention approaches are used for students who may or may not be using substances, but exhibit risk factors that increase the likelihood of involvement with ATOD, or other problem behaviors (violence, academic failure, dropping out). Approaches are designed to reduce the length of involvement in problem behaviors, delay onset of problem behaviors such as substance abuse, and/or reduce the severity of existing problem behaviors.

Indicator: An indicator is a substitute measure for a concept that is not directly observable or measurable (e.g., prejudice, substance abuse). For example, an indicator of "substance abuse" could be "rate of emergency room admissions for drug overdose." Because of the imperfect fit between indicators and concepts, it is better to rely on several indicators rather than on just one when measuring this type of concept.

A variable that relates directly to some part of a program goal or objective. Positive change on an indicator is presumed to indicate progress in accomplishing the larger program objective. For example, a program may aim to reduce drinking among teens. An indicator of progress could be a reduction in the number of drunk driving arrests or the number of teens found to be drinking alcohol in clubs.

Logic Models: Logic models are usually diagrams or schematics that convey programmatic inputs, processes, and outcomes of a program.

NCADI: CSAP's National Clearinghouse for Alcohol and Drug Information.

NCAP: National Center for the Advancement of Prevention.

Needs Assessment: Collection of data on needs of the community and on resources available to address these needs. Common indicators of need for substance abuse prevention services often include high incidence and prevalence of alcohol and drug abuse in the community, and presence of associated risk factors such as crime and violence, economic dislocation, families in poverty, school drop-out rates, and the like. In the context of substance abuse prevention, the inquiry into resources usually focuses on human resources and ways that these resources might be strengthened through training.

NIAAA: National Institute on Alcohol Abuse and Alcoholism (an institute within NIH).

NIDA: National Institute on Drug Abuse (an institute within NIH).

NIH: National Institutes of Health (an agency of DHHS).

NREPP: National Registry of Evidence-Based Programs and Practices. Voluntary classification system for evidence-based substance abuse and mental health prevention and treatment interventions.

NSAA: National Student Assistance Association. Formerly named National Association of Student Assistance Programs (NASAP).

OJJDP: Office of Juvenile Justice and Delinquency Prevention.

OSPI: Office of the Superintendent of Public Instruction (Also known as the Washington State Department of Education).

OTC: Over the Counter. Medicines and inhalants that can be purchased anywhere and consumed as a mood-altering substance.

Outpatient: (Less Than Twenty-Four Hour Care):

Outpatient—Treatment/recovery/aftercare or rehabilitation services provided where the client does not reside in a treatment facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and Supportive services. This also is known as nonresidential services in the alcoholism field.

Intensive Outpatient—Services provided to a client that last two or more hours per day for three or more days per week. Daycare is included in this category.

Detoxification—Outpatient treatment services rendered in less than 24 hours that provide for safe withdrawal in an outpatient setting (pharmacological or nonpharmacological).

Parent Involvement/Family Involvement: All manner of family interaction, policy making, parent education, fundraising, and volunteer time that strengthens the school to home connection in the interest of increasing student improvement. Recognized as a critical component for any prevention effort.

POE: Principles of Effectiveness. Set of six principles established by the US Department of Education to govern recipients use of funds received under Title IV Safe and Drug-Free Schools and Communities Act

Prevention: The objective of primary prevention is to protect the individual in order to avoid problems prior to signs or symptoms of problems. It also includes those activities, programs, and practices that operate on a fundamentally nonpersonal basis and to alter the set of opportunities, risks, and expectations surrounding individuals. Secondary prevention identifies persons in the early stages of problem behaviors associated with alcohol and other drugs and attempts to avert the ensuing negative consequences by inducing them to cease their use through counseling or treatment. It is often referred to as early intervention. Tertiary prevention strives to end compulsive use of alcohol or other drugs and/or to ameliorate their negative effects through treatment and rehabilitation. This is most often referred to as treatment but also includes rehabilitation and relapse prevention.

PRI: Prevention Re-design Initiative; DBHR began implementing PRI in 2011 by redirecting funding to better target and leverage limited prevention resources to higher-need communities. The goal is to support proven strategies that will have a long-term, positive impact on families and others in identified communities. PRI is implemented through active partnerships with counties, Educational Service Districts (ESDs), local school districts, and the Washington State Office of the Superintendent of Public Instruction.

Program Evaluation: Program evaluation is the systematic collection of information to answer important questions about activities, characteristics, and outcomes of a program. Evaluation stages include design, data collection, data analysis and interpretation, and reporting.

Proxy Measures: Data that can be used as an indicator—an indirect measure of substance use or abuse. In general, multiple indirect measures (proxies) are more reliable than a single proxy.

Quantitative Data: Quantitative data is numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale from 1 to 5. Even things that you do not think of as quantitative, like feelings, can be collected using numbers if you create scales to measure them. Quantitative data is used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Qualitative Data: Qualitative data is a record of thoughts, observations, opinions, or words. Qualitative data typically comes from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Examples of qualitative data include answers to questions like, how can the program be improved? or What did you like best about your experience? – used only if the user is not restricted by a pre-selected set of answers. Qualitative data is best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words. Qualitative data is more time-consuming to analyze than quantitative data.

RCW: Revised Code of Washington. Compilation of all permanent laws in force in the State of Washington.

Resource Mapping: Identifying assets and resources that can be used for building an initiative, program, response, etc. Intended to be a more positive approach than needs assessments or other deficit models.

Residential Treatment: Hospital Inpatient (Not Detox.)—Twenty-four hour/day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency.

Short-Term (Thirty Days or Less)—Residential nonacute care in a setting with treatment services for alcohol and other drug abuse and dependency.

Long-Term (Over 30 Days)—Residential nonacute care in a setting with treatment services for alcohol and other drug abuse and dependency (may include transitional living arrangements such as halfway houses).

Reliability: The consistency or stability of a measure or test from one use to the next. When repeated measurements of the same thing give identical or very similar results, the measurement is said to be reliable. A measure is reliable to the extent that it is free of random error. For example, if you got on your bathroom scale and it read 145 pounds, you got off and on again, and it read 139, repeated the process again, and it read 148, your scale would not be very reliable. If, however, in a series of weightings, you got the same answer (say 145), your scale would be reliable – even if it were not accurate (valid) and you really weighed 120 (Vogt, 1993, p. 195).

Resistance Skills/Refusal Skills: A communication skill for avoiding trouble and combating negative peer pressure. Considered an effective prevention strategy.

Risk Factors: Risk factors are characteristics that occur statistically more often for those who develop ATOD problems than for others. These factors, however, are only indicators for a potential problem; their presence does not mean that a problem will necessarily occur. Prevention efforts for children and youth attempt to reduce these risk factors and also to increase resiliency factors. The following may constitute risk factors: the community (e.g. poverty, living in an economically depressed area, community norms favorable to substance use); the family environment (e.g., parental substance dependency, high levels of family stress, social isolation); constitutional vulnerability (e.g., being the child of a substance abuser); adolescent problems (e.g., school failure, delinquency, teen parenthood).

A family history of substance abuse is a biological risk factor while a healthy family history is a protective factor. Anxiety and depression are psychological risk factors, while a healthy self-esteem and ego strength are psychological protectors. Low bonding to family, poor family discipline, low commitment to school, association with substance-using peers, alienation and rebelliousness, and early onset of substance use are social risk factors. On the other hand, family caring and support, consistent discipline, value and encouragement of education, association with non-using peers, autonomy and sense of purpose, and clear expectations about not using substances are protective factors.

Safe and Drug-Free Schools (SDFS): Until FY 2011 SDFS ~~is~~ was the Federal government's primary funding and policy vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools to ensure a disciplined environment conducive to learning. These initiatives ~~are~~ were designed to prevent violence in and around schools, and to strengthen programs that prevented the illegal use of alcohol, tobacco, and drugs, involved parents, and coordinated with related Federal, State, and community efforts and resources. The Safe and Drug-Free Schools Program consisted of two major programs: State Grants for Drug and Violence Prevention Programs and National Programs. State Grants was a formula grant program that provided funds to State and local education agencies, as well as to Governors, for a wide range of school- and community-based education and prevention activities. National Programs carried out a variety of discretionary initiatives that responded to emerging needs. Among these were direct grants to school districts and communities with severe drug and violence problems, program evaluation, and information development and dissemination.

The Safe and Drug-Free Schools Program (SDFS) of the U.S. Department of Education also launched an expert panel process to identify, validate, and recommend to the Secretary of Education those programs that should be promoted nationally as promising and exemplary. This Expert Panel oversaw a valid and reliable process for identifying exemplary school-based programs that promote safe, disciplined, and drug-free schools. Once programs were designated as exemplary or promising, the Department disseminated information about the programs and encouraged their use in new sites. The Expert Panel initiative was a way of enhancing prevention programming by making schools aware of alternative programs that had proven their effectiveness when judged against rigorous criteria.

SAMHSA: The Substance Abuse and Mental Health Services Administration of the United States Public Health Service comprises three centers: the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. SAMHSA's vision is the prevention or successful treatment of substance abuse, mental illness, and co-occurring substance abuse and mental illness, and the full recovery of all Americans who suffer from these conditions. SAMHSA's mission is to provide national leadership to ensure that knowledge, based on science and state-of-the-art practice, is effectively used for the prevention and treatment of addictive and mental disorders. Further, SAMHSA strives to improve access and reduce barriers to high-quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as their families and communities.

SAP: Student Assistance Program. Modeled after the Employee Assistance Program found in industry. A SAP consists of a team of representative school staff who draft policy language, design procedures, trains others, and promotes program awareness in order to identify, assess, refer, and support students with (drug related) problems. SAP focuses on behavior and performance at school and uses a referral process that includes screening for alcohol and other drug involvement. Many programs are not limited to issues of substance abuse but any symptom of negative coping strategies.

SAPISP: Student Assistance Prevention and Intervention Services Program

SBH: School Behavioral Health; also known as School Mental Health; Emphasis on the host of possibilities schools provide for clinicians, teachers, administrators, students, families, and community members to collaborate in providing direct behavioral/mental health services onsite in schools to promote the overall physical, emotional, psychological and social well-being of students.

Selective: Program strategies that are more intensive interventions that target a subset of the population deemed at risk of problem behaviors due to exposure to risk or lack of protective factors such as children of adult alcoholics, drop outs or students who are struggling academically.

Social Emotional Health: Within the context of one's family, community and cultural background, social and emotional health is the child's developing capacity to: form secure relationships; experience and regulate emotions and; explore and learn

Social Skills: Prevention strategy that focuses on teaching students interpersonal skills such as how to problem solve, make decisions, resist peer pressure, resolve conflicts peacefully, negotiation skills, and so on.

Stage of Deployment: When military families are mobilized, they experience a five-phase process of transition.

Pre-Deployment (Stage 1) – Begins with the warning order to Service Member for deployment from home through their actual departure

Deployment (Stage 2) – Period immediately following Service Member's departure from home through first month of deployment

Sustainment (Stage 3) – Lasts from first month of departure through the end of deployment which can be between 9-12 months

Re-Deployment (Stage 4) – Defined as the month before the Service Member is scheduled to return home

Post-Deployment (Stage 5) – Begins with the arrival of the Service Member back home and typically lasts 3-6 months or more

SPF: Strategic Prevention Framework; A five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, State/tribal and community levels.

Supportive Learning Environment: A learning environment that is safe, civil, healthy, and intellectually stimulating, where students are engaged in learning and committed to acquiring the knowledge, attitudes, skills, and behaviors to succeed in the 21st century.

Tertiary Prevention: Intervention, also known as treatment that seeks to address symptoms of substance abuse and prevent further problems. It also refers to strategies designed to decrease the amount of disability associated with an existing disorder or illness.

Title I: Federal funds focus on increasing educational achievement for low income youth.

Title X: The reauthorization of the USDOE ESEA McKinney -Vento Act, which mandates services for homeless students. LEA's (Local Education Authority) are required to eliminate barriers to access for students in transition.

U.A.: Urine Analysis.

Universal: Program strategies that address the entire population and include child-centered approaches designed to create a civil environment that support mutual caring and respect among students and staff. Messages are aimed at preventing or delaying problem behaviors, with the mission of providing all individuals with information and skills necessary to prevent the problem

Validity: A term used to describe a measurement instrument or test that measures what it is supposed to measure; the extent to which a measure is free of systematic error. For example, say we want to measure individuals' height. If all we had was a bathroom scale, we could ask our

individuals to step on the scale and record the results. Even if the measurements were highly reliable, that is, consistent from one weighing to the next, they would not be very valid. The weights wouldn't be completely useless, however, because there generally is some correlation between height and weight. Although we do often have to try to get by with proxy measures, there is no doubt that a yardstick would be more valid for measuring height than a scale (Vogt, 1993, p. 240).

Vulnerable Populations: Community and associated individual characteristics as risk factors predictive of potential incidence of challenges with physical, psychological, emotional and/or social health and well-being

WAC: Washington Administrative Code. Rules and regulations of executive branch agencies issued by authority of statutes. WACs are the regulations necessary to implement RCWs.

Wraparound Services: Services that address clients' total healthcare needs in order to achieve health or wellness. These services "wrap around" core clinical interventions, usually medical. Typical examples include such services as financial support, transportation, housing, job training, specialized treatment, or educational support

SOURCES (unless specified):

<http://swpc.ou.edu/documents/PreventionTermsGlossary.doc>

<http://www.psesd.org/prevention/glossary.html>

<http://p2001.health.org/glossary.htm>

<http://prevention.samhsa.gov/>

Introduction

Program Manual Overview

This publication is a guide for Student Assistance Prevention Intervention Services Program (SAPISP) Specialist, Coordinators, and Supervisors who plan to, or have implemented a comprehensive, research-based program for prevention and intervention services in the school setting related to:

- Alcohol, tobacco and other drugs.
- SEBH issues.

In the early eighties, SAPISP primarily focused on alcohol substance abusing youth and children impacted by others who use alcohol or other drugs. However, recently substance abuse prevention and intervention has been placed under a broader umbrella of behavioral health. The Center for applied Principles and Technology (CAPT) Behavioral Health Fact Sheets (2012)¹ explains “placing this work in the context of overall behavior health requires a critical shift in perspective. Applying a behavioral health lens to our current prevention efforts helps us to see the connections between substance abuse and related problems, and to take the necessary steps to address these problems in a comprehensive and collaborative way.”

Behavioral health is defined as a “state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness. See additional information on behavioral health, and the shift in the field at the end of the Introduction under Additional Resources. For the purpose of this manual, behavioral health is inclusive of SEBH including substance abuse and will be referred to throughout the manual as SEBH.

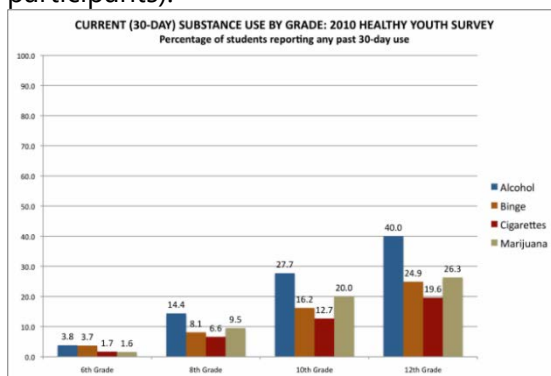
The primary purposes of school-based SAPISP are to address nonacademic barriers such as SEBH to learning and to foster academic success.

The Introduction Section discusses the framework for the theoretical underpinnings of the school-based prevention and intervention model; outlines effective program approaches; describes Washington State’s SAPISP model; and suggests primary areas of focus. Information provided within each section of the manual is aligned with the nine components of an effective Student Assistance Program as recommended by the National Student Assistance Association (NSAA), under the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and includes an additional section on consideration for vulnerable youth populations.

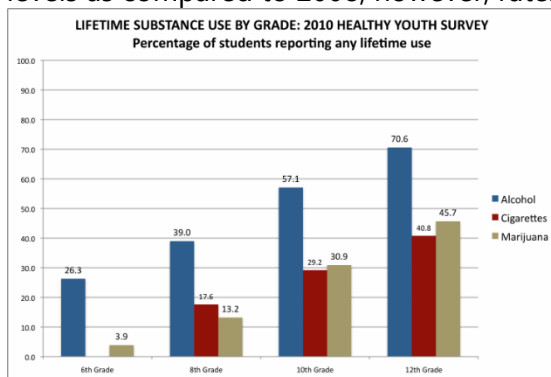
¹ CAPT Behavioral Health Fact Sheets (2012). Retrieved from <http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/1>.

Background and Significance

Substance Use by Adolescents. Substance use continues to be a significant problem among young people, here as elsewhere. According to the 2010 Washington State Healthy Youth Survey (HYS) alcohol was reported as the drug of choice among students statewide, followed by marijuana and cigarettes. Of those student participants, 70.6 percent of 12th graders, 57.1 percent of 10th graders, 39.0 percent of 8th graders, and 26.3 percent of 6th grade students had tried alcohol at some time in their lives. Reported lifetime use of marijuana included 45.7 percent of 12th graders, 30.9 percent of 10th graders, 13.2 percent of 8th graders, and 3.9 percent of 6th grade youth (DSHS, 2011). (Note: Lifetime cigarette use is not asked of 6th grade participants).



Of greater concern is the number of youth who report recent substance use. Among 2010 HYS respondents, 40.0 percent of high school seniors, 27.7 percent of 10th graders, 14.4 percent of 8th graders and 1.6 percent of 6th grade youth reported having used alcohol in the past 30 days. Among alcohol users, many reported heavy (binge) use with one in four 12th graders (24.9 percent) and 16.2 percent of 10th graders who binge drink. Findings indicate that 26.3 percent of 12th grade participants, 20.0 percent of 10th graders, 9.5 percent of 8th graders, and nearly 2 percent of younger students reported current marijuana use (DSHS, 2011). Trend data indicate that among Washington State youth, rates of recent alcohol use has declined across all grade levels as compared to 2008; however, rates of marijuana use among participants increased.



These findings underscore the need for student assistance services that support students' positive decision-making regarding alcohol, tobacco and other drug use.

Other SEBH-Related Risk. Students also reported engagement in other health risk behaviors (e.g., bullying, violence, and suicide-related behaviors) that raise concern about their health and wellbeing. For example, attempted suicide increases the risk of suicide, and is linked to other problem behaviors such as substance abuse and delinquency. Mental, emotional, and behavioral disorders e.g., depression, conduct disorder, and substance abuse is estimated to affect between 14 to 20 percent of children and youth (O’Connell, Boat & Warner, 2009). Early onset of mental disorders is predictive of lower school achievement and involvement in the juvenile justice system (O’Connell, Boat & Warner, 2009). According to 2010 HYS results, students reported the following suicide- related behaviors (DSHS, 2011, p. 46):

- Seriously considered attempting suicide in the past year: 15 percent of Grade 8, 18 percent of Grade 10, and 14 percent of Grade 12 students.
- Made a plan about how to attempt suicide in the past year: 10 percent of Grade 8, 12 percent of Grade 10, and 11 percent of Grade 12 students.
- Actually attempted suicide: 7 percent of Grade 8 and 10, and 6 percent of Grade 12 students.
- Felt that they did not have an adult to turn to for help when feeling sad or hopeless: 26 percent of Grade 6, 39 percent of Grade 8 and 10, and 31 percent of Grade 12 students.

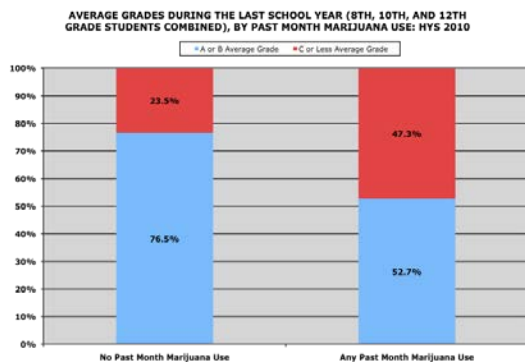
Research on bullying and student intimidation (harassment) demonstrates the negative impact of bullying on student achievement, substance abuse and mental health issues (Lillis, 2011; Juvonen, Wang, & Espinoza, 2011; Tharp-Taylor, Haviland & D’Amico, 2009). In 2010, 30 percent of 6th and 8th grade students, 24 percent of 10th graders, and 17 percent of 12th grade youth were bullied on one or more days in the past month. Middle school aged students were more likely than their high school-aged peers to be bullied and 8th and 10th grade girls reported high incidences as compared to the male peers (DSHS, 2011). Findings from the 2010 HYS further demonstrate that about one in ten 8th, 10th, and 12th grade reported being harassed via computer or cell phone. Additionally, 13 percent of 8th graders, 11 percent of 10th graders, and 8 percent of 12th grade participants reported being harassed because someone thought they were gay, lesbian or bisexual (DSHS, 2011).

Finally, for lesbian, gay, bi-sexual, questioning, or transgender (LGBTQ) youth, studies demonstrate that these youth are at increased risk of mental and emotional disorders, victimization, harassment, and substance abuse as compared to their peers (Substance Abuse and Mental Health Services Administration, 2012).

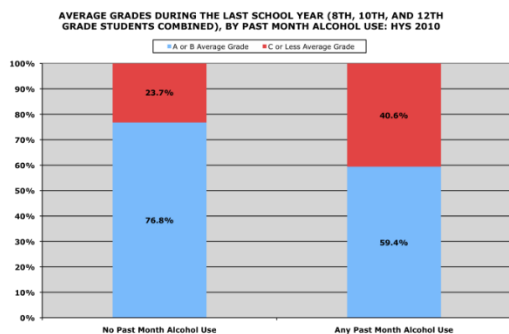
Social, Emotional and Behavioral Health issues and Impact on Academics Academic. Recent studies link drug and alcohol use, bullying, and mental health issues to negative impacts on a student’s school performance. According to the National Center for Mental Health Promotion and Youth Violence Prevention, “Substance abuse, violence, and emotional disorders interfere with the ability of children to learn and the ability of a school to educate. Students who are under the influence of alcohol or other drugs or battling emotional problems are not going to be able to learn as well as students who devote their full attention to their education.”²

² For additional information go to www.samhsa.gov

In fact, 2010 HYS data demonstrate that adolescents who used substances in the past 30 days were more likely to have average or below average grades as compared to their non-using peers. Of the 8th, 10th, and 12th grade youth surveyed, 76.8 percent of those who had no recent alcohol use reported an A or B grade average as compared to just 59.4 percent of their using peers.



Similarly, findings indicate that frequency of marijuana use during the past month was also related to poor academic performance. For example, among HYS participants who reported no recent marijuana use, 76.5 percent reported receiving an A or B average grade during the past school year. In comparison, among students who reported recent (past 30 day) use, only 52.7 percent reported achieving higher academic success.



Nishioka and colleagues (2011) found that bullying has many negative associations with academic achievement and the social and emotional development of middle school students. "Middle school students who bully or are victimized by bullying are more likely to have problems that interfere with success in school, such as higher rates of physical complaints, truancy or school avoidance, substance abuse, peer rejection, and mental health conditions such as anxiety and depression" (p. 2). Additionally, meta-analysis of 33 studies found that bullied students are more likely to earn lower grades and to receive lower scores on standardized achievement tests as compared to students who were not victimized (Nakamoto & Schwartz, 2009).

Findings from the 2006 Oregon Healthy Teens Survey, demonstrate that 45 percent of the 8th grade students rated their general emotional and mental health as poor reported having mostly

low grades - C, D, and Fs. In contrast, 14 percent of the 8th graders that rated their emotional and mental health as excellent, reported having mostly low grades.³

These issues are disconcerting given the evidence that suggest such problem behaviors are predictive of academic failure including; dropping out, increased likelihood of delinquency, and involvement with criminal justice (Gottfredson, 2001; Hawkins, Catalano, Miller, 1992; Nakamoto & Schwartz, 2009; O'Connell, Boat & Warner, 2009; Skiba & Peterson, 1999).

School-based SAPISP is an effective means to address the above concerns and are in direct response to public and parental concerns related to high levels of adolescent alcohol and other drug use as well as other social, emotional, behavioral health problems (Adelman & Taylor, 2002; Carlson, 201; Klitzner, Fisher, Stewart, & Gilbert, 1992; Moore & Forster, 1993;). In addition, SAPISP also targets specific vulnerable groups' needs such as children from substance abusing families, military families, lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ), and Native Americans.

Theoretical Foundation

Research literature consistently identifies prevention and intervention as one of the most appropriate strategies for responding to the risks of student problem behaviors of violence, substance abuse, school failure, and delinquency (Bosworth, 2000; Klitzner, Fisher, Stewart, & Gilbert, 1992; Moore & Forster, 1993; Steinberg, 1991; Wagner & MacGowan, 2006). The literature also supports comprehensive strategies involving multiple systems and dealing with numerous issues targeting critical developmental stages (Adelman & Taylor, 1998; Dougherty et al., 1992; Hawkins, Catalano, & Miller, 1992). This structured approach, similar to that found in student assistance programs, allows for the incorporation of two important prevention and intervention principles (Quinn, Osher, Hoffman, & Hanley, 1998, p. 31):

- The intensity of the intervention must be commensurate with the severity or intensity of the problem behavior.
- The effectiveness and efficiency of the individual student system depends on the effectiveness and efficiency of the schoolwide system.

Schools are particularly appropriate sites for providing SAPISP as they function as important social institutions for youth, "second only to families in significance" (Carlson, 2001, p. 3). Additionally, schools are in a unique position to change students' interactions and behaviors, and to model community standards (Hawkins, Farrington, & Catalano, 1998). School-based delivery provides not only a concentration of the target population but also ensures easier access to services for both students and parents. Adelman and Taylor (2000) maintain that offering substance abuse and SEBH related services at schools facilitates access by students and families with this especially true for underserved and difficult-to-reach populations. Noam and

³ Oregon Adolescent Health Section analysis of 2006 Oregon Healthy Teens survey data. Prepared November 13, 2006. Available at www.nasbhc.org/.

colleagues (1999) found school-based services are less affected by the stigma associated with some community-based offerings, thus are often more acceptable to student and parents. Finally, comprehensive, and integrated, school-based delivery systems, conceptually and programmatically, ensure that students' academic, SEBH needs have the potential to be addressed together (Adelman & Taylor, 1997, 2002; O'Connell, Boat & Warner, 2009). Such delivery systems promise to be more useful and efficient as well as more cost effective.

Effective Program Characteristics

Over the past decade, there has been an expansive growth in the knowledge base about the best approaches for delivery of effective student support programs to address barriers to learning. Bond and Hauf (2004), in an extensive review of diverse evaluations, including meta-analyses and best practice approaches of prevention and intervention related programs, identified 11 specific but mutually supporting characteristics of effective programs. These characteristics have been found to be an integral part of successful programs and are offered as guiding principles for framing future prevention and intervention practices. Characteristics **fundamental** to program success include:

1. Theory and research-based program content, structure and implementation.
2. Clearly defined, attainable, and agreed upon goals to guide assessment and evaluation of program effectiveness.
3. Multi-system, multi-level perspectives address numerous influences (e.g., individual, peer, environmental) and various developmental pathways across a wide range of goals.
4. Attends to dosage (intensity of service – insufficient & excessive) as well as follow-up sessions to achieve and sustain outcomes.
5. Adopt strengths perspectives, to address competence and protective factors while diminishing risk and adversity.
6. Sensitive in both content and structure/implementation i.e., developmentally appropriate, culturally sensitive, and responsive to potential stigma, addresses heterogeneity of group, and is oriented toward empowerment.
7. Incorporates high quality evaluation and monitoring.
8. Easily transferable and translatable among settings.
9. Attends to diverse resource needs i.e., funds, time, legitimacy, staff and linkages with and among systems and institutions – generates ownership, buy in and commitment.
10. Characterized by socio-political sensitivity – staff are “adept at building constituencies and connecting with existing power structures” (social marketing) (p.215).
11. Emphasize community-based collaboration.

Research conducted by Gottfredson and Gottfredson Associates (NIJ, 2004), identified other predictors linked to successful school-based prevention and intervention programs, such as **extensive and high quality training** for program staff; **highly structured program activities**, including program manuals, quality control, and implementation standards; programs are **locally initiated and run** by school insiders; **multiple sources** of information are used to support program activities; and program activities **integrated** into the regular school day and are seen as part of the regular school operations.

The optimal model for SEBH-related services to adolescents is a coordinated response to multiple concerns and service needs (Stroul & Friedman, 1994; Duchnowski, Kutash, Friedman, 2002). Current knowledge of school-based prevention and intervention services support the conclusion that there are high needs for such services. These services would be most effective if comprehensive, integrated, multifaceted, and coordinated with other school and community resources (Adelman & Taylor, 1997, 2002; 2010; 2011). In addition, to effectively re-engage students in the learning process, school-based programs must place an increased emphasis on resilience and the promotion of protective factors across multiple domains (Adelman & Taylor, 2002, 2006; O'Connell et al., 2009).

Continuum of Services

Because issues related to student learning and the reasons that place students at-risk are complex, and multifaceted program approaches must adopt multi-level services. These services must be coordinated in a manner to ensure students receive timely assistance and, as stated earlier, services that are appropriate to students' level of need, and are developmentally, and culturally appropriate (Adelman & Taylor, 2006).

To aptly address these issues a continuum of program services should focus on three specific facets (Bosworth, 2000; Dusenbury & Hansen, 2004; National Institute of Drug Abuse, 1997; O'Connell et al., 2009; Quinn, Osher, & Hoffman, 1998):

1. Meaningful and developmentally appropriate content and strategy (i.e., kindergartners learn about stranger safety, not date rape).
2. At each grade level, there is a three-tiered approach to prevention and intervention services (see Introduction additional resource section for additional information and section 7 on SAT related to Response to Intervention RTI) ...
 - a. *Universal*—strategies address the entire population and include whole-child approaches designed to create a safe and Supportive school environment that fosters mutual caring and respect among students and staff. Messages are aimed at preventing or delaying problem behaviors, with the mission of providing all individuals with information, and skills necessary to navigate relationships effectively by increasing self, and social awareness to effectively manage negative emotions, and improved decision-making and negotiation skills to address negative peer pressures. Schoolwide implementations of universal approaches include curricula, social norms campaigns aimed at reshaping attitudes and beliefs, and review of policies and procedures addressing social, emotional behavioral, mental health and ATOD use.
 - b. *Selective (early intervention)*—more intensive intervention activities, curricula, programs and services that target students who are at-risk of engaging in, or experiencing, negative problem behaviors due to exposure of risk or lack of protective factors such as: children from substance abusing families, students who are experimenting or misusing alcohol, tobacco and other drugs (ATOD), children from military families, LGBTQ, social emotional, behavioral and/or mental health problems,

- and youth who are struggling academically. Research suggests that **between 10–15 percent** of students may need this level of more intensive intervention services to help decrease problem behaviors (National Center for Mental Health Promotion and Youth Violence Prevention, and; Quinn et al, 1998);
- c. *Indicated (intensive strategies)*—strategies are designed to address the needs of those students who are showing early warning signs or already demonstrating problem behaviors and provide highly individualized and intensive services. Indicated intervention approaches are used for students who may or may not be using substances, but exhibit risk factors that increase the likelihood of involvement with ATOD, or other social, emotional, behavioral or mental health problem behaviors (i.e., suicide ideation, depression, anxiety violence, academic failure, dropping out). Approaches are designed to reduce the length of involvement in problem behaviors, delay onset of problem behaviors such as substance abuse, and/or reduce the severity of existing problem behaviors. Research has found that generally **between 1–7 percent** of students require this level of intensive services (National Center for Mental Health Promotion and Youth Violence Prevention, and; Quinn et al., 1998).
 3. The levels of intervention are coordinated across the system so that students can move among the levels with minimal disruption to routine or program services. Approximately twenty percent (20 percent) of SAPISP program services are dedicated to providing *Universal* schoolwide interventions. The majority of program services (80 percent) serve those students who make up the smallest proportion of the student body. These students account for the largest part of problem behaviors, and are served under *selective and indicated*, and provided individual, group and case management services.

Suggested Areas of Focus

The following information outlines the types of services recommended for implementation across the continuum of grade levels, including suggested program strategies, rational for services, potential service providers, and risk indicators.

Elementary Level. Research demonstrates that school-based interventions including social-emotional support and prevention can reduce and prevent the delinquent behavior in children, foster mental wellness, and improve student and school outcomes (Burns, Howell, Wiig, Augimeri, Welsh, & Petechuk, 2003; Fleming, Haggerty, Brown, et al., 2005). These findings suggest implementing developmentally appropriate approaches that encompass normative education and social resistance skills training and incorporate:

- Classroom and schoolwide behavior management programs and policies – found to reduce aggressive behaviors on playgrounds and in the school setting social competence promotion curriculums – teach pro-social norms, problem solving, and social interaction skills.
- Conflict resolution and violence prevention curriculums; bullying prevention efforts – also focus on problem solving and social interaction skills – found to reduce aggressive behaviors in students (e.g., Second Step, Steps to Respect).

- Referral to parent education programs designed to provide parents skills to monitor child problem and pro-social behaviors, and effective family management practices.
- Multi-component classroom-based programs and support groups that help teachers and parents manage, socialize, and educate students and improve their cognitive, social, and emotional competencies. These programs seek to reduce misbehaving in and out of the classroom and strengthen academic performance through identification and reduction of early behavior problems.

Rationale: Persistently disruptive children are *two to three times* more likely than are their counterparts to engage in risky behaviors later in life. Additionally, students who perform poorly in school are significantly more likely to become involved in delinquency and dropout of school. At the elementary level, prevention and intervention focuses on students with social, emotional, behavioral or mental health issues or who exhibit conduct disorder symptoms – aggression, persistent disruptive behaviors, acting out, destruction, dishonesty, theft, or serious violations of rules. Initiating interventions early, before or at the onset of problem behaviors, increases the likelihood that students will be successful in school, and will lead productive, healthy lifestyles. However, although these behaviors are *predictive* of more serious delinquency problems in later adolescence it does not mean all children with social, emotional, behavioral or mental health issues and/or conduct disorder symptoms would become juvenile delinquents (Burns, et al., 2003).

Service Providers: In many cases, school counselors provide the majority of prevention services at the elementary school level. Universal program messages are supported by school administrators, classroom teachers and other school staff modeling appropriate behaviors and through school discipline policies. Additionally, parents can support these universal prevention efforts by modeling behaviors and using a “common language” outside of the school environment. Student Assistance Program services include assisting school staff with the identification of appropriate research-based, model program materials. Further, school staff are provided with professional development opportunities to increase knowledge about signs and symptoms of problem behaviors, and information related to community and school-based referral sources. Additionally, these offerings provide school staff with the option of gaining skills such as classroom and behavior management, socialization, establishing pro-social norms, conflict resolution, and working with difficult students.

Risk Indicators: persistent disruptive classroom behavior; aggression (physical/verbal); deceitfulness; theft; destruction of property; poor academic performance (grades, homework); poor attendance/truancy; school sanctions (detention, suspension); low attachment to school; inappropriate peers; social withdrawal; poor social coping skills; victim of violence; students in transition (new to school, divorce in family); and history of family substance abuse, mental illness or violence, military family stress, and extreme poverty.

Middle School Level. Research indicates that at a minimum prevention and intervention strategies should focus on providing services during the critical middle school years (Burns, et al., 2003). Building upon and reinforcing normative education and social resistance skills learned

at the lower grade level, the middle school approach infuses a variety of personal and social skills curricula to include (Burns et al., 2003; Dusenbury & Hansen, 2004; Gottfredson, 2001; Sherman, Gottfredson, MacKenzie, Eck, et al., n.d.):

- Programs and policies aimed at clarifying and communicating norms about behaviors such as bullying, substance resistance, and pro-social, emotional, behavioral and mental health issues that reinforce messages learned at the elementary level while introducing new normative behaviors;
- Comprehensive instructional classroom-based programs that focus on a range of social competency skills (e. g., developing self-control, stress-management, responsible decision-making, social interaction and problem-solving, bullying prevention, communication and Assertiveness skills) that are delivered over a long period of time (10–12 weeks with booster sessions at each grade level) to continually reinforce skills (Universal). Such programs as Life Skills, Project Alert, Get Real About Violence or other classroom based proven effective curricula.
- Behavior modification programs and groups that teach "thinking skills" to high-risk youth, with the aim of increasing resiliency among participants, such strategies focus directly on changing and tracking behaviors, setting behavioral goals, and using feedback or positive or negative reinforcement to change behavior. Efforts to teach students "thinking strategies" (i.e., cognitive-behavioral) that utilize an interactive teaching method versus didactic method such as modeling or demonstrating behaviors and providing rehearsal and coaching in the display of new skills. Such approaches have been shown to reduce substance use; increase pro-social behaviors; and increase protective factors (Sherman, et al, n.d) (Selective/Indicated).

Rationale: Middle schools on average experience the highest level of student social, emotional and problem behaviors, typically have higher levels of disorder, and usually exhibit the greatest level of need. Risk behaviors peak in mid, or late adolescence, as do adolescent stressors. By engaging students who exhibit, or are at-risk of problem behaviors, in support services that increase protective factors, teach resiliency, and provide skills to overcome barriers, intervention programs are more likely to delay the onset of problem behaviors such as ATOD use, social and emotional behavior problems including violence, aggression, delinquency and mental health struggles. In doing so, these programs significantly increase the likelihood of success in school, decrease the likelihood of school dropout and future criminality; therefore, increase the likelihood of success in later life.

Service Providers: At the middle school level, program services are more likely to be provided in a multi-disciplinary or SAT(Core Team) approach. Administrators enforce school/district policies regarding behavior and discipline. Teachers implement classroom management and instructional strategies that include interactive and cooperative learning methods to actively engage students in school. School counselors, in collaboration with the classroom teacher or SAS, provide classroom-based curriculum that promote development of social and emotional competencies, and norms against violence, aggression, and harassment, intimidation, and bullying. In addition, SAS provide more intensive services to students identified as at-risk of

initiating or escalating ATOD use, and other problem behaviors. These services include screening, referral, support groups, individual sessions, recovery support, and case management.

Risk Indicators: Persistent disruptive classroom behavior; aggression (physical/verbal); lying, theft; destruction of property; poor academic performance (grades, homework); poor attendance/truancy; school sanctions (detention, suspension, expulsion); low school bonding/attachment; social withdrawal; limited personal skills (e.g., self-esteem, self-control) or poor social coping skills; victim of violence (physical, emotional, sexual); ATOD experimentation/abuse/dependence; depression; symptoms of substance abuse or dependence; association with inappropriate peers; eating disorders students in transition (new to school, divorce in family); family problems such as history of family substance abuse, mental illness or violence, military family stress, and extreme poverty.

High School Level. Prevention and intervention services at the high school level continue to build upon and support the messages and normative behaviors established at the lower grade levels, with an added emphasis on assisting students navigating through transitional periods – from middle to high school and from school to college and work. At a minimum, program strategies should focus on reinforcing and sustaining prevention and intervention lessons learned during the middle school years and providing “crisis” intervention services to students who are most vulnerable (Dusenbury & Hansen, 2004; Gottfredson, 2001; Sherman, Gottfredson, MacKenzie, Eck, et al., n.d; Quinn et al., 1998). Prevention and intervention approaches include:

- All mentioned above bullet 1 & 2 middle schools prevention and intervention activities;
- Programs and policies that reinforce norms about behaviors learned at the lower school levels (Universal);
- One-on-one substance abuse, social, emotional and behavioral, academic, vocational/career, and other counseling interventions (i.e. LGBTQ, family stressor, gang intervention) (Selective/Indicated); and
- Behavior modification programs and groups that teach “thinking skills” to vulnerable youth thereby increasing resiliency (Selective/Indicated).

Rationale: High school aged students benefit most from programs that offer Participation in community service; substance abuse intervention; violence prevention; job training and employment; and education and counseling for students and parents with an emphasis on adolescent and family issues. For students identified at risk, reinforcement of normative behaviors, academic support, and connection with a caring adult increases the likelihood of continued school involvement, decreases the likelihood of school dropout and future criminality; thus, increases the likelihood of success in later life.

Service Providers: Similar to the middle school level, program services are likely to be provided in a multi-disciplinary approach. Administrators enforce school/district policies regarding behavior and discipline. Teachers implement classroom management and instructional strategies and reinforce prevention messages. School counselors provide transition assistance

from middle to high school; career planning and postsecondary transition; general academic guidance; and assistance and referrals for substance abuse to school and community-based programs. Students identified with risk of dropping out, exhibit social, emotional, behavioral, mental health, and/or have substance use issues, or those disciplined due to violation of the district's zero tolerance ATOD use policies are referred to SAPISP staff who provide more intensive services to students identified as at risk of initiating or escalating ATOD use, and other problem behaviors.

Risk Indicators: Persistent disruptive classroom behavior; aggression (physical/verbal); lying; theft; destruction of property; poor academic performance (grades, homework); poor attendance/truancy; school sanctions (detention, suspension, expulsion); low school bonding/attachment; social withdrawal; limited personal skills (e.g., self-esteem, self-control) or poor social coping skills; victim of violence (physical, emotional, sexual); ATOD experimentation/abuse/dependence; depression; eating disorders, students in transition (new to school, divorce in family); family problems such as history of family substance abuse, mental illness or violence, military family stress, and extreme poverty.

Barriers to Effective Programming

Not surprisingly, there are identified characteristics common among ineffective student support programs (Adelman & Taylor, 2006; Gottfredson & Gottfredson, 2000; National Institute of Justice, 2004). These barriers span a variety of issues, including:

- Lack of adequate training, staff development and technical assistance for program implementation and continued support.
- Inadequate staff resources, program length, and lack of continuity over time.
- Weak school or program leadership.
- Overworked, stressed staff resistant to the idea of implementing new programs, especially without additional resources or support.
- School/district that "enable" or deny the existence of student or other problems.
- Inability to sustain innovative strategies.
- Low teacher and other school staff morale.
- Lack of program "buy in."
- Failure to implement program model with fidelity.
- Inadequately monitoring and evaluating program effectiveness.

Other barriers include school disorganization and climate, lack of leadership and communication, role definition, and failure to involve staff in program design. Schools with high levels of disorder, and low staff morale are more likely to be reactive; using crisis response tactics versus implementing comprehensive student support programs and being proactive in addressing identified problems (Adelman & Taylor, 2006; National Institute of Justice, 2004; Quinn et al., 1998).

Summary

The literature on SAPSIP clearly delineates the components necessary for effective program practices to reduce barriers to student learning while providing safe and Supportive environment conducive to learning. Successful programs are comprehensive, multifaceted, and cohesive, attend to the developmental stages of students, and are provided across the continuum of school grades (K–12).

Washington State's Model

Washington States' comprehensive SAPISP model is based upon findings that support a multi-level approach to prevention and intervention services to address dropout, SEBH and other student problem behaviors to reduce student barriers to learning. As previously noted, this method has been demonstrated as a highly effective practice to address Schoolwide behavior problems. Research findings indicate that to be most effective, *student support programs must take a systematic, multifaceted, integrated approach to intervention services*. Effective programs are developmentally appropriate, embedded, and supported by school policies and procedures, and provided as a continuum, targeting the entire school, classrooms, and individual students. Furthermore, effective programs adhere to the required dosage/intensity of services, include staff development and training, and incorporate family and community involvement. In Washington States' model, the majority of programs focus on providing services to students at the secondary grade levels (6–12); however, some schools provide services across all school levels.

In a review of the literature, Carlson (2001) found the student assistance program to be the dominant model used nationally to provide school-based early intervention services for adolescents with substance abuse, social, emotional, behavioral, mental health related problems. In 2009–10, prevention and intervention specialists in 13 local projects provided direct services to more than three-fourths of Washington State's secondary schools and over 17,000 students (Einspruch, 2011). Here, as elsewhere, "student assistance programs provide a range of services, beginning with prevention and extending through intervention in substance abuse with referrals to more intensive treatment resources and recovery support groups." (Carlson, 2001, p. 1)

Program History⁴

In 1989, the Washington State Legislature passed the Omnibus Alcohol and Controlled Substances Act that provides funding for state agencies to conduct a variety of programs that address the public's concern about the level and consequences of alcohol, tobacco, and other drug use. The SAPISP operated by the Office of Superintendent of Public Instruction (OSPI), places SAS in schools to implement comprehensive student assistance programs that address

⁴ The following information is adapted in part from Einspruch, E., (2011). Addressing adolescent substance abuse: An evaluation of Washington's Student Assistance Prevention and Intervention Services Program. Office of Superintendent of Public Instruction, Olympia, WA.

problems associated with substance use, social, emotional, behavioral, mental health related problems and other at-risk behaviors. As stated in the act (ESSHB 1793, Subpart B, Section 310, Paragraph 2), Student Assistance Specialists: (a) Provide early alcohol and other drug prevention and intervention services to students and their families; (b) Assist in referrals to treatment providers; and (c) Strengthen the transition back to school for students who have had problems of alcohol and other drug abuse. Statewide program goals are:

1. Provide early social, emotional, and behavioral support including drug and alcohol prevention and intervention services to students.
2. Provide high quality prevention and intervention programs to foster a safe and Supportive a SEBH including substance abuse environment for all students.
3. Develop collaborative relationships with community partners/networks mental health and treatment agencies to serve students and families comprehensively.

Where are the local programs? In years past, nearly \$5 million were distributed annually to 13 local grantees—including the four largest school districts (Seattle, Tacoma, Spokane, and Kent) and nine consortia—covering virtually the entire state. Funding allocations were based on a formula that accounts for both the school enrollment and the estimated need for services of each region. In 2010, the Department of Behavioral Health and Recovery (DBHR), formally known as Department of Alcohol and Substance Abuse, began implementing Prevention Redesign Initiative (PRI) in 2011 by redirecting funding to better target and leverage limited prevention resources to higher-need communities. The intention of redirecting these funds is to support proven strategies that will have a long-term, positive impact on families and others in their communities. PRI is being implemented through active partnerships with counties, Educational Service Districts (ESDs), local school districts, and the Office of the Superintendent of Public Instruction. Retrieved 1/20/2011.



How are the students served? According to research, effective student assistance programs provide a comprehensive model for the delivery of K–12 **prevention** (*universal*), **intervention** (*selective and indicated*) and **support services**. These services are developmentally and culturally appropriate.

Universal prevention activities typically target all students through classrooms or entire school events. Examples include assistance to classroom teachers in the use of age-appropriate prevention curricula, district policies, supervision of peer leadership or pledge programs, and promotion of drug-free alternative activities, and social, emotional, behavioral and mental health wellness activities.

Identification and screening involves a formalized process for identifying students who exhibit risk factors leading to behaviors that interfere with the learning process or that are harmful to the student or others in the school setting. If substance use or mental health issues are suspected, a further information is gathered to help determine whether some form of treatment is necessary.

Intervention and support services activities includes the identification of students who are: (a) At-risk of initiating substance use or exhibit signs of SEBH issues, (b) Coping with the substance use and/or mental health issues of significant others, (c) Using tobacco, alcohol, or other drugs (including prescriptions drugs), or (d) Developing a dependence on drugs. SAS help motivate students and their families to address the documented concerns. An array of counseling, peer support groups, social skills training, and individual and family interventions are used to address the particular needs of each student and providing assistance for youth returning to school after treatment.

Referral and case management services are in place when the severity of substance use or social, emotional, or mental health issues requires services that cannot be provided in the school setting, students are referred to community services such as mental health and chemical dependency treatment.

The statewide Student Assistance Prevention-Intervention Services Program (SAPISP) are designed to reduce student risk factors, promote protective factors, and increase asset development. Five organizational factors present in successful SAPISP programs include:

- **Formal Student Identification Process**—Schools have a designated team often referred to as a Child Study Team, Student Assistance Team, Core Team, or RTI to review referrals and prioritize service delivery. Students identified in need of service are then referred to the SAS who then screens for substance use and mental health problems requiring intervention or treatment.
- **Staff Training and Identification**—All school staff receive formal in-service training on signs and symptoms of ATOD, impacts of substance use and mental health issues or other problem behaviors on learning and school environment as well as the referral process. Confidentiality and school policy are also covered with staff at the start of each school year.
- **Staff Involvement in Identification**—All staff—classified and certified—is involved in the identification of students at-risk.
- **Training for Student Assistant Prevention-Intervention Services Program Staff**—Ongoing professional development opportunities are provided to SAPISP staff this includes addressing community and school-based resources, issues related to dropout, social, emotional, behavioral needs including substance abuse, mental health and other problem behaviors, effective intervention techniques such as motivational interviewing, Cognitive Behavioral and Dialectical Behavioral Therapy techniques, group counseling and case management strategies.
- **Formal Assessment and Referrals for Identified Students**—Referral for AOD, mental health and co-occurring assessments to community-based agencies with treatment for

student and family as needed. Case management and recovery support for students returning to the school.

Program Outcomes

Prevention and intervention strategies are intended to, (a) promote the skills and attitudes necessary to resist pressures to use alcohol, tobacco, and other drugs, (b) help students avoid antisocial behavior that may disrupt learning, (c) encourage students to reduce the substance use for which they were referred, and (d) remove barriers to school success. The findings of an independent statewide evaluation suggest that the SAPSIP has resulted in positive outcomes in each of these areas as measured by a self-report instrument administered before and after Participation in program services (Einspruch, 2011).

Skills and attitudes. Students reported that social skills and attitudes that help them resist drug use and other inappropriate behavior strengthened while participating in the SAPISP. Students reported modest but statistically significant gains on nine scales including self-concept, self-control, Assertiveness, and cooperation.

Antisocial behavior. Students with an intervention goal of reducing antisocial behavior indicated modest but significant reductions in five of six indicators.

Substance use. Students with an intervention goal of reducing substance use reported changes in their level of use:

- Significantly more students perceived moderate to high risk in nine of ten types of substance use after the program.
- Significantly fewer students reported using alcohol, tobacco, and marijuana in the past 30 days after Participation in the program. For example, 28 percent fewer students reported marijuana use and 26 percent fewer students reported binge drinking (five or more drinks) and 9 percent fewer students reported tobacco use in the past 30 days after participating.

School success. Both teacher ratings and school records provided some evidence that Participation in the SAPISP can be linked to improved school success:

- Elementary and alternative school teachers observed improved classroom performance in 86 percent of the students with unsatisfactory performance at baseline. Most of the remainder had satisfactory performance that remained unchanged.
- Participating students reported a significant increase in school bonding (Deck, 2002).
- Elementary and alternative school teachers observed improved classroom performance among students who had participated in the program during the school year (Deck, 2002).
- A small high Participation sample of middle school and high school students who were rated as dependent on alcohol or other drugs achieved a higher grade point average at the end of a second school year while a similar low Participation group showed a decline (Deck, 2002).

- Elementary and alternative school teachers observed improved classroom performance among students who had participated in the program during the school year (Deck, 2005).
- A small high Participation sample of middle school and high school students who were rated as dependent on alcohol or other drugs achieved a higher grade point average at the end of a second school year while a similar low Participation group showed a decline (Deck, 2005).

Additionally, research on the effectiveness of the Washington State SAPISP program revealed the success of the SAPISP as follows (Deck, 2002):

- The program is aligned with current reform efforts to improve academic achievement, establish and/or maintain safe healthy and Supportive environments, help students build positive social, emotional and behavioral skills, increase coordination between program specialists and school staff and other school-based programs, and provide alternative learning opportunities for vulnerable high-risk students.
- Student participants from schools where prevention programs are age appropriate, highly coordinated and consistent reported significantly lower usage of tobacco, alcohol or marijuana in the last 30 days compared with students whose programs have been developed and implemented in a generic, ad-hoc fashion.
- Schools offering a continuum of services (prevention, early intervention, treatment referral and aftercare support) ensure safer healthier and Supportive environments where students from diverse groups receive appropriate counseling. SAS directly connect several improvements among students—beyond simply learning to develop and maintain drug-free habits—to the success of prevention and intervention strategies. These include improvements in their students' writing and communication abilities, classroom attendance and Participation, and overall respect for teachers and peers.
- Students receiving intervention services begin to have fewer social, emotional, behavior, and mental health problems at home, better problem-solving skills, and improved relationships with friends.

More detailed findings from the ongoing statewide evaluation are presented in:

Einspruch, E. (2011). *Addressing Adolescent Substance Abuse: An evaluation of Washington's Student Assistance Prevention and Intervention Services Program: 2009–10 Annual Report*. Office of Superintendent of Public Instruction, Olympia, WA.

Deck, D. D. (2004). *Addressing Adolescent Substance Abuse: An Evaluation of Washington's Prevention and Intervention Services Program: 2001–03 Final Report*. Office of Superintendent of Public Instruction, Olympia, WA.

Legislative Directive⁵

Substance Abuse Prevention Awareness – Program Funding. In 1989, the Washington State Legislature adopted RCW 28A.170 – Substance Abuse Prevention Awareness – providing funding for state agencies to conduct a variety of programs to address the public’s concern about the level and consequences of alcohol, tobacco, and other drug use. According to the legislative directive, grants provided under RCW [28A.170.090](#) (as amended in 2005) may be used solely for services provided by a Student Assistance Specialist or for dedicated staff time for counseling and intervention services provided by any school district certificated employee who has been trained by and has access to consultation with an Student Assistance Specialist.

SAPISP, according to the legislation, shall be directed at assisting students in kindergarten through 12th grade to overcome problems of drug and alcohol abuse, and to prevent abuse and addiction to such substances, including nicotine. The services of the program may be obtained by means of a contract with a state or community services agency or a drug treatment center. Services provided by the program staff may include:

- a. Individual and family counseling, including preventive counseling.
- b. Assessment and referral for treatment.
- c. Referral to peer support groups.
- d. Aftercare.
- e. Development and supervision of student mentor programs.
- f. Staff training, including training in the identification of high-risk children and effective interaction with those children in the classroom.
- g. Development and coordination of school drug and alcohol core teams, involving staff, students, parents, and community members.

Selection of Grant Recipients—Program Rules. RCW 28A.170.090 states that the Superintendent of Public Instruction shall select school districts and cooperatives of school districts to receive grants for drug and alcohol abuse prevention and intervention programs for students in kindergarten through twelfth grade, from funds appropriated by the legislature for this purpose. The minimum annual grant amount per district or cooperative of districts shall be twenty thousand dollars. The advisory committee appointed by OSPI shall determine factors to be used in selecting proposals for funding and in determining grant awards, with the intent of targeting funding to districts with high-risk populations. These factors may include:

- a. Characteristics of the school attendance areas to be served, such as the number of students from low-income families, truancy rates, juvenile justice referrals, and social services caseloads.
- b. The total number of students who would have access to services.
- c. Participation of community groups and law enforcement agencies in drug and alcohol abuse prevention and intervention activities.

⁵ Additional information regarding RCW 28A.170 is available at <http://www.leg.wa.gov/rcw/inex.cfm>

Current application process: The application procedures for grantees under this section shall include provisions for comprehensive planning, establishment of a school and community substance abuse advisory committee/community coalition under the new DBHR PRI programming, and documentation of the districts needs assessment and readiness. Planning and application for grants under this section may be integrated with the development of other substance abuse awareness programs by school districts and the local community partners. School districts shall, to the maximum extent feasible, coordinate the use of grants provided under this section with other funding available for substance abuse awareness programs. School districts are directed to allocate resources, with emphasis placed on the provision of drug and alcohol abuse intervention services for the secondary preferable high school students based on targeted state outcomes of substance abuse reduction at the 10th grade level.

Organization of the Manual

The Washington State Student Assistance Prevention-Intervention Services Program manual provides guidance to program coordinators and program staff specific to the implementation and delivery of a research-based, comprehensive, Student Assistance Prevention-Intervention Services Program (SAPISP). The remainder of the manual is organized into 12 sections including nine (9) aligned with the components of a comprehensive student assistance program in accord with the National Student Assistance Association, which merged under National Association of Alcoholism and Drug Abuse Counselors in 2011.⁶ The manual contains the following sections:

- **Section 1 Implementation:** Provides an overview of the implementation of an effective SAPISP program;
- **Section 2 School Board Policy:** Outlines the school board policies that are recommended to be in place to support the SAPISP program.
- **Section 3 Staff Development:** Addresses staff development for school staff and the Student Assistance Specialist (SAS), and describes the necessary components to foster a foundation of knowledge and skills to reduce risks, increase protective factors, and foster resilience through SAPISP services.
- **Section 4 Program Awareness:** Provides information about effective practices to increase awareness about the SAPISP services through social marketing efforts, and education of parents, students, agencies, and the community about the harmful impact of alcohol, tobacco, and other drugs.
- **Section 5 Internal Referral Process:** Outlines suggested procedures for the implementation of the internal referral process.
- **Section 6 Consideration for Vulnerable Youth Populations—Military Families, LGBTQ, COSAP, Mental Health and Native American**
- **Section 7 Student Assistance Team:** Provides information related to the forming of Student Assistance Teams and providing case management.
- **Section 8 Program Evaluation:** Outlines the state's program evaluation process and provides a general framework for quality improvement of student assistance services and outcomes.

⁶ NAADAC retrieved 4/13/12

- **Section 9 Educational Support Groups:** Specifically addresses Washington States' standards of the four educational support groups.
- **Section 10 Cooperation & Collaboration:** Addresses cooperation and collaboration with community agencies and other resources and guides SAS staff in making connections to support program efforts beyond the schoolhouse.
- Appendix A. Current Trends and Impact
- Appendix B. DBHR Redesign
- Appendix C. Glossary of Term
- Appendix D. References

Additional Resources

Information Sheet 1:⁷

A Behavioral Health Lens for Prevention. While many of us working in the substance abuse field have long recognized the value of prevention, placing this work in the context of overall behavior health requires a critical shift in perspective. Applying a behavioral health lens to our current prevention efforts helps us to see the connections between substance abuse and related problems and to take the necessary steps to address these problems in a comprehensive and collaborative way.

What is Behavioral Health? Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness (SAMHSA, 2011). Such problems are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society. Consider these statistics:

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- The annual total estimated societal cost of substance abuse in the United States is \$510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24—in 2008, an estimated 9.8 million adults in the United States had a serious mental illness.

Overlapping Problems, Collaborative Solutions. In the past, practitioners and researchers saw substance abuse prevention as distinct from the prevention of other behavioral health problems. But mounting evidence indicates that the populations affected by these problems overlap significantly, as do the factors that contribute to these problems. Consequently, improvements in one area often have direct impacts on the other.

Many young people have more than one behavioral disorder. These disorders can interact and contribute to the presence of other disorders, leading to concurrent diagnosable disorders or “comorbidity.” An estimated 37 percent of alcohol abusers and 53 percent of other drug abusers also have at least one serious mental illness.

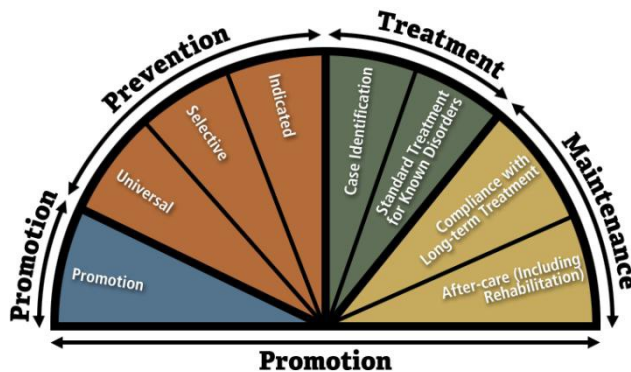
⁷ CAPT Behavioral Health Fact Sheets (2012). Retrieved from <http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behaviorial-health-lens-prevention/1>

Despite extensive research documenting strong associations between multiple problems, it's not always clear what leads to what. For example, can substance abuse lead to thoughts of suicide, or can thoughts of suicide lead to substance abuse? Or are they both the product of a third, unknown causal factor?

Mental and physical health is also connected. Good mental health often contributes to good physical health. Similarly, the presence of mental health disorders, including substance abuse and dependence, is often associated with physical health disorders (O'Connell, 2009). A large number of studies provide strong evidence that drinking alcohol is a risk factor for primary liver, breast, and colorectal (colon) cancer. Positive lifestyle adjustments, however—like sleep, diet, and activity and physical fitness—can also significantly strengthen mental health (O'Connell, 2009).

As prevention practitioners, our responsibility is to be mindful of these linkages and see our work as part of a broader effort to improve overall health. Recognizing these linkages can help us identify opportunities to address health in a more comprehensive way—by working across disciplines, pooling resources, and reaching people in those settings and during those times in their lives where and when services are most likely to have an impact.

Prevention as Part of a Continuum of Care. A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model helps us recognize that there are multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes these components:



- **Promotion:** These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention:** Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment:** These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Maintenance:** These services support individuals' compliance with long-term treatment and aftercare.

Keep in mind; however, that interventions do not always fit neatly into one category or another. For example, consider co-morbidity. If some disorders (like substance use) are risk factors for other disorders (like depression)—does that mean that all treatment can be seen as prevention? Each prom season, communities across the nation implement safe driving campaigns—are they promoting healthy lifestyles or preventing potential substance use?

Working Across the Continuum

The Continuum of Care model reminds us to think, more explicitly, about the relationships between promotion, prevention, and treatment. All too often these relationships are overlooked opportunities for collaboration are missed, and outcomes are compromised. Consider this example:

To address increasing rates of underage drinking, the anti-drug task force of a small New England town decided to strengthen enforcement of its underage drinking laws. Police began arresting youth they found attending underage drinking parties. The arrested youth were required to receive an assessment of their substance use and attend a six-week education program provided by the local substance abuse and mental health agency. The intervention was effective on the prevention end: knowing that the threat of arrest was real, fewer youth attended underage drinking parties and underage drinking decreased. But what about its effects related treatment services? The increased enforcement efforts produced an increase in the number of referrals to the local substance abuse and mental health agency, as well as a change in the type of referrals. Prior to the increased enforcement, most of the youth referred to the agency were at high risk for substance use. These youth received selective interventions tailored to their needs. Now most of the referrals were youth who were at much lower risk; their needs were significantly different. Recognizing the potential impact of its new enforcement policy, the task force worked closely with administrators of the treatment agency to prepare. Knowing what was coming down the pike, the agency was able to more appropriately allocate resources and address the diverse needs of all its referrals. Thus, collaboration and a more comprehensive approach to the problem of underage drinking produced a better outcome overall.

Sources

Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Substance Abuse and Mental Health Services Administration. (2011).

Leading change: A plan for SAMHSA's roles and actions 2011–14. SAMHSA.

World Health Organization. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. Geneva: World Health Organization.

Information Sheet 2:

Levels of Risk, Levels of Intervention. Prevention practitioners have long targeted risk and protective factors as the “influences” of behavioral health problems. The 2009 report preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities defines risk and protective factors as follows:

- **Risk factor:** A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.
- **Protective factor:** A characteristic associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.

Some risk factors are causal: cigarette smoking, for instance, has been closely linked to lung cancer. Others act as proxies (e.g., living in an area with a high prevalence of cigarette smoking) or markers of an underlying problem (e.g., having a smoker’s cough).

Some risk and protective factors, such as gender and ethnicity, are fixed: they don’t change over time. For instance, at a population level being a boy is a risk factor for substance abuse because boys develop substance abuse problems more quickly than girls. Other risk and protective factors are considered variable: these can change over time. Variable risk factors include income level, peer group, and employment status.

Many factors influence an individual’s likelihood to develop a substance abuse or related behavioral health problem. Effective prevention focuses on reducing those risk factors, and strengthening those protective factors, that are most closely related to the problem being addressed.

Prevention: Universal, Selective, and Indicated. Not all people or populations are at the same risk of developing behavioral health problems. Preventive interventions are most effective when they are appropriately matched to their target population’s level of risk. The Institute of Medicine defines three broad types of prevention interventions:

1. **Universal preventive interventions** take the broadest approach, targeting “the general public or a whole population that has not been identified on the basis of individual risk” (O’Connell, 2009). Universal prevention interventions might target schools, whole communities, or workplaces.

Examples: community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse and preventive prescribing practices, social and decision-making skills training for all sixth graders in a particular school system.

2. **Selective preventive interventions** target “individuals or a population sub-group whose risk of developing mental disorders [or substance abuse disorders] is significantly higher than average,” prior to the diagnosis of a disorder (O’Connell, 2009). Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population.

Examples: prevention education for new immigrant families living in poverty with young children, peer support groups for adults with a history of family mental illness and/or substance abuse.

3. Indicated preventive interventions target “high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder” prior to the diagnosis of a disorder (O’Connell, 2009). Interventions focus on the immediate risk and protective factors present in the environments surrounding individuals.

Examples: information and referral for young adults who violate campus or community policies on alcohol and drugs; screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries.

Individual vs. Population Risk. It’s simplest to think about risk on an individual level. Consider this example:

Sandra is a 12-year-old girl with a family history of alcoholism and mental illness Sandra’s mother is a functioning alcoholic and her father suffers from undiagnosed depression. Over the past 5 years, Sandra’s family has moved four times: she now lives in low-income neighborhood with high crime and many abandoned buildings. At night, neighborhood youth use the corner park to drink and use drugs. Sandra is bussed across town to attend school but lives close to her grandparents, with whom she has a close relationship. She attends an after-school program at the local Girls, Inc. where she is the lead scorer on her basketball team.

- What is Sandra’s level of risk?
- What are some of the risk and protective factors in her life?
- Which of these factors are fixed and which are variable?

But it’s important to realize that every community includes many Sandra’s: Adolescents who live in conditions and experience combinations of risk and protective factors that place them at risk for substance abuse and other related behavioral health problems. As prevention practitioners, we focus not only on individuals but on whole populations, looking for ways to address risk and protective factors that contribute to problems on the population level.

Sources

Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, D.C.: The National Academies Press.

O’Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA’s roles and actions 2011-2014*. SAMHSA.

Information Sheet 3:

Key Features of Risk and Protective Factors

The 2009 report *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* presents four key features of risk and protective factors for practitioners to consider when designing and evaluating prevention interventions, each described below:

1. Risk and protective factors can be found in multiple contexts.
 2. Effects of risk and protective factors can be correlated and cumulative.
 3. Some risk and protective factors have specific effects, but others are associated with multiple behavioral health problems.
 4. Risk and protective factors influence each other and behavioral health problems over time.
1. **Risk and Protective Factors Exist in Multiple Contexts.** Individuals come to the table with **biological and psychological** characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

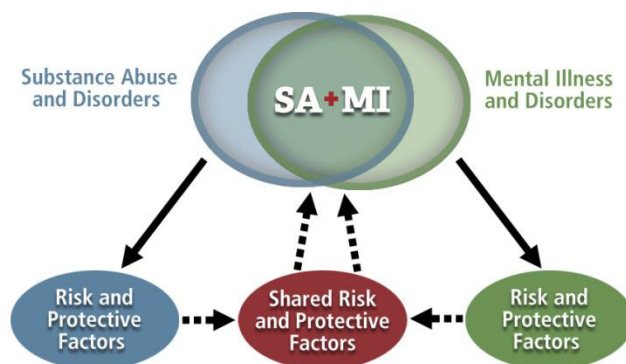


But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

- In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as LGBTQ youth.

Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective— and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

- 2. Risk and Protective Factors are Correlated and Cumulative.** Risk factors tend to be positively correlated with one another, and negatively correlated with protective factors. That is to say, young people with some risk factors have a greater chance of exposure to still more risk factors—they are also less likely to have protective factors. Risk and protective factors also tend to have a cumulative effect on the development—or reduced development—of behavioral health problems. Young people with multiple risk factors have a greater chance of developing a problem, while young people with multiple protective factors are at reduced risk. Understanding how risk and protective factors influence one another—that they do, in fact, influence one another—underscores the importance of, (1) Intervening early, and (2) Developing interventions that target multiple factors, rather than addressing individual factors in isolation.



- 3. Individual Factors Can be Associated with Multiple Problems.** Though preventive interventions are often designed to produce a single outcome, research shows that some risk and protective factors are associated with multiple outcomes. For example, negative life events, such as divorce or sustained neighborhood violence, are associated not only with substance abuse but also with anxiety, depression, and other behavioral health problems. What this tells us is that preventive efforts targeting a particular set of risk and protective factors have the potential to produce positive effects in multiple areas. Interventions with multiple benefits can lead to broad improvements in health and are a cost-effective investment for society.
- 4. Risk and Protective Factors are Influential Over Time.** Risk and protective factors can strengthen or limit the presence of other factors and disorders over a lifetime. For example, risk factors such as poverty and family dysfunction, can contribute to later psychosocial problems and behavioral disorders, such as risky sexual behavior and depression. Moreover,

risk and protective factors within one particular context—such as the family—may also influence or be influenced by factors in another context. For example, effective parenting has been shown to mediate the effects of multiple risk factors, including poverty, parental divorce, parental bereavement, and parental mental health problems. The more we understand about how risk and protective factors interact, the better prepared we will be to develop appropriate interventions. In the past, prevention practitioners typically focused on a select group of factors that they thought contributed to a specific issue or produced a single outcome. Today, practitioners have begun broadening their lens—to look at connections between risk factors and implement effective programs strategically to address multiple outcomes.

Sources

Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Rutter, M. (1987). Psychosocial Resilience and Protective Mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316–331.

Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011–14*. SAMHSA.

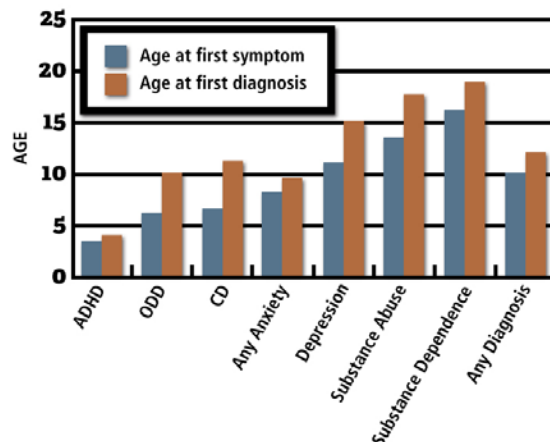
Information Sheet 4:

The Developmental Framework. A developmental approach to prevention helps to ensure that interventions have the broadest and most significant impact. The developmental framework organizes risk and protective factors and their potential consequences and benefits according to defined developmental periods. This enables practitioners to match their prevention and promotion efforts to the developmental needs and competencies of their audience. It also helps planners align prevention efforts with key periods in young peoples' development, when they are most likely to produce the desired, long-term effects.

Stages of Development. Preventing behavioral problems begins with an understanding of how young people develop and how the challenges they face and overcome interact to produce changes in their mental and physical health over their lifetimes. As children grow, they progress through a series of developmental periods. Each of these periods is associated with a set of developmental competencies: cognitive, emotional, and behavioral abilities children need to adapt to new challenges and experiences. Developmental competencies are "essential as a young person assumes adult roles and the potential to influence the next generation of young people." (O'Connell, 2009)

The likelihood of individuals gaining these competencies depends on, (1) Their foundation of other competencies; and (2) The risk and protective factors they encounter at each developmental stage. Information Sheet 5 maps out some of the core competencies and the contextual risk and protective factors for substance abuse associated with each developmental period.

Windows of Opportunity. When addressing risk and protective factors, timing is critical. Half of all behavioral disorders appear during adolescence. While the average age of diagnosis varies by disorder, the first symptoms of most behavioral health disorders typically occur two to four years before diagnosis. In the case of substance abuse disorders, for example, initial symptoms appear around age fourteen—about four years before these symptoms progress to the point of a diagnosable disorder.



If we can intervene during these windows of opportunity—during the period between the time when symptoms can be first detected and disorders can be diagnosed—we are more likely to prevent the onset of the disorder and produce lasting and long-term impacts. And if we can intervene even sooner, to promote healthy lifestyles, our potential for reducing the toll of behavioral health problems on individuals, communities, and society is even greater.

Matching Interventions to Developmental Phase. Certain risk and protective factors are more common and influential during particular developmental periods. The developmental framework helps practitioners match their prevention and promotion efforts to the developmental needs and competencies of their audience. It's important to note that many actors affect more than one phase, as do the corresponding interventions. Consider the following scenarios:

- **Scenario 1:** A prevention and wellness committee of an urban elementary school reviews recent efforts to reduce substance abuse and improve behavioral health. The committee decides to address identified gaps in programming for kindergartners by implementing a program that focuses on healthy decision-making and critical thinking skills.
- **Scenario 2:** A community-wide substance abuse coalition identifies underage drinking as a primary focus for its prevention efforts; coalition members are concerned about alcohol being served at community events and that adults buy alcohol for minors. To address these problems, the coalition decides to implement Across Ages, an evidence-based intervention designed to increase protective factors for high-risk students by matching youth with older adult community mentors.

In both scenarios, the intentions are good, but the developmental appropriateness of the selected interventions is questionable: neither intervention matches the developmental phase of the target audience or addresses the risk and protective factors most influential during that phase. In the first scenario, the intervention addresses competencies that children develop later in life, during their middle-childhood and adolescence. A more appropriate intervention might be one that targets kindergarten teachers, helping them to provide better support for their students' behavioral health. In the second scenario, the intervention targets individual-level behavior change. A more effective approach might be to reduce social access to alcohol—by enforcing bans on serving and selling alcohol to minors.

Matching Interventions to Setting. It's also important to consider the "where" of an intervention. Children develop competencies in a range of settings. In just one day, a child might move from his home to school, then to after-school day-care, then on to a neighborhood park to play with friends. Each of these settings plays a role in a child's development. As individuals progress through their youth and into adulthood, the significance of setting in shaping behavioral health evolves. For example, when individuals are very young, immediate family members play a key role in shaping development. But as children mature their friends and peers become significantly more influential, which introduces new risk and protective factors in, and out-of-school.

Sources

Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011–14*. SAMHSA.

Information Sheet 5:

Developmental Competencies and Associated Risk & Protective Factors by Context

Infancy and Early Childhood

Competencies: Infants begin understanding their own and others' emotions, to regulate their attention, and to acquire functional language

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> difficult temperament. • <i>Family:</i> parental drug/alcohol use, cold and unresponsive mother behavior. 	<ul style="list-style-type: none"> • <i>Individual:</i> Self-regulation, secure attachment, mastery of communication and language skills, ability to make friends and get along with others. • <i>Family:</i> Reliable support and discipline from caregivers, responsiveness, protection from harm and fear, opportunities to resolve conflict, adequate socioeconomic resources for the family. • <i>School/community:</i> Support for early learning, access to supplemental services such as feeding and screening for vision and hearing, stable and secure attachment to childcare provider, low ratio of caregivers to children, regulatory systems that support high quality of care.

Middle Childhood

Competencies: Children learn how to make friends, get along with peers, and understand appropriate behavior in social settings

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> Poor impulse control, sensation-seeking, lack of behavioral self-control, impulsivity, early persistent behavior problems, attention deficit/hyperactivity disorder, anxiety, depression, antisocial behavior. • <i>Family:</i> Permissive parenting, parent-child conflict, low parental warmth, parental hostility, harsh discipline, child abuse/maltreatment, substance use among parents or siblings, parental favorable attitudes toward alcohol 	<ul style="list-style-type: none"> • <i>Individual:</i> Mastery of academic skills (math, reading, writing), following rules for behavior at home and school and in public places, ability to make friends, good peer relationships. • <i>Family:</i> Consistent discipline, language-based rather than physically based discipline, extended family support. • <i>School/community:</i> Healthy peer groups, school engagement, positive teacher expectations, effective classroom management, positive partnering between

Risk Factors	Protective Factors
<p>and/or drug use, inadequate supervision and monitoring, low parental aspirations for child, lack of or inconsistent discipline.</p> <ul style="list-style-type: none"> • <i>School/community:</i> School failure, low commitment to school, peer rejection, deviant peer group, peer attitudes toward drugs, alienation from peers, law and norms favorable toward alcohol and drug use, availability and access to alcohol. 	<p>school and family, school policies and practices to reduce bullying, high academic standards.</p>

Adolescence

Competencies: Adolescents focus on developing good health habits, practice critical and rational thinking, and seek Supportive relationships

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> Emotional problems in childhood, conduct disorder, favorable attitudes toward drugs, rebelliousness, early substance use, antisocial behavior. • <i>Family:</i> Substance use among parents, lack of adult supervision, poor attachment with parents. • <i>School/community:</i> School failure, low commitment to school, not college bound, aggression toward peers, associating with drug-using peers, societal/community norms about alcohol and drug use. 	<ul style="list-style-type: none"> • <i>Individual:</i> Positive physical development, academic achievement/intellectual development, high self-esteem, emotional self-regulation, good coping skills and problem-solving skills, engagement and connections (in school, with peers, in athletics, employment, religion, culture). • <i>Family:</i> Family provides predictable structure with rules and monitoring, Supportive relationships with family members, clear expectations for behaviors and values. • <i>School/community:</i> Presence of mentors and support for development of skills and interests, opportunities for engagement within school and community, positive norms, clear expectations for behavior, physical and psychological safety.

Early Adulthood

Competencies: Individuals learn to balance autonomy with relationships to family, make independent decisions, and become financially independent

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> Lack of commitment to conventional adult roles, antisocial behavior. • <i>Family:</i> Leaving home. • <i>School/community:</i> Attending college, substance-using peers. 	<ul style="list-style-type: none"> • <i>Individual:</i> Identity exploration in love and work and developing a world view, subjective sense of adult status, subjective sense of self-sufficiency, making independent decisions, becoming financially independent, future orientation, achievement motivation. • <i>Family:</i> Balance of autonomy and relatedness to family, behavioral and emotional autonomy. • <i>School/community:</i> Opportunities for exploration in work and school, connectedness to adults outside of family.

Source

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

American Counseling Association, American School Counselor Association, National Association of School Psychologists, School Social Work Association of America

Removing Barriers to Learning and Improving Student Outcomes: The Importance of School-Based Mental Health Services⁸

School mental health services are integral to student success. Mental health is as important as physical health to children's quality of life and directly impacts their learning and development. Children cannot learn effectively if they are struggling with a mental health problem, such as depression, or feel overwhelmed by academic, social or family pressures. It is important to recognize that mental health is not simply the absence of mental illness; it also means having the skills necessary to cope with life's challenges. Students, families, schools, and society at large benefit when schools meet the needs of the whole child by fostering social-emotional skills and identifying and preventing mental health problems early.

Research demonstrates that students who receive social-emotional support and prevention services achieve better in school. School leaders who recognize the relationship between student success, good schooling/instruction, and comprehensive school health programs that include attention to students' mental health will more effectively improve student and school outcomes. A recent longitudinal study provided strong empirical evidence that interventions that strengthen students' social, emotional, and decision-making skills also positively impact their academic achievement, both in terms of higher standardized test scores and better grades (Fleming et al., 2005). Prevention programs that reach all students and early identification and intervention with at-risk students are both crucial. Examples include education on mental health issues, school violence prevention, social skills training, bullying prevention, suicide prevention, conflict resolution, and screening for emotional and behavioral problems.

There is a growing and unmet need for mental health services for children and youth. One in five children and adolescents will experience a significant mental health problem during their school years (US Department of Health and Human Services, 1999). Examples include stress, anxiety, bullying, family problems, depression, a learning disability, and alcohol and substance abuse. Serious mental health problems, such as self-injurious behaviors and suicide, are also on the rise, particularly among youth. Unfortunately, many children and youth do not receive the help they need. Among the 2.2 million adolescents aged 12 to 17 who reported a major depressive episode in the past year, nearly 60 percent did not receive any treatment (SAMHSA, 2005). Of the adolescents who do get help, nearly two thirds do so only in school. In a recent study by the Annenberg Public Policy Center (2004), two thirds of school districts reported that the need for mental health services had increased since the previous year, while over one third of these districts also reported a reduction in mental health program funding.

⁸ Retrieved from <http://www.nasponline.org/advocacy/bigideashandout.pdf>.

Schools are a natural place to provide mental health services. Virtually every community has a school and most children spend at least six hours a day there. Schools offer an ideal context for prevention, intervention, positive development, and regular communication between school and families. Parents and children are familiar with the environment and staff. In fact, students are more likely to seek counseling when services are available in schools (Slade, 2002). In many states, schools are the major providers of mental health services to children (Rones & Hoagwood, 2000; Weist et al., 2003). In some cases, such as rural areas, schools provide the only mental health services in the community.

School mental health services must be integrated with community services on a continuum of care. Not all services, clinical psychiatric care, for example, can or should be provided in schools. **School-employed professionals** must coordinate with **community service providers** to ensure that children receive needed support through a seamless and timely process. Funding and services must follow the needs of students. The UCLA Center for Mental Health in the Schools (Adelman & Taylor, 2005) suggest that policy makers and school staff must work with families and community providers to create a cohesive and integrated continuum of interventions that meets the universal needs of students and those with severe problems.

Crisis events provide vivid examples of the need for mental health services. The terrorist attacks on September 11, 2001 and the Gulf Coast Hurricanes clearly demonstrated the central role schools play in supporting students' mental health needs. School crises range from large-scale disasters like these events to such events as the death of a fellow student, an act of violence on campus, or the deployment for war of a family member who is serving in the military. Too often the mental health concerns of students are not assigned a high priority on a daily basis and only gain stature in the event of a crisis such as a school shooting (Adelman & Taylor, 2005). This elevated stature is only short-lived until the urgency of the crisis passes, compromising the effectiveness of these programs and services. Ideally, mental health services should be in place before a crisis occurs; encompass prevention, rapid response, and recovery services (e.g., counseling); and be coordinated with community services.

Providing quality school mental health services requires that schools have an adequate amount of appropriately trained professionals. The vast majority of school-based services are provided by school-employed school counselors, psychologists, and social workers. They are specially trained in school system functioning and learning, as well as family contexts and mental health. Proper training is critical, as is close collaboration among school-based providers and with other educators. While sharing some core competencies, each profession also has its own unique skills and provides different, albeit interrelated, services. Together, school mental health providers support teachers, improve school safety and climate, and reach out to all students and families, enabling teachers to teach and students learn more effectively.

There is a shortage of school mental health positions. The ratio of students to professionals across all three professions is more than two to three times greater than the maximum ratios recommended by the profession 250 students per counselor; xxx per social worker; and 1,000

per psychologist). The current national averages are 488 per school counselor and over 1,600 per school social worker and psychologist. This shortage compromises the ability of schools to provide broad-based mental health services that span the prevention to intervention continuum.

Meeting children’s mental health needs is a wise investment. Failure to support students’ mental health has serious negative consequences, including increased risk for school failure, social isolation, unsafe sexual behavior, drug and alcohol abuse, and suicide, while exacerbating long-term social problems such as incarceration, unemployment, and poor health. All are costly societal problems both in terms of personal and economic consequences. For example, the Seattle Social Development Project (focused on grades one through six) has been estimated to save \$9,837 per student in averted long-term social problems (Aos et al., 2004). And, it is estimated that the United States loses \$192 billion (1.6 percent of the Gross Domestic Product) in combined income and tax-revenue losses with each cohort of 18-year olds who never complete high school. Increasing the educational attainment of that cohort by one year would recoup nearly half of those losses (Columbia University Symposium on the Social Costs of Inadequate Education, 2005).

Our children need public policy that expands and improves school-based mental health services. The current system is fractured, overburdened, and unable to meet the growing demand for services. Specific goals must be:

- Improved access and availability of quality school mental health services for children and youth.
- Improved coordination and leadership between SAMSHA and the Department of Education.
- Streamlined/blended funding that follows that child.
- Funding for adequate numbers of highly trained school-employed providers, including incentives to reduce shortages in these professions.
- Focus on evidence-based programs and interventions.

Resources

The following websites are excellent sources for information about promising approaches to and “best practices” in the prevention of the use of alcohol, tobacco and other drugs; social, emotional learning; and mental health.

www.health.org/ -- National Clearinghouse for Alcohol and Drug Information (NCADI) is a resource for information about substance abuse prevention and treatment. It distributes recent studies and surveys, as well as information for the general public. The materials available come from a wide variety of government agencies, and most are free or low-cost.

<http://captus.samhsa.gov/> -- SAMHSA's Collaborative for the Application of Prevention Technologies (CAPT) is a national substance abuse prevention training and technical assistance (T/TA) system dedicated to strengthening prevention systems.

www.rwjf.org -- Robert Wood Johnson Foundation

www.csap.org -- Center for Substance Abuse Prevention

www.ncadi.org -- National Clearinghouse of Alcohol and Drug Information
<http://www.schoolbasedhealthcare.org/> -- Center for School, Health and Education
<http://www.samhsa.gov/prevention/> -- Substance Abuse and Mental Health Services Administration a wealth of information and resources for prevention or substance abuse and mental illness, behavioral health, and suicide prevention.
<http://www.pbis.org/> -- Positive Behavioral Intervention and Supports
<http://www.RTI4success.org/> -- National Center on Response to Intervention
<http://casel.org/> -- Collaborative for Academic, Social, and Emotional Learning
<http://smhp.psych.ucla.edu/> -- Center for Mental Health in Schools at UCLA
<http://www.drugabuse.gov/> -- National Institute on Drug Abuse
<http://www.drugabuse.gov/> -- National Institute on Alcohol Abuse and Alcoholism
<http://www.k12.wa.us/CompassionateSchools/default.aspx> -- Compassionate Schools
<http://www.k12.wa.us/OperationMilitaryKids/default.aspx> -- Operation Military Kids
<http://adai.washington.edu/> - Alcohol and Drug Abuse Institute
<https://nsduhweb.RTI.org/> - National Survey on Drug Use and Health (NSDUH)
<http://monitoringthefuture.org/> -- Monitoring the Future

Other useful resources are your Regional Alcohol and Drug Resource Network, your state Clearinghouse for Alcohol and Drug Information, and your state Department of Education media library.

References

Healthy Youth Survey 2010 Analytic Report. Washington State Department of Health, Office of the Superintendent of Public Instruction, Department of Social and Health Services, Department of Commerce, Family Policy Council and Liquor Control Board, June 2011

Tharp-Taylor, S., Haviland, A., and D'Amico, E. (2009) Victimization from Mental and Physical Bullying and Substance Use in Early Adolescence. *Addiction Behavior*, 34(6-7): 561–567.

Retrieved 5/3/2010

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2707251/pdf/nihms120665.pdf>

Lillis, R. (2011) Relationship Between Bullying and Academic Achievement and Direct and Indirect Impact of Olweus Bullying Prevention Program: A Brief Review of Literature.

Evalumetrics Research Report. Available at

http://www.evalumetrics.org/files/Olweus_Bullying_Review.pdf

Juvonen, J., Wang, Y., and Espinoza, G. (2001). Bullying Experiences and Compromised Academic Performance Across Middle School Grades. *Journal of Early Adolescence* 31(1) pp. 152-173.

Retrieved 5/3/2012 at

http://ucla.academia.edu/GuadalupeEspinoza/Papers/400292/Bullying_Experiences_and_Compromised_Academic_Performance_Across_Middle_School_Grades

Nishioka, V., Coe, M., Burke, A., Hanita, M., and Sprague, J. (2011). *Student-reported overt and relational aggression and victimization in grades 3–8*. (Issues & Answers Report, REL 2011–No. 114). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Northwest. Retrieved from <http://ies.ed.gov/ncee/edlabs>.

Nakamoto, J. & Schwartz, D. (2009). Is peer victimization associated with academic achievement? A meta-analytic review. *Social Development*, 19, 221-242.

Adelman, H. S. and Taylor, L. (2011). Expanding school improvement policy to better address barriers to learning and integrate public health concerns. *Policy in Education*, 9 (3), pp. 431 – 446.

Adelman, H. S. and Taylor, L. (2010). Creating successful school systems requires addressing barriers to learning and teaching. *The F.M. Duffy Reports*, 15 (3), 1-11. Available at <http://smph.psych.ucla.edu/publications/duffyreport.pdf>

Wagner, E. and Macgown, M. (2006). School-based group treatment for adolescent substance abuse. In, Liddle, H. and Rowe, C. (Eds.), *Adolescent Substance Abuse*, (pp. 333- 356).

Cambridge, NY: Cambridge University Press.

O’Connell, M., Boat, T., and Warner, K. (2009). Preventing mental, emotional, and behavioral disorders among young people. National Academy of Sciences. Available at http://www.nap.edu/catalog.php?record_id=12480

Stroul, B. A. & Friedman, R. M. (1994). *A system of care for children and youth with severe emotional disturbances*. (Revised edition). Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Schinke, S., Brounstein, P., and Gardner, S. (2002). SAMHSA Model Programs. *Science-Based Prevention Programs and Principles 2002: Effective Substance Abuse and Mental Health Programs for Every Community*. Available at www.samhsa.gov/publications/publications.htm

Substance Abuse and Mental Health Services Administration. (2012). *Top health issues for LGBT populations & resource kit*. HHS Publication No. (SMA) 12-4684. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Adelman, H.S. & Taylor, L. (2006). *The current status of mental health in schools: A policy and practice brief*. Los Angeles, CA: UCLA School Mental Health Project.

Duchnowski, A. J., Kutash, K., and Friedman, R. M. (2002). Community-based interventions in a systems of care and outcomes framework. In, Burns, B., J., and Hoagwood, K. (Eds.), *Community Treatment for Youth*, (pp. 16-37). New York, NY: Oxford University Press, Inc.

National Center for Mental Health Promotion and Youth Violence Prevention. (n.d.). *Positive Behavioral Intervention and Supports Brief*. Retrieved May 5, 2012 from <http://www.pbis.org/>

Fleming, C. B., Haggerty, K. P., Brown, E. C., Catalano, R. F., Harachi, T. W., Mazza, J. J., & Gruman, D. H. (2005). Do social and behavioral characteristics targeted by preventive interventions predict standardized test scores and grades? *Journal of School Health*, 75, 342- 349.

Adelman, H.S. & Taylor, L. (2006). School and community collaboration to promote a safe learning environment. Los Angeles, CA: UCLA School Mental Health Project. Available at <http://smhp.psych.ucla.edu/publications/school&communitycollaboration.pdf>.

Section 1

Implementation of Effective Student Assistance Programs

Implementation of Effective Student Assistance Prevention-Intervention Services Programs

Student Assistance Programs. The Student Assistance Program is a framework for delivery of prevention, intervention, and support services to students and educators in grades K–12. Student Assistance Programs address barriers to learning that impact both the individual and the school in order to improve student academic achievement. These programs emerged in the 1970's to assist secondary schools in dealing with alcohol and other drug problems. The programs are modeled after the successful approach of Employee Assistance Programs (EAPs) popular since the 1960's (Lenhardt, 1994). Changes in Student Assistance Program services evolved over the next 30 years to focus on addressing barriers to learning including substance use, mental health issues, and violence, as well as a host of other individual and environmental problems with the aim of assisting students to succeed academically and to complete the educational process (NSAA, 2003).

Student Assistance Programs utilize both individual strategies for identified students and environmental approaches to improve the educational opportunity for all students and educators. In an era focusing on educational accountability – *Elementary and Secondary Education Act*,⁹ *Race to the Top* and *Investing in Innovation*– schools must strategically assist students in reaching their greatest potential, improving educational outcomes for all students, closing the achievement gaps, increasing equity, and improving the quality of instruction. Student Assistance Programs provide greater opportunities for improvement in student achievement and academic success by addressing the nonacademic barriers to learning.

Student assistance professionals/Specialist (SAS) provide an integrated system of care including prevention, early intervention and support services that address mental health and substance use issues that would otherwise result in barriers to student learning and success. Student assistance programs (SAPs) evolved from the Employee Assistance Program (EAP) model of the 1960s–1970s. Student assist SASPISP services have evolved over the next 30 years to focus on addressing barriers to learning, including substance use, mental health issues and violence, as well as a host of other individual and environmental problems. Ultimately the goal of student assistance programs is to help students to succeed academically and to complete their education (National Associations of Alcoholism and Drug Abuse Counselors [NAADAC] 2011).

According to the Substance Abuse and Mental Health Administration publication, *A Behavioral Health Lens for Prevention Overlapping Problems, Collaborative Solutions* (2012).

⁹ ESEA NCLB Flexibility DoED 1/19/2012

In the past, practitioners and researchers saw substance abuse prevention as distinct from the prevention of other behavioral health problems. But mounting evidence indicates that the populations affected by these problems overlap significantly, as do the factors that contribute to these problems. Consequently, improvements in one area often have direct impacts on the other. Many young people have more than one behavioral disorder. These disorders can interact and contribute to the presence of other disorders, leading to concurrent diagnosable disorders or “comorbidity.” An estimated 37 percent of alcohol abusers and 53 percent of other drug abusers also have at least one serious mental illness. As prevention practitioners, our responsibility is to be mindful of these linkages and see our work as part of a broader effort to improve overall health. Recognizing these linkages can help us identify opportunities to address health in a more comprehensive way—by working across disciplines, pooling resources, and reaching people in those settings and during those times in their lives where and when services are most likely to have an impact (p.1).

The SAPISP model promotes healthy SEBH including substance abuse free choices and through strength-based prevention and intervention approaches foster resilience. The SAPISP model does not provide treatment or mental health therapy but utilize existing resources within the school and community to address identified concerns; link students and their families with resources to meet more intensive, specialized, service needs and case manage.

Service Delivery Models. According to SAMHSA (2007) there are three service delivery models, or program designs, that have emerged from school-based student assistance programs. These are: 1) Internally based; 2) Externally based; 3) Core (or student assistance) team models. In addition to the three service delivery models more recently, school-based health centers have also been introduced and implemented in schools as a service delivery model. Each program has its own unique composition, strengths and weaknesses and schools should consider these when deciding which of the models is most appropriate for their own program needs. These models are evident within Washington State’s SAPISP, and in some cases, programs use a combination of the models.

Internally based programs are composed of staff hired by the school, district or ESD to deliver student assistance prevention and intervention services. Program staff – SAS are usually certified chemical dependency professionals, guidance counselors, school social workers, or prevention specialists that work within the school on a full or part-time basis. Students are referred to program staff who works with the student to attempt to overcome identified problem behaviors or other issues.

Externally based programs, or screening agency models, are staffed by professionals contracted from community-based organizations. In this model, professionals from outside the school spend an allocated amount of time in the schools delivering program services. Students are referred to a contracted professional who either provides direct services or refers the student to other school or community-based resources.

The SAT model incorporates a cadre of staff within the school site to coordinate needed services and is usually composed of administrators, the Student Assistance Specialist, teachers, coaches, and other staff trained to work with identified students. Each member of the team has a key function within the service delivery model. Students are referred to the Student Assistance Team, whose members provide services and make recommendations for additional support as needed to address student SEBH including alcohol, tobacco, and other drug (ATOD) and serious mental health/emotional disturbances.

*Coordinated School Health (CSH) model.*¹⁰ A CSH model program works towards fostering healthy schools and healthy, successful students by coordinating effective policies and programs, and encouraging the collaboration of schools, communities and families. Training in the model has been in partnership with. It is supported by funding from the Centers for Disease Control and

Prevention. Further, the CSH program is a partnership between school administrators, teachers, other staff, students, families, and community members to increase access to health needs, set priorities and plan, implement, and evaluate school health program activities. There are eight components of a coordinated school health program:

- Health education.
- Health services.
- Nutrition services.
- Health promotion for school staff.
- Physical education.
- Mental health and social services.
- Healthy and safe school environments.
- Family and community involvement.

Roles within the SAPISP Model

Role of the State. OSPI is responsible for the administration and oversight of the program. OSPI allocates funds to local grantees, Educational Services District's (ESD) for the purpose of implementing school-based prevention and intervention services. OSPI SAPISP falls under the department of Student Support and supervised by Student Assistance/Dropout Prevention Program Supervisor.

The supervisor oversees multiple state and federal grant programs and influences the planning and implementation of dropout, emotional and behavioral health including substance abuse prevention-intervention services in public schools statewide. In addition, the supervisor retains a leadership role in the overall statewide effort to develop and maintain Supportive learning environments, and to prevent/reduce youth substance abuse and other SEBH through policy development, committee membership, and expert consultation to school districts, ESDs, community organizations, and other state agencies. The program supervisor also serves as a liaison between the ESD and Department of Behavior Health and Recovery by negotiating details of the service delivery contracts; evaluation and participating in monthly prevention redesign planning and implementation meetings/phone conferences.

¹⁰ <http://www.doh.wa.gov/cfh/CWP/CSHP.htm> retrieved 1/2012.

The OSPI Student Support Department also coordinates multiple school programs that are integrated within Student Assistance Program delivery (i.e. School Nurse Corp, Readiness to Learn, 21st Century Afterschool programs, School Safety Center, Homeless – McKinney Vento, Title I D. Neglected and Delinquent JRA/Detention Schools and Education Advocates). Student Support division primary focus is to provide student support to assist schools and districts to develop and improve systems that support student academic success and collaborates with other agencies around the needs of children, families, and communities.

Role of the Program Coordinator

At the local level, the Program Coordinator is responsible for implementation and oversight of all aspects of the comprehensive SAPISP. Coordinators are Masters- and/or Bachelors-level professionals with background and experience in delivery of SAPISP program services, supervision, and working in the school setting. In addition, Coordinators are knowledgeable about adolescent development, social, emotional, behavioral health including substance abuse and mental health issues, risk and protective factors, and resilience concepts, and adolescent social and cultural issues. Depending on the service delivery model, the Coordinator may or may not assume a supervisory role. Coordinators work at an ESD's Prevention, Student Services, or Safe and Civil Schools Center. ESD's may opt to hire directly or contract with a qualified agency to deliver SAPISP services in the schools.

Coordinator supervisory responsibilities encompass providing direct program and clinical supervision as well as on-site supervision, monitoring, recordkeeping of student screening and progress, attendance logs, and data entry collection. Program coordinators plan and coordinate staff schedules, site assignments and orientation and training for SAPISP staff. Coordinators may also provide direct services within school specific to screening and referral, student leadership awareness planning events, parent education, staff training, policy development and coalition Participation.

In the case of contracted services, SAS are employees of an external agency, and the agency assumes supervisory responsibilities as described above. However, the Coordinator shares joint responsibilities with agency supervisors in monitoring program implementation, reviewing data, conducting site visits, and providing staff development opportunities. In addition, the Coordinator is responsible for keeping the agency supervisor informed of program changes and decisions made at the state level.

Coordinator technical assistance responsibilities include assisting with the implementation of overall program services such as meeting with school administration to provide orientation, conducting annual review of progress related to program services, and reviewing needs assessment data such as results from the Healthy Youth Survey or other related data to make program decisions and prioritize services.

Coordinator collaboration efforts include:

1. Working with the state departments OSPI, DBHR and on occasion Department of Health, community partners, and participating in community coalition activities, collaborative needs

assessment, identification/selection of prevention redesign targeted communities, and program promotional activities as a means of changing community norms, fostering healthy behaviors, sustaining and marketing program services. DBHR requires, as part of the PRI Redesign, both ESD Coordinators and County Coordinators to meet at least once per month or more frequently as needed to discuss, progress on strategic work plan, contract compliance, TA/training needs and next steps. For more information on the prevention programming go to <http://www.wa.dshs.gov/pdf/Publications/22-1464.pdf>.

2. Working within the local community to promote and develop an integrated primary and behavioral health services to better address the needs of individuals with serious mental illness and/or substance use disorders. According to SAMHSA (2012), research has shown integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs. Some examples of collaborating integrated partnerships at the local level may include:
 - a. Working with the local mental health center and coalitions on a mental health promotion campaign.
 - b. Networking with treatment providers to streamline screen/assessment and address barriers or issues related to access to services, joint treatment planning, and SAPISP serving as the primary case manager.
 - c. Collaborating on suicide awareness, Trauma, and other related community and school trainings.
 - d. Including suicide training for staff and establishing policies for staff to follow.
 - e. Connecting and consulting with community resources for cultural, ethnic, language and other barriers. Especially with the populations such as LGBTQ, first generation immigrants where there are language barriers, Native American and other ethnic groups, and military insulations.

For more information on development and strategies of integrated primary and behavioral health services to better address and improve the needs of individuals with mental health and substance use conditions, information can be obtained at <http://www.integration.samhsa.gov/about-us>).

Role of the Student Assistance Specialist. Program staff, hired and placed in schools, deliver SAPISP and spend from four to forty hours within the school setting. Fulltime Student Assistance Specialists (SAS) often deliver services in multiple school sites, with part-time SAS assigned to a single school. Staff that are part of the DBHR Prevention Redesign are assigned as a 1.0 FTE (180 days- 7.5-8 hours/day, during the school year). SAS are often trained chemical dependency professionals, guidance counselors, school social workers, or prevention specialists. DBHR (2011) has identified the following as responsibilities of the SAS in providing comprehensive program services.¹¹

- Screening and referral information to students (parents) involved in the SAPISP;

¹¹ Department of Behavioral Health and Recovery (2012 draft). Prevention Redesign Clarification of Roles document.

- Early intervention educational support groups for selected and indicated students.
- Attendance and participate in local community coalition activities.
- Delivery of a prevention education information series to the entry grade level of the targeted school each year.
- Providing information and increase awareness of available prevention, intervention and treatment services to school staff, parents and students.
- Participating as integral member of the multi-disciplinary team at assigned school(s);
- Assisting in developing alcohol, tobacco and other drug related policies at school(s) when needed.
- Conducting data entry for program evaluation.

Role of the School. Schools are particularly appropriate sites for providing SEBH prevention and intervention services as they function as an important social institution for youth, second only to families in significance (Carlson, 2001). More importantly, schools are in a unique position to change students' interactions and behaviors and to model community values and attitudes (Hawkins et al., 1998). As such, schools are an integral component of the SAPISP and if the programs are to be successful, a high level of support and collaboration between the school and the program is necessary.

Schools have specific roles within the statewide SAPISP model, the least of which is the provision of a positive learning environment that supports the healthy growth and development of the student body. Through the adoption, implementation, and enforcement of SEBH including alcohol, tobacco, and other drug policies, and by reinforcing and reflecting healthy values, schools act as a catalyst for change. School administrators can set the tone for staff's acceptance of prevention and intervention efforts by demonstrating support of program services, engaging in policy development, and providing feedback and monitoring of program services. In addition, schools promote prevention and intervention services through the education of school staff, students and parents, and provide staff with professional development opportunities to increase knowledge, awareness, and skills related to SEHB issues including; substance abuse and other problem behaviors that are barriers to student academic success. Moreover, schools provide financial and/or material resources to support program services such as confidential space, encouraging students to participate in out-of-class sessions through flexible scheduling, and demonstrating respect for program aims.

Role of School Faculty. Every staff member in the school has a role in the SAPISP. Through training, all staff members gain awareness and develop knowledge of the levels of the prevention and intervention continuum and the role of the SAS, and the SAT (if applicable). It is important that school faculty members understand the importance of their roles to the success of the SAPISP. These roles include teaching and reinforcing prevention messages, assisting with prevention activities, referring students when they suspect alcohol and other drug use or a student is impacted by someone else's use (i.e. parent, sibling, friend), and becoming knowledgeable about the program, informing parents and students, and assisting them to access services (State of Virginia, Department of Education SAP manual, 2005).

The role of the school faculty is vital to the early identification of students who may need assistance. School personnel, teachers, coaches, librarians, etc., are in the best positions to observe and note changes in student conduct on a regular, daily basis, thus they play the most vital role in early identification of students experiencing difficulties (Anderson, 1993, CSAP 2007). Staff members assist students by:

- Referring students to the SAP.
- Completing the behavior checklist/referral form.
- Consulting with the SAT or SAS.
- Acquiring basic training in fundamental SEBH issues including substance abuse.
- Being informed about LGBTQ, Mental Health and cultural competence prevention and intervention concepts and risk and protective factors.
- Maintaining confidentiality.
- Reporting policy violations immediately.
- Taking care of themselves by not enabling.

Role of the Community Coalitions. The County Prevention Coordinator serves as the staff person to the community coalition. All PRI sites work collaboratively with the ESD's Coordinators and SAS staff to promote and provide awareness education and environmental prevention strategies in the targeted communities. The coalition focus is to change community norms and foster healthy behaviors.

The Role of Cultural Competence. The National Center for Cultural Competence (NCCC), describes cultural competence as "a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum."¹² The NCCC further explains:¹³

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Have the capacity to, 1) Value diversity, (2) Conduct self-assessment, (3) Manage the dynamics of difference, (4) Acquire and institutionalize cultural knowledge, and (5) Adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.
- For more information on cultural competence see additional resources at the end of this section, information includes an excerpt from the NCCC and DBHR.

¹² Retrieved (6/2012) from: <http://nccc.georgetown.edu/foundations/frameworks.html>

¹³ Ibid

Prevention Strategies¹⁴

In a 1994 report on prevention research and recently updated in 2009, the Institute of Medicine, proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The IOM model divides the continuum of care into three parts: prevention, treatment, and maintenance. The prevention category is divided into three classifications--universal, selective, and indicated prevention interventions, which replace the confusing concepts of primary, secondary, and tertiary prevention. Although the IOM system distinguishes between prevention and treatment, intervention in this context is used in its generic sense and should not be construed to imply an actual treatment protocol. This prevention framework provides the foundation for Washington's SAPISP.

Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying social, emotional and behavior health problems including the abuse of alcohol, tobacco, and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for mental health issues and substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for social, emotional, behavioral health or substance abuse risk. The entire population is at-risk and can benefit from prevention programming. Universal prevention strategies in Washington State's SAPISP include:

- Information dissemination.
- Classroom or small group education.
- Schoolwide awareness events e.g., mental health promotion awareness, healthy choices, social norms campaigns, Red Ribbon Week, Great American Smoke Out.
- School and Community-based healthy and positive Supportive activities e.g. dances, community youth activity centers, mentoring, boys and girls clubs and volunteer programs.
- Policies that promote a safe and Supportive school climate and have consequences for inappropriate behaviors including threats, bullying harassment and intimidation and alcohol, tobacco, and other drug use.
- Parent awareness events/information dissemination.

Selective prevention strategies target subsets of the total population that are deemed to be at risk of engaging in, or experiencing, negative and/or social, emotional, behavior issues by virtue of their membership in a particular population segment—for example, children of substance abusing parents, dropouts, youth who are truant or students who are failing academically,

¹⁴ Adapted in part from: National Institute on Drug Abuse. (1997). *Drug abuse prevention: What works*. Pp. 10–15 (Publication No. 97-4110, 1997). National Institute of Health. Bethesda, MD.

history of family violence, mental illness or criminal behavior, youth involved in antisocial peer behaviors including substance use. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994, 2009), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse.

Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for SEBH issues including substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup. Selective prevention strategies in Washington State's SAPISP include:

- Identification, screening and referral.
- Individual counseling.
- At Risk, Children from Substance Abusing Parents/families, and social/coping skills educational support group services.
- Case management.
- Parenting skills training specific to the subgroup target and Family consultation/support.

Indicated prevention strategies are designed to intervene of youth who are harmfully impacted socially, emotionally, behaviorally (SEBH) including mental health and substance abuse who are showing early danger signs, such as being truant and having falling grades use of alcohol and other gateway drugs, depression and rebellious. The purpose of indicated prevention is to identify individuals who are exhibiting early warning signs associated with SEBH problems and to target them with special programs services. Indicated prevention approaches under the student assistance model can also be for individuals: who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem; youth in recovery needing support for staying clean and sober or with serious emotional disturbances (mental health) needing support within the school to cope with stressors within the school setting working in collaboration with community substance abuse treatment or mental health center.

Indicated prevention programs address risk factors associated with the individual, such as depression, suicide risk, conduct disorders, and alienation from parents, school, and positive peer groups, and substance using. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction substance abuse and other problem behaviors, but also reduction in the length of time the signs continue, and/or reduction in the severity of SEBH issues. Individuals can be referred to indicate prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to

participate in indicated prevention programs. Indicated prevention strategies in Washington State's SAPISP include those listed under selective prevention strategies as well as:

- Care-frontation around use.
- Intervention and Recovery Support group services.
- Case management and counseling support specific to accessing treatment and attendance at and motivational counseling.
- Alcohol, tobacco and other drug urine analysis monitoring in collaboration with parents/treatment agency.
- Aftercare/Recovery support and planning.

The SAPISP Three-tiered approach is borrowed from the public health triage models that focus on levels of treatment based on need. Simply put, it is a model consisting of three well-defined and separate processes running on different levels within a system. The different tiers represent a change in how something is done or how supports are delivered. In addition, many schools have implemented a Response to intervention (RTI) a multi-level tiers system where the academic and/or behavioral interventions change, or become more intense, as student needs are addressed. See Introduction section for additional information on the three-tiered approach in SAPISP referred to above and Section 7, Student Assistance Team, for more information on RTI.

Distribution of Targeted Students & Program Services

Research findings indicate that the majority of students (80 percent) will never present major behavioral problems (Gottfredson & Gottfredson, 2000). Nonetheless, all students benefit from universal program services. Staff provide *universal* student-centered interventions, with the aim of creating a civil environment that supports mutual caring and respect among students and staff, creates a common language, increases the likelihood of appropriate behaviors and decreases the frequency and intensity of inappropriate behaviors for all students.

Although a smaller proportion of staff time is dedicated to this level of service, this service will most likely reach the highest number of students. Universal program services set a strong foundation for selective and indicated intervention services.

The majority of program services serve those students who make up the smallest proportion of the student body. These students account for the largest part of problem behaviors; selective and indicated services aimed at addressing these students will most likely have the largest impact. Ten to 15 percent of students require more intensive *Selective* program services designed to address factors that place students at risk for substance abuse and other problem behaviors.

Approximately one to seven percent of students require more targeted, *Indicated* support services, to address significant school problems (truancy, suspension); patterns of individual problem behaviors (ATOD use, discipline problems, internal and external disorders); and pre-delinquent behaviors (runaway, gang association). These students usually account for between 40 to 50 percent of major school problem behaviors (Gottfredson & Gottfredson, 2000).

Targeted interventions for this groups of youth are student-centered, highly individualized, and provide an array of support services. Services aim to increase positive interactions.

Program Logic Model.¹⁵ Comprehensive school-based prevention-intervention services programs require implementation of schoolwide activities as well as individualized and group services. According to Deck (2002, p. viii), “effective programs have clear goals and an explicit, research-based model that relates the needs of the targeted audience to relevant program activities and to desired outcomes.” Such programs provide a continuum of services from universal programming (primary prevention), addressing the needs of the whole school to selective/indicated (early intervention) programming targeting services to students identified as at greatest risk of initiating or escalating problem behaviors. Properly implemented programs are expected to impact short and long term outcomes such as establishment of pro-social emotional and behavioral health norms, increased student knowledge about alcohol, tobacco, and other drug use (ATOD) with long term outcomes effecting delay in onset of use and reduction in the overall prevalence of ATOD use. Figure 1 below illustrates the Universal Prevention Logic Model adopted by Washington State’s Student Assistance Prevention-Intervention Services Program,¹⁶ linking school characteristics, activities, and targeted short and long-term outcomes.

¹⁵ Source: Deck, D. (2004). 2001-03 Final report. Addressing adolescent substance abuse: An evaluation of Washington States’ prevention and intervention services program. Office of Superintendent of Public Instruction. Olympia, WA.

¹⁶ Updated 6/15/2012–Office of Superintendent Public Instruction, Department of Student Support, Educational Service District’s Prevention Directors K–20. Changes will be reflected in the 2012–13 Washington State Student Assistance Prevention and Intervention Program Evaluation.

School or Community Characteristics→	Group Prevention Activities→	Short-term Outcomes→	Long-term Outcomes
<p>Early onset of substance use by students.</p> <p>Unacceptably high level of substance use or other social, emotional behavioral health (SEBH) issues among students in the school.</p> <p>Lack of clear, pro-social, no use attitudes among students and staff.</p> <p>Lack of accurate information about the effects of alcohol and other drugs, the role of the media, and actual prevalence of use.</p>	<p>Age-appropriate prevention curriculum.</p> <p>School policies promoting a safe, Supportive and drug-free environment Peer leadership or pledge programs and peer-lead school activities with no use message and positive SEBH alternatives.</p> <p>Prevention Education classroom presentation on positive social, emotional and behavioral issues and impact of substance abuse.</p> <p>Positive after school programs</p> <p>Parent education and engagement activities.</p> <p>Staff training.</p>	<p>Establishment of pro-social norms and attitudes about positive SEBH issues including substance use.</p> <p>Expanded knowledge of the harmful effects of substance use, the role of the media, and prevalence of use and other negative SEBH issues.</p> <p>Involvement in drug-free activities.</p>	<p>Delayed onset and reduced prevalence of SEBH issues including substance abuse in whole school.</p>

Figure 1: Universal Services Logic Model of services provided by SAP program. Schoolwide activities are in direct response to general community and school risk factors, with activities linked to the delay of and reduction in the prevalence of substance use and violence (Deck, 2004).

In addition to targeting whole school and universal program services, the SAPISP provides selective and indicated services to students identified as at-risk of initiating or escalating ATOD use or other SEBH. These intervention services usually include ATOD and mental health prescreening, support groups, one-on-one counseling and may include educational programs for parents and other adults. Program staff provide referral and case management services, referring students identified in need of substance abuse/addiction or serious mental health issues to community-based treatment agencies/centers.

Figure 2, on the following page, illustrates the logic model for selective and indicated services adopted by Washington State’s SAPISP, linking individual student characteristics, intervention activities, and targeted short- and long-term outcomes (Deck, 2004). Intervention services are initiated when a student is identified as having risk factors that place them at-risk of use or indicate use. Program staff refer students to a variety of school-based interventions or make referrals to other school or community-based resources. If program services are well designed and implemented, and if students fully engage in targeted intervention services, certain short-term outcomes are expected such as increased knowledge of risk of use, strengthened pro-social skills, and increased bonding. Longer term impacts include reduced use, improved

academic performance, decreased SEBH problems, and increased likelihood that the student will make healthy life style choices.

Student Characteristics →	Intervention Activities →	Short-term Outcomes →	Long-term Outcomes
<p>Limited personal skills (e.g., self-esteem, self-control) or social skills to resist substance use or other SEBH.</p> <p>Negative attitudes toward school and distrust of adults.</p> <p>Coping with others who are involved with alcohol and other drugs as well as other SEBH issues.</p> <p>Experimentation with tobacco, alcohol, or other drugs.</p> <p>Symptoms of substance abuse or dependence.</p> <p>Unaware of available school and community services.</p>	<p>Identification process:</p> <ul style="list-style-type: none"> • Staff training. • Referrals from school staff, parents, peers or self • School team <p>Screening and referral:</p> <ul style="list-style-type: none"> • Informal screening • Formal screening • Family consultation • Referral to treatment • Treatment support • Community referrals <p>School interventions:</p> <ul style="list-style-type: none"> • Individual counseling • Group counseling • Staff consultation • Alcohol, tobacco, and other drug education <p>Group skill-building:</p> <ul style="list-style-type: none"> • At-risk • COSAP • Intervention group. • SEBH Social skills group <p>Reentry program:</p> <ul style="list-style-type: none"> • Recovery group 	<p>Expression of feelings on life issues.</p> <p>Recognition of risks of substance use and commitment to healthy life choices.</p> <p>Strengthened personal and SEBH skills.</p> <p>Increased bonding with family, school, and adults.</p> <p>Utilization of available school and community resources.</p>	<p>Delayed onset or reduced level of substance use.</p> <p>Improved academic performance and retention in school.</p> <p>Increase pro-social emotional, and behavioral health.</p> <p>Healthy life choices.</p>

Figure 2: *Early Intervention (selective/indicated) Services Logic Model of services for students referred to the program due to substance use or other risk factors (Deck, 2004).*

Required Components of an Effective SAP Program

The National Student Assistance Association established nine required components for effective SAP services (NSAA, 2003). Washington States’ SAPISP model has adopted the nine components in 2005. The SAPISP and the statewide program manual are based on these identified effective SAP components. The components described below are recommended as the *minimum* requirements needed to reduce barriers to learning and ensure student success in safe, disciplined, and drug-free schools and communities.

Information provided within each section of the manual is aligned with the nine components of an effective Student Assistance Program as recommended by the National Student Assistance

Association (NSAA), under the National Association Alcohol and Drug Abuse (NAADAC) and includes an additional component, consideration for vulnerable youth populations.

School Board Policy: To define the school's role in creating a safe, disciplined and drug-free learning community and to clarify the relationship between student academic performance and the use of alcohol, other drugs, violence and high-risk behavior.

Staff Development: To provide all school employees with the necessary foundation of attitudes and skills to reduce risks, increase protective factors and foster resilience through SAP services.

Program Awareness: To educate parents, students, agencies and the community about the school policy on alcohol, tobacco, other drugs, disruptive behavior and violence and provide information about Student Assistance services that promote resilience and student success.

Internal Referral Process: To identify and refer students with academic and social concerns to a multi-disciplinary problem-solving, student assistance team.

Student Assistance Team: Problem Solving Team and Case Management: To evaluate how the school can best serve students with academic or social problems through solution- focused strategies.

Consideration for Vulnerable Populations: To identify and provide support, teach coping skills, refer and link to community resources.

Educational Student Support Groups: To provide information, support and problem-solving skills to students who are experiencing academic or social problems.

Cooperation and Collaboration with Community Agencies and Resources: To build bridges between schools, parents and community resources through referral and shared case management.

Student Assistance Program Evaluation: To ensure continuous quality improvement of student assistance services and outcomes.

Suggested Program Operations

The following provides program coordinators with suggested program design related to SAPISP service provision by program staff including the SAS's role, distribution of service delivery, targeted number of students served annually as well as a detailed account of the first month of school services.

Student Assistance Specialists Responsibilities. According to **RCW 28A.170 – Substance Abuse Awareness Program**—Student Assistance Specialists (SAS) are qualified chemical dependency professionals, or certified educational staff such as a guidance counselors, school

social workers, school nurses, school psychologists or prevention specialists. Program staff are responsible for the delivery of the comprehensive program within the school setting as well as linking students and families to other school and community-based services. These services, as noted previously, include the delivery of universal and selective/indicated prevention-intervention services such as screening/pre-assessment, resource referral and case management, individual and group counseling, and program awareness.

Universal Prevention Services. SAP services are to be delivered in the area of universal prevention, which includes classroom ATOD presentations or curriculum delivery, Schoolwide awareness events student prevention clubs, and parent education and support (see Section 4 Program Awareness).

Selective and Indicated Prevention/Intervention Services. *Prioritizing students:* There may be times when the SAS will have more students referred than can see on a regular basis. However, general guidelines can be utilized to ensure that students are prioritized based upon need, and that students in crisis are seen immediately. Issues to consider in determining student needs include:

The student is ...

- An immediate danger to self or others.
- Suicidal.
- Using substances regularly and exhibits loss of control.
- Engaging in high-risk behavior when under the influence, i.e., driving, fighting, has weapons.
- In danger due to someone else’s behavior i.e., child abuse.
- A disciplinary referral. and/or
- The student has ready access to a weapon.
- The school is expressing grave concern about the student.
- The parents are requesting assistance with the student.

Prioritizing students is sometimes difficult; professional assessment on the part of the SAS is required; when in doubt the SAS should seek assistance from the program coordinator. If attempts are made to see a high priority student, and the student does not respond because of personal choice or the classroom teacher does not allow access to the student, it is important that the attempts be documented.

Annual Service Delivery Targets. The following provides a guideline for the targeted number of selective/indicated students served annually based upon FTE assignment per school building.

Number of Days Per Week/Building	Minimum Target Number of Students Served
2 days a week/1 building (0.4 FTE)	20 students
2.5–3 days a week/building (0.5 FTE)	30 students
5 days a week	50 students

In Washington State’s model, there are four primary educational support groups:

- *At-Risk/Social Skills*–Prevention-oriented support groups typically focus on students who have been identified as being “at high-risk” for substance use but have not yet started or exhibiting other SEBH. Examples include students who lack commitment to school, exhibit low impulse control, are alienated from peers, or suffer from low self-esteem.
- *Intervention*–Early intervention groups, often referred to as “Insight” groups, are educational, time-limited groups for adolescents identified as at-risk due to increased risk of initiating or escalating their tobacco, alcohol, marijuana, or other drug use.
- *Children from Substance Abusing Parents*–These groups specifically target students who are impacted by someone else’s substance abuse/use. Students are usually from a chemically dependent/substance abusing home environment.
- *Recovery Support*–For students who have stopped using alcohol or other drugs. These are often students who have completed some form of in-patient or out-patient treatment. Students returning to the school environment following treatment services are much more likely to remain abstinent if provided with school-based recovery support groups. Such groups provide students with strategies to cope with peer pressures, to avoid slippery/risky situations, and provide support for staying clean and sober.

The majority of students on a caseload are to be served in the above group settings (*see Section 8 Educational Support Groups for additional details*). In addition, other support groups may be offered depending upon identified school and student need, such as Tobacco education/cessation, ATOD education, and social/coping skills groups.

Depending on the availability of program staff – hours worked – the following table outlines the minimum number of groups to be delivered in the school setting.

NUMBER OF DAYS PER BUILDING	NUMBER OF GROUPS IMPLEMENTED
2–3 days a week	2 groups per week minimum of 4 groups per year
5 days a week	3 groups per week minimum of 6 groups per year

Student Assistance Specialist Role in Program Implementation

Detailed Tasks for First Month of School. The following information outlines the specific tasks to be accomplished by program staff when implementing Student Assistance Prevention-Intervention Services Program or at the start of the school year.

Meet the Building Principal

- Explain groups and alignment with academic standards, staff awareness education groups, ask for assistance.
- Discuss purpose of program.
- Outline a procedure for students leaving classes or ask for input in developing one.
- Ask about Child Protective Services reporting protocol.

- Locate, copy and review district policy and procedures for alcohol, tobacco and other drug discipline, weapons and other safety concerns.
- Ask for time at a staff meeting to explain program.

Presentation to School Staff (with SAT if possible)

- Explain purpose of program.
- Explain process for making referrals.
- Office hours and days in their building.
- Handouts – explain groups, academic alignment, and outline of services available.
- Other ways to communicate with staff including memos and information flyers.

Classroom Presentation to Students (each presentation approximately 10–15 minutes).

Presentation should include:

- Introductions, purpose of program, referral process, office hours, time/days in building.
- Services offered: Group, Individual, Classroom Presentations, etc.
- Sign-up forms – all students receive one; one option on form is for “no service.”

1) Make Sure Paperwork is in Order

- Referral forms, group materials ready.
- Disclosure, consent, and release of information forms.
- RMC record keeping - Pre & Post student forms, Intake and Services form and Universal activities form, and other data collection instruments as applicable.

2) Create a Group Schedule for at least the First Semester

- Outline number of days in building per week, periods when groups are scheduled, specific times and/or periods when you will be doing other activities.
- Meet with individually with students prior to placement.
- Collect permission slips (if required by program) and complete disclosure, consent, and release of information forms with student.

3) Become Knowledgeable about Community Resources

- Treatment agencies.
- Mental Health services.
- Other community resources.

4) Begin Organizing for Schoolwide Awareness Activities

- Red Ribbon Week.
- Day of National Concern About Young People and Gun Violence.
- Great American Smoke Out.
- National Inhalants and Poisons Awareness Week.
- Substance Abuse Prevention Week.
- Kick Butts Day.
- Mental Health Promotion.
- Prom Promise.
- World No Tobacco Day.

Additional Information

Cultural Competency Information

Conceptual Frameworks/Models, Guiding Values and Principles.¹⁷ The NCCC embraces a conceptual framework and model for achieving cultural and linguistic competence based on the work of Cross et. al. (1989). The NCCC uses this framework and model to underpin all activities.

Cultural Competence: Definition and Conceptual Framework. Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) Value diversity, (2) Conduct self-assessment, (3) Manage the dynamics of difference, (4) Acquire and institutionalize cultural knowledge and (5) Adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum (adapted from Cross et. al., 1989).

Culturally Competent Guiding Values & Principles Organizational

- Systems and organizations must sanction, and in some cases mandate the incorporation of cultural knowledge into policy making, infrastructure and practice.*
- Cultural competence embraces the principles of equal access and nondiscriminatory practices in service delivery.*

Practice & Service Design

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.*
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.*
- Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions.*
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

Community Engagement

- Cultural competence extends the concept of self-determination to the community.*
- Cultural competence involves working in conjunction with natural, informal support and

¹⁷ Excerpt retrieved June, 2013 from <http://nccc.georgetown.edu/foundations/frameworks.html>

helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).*

- Communities determine their own needs.**
- Community members are full partners in decision making.**
- Communities should economically benefit from collaboration.**
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.**

Family & Consumers

- Family is defined differently by different cultures.***
- Family as defined by each culture is usually the primary system of support and preferred intervention.***
- Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.***

Linguistic Competence Definition. The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Goode & Jones (modified 2009). National Center for Cultural Competence, Georgetown University Center for Child & Human Development.

Go to

<http://nccc.georgetown.edu/documents/Definition%20of%20Linguistic%20Competence.pdf> for the full text definition of linguistic competence..

Guiding Values and Principles for Language Access

- Services and supports are delivered in the preferred language and/or mode of delivery of the population served.
- Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served.
- Interpretation and translation services comply with all relevant Federal, state, and local mandates governing language access.
- Consumers are engaged in evaluation of language access and other communication services to ensure for quality and satisfaction.

Footnotes

* Adapted from Cross, T. et al, 1989

** "Other Guiding Values and Principles for Community Engagement" and "Family & Consumers" are excerpts from the work of Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program, and
*** "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.

Go to <http://nccc.georgetown.edu/resources/index.html>, [Resources and Tools](#) for checklists that reflect these values and principles in policy and practice.

Guidelines for a Student Support Component¹⁸

1. Major Areas of Concern Related to Barriers to Student Learning

- 1.1. Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity; physical health problems).
- 1.2. Countering external stressors (e.g., reactions to objective or perceived stress/demands/crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions).
- 1.3. Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities; Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities).

2. Timing and Nature of Problem-Oriented Interventions

- 2.1. Primary prevention.
- 2.2. Intervening early after the onset of problems.
- 2.3. Interventions for severe, pervasive, and/or chronic problems.

3. General Domains for Intervention in Addressing Students' Needs and Problems

- 3.1. Ensuring academic success and also promoting healthy cognitive, social, emotional, and physical development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity).
- 3.2. Addressing external and internal barriers to student learning and performance.
- 3.3. Providing social/emotional support for students, families, and staff.

4. Specialize Student and Family Assistance (Individual and Group)

- 4.1. Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets).

¹⁸ Adapted from: *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* a document developed by the Policy Leadership Cadre for Mental in Schools. Available from the Center for Mental Health in Schools at UCLA. Downloadable from the Center's Web site at: <http://smhp.psych.ucla.edu>.

- 4.2. Referral, triage, and monitoring/management of care.
- 4.3. Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, schoolwide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological and physical first-aid; pre-referral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short, and longer term treatment, remediation, and rehabilitation).
- 4.4. Coordination, development, and leadership related to school-owned programs, services, resources, and systems – toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services.
- 4.5. Consultation, supervision, and in-service instruction with a trans-disciplinary focus.
- 4.6. Enhancing connections with and involvement of home and community resources (including but not limited to community agencies).

5. Assuring Quality of Intervention

- 5.1. Systems and interventions are monitored and improved as necessary.
- 5.2. Programs and services constitute a comprehensive, multifaceted continuum.
- 5.3. Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development.
- 5.4. School-owned programs and services are coordinated and integrated.
- 5.5. School-owned programs and services are connected to home & community resources.
- 5.6. Programs and services are integrated with instructional and governance/management components at schools.
- 5.7. Program/services are available, accessible, and attractive.
- 5.8. Empirically supported interventions are used when applicable.
- 5.9. Differences [Cultural Competency] among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses).
- 5.10. Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences).
- 5.11. Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion).
- 5.12. Contexts for intervention are appropriate (e.g., office; clinic; classroom; home).

6. Outcome Evaluation and Accountability

- 6.1. Short-term outcome data.
- 6.2. Long-term outcome data.
- 6.3. Reporting to key stakeholders and using outcome data to enhance intervention quality.

Section 2

School Board Policy

Introduction

To better understand the nature of the policies that may be in use around the country, the Institute of Education Sciences commissioned a study to examine the features of the written substance-related policies for the 100 largest school districts in the country.

Key findings include:

- A large majority of districts indicate that students may or will be reported to law enforcement for incidents involving the possession or use of alcohol or drugs (86 percent of districts), or sale or distribution of alcohol or drugs (87 percent of districts).
- Other responses include principal-determined suspensions (98 percent of districts indicate that students may or will be subject to a principal-determined suspension for possession or use; 84 percent of districts indicate that students may or will be subject to a principal-determined suspension for sale or distribution), recommendation for an expulsion hearing (90 percent for possession or use; 94 percent for sale or distribution), placement in an alternative schooling program (80 percent for possession or use; 71 percent for sale or distribution), and parent conference or notification (85 percent for possession or use; 82 percent for sale or distribution).
- Nearly one-third of districts (30 percent) report having graduated sanctions for repeat offenses. For example, 15 percent of districts explicitly allow principals to increase the duration of a suspension for possession or use if it is the student's second offense.

Institute of educational sciences – national center for education evaluation and regional assistance retrieved 2/1/2012 <http://ies.ed.gov/ncee/pubs/20124022/>.

Goal seven of the *Goals 2000: Educate America Act* calls for safe, disciplined, and drug-free schools. This goal was codified in the 1994 Safe and Drug-Free Schools and Communities Act (Title IV of the Improving America's Schools Act of 1994, P.L. 103–382) in response to increased occurrence of thefts and violent crimes occurring on or near school campuses. The Act requires all schools to design programs to:

- Prevent the use, possession and distribution of tobacco, alcohol and illegal drugs by students and to prevent the illegal use, possession, and distribution of such substances by employees.
- Prevent violence and promote school safety.
- Create a disciplined environment conducive to learning (Section 4116(a) Drug-Free Schools and Communities Act of 1994).

In direct response to this act in 1998, the federal government required that school districts develop and implement policies related to alcohol and other drugs. Although not funded, the act and subsequent requirements remain in the Elementary and Secondary Education Act.

Related Policies

Bullying. In addition to well established schoolwide substance abuse policy, there has been a great deal of attention given to student safety. In Washington State, the 2010 Legislature passed [Substitute House Bill 2801](#), a Washington State law which prohibits harassment, intimidation, and bullying (HIB) in our schools. [RCW 28A.300.285](#) defines harassment, intimidation and bullying as any intentionally written message or image—including those that are electronically transmitted—verbal, or physical act, including but not limited to one shown to be motivated by race, color, religion, ancestry, national origin, gender, sexual orientation, including gender expression or identity, mental or physical disability or other distinguishing characteristics, when an act:

- Physically harms a student or damages the student’s property, or
- Has the effect of substantially interfering with a student’s education, or
- Is so severe, persistent or pervasive that it creates an intimidating or threatening educational environment, and/or environment, or
- Has the effect of substantially disrupting the orderly operation of the school.

Bullying, per se, is repeated negative behavior toward a less powerful person or persons. Hitting, name-calling, shunning, and shaming are common examples of bullying. Spreading rumors, gossiping and making threats are also forms of bullying. Electronic forms of HIB, commonly referred to as cyber-bullying, is also included under this bullying RCW.

Districts are required to adopt the state model policy and procedures, and training for all staff around these policy and procedures is also required. In addition, districts are to identify an HIB Compliance Officer, a point person to ensure that policies and procedures are upheld. Schools are required to take action if students report they are being bullied. If an incident of bullying becomes so severe and persistent that it is reported to the school, strict investigation and parental contact timelines are also in place. Compliance Officers are also charged with collecting the results of the investigations.

Information on state policy and procedures is posted on the OSPI Safety Center website along with contact information for district Compliance Officers. Training and additional resource materials are also available on the Safety Center Web site.

<http://www.k12.wa.us/SafetyCenter/BullyingHarassment/default.aspx>

Threat Assessment. Further, effort has been put into a statewide Threat Assessment policy and procedure. Threat assessment is a structured group process used to evaluate the risk posed by a student or another person, typically as a response to an actual or perceived threat or concerning behavior. Threat assessment as a process was developed by the Secret Service as a response to incidents of school violence. Washington follows the model initially developed by the Secret Service. Information about the Secret Service model is available on the [National Threat Assessment Center](#).

The primary purpose of a threat assessment is to prevent targeted violence. The threat assessment process is centered upon on analysis of the facts and evidence of behavior in a given situation. The appraisal of risk in a threat assessment focuses on actions, communications, and specific circumstances that might suggest that an individual intends to mount an attack and is engaged in planning or preparing for that event.

In a situation that becomes the focus of a threat assessment inquiry or investigation, appropriate authorities gather information, evaluate facts, and make a determination as to whether a given student poses a threat of violence to a target. If an inquiry indicates that there is a risk of violence in a specific situation, authorities conducting the threat assessment collaborate with others to develop and implement a plan to manage or reduce the threat posed by the student in that situation.

Information on state law related to threat assessments is posted on the OSPI Safety Center Web site along with sample threat assessments and policies. Training and additional resource materials are also available on the Safety Center page.

<http://www.k12.wa.us/SafetyCenter/Threat/default.aspx>

Putting Policy into Action

The purpose of any school policy is to define the school's role in creating a safe, disciplined, and drug-free learning environment and to clarify the relationship between student academic performance and high-risk behaviors. Appropriate policy language represents the principal legal document that establishes *due process* in the school system for students, staff, and parents regarding the management of problems. Through the adoption and enforcement of such policies, the school sends a clear "no tolerance" message to students, staff, and parents setting the foundation to implement student assistance program practices to address these issues (Anderson, 1993; Burk, 1998; Newsam, 1992).

In addition to addressing violator sanctions, the policy should offer assistance. Policies should address actions to be taken by the school to intervene or assist students or staff struggling with personal or family problems. Once implemented, schools should be consistent and fair in their adherence to enforcement of policies. Finally, records regarding enforcement should be maintained, through the implementation of a reporting system that tracks policy violations.

At minimum, adopted policies should address the following information:

- A statement outlining the school's commitment to assist students and staff with any ATOD, bullying and/or safety related problems.
- Clear definition of offense including jurisdictional area of the school (school property, school sponsored events).
- Use, possession, distribution, sale, and manufacturing of substances;
- Clearly stated standards of conduct – student and staff.

- Clearly delineated procedures for violation of policies including first, second, or third offense.
- Clear statement about disciplinary sanctions up to and including expulsion, and referral for prosecution for students that violate the standards of conduct.
- A statement that prevention and intervention services are available to students that violate the policy.
- Language that suspension and expulsion may be reduced "in lieu of" if a student agrees to participate in intervention services.

Policies are reviewed with school and program staff annually to ensure clear understanding and implications of enforcement. In addition, all students and parents are informed of policies in a timely manner with these distributed to students and their parents as part of the school's student handbook.

DEFINITION – SCHOOL BOARD POLICY

Defines the school's role in creating a safe, disciplined, and drug-free learning community and to clarify the relationship between student academic performance and the use of alcohol, other drugs, violence, and high risk-behavior.

- *The policy includes the school's "zero tolerance" for crimes involving alcohol, tobacco, other drugs, weapons, or violence; including consequences for violations; and identifies procedures for attaining help through the SAPISP.*
- *The policy clarifies the process of self-referral, the limits of confidentiality for minors, parents' right-to-know, procedures for reporting knowledge of a crime (i.e., illegal possession), and the responsibility of a witness. In addition, the relationship of student assistance services to policies regarding other co-curricular activities, including athletics, plus the involvement of law enforcement, juvenile justice, and mental health professionals are explained in a school board policy.*

Sample ATOD No Use Policy

3.22 Substance Use Policy. In order to maintain "safe and drug-free schools" and in accordance with the "Elementary and Secondary Education Act," the possession, distribution, dispensation, use, and/or being under the influence of any form of alcohol, anabolic steroid, narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana or other controlled substance (as defined in the Drug control Act of Chapter 15.1 of Title 54of the Code of Virginia and as defined in schedules IV of 21 USC *182), imitation controlled substance, or drug paraphernalia (as described in *18.2-265.1 of the Code of Virginia) is prohibited within any Roanoke County Public School or its property to include school vehicles, at any school-sponsored event/trip, going to and from school, or while participating in school-sanctioned activities. Furthermore, in handling such violations the school board authorizes the superintendent who may authorize a designee to conduct a preliminary review of substance use policy violations to determine whether a disciplinary action other than expulsion is appropriate (State of Virginia, Department of Education, 2005).

Alternative to Suspensions. "Alternative to Suspension" is a term applied to a wide variety of school-based interventions. Its purpose is to provide opportunities to keep students engaged in school while still holding them accountable for their suspendable behavior. Alternatives to suspension are most effective when supported by policies and procedures that address a tiered approach. A safe and Supportive school culture with an early warning identification system can avert suspendable behaviors from happening and increase the support for when they do. An active, multidisciplinary designed to provide for screening, referral and intervention recommendations for affected youth is an essential element to successful reengagement. Alternatives to Suspension are about creating opportunities to remove the barriers to a student's success in school rather than removing the student.

Suggested Program Operations

The following provides program coordinators with suggested program operations related to technical assistance for ATOD policy and procedure development and implementation as well as suggested guidelines for the SAS's role in responding to disciplinary referrals.

ESD Coordinator's Role in Policy Implementation. The ESD Coordinator may assist school districts and schools in the development, adoption, implementation, and periodic review of policies and procedures related to ATOD violations. In order to facilitate buy-in from the schools, the coordinator educates administration about effective policy and procedure practice; provides sample policies; and builds awareness about the importance of getting help for youth who are harmfully involved in alcohol, tobacco or other drug.

SAS's Role. The SAS may participate in policy and procedure development, adoption, implementation and periodic review of policies and procedure in collaboration with the coordinator. In terms of policy violations, it is important that the SAS maintains neutrality and refrains from involvement in the investigative, punitive or disciplinary process. The role of the SAS in disciplinary procedures is to serve the student once the consequences have been determined as part of a "buy-back" or in lieu of suspension alternatives. Specific information related to the SAS's role in the disciplinary process is described in detail in Section 5—Internal Referral Process.

Additionally, the SAS can serve as a resource to community coalitions relative to school board policy. They may provide education relative to the content of the policy, as well as the actual procedures that are followed.

Sample Policy¹⁹

3.22 – AR Substance Use Policy

- I. **Purpose.** The purpose of the Roanoke County Public Schools substance use policy is to promote safe and drug-free schools. Furthermore, it is designed to establish guidelines in accordance with the “Elementary and Secondary Education Act of 2001” for dealing with students who show evidence of substance involvement.
- II. **Definitions and Clarifications**
 - A. Under the influence means when a student’s comportment, behavior, condition, speech, or appearance is affected by or evinces prior use of alcohol, controlled substances, other substances and/or inhalants.
 - B. Alcoholic beverage shall include alcohol, spirits, wine and beer, and any one or more of such varieties containing one-half of one percent or more of alcohol by volume, including mixed alcoholic beverages, and every liquid or solid, patented or not, containing alcohol, spirits, wine, or beer and capable of being consumed by a human being.
 - C. Controlled substances include, but are not limited to, narcotic drugs, hallucinogenic or mind-altering drugs or substances, amphetamines, barbiturates, stimulants, depressants, marijuana, anabolic steroids, designer drugs, and other controlled substances as defined in the Drug Control Act of Chapter 15.1 of Title 54 of the Code of Virginia and as defined in schedules I through V of 21 USC & 812.
 - D. Imitation controlled substance shall mean a pill, capsule, tablet, or other item which is not a controlled substance, an alcoholic beverage, anabolic steroid, marijuana, or any of those substances commonly referred to as designer drugs but which by overall dosage unit appearance, including color, shape, size, marking or package, or by representations made, is intended to lead or would lead a reasonable person to believe that such pill, capsule, tablet or other item is a controlled substance, an alcoholic beverage, anabolic steroid, or marijuana.
 - E. Other substances include, but are not limited to, prescription medications and/or over-the-counter drugs which may not or may contain a combined dosage of caffeine and ephedrine hcl, herbal stimulants, herbal euphoriant, ephedra or ma huang such as Magnum 357, Mini-Thin, Max Aler, Perk Mini-hearts, Bidis, Beedees, No-Doz, Jimson Weed, cold medications and cough syrups such as Robitussin or drugs manufactured using such DXM or other over-the-counter drugs not taken in accordance with the medication policy.

¹⁹ Source: State of Virginia, Department of Education

- F. Inhalants include any substance not prescribed by a physician and inhaled as a vapor, gas or mist. Inhalants may include, but are not limited to, adhesives; aerosols; solvents and gases (freon and butane); cleaning agents; and room deodorizers.
- G. Anabolic steroids include natural synthetic compounds ingested for the purpose of enhancing physical strength, but which have detrimental effects on the healthy growth and development of students.
- H. Drug paraphernalia shall include, but are not limited, those items defined in Section 18.1-265.1 of the Code of Virginia.
- I. An offense is the violation of any rule or combination of rules as defined in the Student Conduct Code.
- J. To be in possession of means to have alcoholic beverage(s), imitation and/or controlled substances, other substances, inhalants, anabolic steroids and/or drug paraphernalia on one's person, or in one's personal property, automobile, or other vehicle, or locker, desk or other school-provided storage area.
- K. Possession with the intent to sell, give, or distribute means to have alcoholic beverage(s), controlled substances, other substances, inhalants, anabolic steroids and/or drug paraphernalia, and it is determined by the evidence of the packaging, amount, etc. that the intent was to sell, give or distribute.
- L. Distribution means to pass, give or sell alcoholic beverage(s), imitation and/or controlled substances, other substances, inhalants, anabolic steroids and drug paraphernalia.
- M. Unlawful manufacture means the illegal act of producing or assembling alcoholic beverage(s), controlled substances, other substances, inhalants and/or drug paraphernalia.
- N. Where and when policy violations occur include on school property, in a school vehicle, at any school-sponsored event, going to and from school or while participating in school-sanctioned activities. It also extends to off school property, if the acts committed are either detrimental to the interest of the school or adversely affect school discipline.

III. Substance Use Violations

- A. **Under the Influence** – Students shall not be under the influence of any no prescribed substance, including but not limited to: alcohol, marijuana, inhalants, anabolic steroid, imitation and/or controlled substance, designer substance, and/or other substances. In order to be found in violation of being under the influence (versus in "possession" of a substance), the student must have used the substance away from school and/or its property (as described within the substance use policy statement). If the student admits to having

possession of the substance and taking the substance in any Roanoke County Public School or on its property, then the student would have committed a "possession" violation.

First Offense: Parent/guardian(s) and law enforcement will be contacted immediately upon verification of the violation. From the day of the offense, the student will receive an out-of-school suspension, with no right to make up missed work, for ten (10) school days and will be ineligible to participate in or attend all extracurricular activities for twelve (12) calendar months and will lose school parking privileges for up to twelve calendar months.

The building administrator may reduce the ten-day suspension to five (5) days in school suspension with the right to make up work. Also, the twelve (12) month loss of attending or participating in extracurricular activities will be reduced to thirty (30) calendar days and the loss of parking privileges for up to thirty (30) school days if:

1. The student and parent/guardian(s) agree to participate in the Student Assistance Prevention Intervention Services Program (SAPISP) and follow the recommendations made by the SAP (Student Assistance Program) core team for up to one year from the date the contract is signed.
2. The student must complete a urine screen within two business days of the contract and an evaluation for alcohol and other drug abuse within fifteen (15) calendar days from the date of the contract. The expense of such services is the responsibility of the parent/guardian(s).
3. The student and parent/guardian(s) release the results of the evaluation and urine drug screen to the SAS.
4. The student and parent/guardian(s) complete a two-session educational program on substance use/abuse as coordinated by the SAS.
5. The student must complete periodic drug testing for up to one year, releasing the results of testing to his/her parent/guardian(s) and the SAS Coordinator. The expense of the testing is the responsibility of the parent/guardian(s).
6. If recommended by the substance evaluation and with the consent of the student's parent/guardian(s), the student participates in a substance abuse treatment program. The expense of such services is the responsibility of the parent/guardian(s).

Failure on the part of the student and/or parent/guardian(s) to comply with any of these conditions will result in a recommendation to the school board for expulsion, as will any additional substance use policy violation.

- B. Possession/Distribution** – Students shall not possess nor possess with the intent to give, sell or distribute alcoholic beverage(s), imitation and/or controlled substances, other substances, inhalants, anabolic steroids, or drug paraphernalia.

First Offense – Parent/guardian(s) and law enforcement will be contacted immediately upon verification of the violation. The superintendent or designee will be notified and will conduct a preliminary review of the case to determine if a recommendation for expulsion is warranted or if another discipline action would be more appropriate. This preliminary review will take place within ten (10) school days from the date of the incident with the student not being allowed to attend regular school sessions during that time. If available and deemed appropriate by the superintendent or designee, the student may be placed in an alternative setting during the interval.

If the recommendation from the superintendent or designee is expulsion, the school board will hear the student's case. The school board will consider the details of the student's case and then make a determination regarding what disciplinary action is indicated. If the student is expelled the school board will consider conditions/stipulations by which the student and parent/guardian(s) may comply in order for the student to be reinstated. At the same time, the school board retains the authority to not reinstate.

If the student is to remain in school or be reinstated at some later point, the school board will similarly consider conditions by which the student must comply. Conditions/stipulations will be consistent with the standard practices of substance abuse intervention services and according to the needs of the youth. Meeting these conditions will be the financial responsibility of the parent/guardian(s).

Examples of conditions/stipulations that the school board might implement include but are not limited to: SAPISP involvement and compliance with SAP Core Team recommendations; completion of a substance abuse evaluation, including urine drug test and release of results to the SAS; completion of student/parent education program; Participation in a substance abuse treatment program; compliance with periodic drug testing for a designated time period.

If the superintendent or designee determines that a disciplinary action other than expulsion is appropriate, consequences will include at a minimum:

1. The student will serve five (5) days of in school suspension with the right to make-up work.
2. The student will be ineligible to attend or participate in extracurricular activities for thirty (30) calendar days and parking privileges for up to thirty (30) school days.
3. The student and parent/guardian(s) must agree to participate in the SAPISP and satisfactorily follow the recommendations made by the SAP Core Team for up to one year from the date a contract is signed.

4. The student must complete a urine drug screen within two business days of the date of a contract and release the results of that screen to the SAS—the expense being the responsibility of the parent/guardian(s).
5. The student must complete an evaluation for alcohol and other drug abuse within fifteen (15) calendar days from the date of a contract and release the results of that evaluation to the SAP Coordinator—the expense of such services being the responsibility of the parent/guardian(s).
6. The student and parent/guardian(s) must complete a two-session educational program on substance use/abuse as coordinated by the SAS.
7. The student must complete periodic drug testing for up to one year, releasing the results of the testing to their parent/guardian(s) and the SAS—the expense of that testing being the responsibility of the parent/guardian(s).
8. If recommended by the substance evaluation and with the consent of the student's parent/guardian(s), the student will participate in a substance abuse treatment program with the expense of such services being the responsibility of the parent/guardian(s).
9. In addition, the superintendent or designee may stipulate other conditions for the student, consistent with the standard practices of substance abuse intervention services, and according to the needs of the youth. Financial responsibility will be the parent/guardian(s).
10. Failure on the part of the student and/or parent/guardian(s) to comply with any of these conditions will result in a recommendation to the school board for expulsion, as will any additional substance use policy violation.

Second Offense – If a student violates the substance use policy within (12) calendar months of a previous violation, the event will be considered a Second Offense. Parent/guardian(s) and law enforcement will be contacted immediately upon verification of the violation. The superintendent or designee will be notified and will conduct a preliminary review of the case to determine if a recommendation for expulsion is warranted or if another discipline action would be more appropriate. This preliminary review will take place within ten (10) school days from the date of the incident with the student not being allowed to attend regular school sessions during that time. If available and deemed appropriate by the superintendent or designee, the student may be placed in an alternative setting during the interval.

If the recommendation from the superintendent or designee is expulsion, the school board will hear the student's case. The school board will consider the details of the student's case and then make a determination regarding what disciplinary action is indicated. If the student is expelled the school board will consider conditions/stipulations by which the student and

parent/guardian(s) may comply in order for the student to be reinstated. At the same time, the school board retains the authority to not reinstate.

If the student is to remain in school or be reinstated at some later point, the school board will similarly consider conditions by which the student must comply. Conditions/ stipulations will be consistent with the standard practices of substance abuse intervention services and according to the needs of the youth. Meeting these conditions will be the financial responsibility of the parent/guardian(s). Examples of conditions/stipulations that the school board might implement include but are not limited to: SAPISP involvement and compliance with SAP Core Team recommendations; completion of a substance abuse evaluation, including drug test and release of results to the SAS; completion of student/parent education program; Participation in a substance abuse treatment program; compliance with periodic drug testing for a designated time period. If the superintendent or designee determines that a disciplinary action other than expulsion is appropriate, alternative consequences of the possession/distribution violation at a minimum must include:

1. The student will serve five (5) days of in-school suspension with the right to make-up work.
2. The student will be ineligible to attend or participate in extracurricular activities for thirty (30) calendar days, and parking privileges for up to thirty (30) school days.
3. The student and parent/guardian(s) must agree to participate in the SAPISP and satisfactorily follow the recommendations made by the SAP Core Team for up to one year from the date the contract is signed.
3. The student must complete a urine drug screen within two (2) business days of the date of the contract and release the results of that screen to the SAS. The expense of the screen will be the responsibility of the parent/guardian(s).
4. The student must complete an evaluation for alcohol and other drug abuse within fifteen (15) calendar days from the date of the contract and release the results of that evaluation to the SAS—the expense of such services being the responsibility of the parent/guardian(s).
5. The student and parent/guardian(s) must complete a two-session educational program on substance use/abuse as coordinated by the SAS.
6. The student must complete periodic drug testing for up to one year, releasing the results of the testing to their parent/guardian(s) and the SAS—the expense of that testing being the responsibility of the parent/guardian(s).

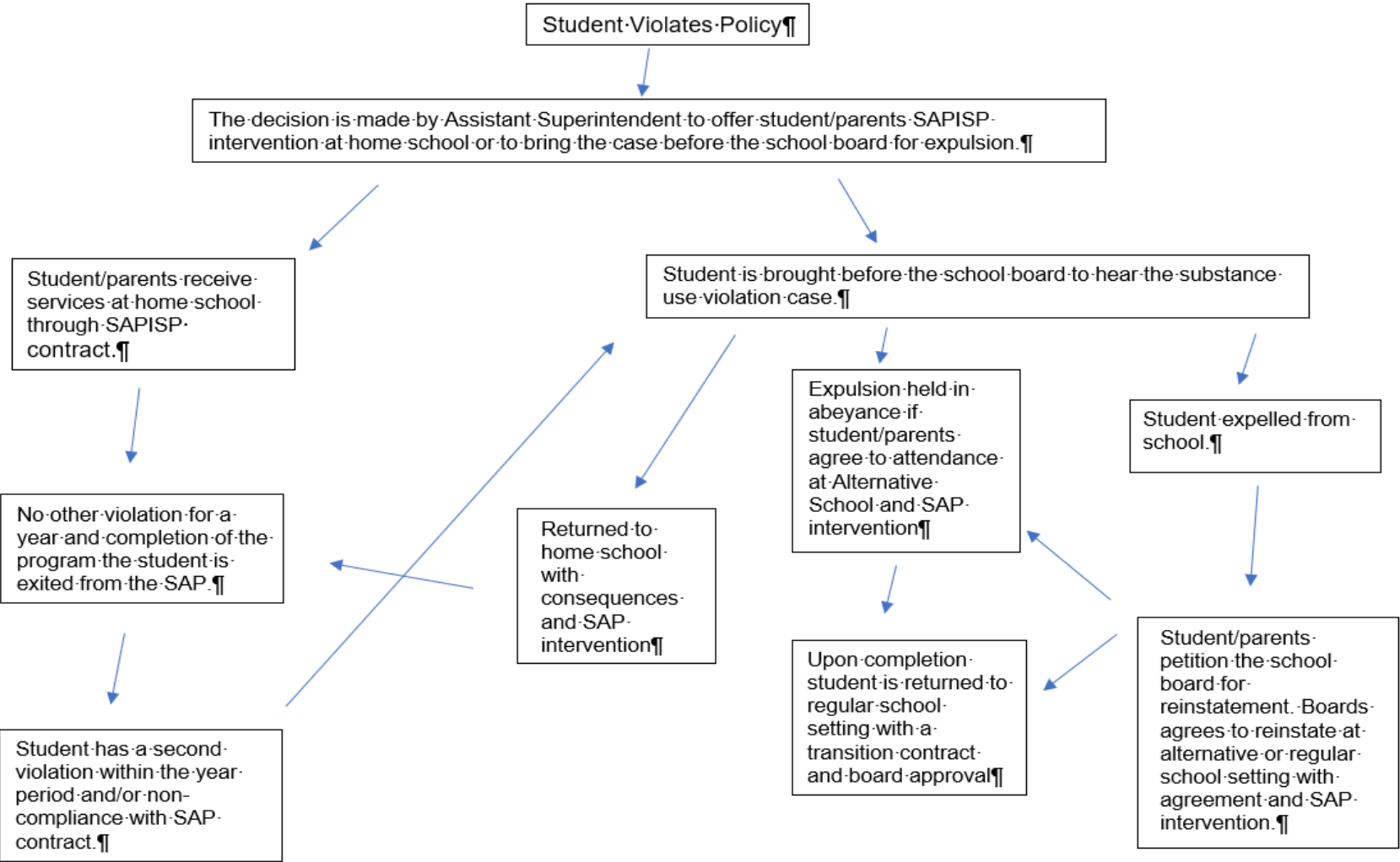
7. If recommended by the substance evaluation and with the consent of the student's parent/guardian, the student will participate in a substance abuse treatment program with the expense of such services being the responsibility of the parent/guardian(s).
8. In addition, the superintendent or designee may stipulate other conditions for the student consistent with the standard practices of substance abuse intervention services according to the needs of the youth. Financial responsibility will be the parent/guardian(s).
9. Failure on the part of the student and/or parent/guardian(s) to comply with any of these conditions will result in a recommendation to the school board for expulsion, as will any additional substance use policy violation.

IV. Responsibilities and Privacy

- A. Evaluations concerning satisfactory progress in the SAPISP will be made by the SAS Coordinator in consultation with the building administrator and other core team members.
- B. Failure on the part of parent/guardian(s) and/or student to comply with any of the recommendations agreed upon in conjunction with the SAS representative(s) will result in a recommendation for expulsion.
- C. The school board regards chemical dependency to be a chronic, progressive illness, which is fatal if left untreated. Consequently, refusal by parents to seek treatment for a chemically dependent child will result in a report to the Department of Social Services for suspected child abuse/neglect under Section 63.1-248.3 of Virginia Statutes.
- D. Given the imminent danger that drug use poses, students exhibiting evidence of acute intoxication, incapacitation, or a drug overdose in school or at school-sponsored events will be transported immediately to the local hospital or detoxification facility, followed by immediate notification of parents and police. Following his/her return to school, Section 2 of this policy will be implemented.
- E. The use of prescription medications is to be construed as an exception to this policy when the medication is being used by the individual for whom it is prescribed, in a manner and amount as prescribed, and in accordance with other school policies governing student medications.

Revised 7/19/00, 10/11/00, 9/3/03

Sample: Substance Use policy Violation Flowchart²⁰



²⁰ Ibid.

Sample Policy²¹

7.6 – AR RULES FOR MIDDLE SCHOOL AND VIRGINIA HIGH SCHOOL LEAGUE PARTICIPANTS

I. **Purpose:** To establish rules and guidelines for students' Participation in Virginia High School League (VHSL) contests:

II. **To be eligible to represent a school in any VHSL contest, a student:**

Must be a regular bona fide student in good standing of the school he/she represents. Must be enrolled in the last four years of high school.

Must have enrolled no later than the 15th day of the current semester.

For the first semester, must be currently enrolled in no fewer than five subjects, or their equivalent, offered for credit, and which may be used for graduation the immediately preceding year or the immediately preceding semester for schools that certify credits on a semester basis. (Take five subjects - pass five subjects)

For the second semester, must be currently enrolled in no fewer than five subjects, or their equivalent, offered for credit, and which may be used for graduation and have passed five subjects, or their equivalent, offered for credit and which may be used for graduation the immediate preceding semester.

Must sit out all VHSL competition for 365 consecutive calendar days following a school transfer unless the transfer corresponded with a family move. (Take five subjects - pass five subjects)

Cannot repeat and use a previously passed course for eligibility purposes.

Must not have reached your 19th birthday on or before the first day of August of the current school year.

Must not, after entering the ninth grade for the first time, have enrolled in or been eligible for enrollment in high school not more than eight consecutive semesters.

Must have submitted to your principal before any kind of Participation, including tryouts or practice as a member of any school athletic team, an Athletic Participation/Parent Consent/Physical Examination form, completely filled in and properly attesting that you have been examined during this school year and found to be physically fit for athletic competition, and that your parents' consent to your Participation.

²¹ Ibid.

Must not be in violation of VHSL Amateur, Awards, All-Star, or College Team rules. This section does not apply to cheerleaders.

A team meeting shall be held prior to the beginning of each season to discuss safety, team rules and VHSL rules changes and eligibility. The principal or athletic director will interpret and explain exemptions provided under VHSL rules.

(Adapted from the Virginia High School League Handbook, 1996–97)

III. The Participant Shall:

- A. Be courteous to visiting teams and officials.
- B. Play hard and to the limit of ability, regardless of discouragement. The true athlete does not give up nor does he/she quarrel, cheat, gripe or grandstand.
- C. Retain his/her composure at all times and never leave the bench or enter the playing field/court to engage in a confrontation.
- D. Be modest when successful and be gracious in defeat. A true sportsman does not offer excuses for losing.
- E. Maintain a high degree of physical fitness by observing team and training rules conscientiously.
- F. Demonstrate loyalty to the school by maintaining a satisfactory scholastic standing and by participating in or supporting other school activities.
- G. Play for the love of the game.
- H. Understand and observe the rules of the game and the standards of eligibility.
- I. Set a high standard of personal cleanliness.
- J. Respect the integrity and judgment of officials and accept their decisions as a good sportsman.
- K. Respect the facilities of host schools and the trust entailed in being a guest.

IV. Specific Rules to Observe

Training - In order to achieve the ultimate goal of maximum effort and efficiency, athletes must get proper rest, eat right and train effectively. The use of any form of tobacco, alcoholic beverage(s), stimulants, steroids, other illegal substances and other substances used improperly as defined in the Roanoke County Public Schools Substance Use Policy 3.22 is prohibited.

The use, possession and/or distribution of any of these substances may lead to dismissal from the team. This rule applies for the full duration of the specific sport season and is inclusive of out-of-school events which occur during the season. The use of illegal substances will lead to a referral to the Student Assistance Prevention Intervention Services Program (SAPISP).

Training rules apply during a specific sport season. Authority is not given out of season except for school violations when the student is under the supervision of schools.

Disregard of training rules will lead to disciplinary action by the head coach which may consist of a conference, warning, suspension or dismissal. The head coach must review recommendations for suspensions and dismissals with the principal before arriving at a final decision. However, upon the occurrence of a substance use policy violation, the principal and head coach must follow procedures according to Policy 7.6 and make a referral to SAP.

- V. Punctuality.** Athletes are expected to arrive at practices and games on time as well as depart for practices, games and other meetings at the established times.
- A. Attendance - Attendance is required at practices, games and all called meetings except for excused absences documented by parents and/or physicians. An athlete may not participate in a game, practice or scrimmage held on a school day unless that student has attended a minimum of one-half of scheduled classes. If an athlete leaves school early because of illness, the student may not participate in an athletic event that evening. The principal may, under extenuating circumstances, make exceptions to these rules.
 - B. Absences - The coach/school shall be called in the first half of the day when an athlete is home ill or must be out of school. Parents may be required to verify the reason the athlete is absent.
 - C. Truancy - The athlete, when truant from school, will be treated as a regular student and will be subject to school and school board policies which may prevent him/her from participating in games or practices.
 - F. Travel with team - Athletes must travel with their respective teams according to school arrangements unless permission is specifically approved by the athletic director or coach. In any event, this permission must conform to school board policy.
 - D. Reporting of injuries - Athletes must report known injuries to the coach immediately and seek attention from the trainer or medical doctor as soon as possible as needed. The coach will follow recommendations of the Roanoke County trainer and/or doctor. The Roanoke County trainer and/or doctor determine when the athlete may participate again.
 - E. Attendance at parties - Athletes are discouraged from attending non-chaperoned parties and other events where illegal substances may be used and abused. Athletes who, in their sport season, do attend such events and are found to have in their possession and/or participated in the use, abuse and/or distribution of substances are subject to consequences outlined in this policy. Athletes who participate in the use and abuse of substances are subject to team training rules and will be disciplined, up to and including dismissal from the team. The athlete will be referred to the student assistance program.
 - F. Letters and awards - Athletes will be given the requirements for lettering in each sport and will be provided information on awards that are to be given and the criteria for each. Each athlete must meet all requirements.
 - G. Communication - Parents, coaches and athletes must maintain open lines of communication.
 - H. Misdemeanor/Felony Conviction - VHSL participants convicted of a felony or misdemeanor may be disciplined up to and including dismissal from the team at the discretion of the principal.
 - I. Consequences for Violation of Athletic/Training Policy 7.6 Substance Use (nontobacco)

1. Initial steps as mandated by school board policy:
 - a. In the event that the substance use violation occurred on school property, in a school vehicle, at any school-sponsored event, going to and from school or while participating in school-sanctioned activities and involves the above-mentioned substances, then the Substance Use Policy 3.22 shall be followed.
 - b. If the substance use violation did not occur during any of the above-mentioned conditions, then the consequences for Substance Use under Policy (7.6) shall be followed.
 - c. Parents will be contacted and informed.
 - d. Parents will attend a conference with the SAP Coordinator and/or Core Team members.

2. Consequence Options: The student will receive a suspension from the squad and will be ineligible for Participation in all extracurricular activities for a period of twelve (12) calendar months and will lose school parking privilege for up to twelve (12) months from the date of the offense. OR

3. The building administrator may reduce the suspension and loss of extracurricular eligibility to thirty (30) calendar days and parking privilege for up to thirty (30) school days if the student and parent/guardian(s):
 - a. Agree to participate in the Student Assistance Prevention Intervention Services Program and satisfactorily follow the recommendations made by the Student Assistance Program Core Team and,
 - b. Agree to complete a drug urine screen within two (2) business days from the date of the contract. The expense of such service is the responsibility of the parent/guardian(s).
 - c. Agree to complete an evaluation for alcohol and other drug abuse within fifteen (15) calendar days from the date of the contract. The expense of such service is the responsibility of the parent/guardian(s).
 - d. Release the evaluation and urine drug screen results to the SAP Coordinator, and thereafter complete periodic drug screens for up to one year from the date of the contract, releasing the results to the SAS and parent/guardian(s). The expense of such services is the responsibility of the parent/guardian(s).
 - e. If recommended by the substance evaluation and with the consent of the student's parent/guardian(s), the student will participate in a substance abuse treatment program. The expense of such services will be the responsibility of the parent/guardian(s).
 - f. The parent/guardian(s) and student will complete the two-session parent/student educational program on substance use/abuse coordinated by the SAS.
 - g. The student may continue to participate in practice without the opportunity to attend contests/games and shall not participate in any other extra-curricular activities for thirty (30) calendar days.
 - h. An event occurring at the end of a season shall carry over to the following season. Any remaining calendar days would be picked up at that time.

Failure on the part of the parents and/or students to comply with any of the conditions agreed upon in conjunction with the Student Assistance Program representative(s) will result in a recommendation of the full one-year suspension from the team or squad. In addition, the student will be ineligible for participating in all extracurricular activities during the same period

Student Violates Substance Use Policy 3.22, Under the Influence.

Under the Influence - Students shall not be under the influence of any non-prescribed substance, including but not limited to; alcohol, marijuana, inhalants, anabolic steroid, imitation and/or controlled substance, designer substance, and/or other substance. In order to be found in violation of being under the influence (versus in "possession" of a substance) the student must have used the substance away from school and/or its property (as described within the substance use policy statement). If the student admits to having possession of the substance and taking the substance in any Roanoke County Public School or on its property, then the student would have committed a "possession" violation

1. Parent(s)/guardian(s) and law enforcement are contacted immediately upon verification of the violation.
2. Parent(s)/guardian(s) attend a conference with the building administrator, SAP Coordinator and/or Core Team Member(s). Parents/students are given option A or B.

Option A. From the date of the offense, the student will receive an out-of-school suspension, with no right to make up missed work, for ten (10) school days and will be ineligible to participate or attend all extracurricular activities for twelve (12) calendar months and will lose school parking privileges for up to twelve (12) calendar months.

Option B. The building administrator may reduce the suspension to five (5) days in school with the right to make up work and reduce the loss of attending or participating in extracurricular activities to thirty (30) calendar days and the loss of parking privilege for up to thirty (30) school days if:

1. The student and parent/guardian(s) agree to participate in the Student Assistance Program and follow the recommendations made by the Student Assistance Program (SAP) Core Team for up to one year from the date the contract is signed.
2. The student must complete a urine drug screen within two business days of the date of the contract and an evaluation for alcohol and other drug abuse within fifteen (15) calendar days from the date of the contract. The expense of such services is the responsibility of the parent/guardian(s).
3. The student and parent/guardian(s) release the results of the evaluation and urine drug screen to the SAP Coordinator.
4. The student and parent/guardian(s) complete a two-session parent/student educational substance use/abuse program coordinated by the SAP.
5. The student must complete periodic drug testing for up to one year from the date of the contract and release the results to his/her parent/guardian(s) and the SAP Coordinator, the

expense of these services being the responsibility of the parent/guardian(s).

6. If recommended by the substance evaluation and with the consent of the student's parent/guardian(s), the student participates in a substance abuse treatment program, the expense of such services being the responsibility of the parent/guardian(s).
7. Failure on the part of the student and/or parent/guardian(s) to comply with any of these conditions will result in a recommendation to the school board for expulsion, as will any additional substance use policy violation.

Use "Contract for Being Under the Influence" (Form 1)

Section 3

Staff Development

Staff Development

The Importance of Staff Development. Key to the success of an effective Student Assistance Prevention Intervention Services Program (SAPISP) is the ongoing support and professional development of program and school staff.

Consistent training builds a strong foundation and increases knowledge and awareness, provides staff with attitude and skills to effectively address social, emotional, behavioral health (SEBH) issues including substance abuse. Presentations include information about making appropriate referrals, reducing risk and increasing protective factors, understanding the addiction process, mental health promotion and strategies to foster resilience through student assistance program services.

Staff development opportunities target core staff members such as administrators, classroom teachers, counselors, custodial and playground staff, and administrative staff. Professional development opportunities are necessary to support effective program services. Staff development offerings are practical, experiential and designed to increase knowledge and skills, as well as shape attitudes, change behaviors, and challenge participants to expand their knowledge base and increase awareness.

Staff Development for School Faculty. The purpose of providing school staff development offerings is to:

- Educate faculty about the identification and referral processes of SAPISP.
- Educate staff about the impacts of substance use, as well as other SEBH issues on the learning environment and academic achievement.
- Build awareness about the program's aim to reduce barriers to learning.
- Increase staff awareness and skill level to reduce risks, increase protective factors, and foster resilience in students.
- Support staff wellness through education and referral.

The goals for staff development include:

- Increasing the number of students with problem behaviors identified by school staff.
- Linking students to support systems – Student Assistance Prevention-Intervention Services Program.
- Providing school staff with a common language that encourages students in need, particularly those from vulnerable populations, to seek out assistance.

Generally, staff development in-service topics addressing these goals include:

- Overview of SAPISP program and its core components including review of SAPISP role, duties, and purpose, policy and procedures for referral (i.e. staff, disciplinary, parent, outside, peer and self) and review of school policy specific to disciplinary referrals.
- Staff members' role in identification and referral.
- Confidentiality.
- ATOD dynamics of use, abuse, and dependency and symptomology of use associated with each substance including summary of drugs of abuse - current trends and signs and symptoms.
- Overview of mental health, social, emotional and behavioral correlations to substance abuse risks as well as high risk populations such as military families, lesbian, gay, transgender and questioning/queer (LGBTQ), and cultural risks. This also includes adverse childhood experiences.
- Impact of substance abuse on the family structure and especially upon children in the case of adult children of substance abusing parent (COSAP).
- Denial and enabling concepts.
- Services provided to families for pre-assessments, treatment referrals, and re-entry support following treatment.
- Student Assistance Program model and the relationship to academic achievement and the School Improvement Process.
- Interface of SAPISP and response to intervention model focusing on the purpose of universal, early intervention (selective) and Intensive strategies (indicated services) and activities such as schoolwide awareness events, individual and group counseling and case management.
- Student Assistance/Core Team model and approach.
- Risk and Protective factor theory, Assets model and Resiliency theory.
- Needs assessment data such as Healthy Youth Survey results and how to put them to use.

Staff Development for Student Assistance Specialists. Student Assistance Specialists (SAS) require sufficient staff development to ensure the implementation of an effective student assistance program as well as to improve the probability of reaching targeted program outcomes. Staff development is also continuous and ongoing. The purpose of staff development for the SAS is to provide the SAS's with the basic knowledge, skills, and competencies to effectively implement deliver and provide school-based prevention and intervention services (*see Program Staff Competency Rubric, at end of this section*).

The goals for SAS staff development include:

- Providing staff with a general understanding of core components of a SAPISP.
- Decision-making regarding student service needs based upon screening/pre-assessment findings.
- Ensure staff are prepared to navigate the school system, with experience and knowledge regarding learning theory and strategies, classroom management, school policy, school disciplinary and restorative practices, and teacher, other staff and parent roles.

- Program staff are also equipped with the knowledge of community collaboration and partnerships to support and sustain SAPISP efforts and available resources for community-based referrals. Training topics for staff development opportunities for SAS's are recommended as follows:
 - Awareness of the components of a comprehensive SAPISP.
 - Nature and progression of adolescent substance use, abuse, and dependency (continuum of use) including dynamics of denial and enabling.
 - Understanding and skills related to screening, pre-assessment, identification and the internal referral process including the "how to" in using the Washington State mandated screening tool Global Appraisal of Individual Needs - Short Screener GAIN SS screening tool.
 - Knowledge of American Society of Addiction Medicine (ASAM) placement, Diagnostic and Statistical Manual of Mental Disorders IV(DSM VI) criteria and Counseling skills and techniques such as group facilitation and dynamics, working with families, and motivational interviewing.
 - Clarification of roles – administrator, counselor, classroom teacher, other school and program staff – in the identification, assessment, intervention, treatment and support of students identified with ATOD related problems.
 - Clear understanding of the types and purposes of educational support groups – objectives, targeted students – and issues related to implementation.
 - Confidentiality and student rights to privacy (42 CFR part 2, FERPA, and HIPPA).
 - Record keeping and data entry requirements.
 - Risk, protective and resilience factors related to overall social, emotional behavioral including substance abuse mental health.
 - Vulnerable populations at-risk such as COSAP, LGBTQ, mental health/co- occurring diversity and risk with certain ethnic groups, and military families. Including adverse childhood experiences (ACE) including family dynamics, rule, and roles and the impact of family chemical dependency and other ACE's.
 - Cultural and linguistic competency.
 - Alignment of Student Assistance Services with state academic standards.
 - Exploration of the treatment and recovery process.
 - Self-care practices and wellness.

In addition, specialized training is provided for all SAS expected to conduct educational support groups. Training topics include: Group dynamics and stages, Group activities, Active listening, Motivational intervening and solution focused counseling techniques, Dealing with challenging behaviors, Co-facilitation, Empathizing, Evaluating goals and outcomes, Terminating, and Content information specific to each group. To help avoid burnout Student Assistant Specialists must have realistic expectations regarding group outcomes.

Suggested Program Operations

The following Competency Rubric Assessment Tool provides program coordinators with suggested guidelines for use in determining program staffs' level of capabilities across all

components of an effective SAPISP program. The information within the rubric can be used to establish job descriptions, identify areas of professional growth and development, and staff training needs.

Information is also provided on the Ethical Guidelines and Standards of Practice for program staff written by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the state legislation (RCW 18.130.180) related to Unprofessional Conduct for registered counselors.

**Student Assistance Specialist (SAS)
Competency Rubric Assessment**

Name of Specialist: _____

Supervisor: _____

Date completed: _____

Follow-up review date(s): _____

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
STUDENT ASSISTANCE PROGRAM SERVICES MODEL	<p>Limited understanding of student assistance program services model evidenced by:</p> <ul style="list-style-type: none"> • Inability to implement the SAPISP core components within the school setting. • Inability to work within the school to provide an adequate continuum of care (prevention-early intervention-treatment – recovery support and follow up) 	<p>Demonstrates a basic understanding of student assistance program services model evidenced by the ability to:</p> <ul style="list-style-type: none"> • Implement, identify, intervene, refer, support and follow up • Most students are placed appropriately according to screening and served by the SAPISP according to the continuum of care prevention-early intervention-treatment – recovery support and follow up. 	<p>Holds a proficient understanding of the purposes of the student assistance program services model, evidenced by ability to provide examples of services in the following context:</p> <ul style="list-style-type: none"> • Consistently places students in the appropriate in program target groups (at-risk, COSAP, abuse/dependent, recovery support and nonusers) • Meet expectations for required number of groups and effectively manages prevention (universal) and selective and indicated intervention level of service determined by the Supervisor (e.g., 20 percent universal and 80 percent selective & indicated or 40 percent universal and 60 percent selective & indicated split). • Case manage students served based on the continuum of care (prevention-early intervention-treatment –recovery support and follow up) • Provides multiple examples of integration of SAPISP services within the school setting 	<p>Distinguished in all areas of understanding the depth and necessary SAPISP services, evidenced by ability to:</p> <ul style="list-style-type: none"> • Mentor new staff assigned to shadow the SAS. • Have groups well integrated in the school programming • Consistently places students in program target groups (at-risk, COSAP, abuse/dependent, recovery support and nonusers) and also offers more than the required groups (i.e. social, coping and anger management skills) • Provides input at staff meetings and in one-one to peers on counseling support and case management based on the continuum of care (prevention-early intervention treatment – recovery support and follow up) • Links to community partners and coalitions (for PRI sites) in promoting the program services and maintains a level of interest at the school level and sustaining SAS within the school setting.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
KNOWLEDGE OF PREVENTION CONCEPTS & THEORY	<ul style="list-style-type: none"> • Unable to identify and apply risk, protective and resiliency concepts to intervention services evidence in student group and individual lesson planning, and staff presentations. • Unable to implement effective response to intervention delivery of program services based on universal, early intervention (selective) and intensive (indicated) levels. This is evidenced by the continuum of care that is weighted more heavily in one area such as most of SAS time is focused on prevention or early intervention. 	<ul style="list-style-type: none"> • Follows manual accordingly in appropriately applying risk, protective and resiliency concepts to intervention as evidenced by lesson plans, group notes and staff presentations. • Implements as required the three-tiered response to intervention delivery of program services based on universal, early intervention (selective) and intensive (indicated) levels with guidance and suggestions provided by supervisor. This is evidenced by services meeting the 20/40 percent universal and 80/60 percent selective-indicated and most of the delivery is done by the SAS. 	<ul style="list-style-type: none"> • Further developed his/her understanding of prevention concepts and theory's by participating in continual professional development on current research and trends. This is evidenced by articulating and sharing information learned with supervisors and actively participating in professional development opportunities (i.e. trainings, book reads and article reviews). • Appropriately applies risk, protective and resiliency concepts to intervention as evidenced by lesson plans, group notes and staff presentations. • Program services delivered at the school encompass and effectively implement response to intervention delivery of program services based on universal, selective and indicated levels without supervision, guidance or monitoring. Evidenced by SAS coordinating most activities with some faculty involvement in prevention awareness events and SAT. 	<ul style="list-style-type: none"> • Takes initiative/actively seeks up-to-date information on prevention concepts and theories. SAS in turn uses the knowledge to train others (i.e. school faculty, community partners, parents and peers) on current research and trends. • Develops lesson plans using current prevention concepts and theories to further enhance group offerings and classroom presentations as appropriate. • Is well integrated in school-based planning from multiple program services that encompass response to intervention delivery of universal, selective and indicated levels. This is evidenced by schoolwide prevention activities, school climate, and curriculum delivery is not only the SAS responsibility and SAT is established with active Participation from school staff in identifying appropriate interventions.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
POLICY AND PROCEDURE	<ul style="list-style-type: none"> • Lacks knowledge about effective policy and procedure. • Lacks knowledge in required school policy related to ATOD offenses. • “Alternative to suspension” disciplinary process is not in place at the school served by the specialists. • Has not presented to school faculty about policy and referral and few school staff have a clear understanding of the ATOD policy. 	<ul style="list-style-type: none"> • Knowledgeable about effective policy and procedure. • Knowledgeable in required school policy related to ATOD offenses. • “Alternative to suspension” disciplinary process is in place at the school sites served by the specialist. Evidenced by SAS getting referrals for discipline. • Faculty presentation has been conducted and faculty members are aware of ATOD policy. 	<ul style="list-style-type: none"> • School administration articulates value in effective policy and procedure to ATOD offenses. • “Alternative to suspension” disciplinary process has been integrated within the school setting and is maintained each year as part of the disciplinary procedures. Evidenced by SAS providing ongoing guidance and is involved in the referral process and informed. • Presentations on SAPISP components and policy review is well integrated into the school setting. The majority of faculty have a clear understanding of the ATOD policy and make appropriate referrals. 	<ul style="list-style-type: none"> • Articulates to school board, building administration, faculty, parents and community partner’s effective policy and procedures that address student use, distribution, sale and manufacturing of substances. • The policy includes a clear statement that disciplinary sanctions up to and including expulsion and referral for prosecution for students that violate code of conduct. • Has implemented a parent component that includes information and education to parents regarding effective prevention/intervention parenting strategies.
STAFF DEVELOPMENT SAS KNOWLEDGE	<ul style="list-style-type: none"> • Staff have not pursued or advanced knowledge related to Student Assistance Program. 	<ul style="list-style-type: none"> • Staff maintains required hours for certification and/or attends all required trainings offered through the Educational Service District. 	<ul style="list-style-type: none"> • Staff identifies and participates in professional development opportunities to further enhance skills and knowledge. 	<ul style="list-style-type: none"> • Staff consistently seeks out information, research, and professional development to maintain ongoing and continuous improvement in knowledge and skill level. • Shares with peers and supervisor information that adds value to the profession.
STAFF DEVELOPMENT FOR SCHOOL FACULTY	<ul style="list-style-type: none"> • Has not hosted/provided a presentation or training to faculty. 	<ul style="list-style-type: none"> • Has provided 1-2 faculty presentations (for the school year) specific to increasing knowledge or skills about Student Assistance Services. (See above staff development for faculty as list of options). 	<ul style="list-style-type: none"> • Faculty presentations are integrated within the school setting to provide information to school faculty on a regular basis. • Works with supervisor to sponsor a professional development event that includes clock hours for educators (3 hours or more). 	<ul style="list-style-type: none"> • Works with community partners and promotes trainings offered though the community within the school setting. • Plans and develops professional development training schedule for educators that is integrated as part of educator’s professional development.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
PROGRAM AWARENESS Includes Prevention Groups and Students Against Destructive Decisions (SADD) Groups	<ul style="list-style-type: none"> • Has not coordinated/sponsored a large awareness event. • Has not engaged school/community partners in awareness activities. • Student classroom presentation are limited or nonexistent. 	<ul style="list-style-type: none"> • Coordinates at a minimum one large (all school) awareness event that reaches all students within the school setting. • Hosts events involving school and community partners. • Implements and delivers a prevention education series, as assigned by supervisor. 	<ul style="list-style-type: none"> • Awareness events are integrated within the school setting. Planning and involvement for the events include both faculty and students. • Partnerships are well established with community stakeholders and events are planned jointly. • Prevention education series is implemented, and other classroom presentations take place throughout the school year. 	<ul style="list-style-type: none"> • Majority of awareness events are coordinated with community and school staff who take on a lead role in assisting the SAS. • Awareness activities stretch beyond the school-day and include athletic events and other extra curricula activities.
INTERNAL REFERRAL PROCESS (Screening)	<p>Referrals are not being made to the SAS and caseload is low²²</p> <p>SCREENING COMPETENCY</p> <ul style="list-style-type: none"> • Needs further training on the use of appropriate screening protocol. • Supervisor staffs with SAS for identification of risk and placement of youth in appropriate school-based and community-based services. • Supervise or assist with coaching staff on appropriate intervention methods and ongoing follow-up and the potential need for consecutive and sequential intervention. 	<p>Faculty as well as school administrators make referrals to the SAS. This is evidenced by the majority of referrals recorded.</p> <p>SCREENING COMPETENCY</p> <ul style="list-style-type: none"> • Follows appropriate screening protocol. • Identifies risks according to screening protocol and places youth in appropriate school-based or community-based services with little guidance and direction from supervisor. • Demonstrates various intervention methods and differentiate when appropriate. • Possesses the ability to identify and plan for ongoing follow-up and the potential need for consecutive and sequential intervention. 	<ul style="list-style-type: none"> • Faculty makes regular referrals to the SAPISP and is well informed by the SAS on the referral process. This is evidenced by the majority of referrals recorded coming from faculty. • Faculty education on the referral process and signs and symptoms is integrated into the school setting • Referrals include student and self-referrals. <p>SCREENING COMPETENCY</p> <ul style="list-style-type: none"> • Ability to screen efficiently and proficiently without guidance from supervisor. • Identifies and places youth in appropriate school-based and community-based services according to GAIN SS. 	<ul style="list-style-type: none"> • Has the ability to train/mentor others on how to establish a referral/screening process. • Peers contact SAS to case consult on students who are screened and need to be referred. • Has the ability to engage and enroll students in services and carry a high caseload of student and self-referrals.

²² Minimum number of students to be served if in building: 2 days = 20; 2.5–3 days = 30; and 5 days = 50

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
STUDENT ASSISTANCE TEAM	<ul style="list-style-type: none"> • Has limited connection to an operating and functioning SAT • Referrals are made in isolation of a Response to Intervention (RTI) framework. 	<ul style="list-style-type: none"> • SAS is part of a SAT where referrals are staffed. The team may not be formalized but a system for staffing is in place. 	<ul style="list-style-type: none"> • SAS is part of a SAT that is formalized and meets on a regular basis to staff student referrals and concerns. • The RTI framework is being used as a means to monitor student progress and identify strategies to inform the school, students, parents and community of the SAP team process. 	<ul style="list-style-type: none"> • SAS is an active member of the RTI SAT at the school. • Demonstrates strategies for selecting, integrating, retaining, and rotating team members.
STUDENT ASSISTANCE PROGRAM EVALUATION	<ul style="list-style-type: none"> • Evaluation data is not consistently entered into the Web-Based reporting system. 	<ul style="list-style-type: none"> • Ability to enter data into Web-Based reporting system with little assistance. • Data is entered on a monthly basis and student pre/post-evaluation sheets are sent in monthly. • Data is used shared with building and/or district administration. 	<ul style="list-style-type: none"> • Data is entered on time consistently and student pre/post-evaluation sheets are submitted monthly. • Generates and utilize on-line performance reports by incorporating results of SAP evaluation in program planning, service delivery and improvement with little guidance from supervisor. 	<ul style="list-style-type: none"> • Evaluation data is used for presentations to students, faculty, parents and community partners on an ongoing basis without supervisor direction or guidance.
EDUCATIONAL SUPPORT GROUP (Selective and Indicated)	<ul style="list-style-type: none"> • Direction from supervisor is needed to organize groups and properly screen as well as place in appropriate groups settings. • Direction from supervisor is needed to develop content for support groups. 	<ul style="list-style-type: none"> • Demonstrated the ability to organize groups according to target populations. • Students are properly screened and placed in appropriate groups settings. • Each support group has clear goals and objectives for student learning, outcome measures for student progress, and focused on removing barriers to academic learning. 	<ul style="list-style-type: none"> • Groups have been integrated into the school setting and are part of the SAP programming. • Faculty are aware of support group goals and objectives and see value in SAP services as it addresses barriers to academic learning. 	<ul style="list-style-type: none"> • SAS provides guidance and provides group activity content and ideas to peers. • School expects and sees value in support groups as part of schoolwide efforts to address barriers to learning. • Faculty receive information/education through faculty presentations on benefits of support groups in addressing barriers to academic learning.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
EDUCATIONAL SUPPORT GROUPS Continued²³	<ul style="list-style-type: none"> Core groups (At-Risk, COSAP, Intervention, and Recovery Support) are not offered on a consistent basis. Staff continually struggle to get referrals for group and meet target number of students to be served by the SAS in the building. 	<ul style="list-style-type: none"> Core groups (At-Risk, COSAP, Intervention, Recovery Support) are offered according to the minimal expectations. SAS is able to articulate, pursue, and gain support for a pull-out model to best serve youth within the school system. Staff consistently remain on target for number of students to be served by the SAS in the building. 	<ul style="list-style-type: none"> Core groups (At-Risk, COSAP, Intervention, Recovery Support) are implemented according to expectations and additional groups (i.e. coping, gang prevention, social skills etc.) are offered. 	<ul style="list-style-type: none"> Group offerings have been expanded beyond the three primary core groups based on identified needs within the school setting. Staff exceeds expected number of group offerings. Utilized community partners and services to provide groups and also present to students in the groups the SAS provides.
COOPERATION AND COLLABORATION	<ul style="list-style-type: none"> Works in isolation. SAP program is a one-person program with little or no involvement from school staff. RMC data indicates few referrals were made to outside services and there was minimal student follow through. Relationships have not been established with local service agencies and coalitions. 	<ul style="list-style-type: none"> Referral process is implemented within the school setting that includes referrals from administration for discipline violation and faculty. RMC data indicates students and families are being referred in the appropriate services in community for ATOD and mental health assessments and treatment. Relationships have been established with local service agencies and coalitions. 	<ul style="list-style-type: none"> Referral process is implemented within the school setting. Referrals are also made by students, and parents. Referrals include youth at –risk of dropping out, failing academically, social, emotional and behavioral issues and/or have attendance problems. RMC data indicates the majority of student’s access services when identified with a substance use or mental health issue. Youth are referred for ATOD and mental health assessments and treatment as needed.²⁴ SAS actively meets with local service agencies to case consult and coordinate services. 	<ul style="list-style-type: none"> The referral process is well integrated into the school system. Administration and faculty report they cannot live without the service. SAS can take a lead role in training/providing staff with information on how to work with school staff to include discipline referrals related to youth at-risk of dropping out, failing academically, social, emotional and behavioral issues and/or have attendance problems. RMC data shows thoroughness in program case management and consistent follow through by the SAS. Positive working relationships are maintained with local service agencies. Community partnerships are well integrated and part of prevention efforts.

²³ The expected number of groups if 2 days minimum is 2 groups per week and 4 groups per year; and 5 days per week 3 groups per week minimum is 6 groups per year. However, Supervisor may change expectations depending on school readiness, climate, and number of disciplinary referrals/grouping needs.

²⁴ Exception, if treatment services are not available, transportation is a variable or other related barrier due to rural locations, and supervisor is informed.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
CULTURAL COMPETENCY Includes Ethnicity, gender, Social Economic, Community Dynamics, Mental Health (social, emotional and behavioral), COSAP's, ACE's, LGBTQ and Military families.	<ul style="list-style-type: none"> • Demonstrates minimal awareness of local diversity issues and how they impact school climate. • Possesses limited knowledge in regards culturally competent communication skills. • Demonstrates minimal knowledge regarding diversity of culture, ethnicity, socio-economic, gender, religion etc. 	<ul style="list-style-type: none"> • Shows a basic understanding of local diversity issues and how they impact the school climate. • Identifies own cultural rules and biases and the impact it can have on providing counseling support services. • Understands cultural competency and is able to appropriately and effectively communicate with students and families. 	<ul style="list-style-type: none"> • Recognizes and understands the local community and school cultural and issues in regard to the impact on school climate. • Possesses the ability to identify and discuss the factors that help to define the culture of each individual student and family. • Identifies and uses professional practices that respect the diversity of each student and family. • SAS understands their own strengths, needs, and boundaries when working with each student and family. • Demonstrates culturally competent communication skills with students and families. • Continues to explore at a deeper level cultural and social justice issue as it applies to providing se. 	<ul style="list-style-type: none"> • Provides guidance and consults with peers on the local community cultural and how they impact the school climate. • Possesses the ability to articulate insights into own cultural rules and biases and recognizes how to respond to cultural biases. • Seen as a resource by peers to case consult on cultural issues, strategies and ideas. • Initiates and develops interactions with diverse groups of people and. suspends judgments in valuing interactions with the diversity of others.
PROFESSIONALISM, LAWS AND REGULATIONS	<ul style="list-style-type: none"> • Does not know legal rights of parents/caregivers and students in the SAP (i.e. HIPPA, FERPA and Federal Confidentiality laws). • Does not understand the laws related to confidentiality and release of records. 	<ul style="list-style-type: none"> • Possesses the ability to identify legal rights of parents/caregivers and students in the SAP process (i.e. HIPPA, FERPA and Federal Confidentiality laws). • Understands laws regulating confidentiality and release of records. 	<ul style="list-style-type: none"> • Possesses a clear at understanding of the legal rights of parents/caregivers and students in the SAP process (i.e. HIPPA, FERPA and Federal Confidentiality laws). • Is able to provide examples of when such laws come into effect in providing services. • Understands the purpose and application of confidentiality laws and demonstrates the ability to work within the restrictions of confidentiality and educating others without violating confidence. 	<ul style="list-style-type: none"> • Demonstrates the ability to provide guidance to peers on practical implications of legal rights of parents/caregivers and students in the SAP process. • Complies with all components of program implementation related to the laws regulating confidentiality and release of records.

	Rating 1: Unsatisfactory	Rating 2: Basic	Rating 3: Proficient	Rating 4: Distinguished
ENGAGING PARENTS/ CARE GIVERS IN THE SAP PROCESS	<ul style="list-style-type: none"> Needs guidance and structure from supervisor to identify strategies for establishing and maintaining working relationships with parents/caregivers. 	<ul style="list-style-type: none"> Engages the majority of parents/ caregivers in the SAP process. Identifies strategies for establishing and maintaining working relationships with parents/caregivers. 	<ul style="list-style-type: none"> Thoroughly understands the purpose and importance engaging the parents/caregivers in the SAP process. Develops intervention strategies based on the identification of the students and parent's/caregiver's level of motivation and the level of concern regarding the student's observable behaviors. Utilizes multiple strategies for establishing and maintaining working relationships with parents/caregivers. Has the ability to describe adaptations and considerations needed for culturally effective/competent communication with parents/caregivers. 	<ul style="list-style-type: none"> Possesses the ability to train others and serve as a role model to peers in engaging parents/ caregivers in the SAP process. Utilizes the stages of change as they relate to students and parents/ caregiver motivation to intervene on substance using/abusing/dependent youth and families. Consistently is involved with, and working with, parents/caregivers in efforts to better the family system. Ability to adapt intervention strategies with family system/culture.

Suggested Ethical Guidelines and Standards of Practice

Philosophy Statement for Student Assistance Programs. A Student Assistance Program (SAP) is a school based comprehensive prevention and intervention program for students that utilize a response to intervention system to address the educational, SEBH barriers which interfere with student learning, and works to enhance the developmental assets of students. This professional, systematic process is designed to provide education, universal prevention, early identification and intervention, intensive support services and referral, for students exhibiting vulnerable behaviors which are interfering with their education. The positive influence of Student Assistance Programs encourages student success in a safe school environment, provides skills development, risk reduction and fosters positive asset and resiliency development.

The primary services provided under a Student Assistance Program are delivered by the Student Assistance Specialist who has a counseling background with specific training in the field of addictions including SEBH issues. Therefore, it is recommended that the SAS and project coordinators follow The National Associations of Alcohol and Drug Abuse Counselors (NAADAC) of which the National Student Assistance Association merged with in 2011. In addition, SAS and project coordinators should be aware of and use as a guide the Washington State's Department of Licensing unprofessional conduct regulations. Both the ethics and unprofessional conduct regulations are provided below.

Introduction to NAADAC Ethical Standards²⁵ Ethics are generally regarded as the standards that govern the conduct of a person. Smith and Hodges define ethics as a "human reflecting self-consciously on the act of being a moral being." This implies a process of self-reflection and awareness of how to behave as a moral being. Some definitions are dictated by law, individual belief systems, religion or a mixture of all three.

NAADAC recognizes that its members and certified counselors live and work in many diverse communities. NAADAC has established a set of ethical best-practices that apply to universal ethical deliberation. Further, NAADAC recognizes and encourages the notion that personal and professional ethics cannot be dealt with as separate domains. NAADAC members, addiction professionals and/or licensed/certified treatment providers (subsequently referred to as addiction professionals) recognize that the ability to do well is based on an underlying concern for the well-being of others. This concern emerges from recognition that we are all stakeholders in each other's lives - the well-being of each is intimately bound to the well-being of all; that when the happiness of some is purchased by the unhappiness of others, the stage is set for the misery of all. Addiction professionals must act in such a way that they would have no embarrassment if their behavior became a matter of public knowledge and would have no difficulty defending their actions before any competent authority.

²⁵ Source: Excerpt from The National Association for Addiction Professionals Code of Ethics. Retrieved (4/10/2012) from www.naadac.org/resource/codeofethics.

The NAADAC Code of Ethics was written to govern the conduct of its members and it is the accepted standard of conduct for addiction professionals certified by the National Certification Commission. The code of ethics reflects ideals of NAADAC and its members. When an ethics complaint is filed with NAADAC, it is evaluated by consulting the NAADAC Code of Ethics. The NAADAC Code of Ethics is designed as a statement of the values of the profession and as a guide for making clinical decisions. This code is also utilized by state certification boards and educational institutions to evaluate the behavior of addiction professionals, and to guide the certification process.

The Revised Code of Ethics is divided under major headings and standards. The sections utilized are: The Counseling Relationship, Evaluation, Assessment and Interpretation of Client Data, Confidentiality/Privileged Communication and Privacy, Professional Responsibility, Working in a Culturally Diverse World Workplace Standards Supervision and Consultation, Resolving Ethical Issues, Communication and Published Works Policy, and Political Involvement.

I. The Counseling Relationship. It is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure that the client is provided with services that are most beneficial. The client will be provided access to effective treatment and referral giving consideration to individual educational, legal and financial resources needs. Addiction professionals also recognize their responsibility to the larger society and any specific legal obligations that may, on limited occasions, supersede loyalty to clients. The addiction professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship. In all areas of function, the addiction professional is likely to encounter individuals who are vulnerable and exploitable. In such relationships he/she seeks to nurture and support the development of a relationship of equals rather than to take unfair advantage. In personal relationships, the addiction professional seeks to foster self-sufficiency and healthy self-esteem in others. In relationships with clients he/she provides only that level and length of care that is necessary and acceptable.

Standard 1: Client Welfare. The addiction professional understands that the ability to do good is based on an underlying concern for the well-being of others. The addiction professional will act for the good of others and exercise respect, sensitivity and insight. The addiction professional understands that the primary professional responsibility and loyalty is to the welfare of his or her clients and will work for the client irrespective of who actually pays his/her fees.

1. The addiction professional understands and supports actions that will assist clients to a better quality of life, greater freedom and true independence.
2. The addiction professional will support clients in accomplishing what they can readily do for themselves. Likewise, the addiction professional will not insist on pursuing treatment goals without incorporating what the client perceives as good and necessary.
3. The addiction professional understands that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the

- understanding of the disorder. On that basis, the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
4. Services will be provided without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee or are waived from fees.

Standard 2: Client Self Determination. The addiction professional understands and respects the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. In that regard, the counselor will be open and clear about the nature, extent, probable effectiveness and cost of those services to allow each individual to make an informed decision about his or her care. The addiction professional works toward increased competence in all areas of professional functioning; recognizing that at the heart of all roles is an ethical commitment contributing greatly to the well-being and happiness of others. He/she is especially mindful of the need for faithful competence in those relationships that are termed fiduciary - relationships of special trust in which the clients generally do not have the resources to adequately judge competence.

1. The addiction professional will provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, including the Code of Ethics and documentation regarding professional loyalties and responsibilities.
2. Addiction professionals will provide accurate information about the efficacy of treatment and referral options available to the client.
3. The addiction professional will terminate work with a client when services are no longer required or no longer serve the client's best interest.
4. The addiction professional will take reasonable steps to avoid abandoning clients who are in need of services. Referral will be made only after careful consideration of all factors to minimize adverse effects.
5. The addiction professional recognizes that there are clients with whom he/she cannot work effectively. In such cases, arrangements for consultation, co-therapy or referral are made.
6. The addiction professional may terminate services to a client for nonpayment if the financial contractual arrangements have been made clear to the client and if the client does not pose an imminent danger to self or others. The addiction professional will document discussion of the consequences of nonpayment with the client.
7. When an addiction professional must refuse to accept the client due to inability to pay for services, ethical standards support the addiction professional in attempting to identify other care options. Funding constraints might interfere with this standard.
8. The addiction professional will refer a client to an appropriate resource when the client's mental, spiritual, physical or chemical impairment status is beyond the scope of the addiction professional's expertise.
9. The addiction professional will foster self-sufficiency and healthy self-esteem in others. In relationships with clients, students, employees and supervisors, he/she strives to develop full creative potential and mature, independent functioning.

10. Informed Consent: The addiction professional understands the client's right to be informed about treatment. Informed consent information will be presented in clear and understandable language that informs the client or guardian of the purpose of the services, risks related to the services, limits of services due to requirements from a third party payer, relevant costs, reasonable alternatives and the client's right to refuse or withdraw consent within the time frames covered by the consent. When serving coerced clients, the addiction professional will provide information about the nature and extent of services, treatment options and the extent to which the client has the right to refuse services. When services are provided via technology such as computer, telephone or web-based counseling, clients are fully informed of the limitations and risks associated with these services. Client questions will be addressed within a reasonable time frame.
11. Clients will be provided with full disclosure including the guarantee of confidentiality if and when they are to receive services by a supervised person in training. The consent to treat will outline the boundaries of the client-supervisee relationship, the supervisee's training status and confidentiality issues. Clients will have the option of choosing not to engage in services provided by a trainee as determined by agency policies. Any disclosure forms will provide information about grievance procedures.

Standard 3: Dual Relationships. The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties.

Addiction professionals will provide services to clients only in the context of a professional setting. In rural settings and in small communities, dual relationships are evaluated carefully and avoided as much as possible.

1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.
2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over \$25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).

7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion of the counseling relationship and take steps to distinguish the counseling relationship from other interactions.
8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.
10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self-care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting Participation in recovery support groups.

Standard 4: Group Standards. Much of the work conducted with substance use disorder clients is performed in group settings. Addiction professionals shall take steps to provide the required services while providing clients physical, emotional, spiritual and psychological health and safety.

1. Confidentiality standards are established for each counseling group by involving the addiction professional and the clients in setting confidentiality guidelines.
2. To the extent possible, addiction professionals will match clients to a group in which other clients have similar needs and goals.

Standard 5: Preventing Harm. The addiction professional understands that every decision and action has ethical implications leading either to benefit or harm, and will carefully consider whether decisions or actions have the potential to produce harm of a physical, psychological, financial, legal or spiritual nature before implementing them. The addiction professional recognizes that even in a life well lived, harm may be done to others by thoughtless words and actions, If he/she becomes aware that any word or action has done harm to anyone, he/she readily admits it and does what is possible to repair or ameliorate the harm except where doing so might cause greater harm.

1. The addiction professional counselor will refrain from using any methods that could be considered coercive such as threats, negative labeling and attempts to provoke shame or humiliation.
2. The addiction professional develops treatment plans as a negotiation with the client, soliciting the client's input about the identified issues/needs, the goals of treatment and the means of reaching treatment goals.
3. The addiction professional will make no requests of clients that are not necessary as part of the agreed treatment plan. At the beginning of each session, the client will be

informed of the intent of the session. Collaborative effort between the client and the addiction professional will be maintained as much as possible.

4. The addiction professional will terminate the counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the exchange.
5. The addiction professional understands the obligation to protect individuals, institutions and the profession from harm that might be done by others. Consequently, there is awareness when the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions or the profession. The addiction professional will assume an ethical obligation to report such conduct to competent authorities.
6. The addiction professional defers to review by a human subjects committee (Institutional Review Board) to ensure that research protocol is free of coercion and that the informed consent process is followed. Confidentiality and deceptive practices are avoided except when such procedures are essential to the research protocol and are approved by the designated review board or committee.
7. When research is conducted, the addiction professional is careful to ensure that compensation to subjects is not as great or attractive as to distort the client's ability to make free decisions about Participation.

II. Evaluation, Assessment and Interpretation of Client Data. The addiction professional uses assessment instruments as one component of the counseling/treatment process taking into account the client's personal and cultural background. The assessment process promotes the well-being of individual clients or groups. Addiction professionals base their recommendations/reports on approved evaluation instruments and procedures. The designated assessment instruments are ones for which reliability has been verified by research.

Standard 1: Scope of Competency. The addiction professional uses only those assessment instruments for which they have been adequately trained to administer and interpret.

Standard 2: Informed Consent. Addiction professionals obtain informed consent documentation prior to conducting the assessment except when such assessment is mandated by governmental or judicial entities and such mandate eliminates the requirement for informed consent.

When the services of an interpreter are required, addiction professionals must obtain informed consent documents and verification of confidentiality from the interpreter and client.

Addiction professionals shall respect the client's right to know the results of assessments and the basis for conclusions and recommendations. Explanation of assessment results is provided to the client and/or guardian unless the reasons for the assessment preclude such disclosure or if it is deemed that such disclosure will cause harm to the client

Standard 3: Screening. The formal process of identifying individuals with particular issues/needs or those who are at risk for developing problems in certain areas is conducted as a preliminary procedure to determine whether or not further assessment is warranted at that time.

Standard 4: Basis for Assessment. Assessment tools are utilized to gain needed insight in the formulation of the most appropriate treatment plan. Assessment instruments are utilized with the goal of gaining an understanding of the extent of a person's issues/needs and the extent of addictive behaviors.

Standard 5: Release of Assessment Results. Addiction professionals shall consider the examinee's welfare, explicit understanding of the assessment process and prior agreements in determining where and when to report assessment results. The information shared shall include accurate and appropriate interpretations when individual or group assessment results are reported to another entity.

Standard 6: Release of Data to Qualified Professionals. Information related to assessments is released to other professionals only with a signed release of information form or such a release from the client's legal representative. Such information is released only to persons recognized as qualified to interpret the data.

Standard 7: Diagnosis of Mental Health Disorders. Diagnosis of mental health disorders shall be performed only by an authorized mental health professional licensed or certified to conduct mental health assessments or by a licensed or certified addictions counselor who has completed graduate level specific education on diagnosis of mental health disorders.

Standard 8: Unsupervised Assessments. Unless the assessment instrument being used is designed, intended and validated for self-administration and/or scoring, addiction professional administered tests will be chosen and scored following the recommended methodology.

Standard 9: Assessment Security. Addiction professionals maintain the integrity and security of tests and other assessment procedures consistent with legal and contractual obligations.

Standard 10: Outdated Assessment Results. Addiction professionals avoid reliance on outdated or obsolete assessment instruments. Professionals will seek out and engage in timely training and/or education on the administration, scoring and reporting of data obtained through assessment and testing procedures. Intake data and other documentation obtained from clients to be used in recommending treatment level and in treatment planning are reviewed and approved by an authorized mental health professional or a licensed or qualified addiction professional with specific education on assessment and testing.

Standard 11: Cultural Sensitivity Diagnosis. Addiction professionals recognize that cultural background and socioeconomic status impact the manner in which client issues/needs are defined. These factors are carefully considered when making a clinical diagnosis. Assessment procedures are chosen carefully to ensure appropriate assessment of specific client populations. During assessment the addiction professional shall take appropriate steps to evaluate the assessment results while considering the culture and ethnicity of the persons being evaluated.

Standard 12: Social Prejudice. Addiction professionals recognize the presence of social prejudices in the diagnosis of substance use disorders and are aware of the long-term impact of recording such diagnoses. Addiction professionals refrain from making and/or reporting a diagnosis if they think it would cause harm to the client or others.

III. Confidentiality/Privileged Communication and Privacy. Addiction professionals shall provide information to clients regarding confidentiality and any reasons for releasing information in adherence with confidentiality laws. When providing services to families, couples or groups, the limits and exceptions to confidentiality must be reviewed and a written document describing confidentiality must be provided to each person. Once private information is obtained by the addiction professional, standards of confidentiality apply. Confidential information is disclosed when appropriate with valid consent from a client or guardian. Every effort is made to protect the confidentiality of client information, except in very specific cases or situations.

1. The addiction professional will inform each client of the exceptions to confidentiality and only make a disclosure to prevent or minimize harm to another person or group, to prevent abuse of protected persons, when a legal court order is presented, for purpose of research, audit, internal agency communication or in a medical emergency. In each situation, only the information essential to satisfy the reason for the disclosure is provided.
2. The addiction professional will do everything possible to safeguard the privacy and confidentiality of client information, except where the client has given specific, written, informed and limited consent or when the client poses a risk of harm to themselves or others.
3. The addiction professional will inform the client of his/her confidentiality rights in writing as a part of informing the client of any areas likely to affect the client's confidentiality.
4. The addiction professional will explain the impact of electronic records and use of electronic devices to transmit confidential information via fax, email or other electronic means. When client information is transmitted electronically, the addiction professional will, as much as possible, utilize secure, dedicated telephone lines or encryption programs to ensure confidentiality.
5. Clients are to be notified when a disclosure is made, to whom the disclosure was made and for what purposes.
6. The addiction professional will inform the client and obtain the client's agreement in areas likely to affect the client's Participation including the recording of an interview, the

use of interview material for training purposes and/or observation of an interview by another person.

7. The addiction professional will inform the client(s) of the limits of confidentiality prior to recording an interview or prior to using information from a session for training purposes.

IV. Professional Responsibility. The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

Standard 1: Counselor Attributes

1. Addiction professionals will maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed but will take initiative toward improving such policies when it will better serve the interest of the client.
2. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
3. The addiction professional, as an advocate for his or her clients, understands that he/she has an obligation to support legislation and public policy that recognizes treatment as the first intervention of choice for nonviolent substance-related offenses.
4. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and accurate reporting of interactions with clients and accurate reporting of professional activities.
5. The addiction professional recognizes that much of the property in the substance use disorder profession is intellectual in nature. In this regard, the addiction professional is careful to give appropriate credit for the ideas, concepts and publications of others when speaking or writing as a professional and as an individual.
6. The addiction professional is aware that conflicts can arise among the duties and rights that are applied to various relationships and commitments of his/her life. Priorities are set among those relationships and family, friends, and associates are informed to the priorities established in order to balance these relationships and the duties flowing from them.

7. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.
8. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and Participation in activities with professionals in other disciplines. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.
9. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.
10. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance. (See Standard 2, item 3 below).

Standard 2: Legal and Ethical Standards. Addiction professionals will uphold the legal and ethical standards of the profession by being fully cognizant of all federal laws and laws that govern practice of substance use disorder counseling in their respective state. Furthermore, addiction professionals will strive to uphold not just the letter of the law and the Code, but will espouse aspirational ethical standards such as autonomy, beneficence, non-maleficence, justice, fidelity and veracity.

1. Addiction professionals will honestly represent their professional qualifications, affiliations, credentials and experience.
2. Any services provided shall be identified and described accurately with no unsubstantiated claims for the efficacy of the services. Substance use disorders are to be described in terms of information that has been verified by scientific inquiry.
3. The addiction professional strives for a better understanding of substance use disorders and refuses to accept supposition and prejudice as if it were the truth.
4. The impact of impairment on professional performance is recognized; addiction professionals will seek appropriate treatment for him/herself or for a colleague. Addiction professionals support the work of peer assistance programs to assist in the recovery of colleagues or themselves.
5. The addiction professional will ensure that products or services associated with or provided by the member by means of teaching, demonstration, publications or other types of media meet the ethical standards of this code.

6. The addiction professional who is in recovery will maintain a support system outside the work setting to enhance his/her own well-being and personal growth as well as promoting continued work in the professional setting.
7. The addiction professional will maintain appropriate property, life and malpractice insurance policies that serve to protect personal and agency assets.

Standard 3: Records and Data. The addiction professional maintains records of professional services rendered, research conducted, interactions with other individuals, agencies, legal and medical entities regarding professional responsibilities to clients and to the profession as a whole.

1. The addiction professional creates, maintains, disseminates, stores, retains and disposes of records related to research, practice, payment for services, payment of debts and other work in accordance with legal standards and in a manner that permits/satisfies the ethics standards established. Documents will include data relating to the date, time and place of client contact, the services provided, referrals made, disclosures of confidential information, consultation regarding the client, notation of supervision meetings and the outcome of every service provided.
2. Client records are maintained and disposed of in accordance with law and in a manner that meets the current ethical standards.
3. Records of client interactions including group and individual counseling services are maintained in a document separate from documents recording financial transactions such as client payments, third party payments and gifts or donations.
4. Records shall be kept in a locked file cabinet or room that is not easily accessed by professionals other than those performing essential services in the care of clients or the operation of agency.
5. Electronic records shall be maintained in a manner that assures consistent service and confidentiality to clients.
6. Steps shall be taken to ensure confidentiality of all electronic data and transmission of data to other entities.
7. Notes kept by the addiction professional that assist the professional in making appropriate decisions regarding client care but are not relevant to client services shall be maintained in separate, locked locations.

Standard 4: Interprofessional Relationships. The addiction professional shall treat colleagues with respect, courtesy, fairness and good faith and shall afford the same to other professionals.

1. Addiction professionals shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

2. The addiction professional shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.
3. The addiction professional shall not in any way exploit relationships with supervisees, employees, students, research participants or volunteers.

V. Working in a Culturally Diverse World. Addiction professionals understand the significance of the role that ethnicity and culture plays in an individual's perceptions and how he or she lives in the world. Addiction professionals shall remain aware that many individuals have disabilities which may or may not be obvious. Some disabilities are invisible and unless described might not appear to inhibit expected social, work and health care interactions. Included in the invisible disabled category are those persons who are hearing impaired, have a learning disability, have a history of brain or physical injuries and those affected by chronic illness. Persons having such limitations might be younger than age 65. Part of the intake and assessment must then include a question about any additional factor that must be considered when working with the client.

1. Addiction professionals do not discriminate either in their professional or personal lives against other persons with respect to race, ethnicity, national origin, color, gender, sexual orientation, veteran status, gender identity or expression, age, marital status, political beliefs, religion, immigration status and mental or physical challenges.
2. Accommodations are made as needed for clients who are physically, mentally, educationally challenged or are experiencing emotional difficulties or speak a different language than the clinician.

VI. Workplace Standards. The addiction professional recognizes that the profession is founded on national standards of competency which promote the best interests of society, the client, the individual addiction professional and the profession as a whole. The addiction professional recognizes the need for ongoing education as a component of professional competency and development.

1. The addiction professional recognizes boundaries and limitations of their own competencies and does not offer services or use techniques outside of their own professional competencies.
2. Addiction professionals recognize the impact of impairment on professional performance and shall be willing to seek appropriate treatment for oneself or for a colleague.

Working Environment. Addiction professionals work to maintain a working/therapeutic environment in which clients, colleagues and employees can be safe. The working environment should be kept in good condition through maintenance, meeting sanitation needs and addressing structural defects.

1. The addiction professional seeks appropriate supervision/consultation to ensure conformance with workplace standards.

2. The clerical staff members of the treatment agency hired and supervised by addiction professionals are competent, educated in confidentiality standards and respectful of clients seeking services.
3. Private work areas that ensure confidentiality will be maintained.

VII. Supervision and Consultation. Addiction professionals who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation. Counseling supervisors are aware of the power differential in their relationships with supervisees and take precautions to maintain ethical standards. In relationships with students, employees and supervisees he/she strives to develop full creative potential and mature independent functioning.

1. Addiction professionals must take steps to ensure appropriate resources are available when providing consultation to others. Consulting counselors use clear and understandable language to inform all parties involved of the purpose and expectations related to consultation.
2. Addiction professionals who provide supervision to employees, trainees and other counselors must have completed education and training specific to clinical and/or administrative supervision. The addiction professional who supervises counselors in training shall ensure that counselors in training adhere to policies regarding client care.
3. Addiction professionals serving as supervisors shall clearly define and maintain ethical professional, personal and social relationships with those they supervise. If other professional roles must be assumed, standards must be established to minimize potential conflicts.
4. Sexual, romantic or personal relationships with current supervisees are prohibited.
5. Supervision of relatives, romantic partners or friends is prohibited.
6. Supervision meetings are conducted at specific regular intervals and documentation of each meeting is maintained.
7. Supervisors are responsible for incorporating the principles of informed consent into the supervision relationship.
8. Addiction professionals who serve as supervisors shall establish and communicate to supervisees the procedures for contacting them, or in their absence alternative on-call supervisors.
9. Supervising addiction professionals will assist those they supervise in identifying counter-transference and transference issues. When the supervisee is in need of counseling to address issues related to professional work or personal challenges, appropriate referrals shall be provided.

VIII. Resolving Ethical Issues. The addiction professional shall behave in accordance with legal, ethical and moral standards for his or her work. To this end, professionals will attempt to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation as appropriate.

1. When ethical responsibilities conflict with law, regulations or other governing legal authority, addiction professionals should take steps to resolve the issue through consultation and supervision.
2. When addiction professionals have knowledge that another counselor might be acting in an unethical manner, they are obligated to take appropriate action based, as appropriate, on the standards of this code of ethics, their state ethics committee and the National Certification Commission.
3. When an ethical dilemma involving a person not following the ethical standards cannot be resolved informally, the matter shall be referred to the state ethics committee and the National Certification Commission.
4. Addiction professionals will cooperate with investigations, proceedings and requirements of ethics committees.

IX. Communication and Published Works. The addiction professional who submits for publication or prepares handouts for clients, students or for general distribution shall be aware of and adhere to copyright laws.

1. The addiction professional honestly respects the limits of present knowledge in public statements related to alcohol and drug abuse. Statements of fact will be based on what has been empirically validated as fact. Other opinions, speculations and conjectures related to the addictive process shall be represented as less than scientifically validated.
2. The addiction professional recognizes contributions of other persons to their written documents.
3. When a document is based on cooperative work, all contributors are recognized in documents or during a presentation.
4. The addiction professional who reviews material submitted for publication, research or other scholarly purposes must respect the confidentiality and proprietary rights of the authors.

X. Policy and Political Involvement

Standard 1: Societal Obligations. The addiction professional is strongly encouraged to the best of his/her ability, actively engage the legislative processes, educational institutions and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.

1. The addiction professional understands that laws and regulations exist for the good ordering of society and for the restraint of harm and evil and will follow them, while reserving the right to commit civil disobedience.
2. The one exception to this principle is a law or regulation that is clearly unjust, where compliance leads to greater harm than breaking a law.
3. The addiction professional understands that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation,

deliberation and dispute, and will willingly accept that there may be a penalty for justified civil disobedience.

Standard 2: Public Participation. The addiction professional is strongly encouraged to actively participate in community activities designed to shape policies and institutions that impact on substance use disorders. Addiction professionals will provide appropriate professional services in public emergencies to the greatest extent possible.

Standard 3: Social and Political Action. The addiction professional is strongly encouraged to understand that personal and professional commitments and relationships create a network of rights and corresponding duties and will work to safeguard the natural and consensual rights of each individual within their community. The addiction professional, understands that social and political actions and opinions are an individual's right and will not work to impose their social or political views on individuals with whom they have a professional relationship.

This resource was designed to provide an ethics code and ethical standards that will be used by counseling professionals. These principles of ethical conduct outline the importance of having ethical standards and the importance of adhering to those standards. These principles can help professionals face ethical dilemmas in their practice and explore ways to avoid them.

Washington State's Unprofessional Conduct Regulation

RCW 18.130.180: Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

- (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
- (2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
- (3) All advertising which is false, fraudulent, or misleading;
- (4) Incompetence, negligence, or malpractice which result in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
- (5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
- (6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
- (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
- (8) Failure to cooperate with the disciplining authority by:
 - (a) Not furnishing any papers or documents;
 - (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
 - (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
 - (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
- (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

- (10) Aiding or abetting an unlicensed person to practice when a license is required;
- (11) Violations of rules established by any health agency;
- (12) Practice beyond the scope of practice as defined by law or rule;
- (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
- (14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
- (15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;
- (16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
- (17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
- (18) The procuring, or aiding or abetting in procuring, a criminal abortion;
- (19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;
- (20) The willful betrayal of a practitioner-patient privilege as recognized by law;
- (21) Violation of chapter 19.68 RCW;
- (22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
- (23) Current misuse of: (a) Alcohol; (b) Controlled substances; or (c) Legend drugs;
- (24) Abuse of a client or patient or sexual contact with a client or patient;
- (25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards. [1995 c 336 § 9; 1993 c 367 § 22. Prior: 1991 c 332 § 34; 1991 c 215 § 3; 1989 c 270 § 33; 1986 c 259 § 10; 1984 c 279 § 18.]

Section 4 Program Awareness

Prevention Universal Strategies for Substance Abuse Prevention and Mental Health Promotion

Purpose of Program Awareness. Program awareness is an important component of an effective Student Assistance Prevention and Intervention Program (SAPISP). Program awareness activities target both those inside and outside of the school environment, with the aim of delaying unhealthy choices such as substance abuse and/or changing behaviors through strategic use of communication strategies. This is the “universal” component of SAPISP.

The purpose of program awareness is to educate school staff, parents, students, and the community about mental health, social, emotional, behavioral including substance abuse issues, and to provide information about student assistance services that promote resilience and student success. This is done through schoolwide awareness activities, prevention clubs (aka as SADD groups), prevention education curriculum and other classroom presentations.

Program awareness involves parents, students, school staff, and community members in fostering a safe and Supportive learning environment. This includes disseminating information on school policies related to alcohol, tobacco and other drugs, bullying, intimidation and harassment, and threatening and disruptive behaviors; promoting the SAPISP services available and how to access these services; and conducting educational schoolwide events and classroom presentations geared towards raising awareness and changing attitudes.

Within the school setting, program awareness is a tool to accomplish social change, aimed to influence action, to change attitudes and behaviors. Substance Abuse Mental Health Services Administration *Prevention Training and Technical Assistance* Center describes social marketing²⁶ as practitioners who “use advertising principles to change social norms and promote healthy behaviors. Like public education, social marketing uses a variety of media channels to provide a message to targeted groups of individuals.”

Program awareness aligns with the social marketing as described by SAMHSA in that awareness activities aim to change social norms and promote healthy behaviors. Program Awareness activity efforts are about motivating students to make healthy choices and avoid engagement negative SEBH behaviors. According to the Center for Substance Abuse Prevention, social marketing message must:

- Capture the attention of the audience.
- Be meaningful.
- Provide one small, practical step to begin the change process.

²⁶ Retrieved (6/2012) from: <http://captus.samhsa.gov/prevention-practice/prevention-approaches/communication-education/2>.

In the school environment, the concepts of social marketing and program awareness are concerned with creating readiness for change: mobilizing participants (students, staff, parents, and others); guiding understanding of program aims; gaining commitment, support, and building enthusiasm toward substance abuse prevention and mental health promotion initiatives. It is within this context that student assistance professionals are called to work.

Program Awareness within the school setting spans several topical areas including (Deck, 2004):

1. *Dissemination strategies* encompass program outreach efforts such as participating in health fairs, curriculum development, speaking engagements, media campaigns, and materials development and dissemination.
2. *Educational strategies* include classroom based educational services, parent/family education, peer leader programs, and educational services for youth groups. Generally, activities involve multiple sessions with a structured or semi-structured curriculum.
3. *Alternative strategies* incorporate drug-free social events, positive peer support activities and youth leadership functions.
4. *Environmental strategies* include establishing and enforcement of Alcohol Tobacco and Other Drugs (ATOD)-free and safe and Supportive school climate policies, changing students, parents and community attitudes, norms and perspectives, and public policy efforts.
5. *Community strategies* include assessing community needs, targeting resources according to the need, providing training and town meetings, mentoring and other community/volunteer services.

Schoolwide program awareness prevention activities, as noted above, aim to change attitudes and norms around ATOD use and promote a positive school climate that fosters a Supportive social, emotional and behavioral environment. Program/social marketing awareness events are considered universal prevention and can target students, parents or the community. These events are generally large in scope and have a concrete message. If implemented properly, expected outcomes include increased perception of harm, decreased ATOD use or reduction of age onset, increased safety, social responsibility and overall wellness of children and youth.

Suggested Program Operations. The following provides program coordinators with suggested activities related to social marketing and program awareness events as they pertain to the SAS's role within the school setting.

The SAS are the "front line" marketers of SAPISP program services. Part of program staffs' responsibilities is to promote services and raise awareness through the above-mentioned universal prevention strategies to students, faculty, parents, and the community-at-large. The community-at-large, includes, but is not be limited to, agencies such as the health department, juvenile justice, law enforcement, Department of Social and Health Services, medical and mental health treatment agencies, and local businesses. The SAS is the primary person responsible for organizing, coordinating, and facilitating school-based prevention program awareness activities. The SAS's may assist with community coalition activities as applicable, this may include being a liaison with the school and community coalition, keep school administration informed of events

being planned, recruiting youth involvement, and aligning school prevention activities with community, state and national awareness events as applicable.

Suggested Schoolwide Program Awareness Activities. The SAS's fosters a positive, Supportive environment in the school by employing a variety of marketing activities such as:

- Visibility. Getting out into the hallways. Be available in the lunchroom. Students are naturally curious about school staff, especially if they're a bit more casual and relaxed.
- Arranging to appear in classrooms for a 5-minute "commercial."
- Knowing where students congregate and be there.
- Talking to students in the lunchroom.
- Conducting prevention activities via prevention clubs such as putting up positive social norm messages,²⁷ create, and distribute posters.
- Being interviewed for the school newspaper or having a column in the student newsletter or bulletin sending a positive social norms message.
- Make regular announcement concerning ATOD and mental health issues and program services.
- Inform incoming students of program services.
- Being visible in the teachers' lounge. Introduce yourself to everyone in the school.
- Attending and participating in open house or other extracurricular or school supported activities. Distribute program promotional flyers, brochures, and resource materials.
- Having an open door policy to invite students to drop in.

It is important to remember that program awareness and social marketing activities are a *continuous process*: it works best to start early and continue throughout the school year!

Other Schoolwide Program Awareness Ideas:

- Write informative articles for the school's newsletters for parents and staff on topics such as fad drugs, recognizing new drug trends, abuse of over the counter medications, etc.;
- Creating and maintain a SAPISP Web site via the school.
- Creating a SAPISP pamphlet or add a SAPISP column to an existing Counseling Center pamphlet.
- Attending community-based task force meetings.
- Presenting at community forums.
- Connecting with mental health and substance abuse treatment providers, pediatricians, other doctors, probation officers and law enforcement personnel.

²⁷ A *social norms campaign* is based on the central concept that much of people's behavior is influenced by their perceptions of what is "normal" or "typical." The problem is that people often misperceive behaviors or attitudes of their peers. For example, if students believe that the majority of their peers smoke, then they are more likely to smoke. However, data related to the actual use is much less. By correcting the commonly held misperception that "everybody does it," the true message becomes the majority choose not to use tobacco. A social norms campaign consisted of daily announcements and lunchtime activities, including a student pledge to support an alcohol, tobacco and drug-free school. In addition, students covered the school in posters with social norms messages. For more information on positive social norms go to www.mostofus.org.

- Offering a parent education series.

Program Awareness through Classroom Presentations. An effective way to promote programs services, generate referrals, reinforce positive social norms and teach about the harmful effects of alcohol, tobacco and other drugs is through classroom presentation. DBHR requires as part of the PRI sites that a prevention education series is provided by the SAS at the entry level of the school where SAS services are being provided, this is also recommended for nonPRI sites. In SAMHSA (2007), *Help is Down the Hall, A Handbook on Student Assistance*, recommends prevention education curriculum includes:

- The impact of alcohol, tobacco, marijuana and other drug abuse and addiction on the individual and family.
- The pervasiveness of alcohol and other drug addiction.
- What to do if concerned about someone's behavior or alcohol/drug addiction.
- A clear understanding that children are not to blame for the disease.
- Encouragement and permission to ask for help if worried about the alcohol/drug abuse of a family member.
- How to access any part of the SAPISP, including various educational support groups
- Decision making, refusal and coping skills (p. 85).

A follow-up presentation may include information on the effects of drug abuse on the family, military family stressor, and discuss support groups.

School Faculty Program Awareness. In general, when promoting program services to school staff, it is important to develop strategies designed to orient staff to the overall goals and objectives of the program, the level of services available, how students access services (including the internal and disciplinary referral processes), and to emphasize the importance of their role in creating and maintaining a successful program. The best marketing strategies are completed and implemented at the beginning of the school year - a natural time for school orientation. Continued program marketing takes place throughout the school year. Staff provide updates on number of students served, inform staff about the outcomes of the program, and share factual information on substance abuse trends and social, emotional and behavioral support activities that teachers can do to foster resiliency and promote wellness.

Suggested Faculty Program Awareness Activities. At the beginning of the school year the SAS provide school faculty with an overview of program services and basic structure as well as a summary of the program outcomes the year prior.

Other topics that maybe covered include:

- Fundamentals of ATOD and mental health issues.
- Review of signs and symptoms.
- Role of program staff.
- Internal referral process.
- Guidelines and constraints of federal and state confidentiality laws.
- Opportunity for feedback–What's working, what's not, and how to make it better.

SAS's continue with program awareness/social marketing to school faculty throughout the school year by:

- Providing regular updates at staff meetings on program services.
- Distributing a SAPISP Newsletter.
- Hosting training offerings.
- Reviewing and summarizing current trends.
- Disseminating information on vulnerable populations (i.e. COSAP, military families, LGBTQ and Native Americans) and how to best support these populations in the school setting.
- Summarizing and presenting on Healthy Youth Survey data, as applicable.

Community Program Awareness. It is important for the SAS to network within the community to promote the SAPISP program services and interface with the coalition on awareness events and campaigns. Activities include:

- Conducting informal site visits at local agencies to orient agency staff to the overall program and basic structure.
- Distributing program information in the community setting.
- Networking with community-based program providers.
- Attending at coalition meetings, health fairs, and other ATOD related prevention activities.
- Collaborating with community partners to host ATOD awareness, mental health promotion, social responsibility and violence, bullying, harassment and intimidation well as awareness events.

Additional Resources

Mental Health Promotion²⁸

In 1994, the Substance Abuse and Mental Health Services Administration (SAMHSA) began a public awareness effort "Caring for Every Child's Mental Health" with a mission to increase awareness around children's mental health. The "Caring for Every Child's Mental Health" team works to support SAMHSA-funded sites that promote social marketing and communications strategies. The team's overarching purpose is to stimulate support for a comprehensive, systems of care approach to children's mental health services

In 2005, SAMHSA, United States Department of Health and Human Services, established an annual National Children's Mental Health Awareness Day. Now, as a result of this initiative, year-round activities take place and connect cross-disciplinary organizations in their efforts to promote awareness of children's mental health issues.

The National Children's Mental Health Awareness Day is a key strategy of the Caring for Every Child's Mental Health Campaign. The effort seeks to raise awareness about the importance of children's mental health and that positive mental health is essential to a child's healthy development from birth. Communities around the country participate by holding their own Awareness Day events, focusing either on the national theme, or adapting the theme to the populations they serve. For more information go to http://www.samhsa.gov/children/preparing_for_awarenessday.asp.

The benefits of participating in of the Mental Health Awareness Day/Events:²⁹

- Reinforces one's commitment to the total wellness of children and youth.
- Highlights at the local level, Participation in collaboration with other national organizations and Federal agencies addressing children's mental health needs.
- Promotes schools, communities and other organization or company brand in the materials and online content produced to educate and inform participants and the public on Awareness Day.
- Provides access to SAMHSA's social marketing tools to support awareness-raising initiatives for children's mental health.
- Enhances agencies reputation as service provider in providing greater access to children's mental health services and supports.

²⁸ Retrieved 4//16/2012 <http://www.samhsa.gov/children/national.asp>

²⁹ Retrieved 4/16/2012 <http://www.samhsa.gov/children/benefits.asp>

Technical Assistance Bulletin³⁰

You Can Avoid Common Errors as You Develop Prevention Materials

An organization may spend thousands of dollars in developing a campaign to fight the problems caused by alcohol, tobacco, and other drugs. But that money goes to waste if the messages promoted in the campaign are unclear, outdated, or irrelevant.

September 1994

Prevention materials can play a key role in the fight against alcohol, tobacco, and other drug problems. A well-executed campaign can foster an environment where dangerous drug-related behavior is widely recognized as unacceptable. And a young person who might otherwise have been inclined to begin using alcohol, tobacco, or other drugs might lose that inclination if he or she is fully informed about the dangers of alcohol, tobacco, and other drug use and addiction. But sometimes prevention materials fail to achieve the desired response because the intended audience either misinterprets or ignores the prevention message. Poorly executed campaigns may even stimulate dangerous drug-related behavior or offend the target audience, thus ensuring that no prevention message will be heard. In order to achieve their goals, developers of prevention materials must do all that they can to ensure that their products are clear, based on solid scientific findings, and relevant to the intended audience.

The Center for Substance Abuse Prevention (CSAP) in the Substance Abuse and Mental Health Services Administration (SAMHSA) has reviewed thousands of products intended to prevent alcohol, tobacco, and other drug abuse and found several unacceptable messages — messages that are open to misinterpretation, messages that are not adequately supported by scientific research, and messages that fail to address the real concern of, or appeal to, the intended audience.

In order to eliminate the chance for misinterpretation of prevention messages, and to ensure that messages actually reach their intended audiences, CSAP has developed public health principles, and scientific and communications guidelines. These principles and guidelines form the basis of CSAP's evaluation of all prevention materials. These principles and guidelines are first and foremost based on the major tenet of "Do no harm." Prevention workers are urged to use these principles and guidelines when screening or developing materials for use in Federal, State, or local prevention programs.

The purpose of this bulletin is to help developers of prevention materials avoid those messages that may do more harm than good. The bulletin focuses on the principles and guidelines with which prevention programmers most often fail to comply.

³⁰ Developed and Produced by the CSAP Communications Team. Patricia A. Wright, Ed.D., Managing Editor. Distributed by the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

Make the Message Clear. Prevention materials sometimes contain subtle messages that run counter to the intent of the prevention program. An individual who is inclined to smoke, abuse alcohol, or use other drugs is likely to look for any justification for his or her behavior. That individual may misinterpret a prevention message in order to find that justification. This section provides examples both of mixed messages and of clear messages. The examples of mixed messages are derived— although not directly quoted—from materials reviewed by CSAP. Some of these messages may be interpreted to condone what is actually unwise or unsafe behavior. Some of the examples of clear messages may have a familiar ring. These are adapted from national campaigns that have received CSAP approval. Others are also taken from materials submitted by CSAP grantees. These examples are provided to illustrate the clear, positive communication that CSAP is seeking to promote as well as the mixed communication CSAP is seeking to avoid.

Public Health Principle:

Make it clear that illegal and unwise drug use is unhealthy and harmful for all. In an attempt to be "even handed" or "realistic," many prevention materials acknowledge (either directly or indirectly) illegal drug use as a "fact of life." Even though the ultimate intention may be to prevent this kind of behavior, this acknowledgment will be read by some to mean that such drug use is "normal." All prevention materials should take a clear stand against:

- The use of any legally prohibited drug.
- The use of a drug for a purpose other than its prescribed use.
- The use of any product or substance that can produce a drug-like effect.
- The use of any legal drug, including alcohol or tobacco, by individuals legally underage for its use.
- The illegal or unwise use of a legal drug.

Mixed Messages

- "While some people may be able to use a 'soft,' mood-altering drug like marijuana for occasional recreational purposes without any apparent ill effects, no individual can be sure that he or she will not have a negative response to a such drug."
- "Any substance, in and of itself, is neither good nor bad. It is only the improper use, misuse, or abuse of substances that is bad."

Note that these mixed messages imply that some illegal drug use may be "safe" even though they are intended to discourage drug use.

Clear Messages

- "It is unlawful to produce, distribute, or purchase cocaine under any circumstances."
- "Even substances that are not prohibited by law can harm your health if they are used improperly."
- "It is not only unhealthy to allow your teenager to smoke cigarettes, but it's also against the law."

Public Health Principle:

Give a clear message that "risk" is associated with using any form or amount of alcohol, tobacco, or other drugs. Even though alcohol consumption and tobacco use are legal for individuals who are 21 or older, this does not mean that these practices have no adverse consequences. Even small amounts of alcohol, tobacco, and other drugs increase injury or health risks.

Mixed Messages

- "The alcoholic content of beer and wine is not as high as that of hard liquors like whiskey or vodka."
- "Many people use alcohol in social settings to relax and to celebrate special occasions. There is nothing wrong with social drinking as long as one stays within moderation and does not drive after drinking."

Clear Messages

- "The alcohol content of one bottle of beer is the same as that of a martini or a shot of whiskey."
- "Alcohol is a drug. And like any drug, it will affect your judgment and your physical coordination, even when taken in small amounts. Another danger of alcohol is that it can be addicting."

Note that euphemistic terms like "mood-altering drug" or "recreational use" should be replaced with more accurate terms like "mind-altering."

Public Health Principle:

When targeting persons under 21 years of age, pregnant women, recovering alcoholics, or persons taking prescription or nonprescription drugs, give a clear message of no alcohol use. Many prevention materials aimed at youth stress the importance of learning to make wise decisions. But these materials stop short of giving all the information that would help the teenager make the wise decision of abstinence from alcohol or other drug use. Materials often fail to mention that alcohol consumption by anyone under 21 years of age is illegal. Materials that urge moderation in alcohol use for pregnant women fail to take into account recent research that reveals that even small amounts of alcohol will increase the risk of birth defects.

Mixed Messages

- "Part of growing up is learning how to make wise decisions. If you choose to drink, drink responsibly. Don't overdo it. And don't drink and drive."
- "You owe it to yourself and your unborn child to be informed about drinking during pregnancy and to avoid excessive or abusive drinking."

These mixed messages do not contain any incorrect information. But they fail to give the clear "no use" message that should be sent to all underage individuals, pregnant women, recovering alcoholics and drug addicts, and individuals using prescription or nonprescription medications.

Furthermore, materials should clearly state that pregnant women should consult their physician before buying any new medication, refilling a prescription, or taking medication on hand for common ailments, such as headaches and colds.

Common over-the-counter drugs that should be avoided by pregnant women without first consulting their physicians include antacids, nasal sprays, nose drops, aspirin, laxatives, and vitamins.

Likewise, commonly prescribed drugs that can be dangerous to the fetus include antibiotics, antihistamines, vaccinations, anti-migraines, tranquilizers, anti-nauseants, sedatives, diuretics, or hormones (e.g., oral contraceptives).

Materials must state clearly that these and other drugs should only be used by pregnant women on the advice of their physicians or other medical practitioners.

Clear Messages

- "Part of growing up is learning how to make wise decisions. You should know that if you choose to drink before you are 21, you are breaking the law."
- "The United States Surgeon General says that 'the safest choice is not to drink at all during pregnancy or if you are planning pregnancy.'"

Public Health Principle:

Materials targeting youth should not use recovering addicts or alcoholics as role models.

A number of celebrities who have had problems with alcohol or other drugs are eager to use their celebrity status to help others. But the message the celebrity intends to convey may not be the message that teenagers and preteens receive. While the celebrity may be saying, "Don't do it," the youth are hearing, "I did it, and I'm okay now. Taking drugs is part of being famous."

Mixed Message

- "I was stupid to do drugs. I almost threw away my whole career. But now that I'm off drugs, I've been able to turn out hit records just like I used to."

Clear Message

- "Taking drugs lessens your chance of succeeding at whatever career you would choose to pursue. Drugs close the doors of opportunity."

An exception may be made for role models who clearly show that they have been negatively affected by the use of alcohol, tobacco, and other drugs, such as someone now visibly disabled or injured as a result of alcohol, tobacco, and other drug use.

Public Health Principle:

Do not unintentionally glamorize or glorify the use of alcohol, tobacco, and other drugs.

In the effort to be informative about drugs, many prevention materials detail the effects the drug has on the user. Even though most prevention materials focus on the negative effects, even a brief description of a drug's positive or euphoric effects might attract a potential user.

Mixed Messages

- "Alcohol helps many people relax or be more sociable at parties."
- "Jeremy giggled a lot when he smoked marijuana because the drug made him think that everything was funny."

Clear Messages

- "Alcohol impairs the drinker's speech, coordination, and judgment."
- "Even more cancer-causing agents are found in marijuana smoke than in tobacco smoke."
- "People who snort cocaine frequently develop nasal problems, including holes in the cartilage separating the nostrils."

Public Health Principle:

Do not include illustrations or dramatizations that could teach people ways to prepare, obtain, or ingest illegal drugs. Many prevention materials use photographs or illustrations of illegal drugs or drug paraphernalia as graphic fillers. Illustrations of drugs or drug paraphernalia should be used only when they serve a specific purpose (e.g., helping parents to recognize signs of drug use by children.) Materials intended to warn against drugs may inadvertently teach someone how to use drugs.

Furthermore, scenes of people injecting drugs, sniffing cocaine, or drinking alcohol may stimulate the behavior. These are best portrayed as implied actions. For example, someone representing a drug user might be shown with his or her back toward the camera so that only a general suggestion of drug use is presented. Prevention materials should avoid representing any details of the procedures of drug use. A powerful craving for cocaine has been found to be very common for all cocaine addicts and can be easily triggered by the sight of this drug and by objects, people, paraphernalia, places, and emotions associated in the addict's mind with this drug.

Public Health Principle:

Do not "blame the victim." Addiction is an illness. Therefore, materials should focus on preventing and treating the disease and not on berating the individual. When you use negative terms to describe an addict, you may be sending the message that the individual is not worth helping. Do not use insulting terms about the victims of alcohol, tobacco, or other drug abuse. Likewise, do not focus on an individual's shortcomings as a reason for use or addiction. This

does not imply that a person should not take responsibility for his or her alcohol, tobacco, and other drug problems, whether related to addiction, dependence, or unwise use. Encourage the person to take responsibility for seeking help if alcohol, tobacco, and other drug problems continue or if dependence is suspected.

Mixed Messages

- "Only losers take drugs."
- "Stay away from pot heads and dope fiends."
- "Some people start taking drugs as a form of escape because they do not have the courage to face their problems."

Clear Messages

- "Be smart. Don't start."
- "If you have problems with alcohol, tobacco, or other drugs, you can get help. But YOU have to take the first step."

Materials that encourage individuals to seek help should include information about organizations or agencies where help is available.

Public Health Principle:

State that abstinence is a viable choice. In a culture that is conditioned to treat any ailment with a drug, it may not occur to some individuals that they have the option of not taking a drug at all. Be careful to avoid implying that the only solution for a headache is an over-the-counter analgesic or that the only way to celebrate a special event is with an alcohol beverage toast. In fact, prevention materials should strongly recommend alternatives to drug-reliant behaviors. Materials that focus on reducing or limiting the amount of alcohol, tobacco, or other drug taken send a mixed message if they do not include total abstinence as another viable choice.

Mixed Messages

- "If you want to teach your children to be responsible with alcohol, be a responsible drinker yourself."
- "It's fine to relax with a beer at the end of a hard day. But know your limit."
- "In most cases, curing insomnia requires nothing stronger than the sleeping pills you can buy at your local grocery store."

Clear Messages

- "If you want to teach your children to be responsible with alcohol, show them that you can abstain from alcohol and still have good time."
- "It's fine to relax with a beer at the end of a hard day. But you don't need a beer to relax."
- "If you have trouble getting to sleep, do not assume that finding the right pill to take is the solution. A change in your nighttime routine might be just as effective."

This last message in no way implies that valid medical attention, including appropriate drugs, should be withheld from anyone for any reason.

Make the Message Accurate. In addition to being clear, prevention messages must be accurate and based on solid evidence derived from the latest scientific research. Unjustified claims can undermine the credibility of a prevention message. Furthermore, outdated information may fail to contain important findings. For example, as more is learned about Fetal Alcohol Syndrome (FAS), the clearer it becomes that abstinence from alcohol is the wisest course for pregnant women. But in the 1970's, it was common for medical officials to recommend only that women limit their consumption of alcohol. It was even suggested in some materials that as much as two drinks a day was a safe level of alcohol consumption for pregnant women.

Scientific Guideline:

Be sure your message is scientifically significant, based on valid assumptions, accurately referenced, and appropriately used. If you are working from hypotheses, theories, or models but not from statistically significant, conclusive, and replicated research, be especially careful that your assumptions will not increase drug use and that application will not result in misperception or other harm.

For example, if you are reporting that research has not yet conclusively proven a link between a drug and a suspected health hazard, be very careful not to imply that the drug has been proven harmless. Promoters of some substance (e.g., the tobacco industry) have used a "lack of conclusive scientific evidence" as an argument against restrictions imposed on their products. As the FAS example demonstrates, prevention materials should make it clear that a lack of conclusive evidence is grounds for greater caution rather than for lighter restrictions.

Occasionally, CSAP reviewers find statements that have no apparent scientific base. An example is a course purporting that men required 10 to 12 years to develop the disease of alcoholism while women required half that long and teenagers "only 6 months." These statements may be a misapplication of a sound scientific study, but the reader has no way of discovering the mistake because no source is cited in the course materials. These statements are dangerous not only because of their inaccuracy and their lack of referencing, but also because they may encourage irresponsible use of alcohol. While the statements are clearly intended to demonstrate how easily a teenager may be trapped by alcohol, the statements inappropriately suggest that adults, especially adult men, are relatively immune to the disease for a long period of time. Such a statement clearly violates the tenet of "do no harm."

If you are presenting information derived from scientific research, be certain that the information is adequately referenced and appropriately applied to the issue at hand. Many prevention materials give relevant information but fail to identify the source of that information. While some readers may be convinced that a statement is true simply because it appears in print, others demand and deserve to know the source of the findings that are being presented. If evidence is derived from sound scientific experiments conducted by respected individuals at

reputable institutions, citing the source of the evidence can only help to make the prevention message more convincing.

Make the Message Relevant. Even though your message is clear and accurate, it will serve no purpose if your intended audience ignores the message. In order to reach their targets, prevention messages must be relevant. That is, they must appeal to the values and interests of the audience.

Prevention messages must be cast in a language and at a level of diction that is understood by the audience. However, prevention workers should be careful when attempting to use the dialect or slang that is associated with the target audience. Such attempts may be perceived as inauthentic and condescending. Furthermore, imitations of a group's dialect may reinforce negative stereotypes.

Public Health Principle:

Check for cultural and ethnic biases and sensitivity. Many of the negative stereotypes associated with minority groups involve perceptions of their alcohol, or other drug-related behaviors. Prevention materials that address alcohol, tobacco, and other drug abuse problems within a specific minority should avoid reinforcing those negative stereotypes. Information about any group's pattern of alcohol, tobacco, or other drug use should be presented objectively—and based only on scientific and demographic research findings.

Presenting role models from a targeted minority can be an effective means of appealing to that audience. But program developers should avoid limiting their chosen spokespersons to minority athletes and entertainers. Community leaders, teachers, doctors, lawyers, educators, military personnel, writers, parents, and many others can help to demonstrate the variety of opportunities open to minority youth.

Prevention messages must reflect the cultural norms of the audience. It is not enough simply to include images of an ethnic or economic group in the prevention materials. Be sure to reflect the social, economic, and familial norms and symbols of your audience as well as their physical appearance. For example, groups are more important than individuals among some populations; spiritual symbols are important among others. You may also want to reflect such cultural factors as the importance of the extended family, the key role of grandparents, and religion.

Always be extremely careful that you do not inject any of your own biases that could perpetuate a myth or stereotype about a group of people. For example, do not portray everything good with white symbols and everything bad with dark symbols. And don't show only males being arrested for alcohol-impaired driving.

A campaign aimed at any group should communicate that the message sender cares about the well-being of the audience. If a campaign aimed at a specific ethnic group contains negative stereotypes of that group or fails to include any positive symbols of the audience's culture, the

audience will receive the mixed message that you are insensitive to their needs. The intention may be to say, "We want to help you." But what is being said is "We don't care enough about you to learn anything about your culture."

The best way to ensure that prevention materials will appeal to their intended audience is to involve members of the targeted cultural or ethnic group in the planning and development processes. If your organization does not already include members of the targeted group, people with knowledge of the intended audience should be sought out to provide input at an early stage.

Furthermore, all materials should be pre-tested before they are widely distributed. Pre-testing may include the use of focus groups or individual interviews with representatives of the targeted cultural or ethnic group. Questions asked during pre-testing should be designed to reveal whether the audience understands the central message of your product, whether the audience believes the message and the message giver, and whether the audience finds the message personally relevant.

Pre-testing may not guarantee the success of a campaign. But it should identify any mistakes that could guarantee its failure. Pre-testing can identify the barriers to communication that often keep prevention messages from reaching those who need them most.

The No-Harm Checklist

- Give a clear no-use message for:
 - Any illegal drug use.
 - Anyone under 21 years of age
 - Pregnant women.
 - Recovering alcoholics or drug addicts.
- Ensure that scientific findings:
 - Will not encourage drug use.
 - Are up to date.
 - Are adequately referenced.
- Make your materials:
 - Relevant to the targeted audience.
 - Free of negative stereotypes.
 - Appealing.
- Pretest your materials.

Communication Guidelines:

Prevention messages should include appeals that the target audience will perceive as personally relevant. The producers of prevention messages may strive to keep teens from becoming addicted to drugs or facing other risks, including injuries or health problems. Yet teens who perceive themselves to be immortal may turn off messages that emphasize effects

they don't believe they are at risk for. Rather, appeals should be based on something that teens value or consider important, such as peer pressure or looking good and feeling good.

Communication Guideline:

Prevention messages should inform the reader of the seriousness of the problem, persuade the reader of the need for change, and engage the reader with a call for action.

Messages should make the reader aware of the need for change, the need for further information, or the seriousness of alcohol, tobacco, and other drug problems. Materials must not preach but rather find positive appeals that engage and motivate the target audience. And finally, materials must present a desired behavior, so the message is not merely negative. Positive actions called for in prevention materials might include seeking treatment, calling a referral number, confronting a drug-using spouse or friend, or joining a parent group.

Communication Guideline:

Do all you can to make your product professional and attractive in appearance. Gear the format (type, size, layout, style) to your target audience. You do not have to use high-cost techniques to reflect high productions quality. For example, although people generally do pay more attention to materials that use color, black, white materials can be very appealing. Use screens to achieve various shades of gray; box in some copy; use photographs, figures, and bullets.

When developing publications or other products relying on the written word, use white space generously to keep the text from becoming dense and the heading and photo captions to impart essential information. In addition, use a large typeface for materials that will be read by young children, people with low literacy level, or the elderly.

Audiovisual materials should offer clear and understandable sound and visual quality.

Finally, the style of the product should be appropriate to the audience. For example, teens may find some cartoons "babyish." Some Hispanics may be attracted to fotonovellas. MTV-style videos may appeal to teens and be incomprehensible to their parents.

Developed and Produced by the CSAP Communications Team. Patricia A. Wright, Ed.D., Managing Editor. Distributed by the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852. This bulletin is one in a series developed to assist programs that are working to prevent alcohol, tobacco, and other drug problems. We welcome your suggestions regarding information that may be included in future bulletins. For help in learning about your audience, developing messages and materials, and evaluating communications programs, contact the CSAP Communications Team.

Section 5

Internal Referral Process

Introduction

Essential to the success of the Student Assistance Prevention- Intervention Services Program is the implementation of a standardized internal referral process. The purpose of the referral process is to provide school staff with a mechanism for identifying and referring students with social, emotional, behavioral problems including substance abuse and academic problems, or violation of no use policies to program services. Administrators, teachers, counselors, and other school staff are trained to recognize and refer students experiencing problems to the Student Assistance Specialist or SAT for appropriate screening, referral, and support services.

Washington State's comprehensive SAPISP model's internal referral process consists of five components: 1) Early identification; 2) Screening; 3) Referral to other school and community-based services; 4) Intervention; and, 5) Support services.

- *Early identification.* A process for identifying students who are using alcohol, tobacco, and other drugs, or are exhibiting other risk factors which lead to behaviors that interfere with the learning process or are harmful to the student or others in the school setting (Deck, 2004).
- *Screening.* The collection of information designed to identify students who are at increased risk of having substance use disorders or other problem behaviors that justify program placement decisions such as immediate attention, school-based support services, or a referral to a community-based agency for more comprehensive assessment (Grisso & Underwood, 2004).
- *Referral.* Students are referred to in-school programs or community-based AOD assessment, treatment (out-patient, in-patient), mental health counseling or other community-based services based upon the student's identified needs (Deck, 2004).
- *Intervention.* School-based activities provided by the Student Assistance Specialist in group or individual settings that are informative and educational to motivate students to change negative, disruptive behaviors (see Section 7 Educational Support Groups). Educational support groups also serve as an alternative to other disciplinary actions e.g., suspension. Additional school-based interventions provided by the SAS include parent conferences, behavior contracts, and peer support groups (Deck, 2004). Other school interventions may include groups provided by the school counselor or another professional in the school (i.e. loss a grief and divorce groups; or military families, academic, LGBTQ and other supports).
- *Support Services.* Support services include advocating for students, by helping them overcome barriers to accessing treatment and/or mental health counseling or other community support services, providing re-entry support for students returning to school after treatment, and case management (Deck, 2004).

The establishment of an internal referral process requires the program to:

- a. Implement or review with school administrators no use policies and procedures, disciplinary referral processes, and possible buy back structure – *in lieu of suspension*.
- b. Educate faculty about ATOD signs and symptoms, social, emotional, behavioral and mental health concerns, and school policies and procedures for ATOD violations, explain the referral process, confidentiality and students' rights to privacy.
- c. Provide staff development and in-service trainings ongoing related to nonacademic barriers (see Section 3 Staff Development).
- d. Promote program services to students; parents and the community at large (see Section 4 Program Awareness).

Early Identification. The early identification of students at risk for substance use or other social, emotional or behavioral problems is the first step to getting students referred to program services. Early identification involves "*being alert to any unexplained change in the pattern of a student's behavior, conduct, and/or academic performance* – especially where such changes represent a decline" (Anderson, 1993, p. 89). These can include changes in:

- Academic performance – a decline in grades, or Participation.
- Attendance – unexplained absences or increased tardiness.
- Disruptive classroom behaviors – fighting, sleeping in class, acting out.
- Disciplinary problems.
- Legal problems – possession charges, shoplifting, vandalism;
- Problems with out of school activities – sudden loss of involvement and/or interest in extracurricular activities.
- Problems at home.
- Violation of no use policies or ATOD specific behaviors.

In addition to the above, special considerations should be in relation to vulnerable populations who are at greater risk of substance abuse. This includes LGBTQ, a student from a military family where a family member has been deployed, children from substance abusing home or family member with mental illness, or student with severe emotional issues (see Section 6 Vulnerable Populations).

As part of the early identification process, SAS educate referral sources about the signs and symptoms of social, emotional and behavioral problems changes in a student's attitude or behaviors, and vulnerable populations that generate a referral to the SAPISP program (see Section 3: Staff Development). School staff completes a Referral Form (sample is provided at end of this section under additional resources) and forward the form to the SAS for review and implementation of next steps. Referrals sources include school administrators, school staff, self, peers, parents, and community members.

Referral Sources

Administrative Referrals. School administrators enforce the school and/or district's ATOD policies by referring students to the SAS to begin the intervention process. The administrator

may also refer students who have truancy problems, disciplinary offenses, and/or social, emotional, and behavioral issues that are disruptive to the learning environment. In general, the administrator offers the disciplined student an “*alternative to suspension*” or “*in lieu of suspension*” alternative in accordance with district’s ATOD policies. In general, the “buy back” option shortens the student’s recommended suspension time providing the student agrees to meet with the SAS to complete the screening/pre-assessment process and that the student follows through with referral and program service recommendations.

Staff Referrals. Teachers, counselors, and other school staff make up the largest proportion of referrals to program services. Due to school staffs regular contact with students they are in the best position to observe attitude or other changes in student conduct and behavior, and as such are a vital component in the early identification process.

At times school staff may request information from the SAS about a student referred to program services. Most often staff want to be reassured that the student receives the assistance needed, however, federal confidentiality regulations limit the disclosure of information regarding the student as well as placement decisions (*See Confidentiality information in this section under additional resources*). Nonetheless, it is permissible to follow-up with staff and to inform him/her that the referral was received. Also, providing staff with a quarterly newsletter highlighting the number of students referred and served is a good way to promote services (*See Section 4 Program Awareness*).

There may be times that staff members do not want to jeopardize their classroom relationships with students and ask to remain anonymous. Honoring this request is important. If school staff knows they can refer students of concern anonymously and are assured that students are getting needed services, they will continue to refer and gain trust in the SAPISP program.

Peer Referrals. Adolescents usually know what is going on in their friends’ lives better than adults do, and may be aware of social, emotional, behavioral problems including mental health and substance abuse issues long before school staff or parents. This makes peer referrals a critical component of the SAPISP program. Peer pressure is strong during the adolescence, and so is the desire to refrain from “snitching.” Using classroom presentations to address fears associated with seeking help for friends (“snitching”), dispelling use myths, and providing students with a broad understanding of the SAPISP program increases peer and self-referrals. Students need to be assured that the information shared is kept in strictest confidence and that a Supportive adult is available to discuss concerns (Anderson, 1993). When informed, coached, and supported, students generally understand the importance of referring.

Self-Referrals. Self-referrals take place when a student voluntarily seeks out information or assistance from program staff. Students who self-refer need to be certain that information shared during initial visits, unless otherwise noted, is confidential. In general, *effective [programs] contain assurances that students will not be punished or penalized for behavior that occurs prior to the point of self-referral*” (Anderson, 1993, p. 94). (**Note of Caution:** All students need to be informed of their right to confidentiality and the conditions under which this right is waived (i.e.,

harm to self (suicide ideation), or others, or under the influence at school). A sample Student Consent to Services and Disclosure form is available under additional resources in this section and provides detailed information on what a student needs to understand when agreeing to participate in program services.)

Parent Referrals. Parent referrals can be a powerful asset in identifying students at-risk. When the SAS receives a referral, a first step is to try and contact the parents/guardian to: a. provide an overview of SAPISP program services; b. ask the parent about any concerns he/she may have had with his/her son/daughter (this may include exploring family history of mental health and substance abuse); c. provide general information about signs and symptoms of ATOD use; and d. provide information about the parents'/guardians' role in the prevention-intervention process. *(Note: Depending on individual ESD/school district policies, the SAS may not always contact parents first. Follow policies established at the local level regarding parental engagement).*

Additional ways to engage parents in program services are to provide information on signs of symptoms, behaviors of concern, and the internal referral process in the school newsletter, or annually published student handbook, and by hosting awareness events. The more parents are aware of SAPISP services and perceive the program to be "credible, safe, and confidential" the more likely they will be to contact the school for information and assistance to help their child (Anderson, 1993, p. 94).

Community Referrals. Outside referrals from community-based agencies increase when community partners are aware of program policies, services, and the referral processes. Pediatricians, primary care physicians, and dentists may refer to school-based tobacco programs or educational support groups. Clergy and religious leaders may refer families or students for education or intervention services or family education groups, if provided. Juvenile justice programs may refer students of concerns through probation and diversion programs. Outside therapists and mental health care providers may work with the SAS when families inform them of their child's involvement in SAPISP support groups. Local treatment agencies may refer students who are in treatment back to the SAPISP program for recovery support.

Suggested Program Operations

The following information provides project coordinators and SAS's with suggested program operations related to implementing an internal referral process including steps to screening/referred students. Also provided, is information on the state mandated adolescent screening tools, suggested protocols related to confidentiality and record keeping as well as a collection of sample forms.

This section of the manual is of vital importance in assisting the SAS in understanding his/her role in providing SAPISP services to youth impacted social, emotional, behavioral substance abuse issues. The Internal Referral Process is the most in-depth and detailed section of the manual; therefore, we recommend the project coordinator carefully review this section in its

entirety and work with the SAS to establish the SAPISP internal referral process in his/her school(s).

Screening Process

According to the National Institute of Alcohol Abuse and Alcoholism (2003), screening is defined as:

The formal process of testing to identify individuals with substance-related problems or consequences, or those who are at-risk for such difficulties. Screening is used to determine whether a client does or does not warrant further assessment at the current time (n.p.).

Screening is *not diagnostic*; "it does not establish definitive information about diagnosis and possible treatment" (Winters, 1999, p.2). Rather the screening process "focuses on empirically verified "red flags" or indicators of serious substance-related problems" across "two broad categories: those that indicate substance use problem severity and those that are psychosocial factors" (Winters, p. 3). The findings of the screening process identify issues that require more formal assessment and assists program staff in making effective recommendations for referral and intervention services. Screening instruments provide a preliminary indication of problem behaviors and address a variety of problems from substance use/abuse to mental health and other psycho-social issues. However, even the most accurate and reliable screening instruments rely on the SAS's professional judgment to make the appropriate placement decisions guided by the screening results (Center for Mental Health in Schools, 2001; Winters, 1999).

Once a student is referred to the SAPISP program, the SAS begins a multi-step screening process. The four-step process yields a clear understanding of the student's needs and assists program staff in developing a plan to address these. This "triage" process starts with the collection of information from a variety of sources, and reviews data related to student behavior, presence of risk and protective factors, and includes a brief ATOD screening. The process assists the SAS to "identify students exhibiting risk factors leading to behaviors that interfere with the learning process or that are harmful to the student or others in the school setting" (Deck, 2002, p 17). The intent of the screening process is not to provide a clinical and/or psychiatric diagnosis, but to recognize the "red flags" that:

1. Identify those students who may benefit from SAPISP intervention services.
2. Guide staff to make effective referral and placement decisions based upon identified risks and needs.
3. Indicate students in need of a longer, more formal assessment for treatment services (AOD or mental health).

Step One – Gather Supporting Data. *The first step* is to gather information and data prior to an initial meeting with the student. Information is obtained from school files (attendance records, grades, and discipline data); discussions with the referral source, other school staff or administrators regarding areas of concern; and parent interviews. This step is often referred to as collecting *collateral or corroborative information* – information that supports or informs program staff about the student from multiple sources such as teachers, administrators,

probation officers, and parents. School staff may have firsthand information regarding the student's conduct and recent changes in attitude and behaviors. Parents can provide valid information regarding externalizing behaviors (conduct problems, delinquency, and attention deficits) as well as confirm information about internalizing issues (mood disorders, self-concept) (Winters, 1999). According to Winters (1999), "Getting information from other sources helps the [Student Assistance Specialist] guard against developing an incorrect picture based solely on the young person's self-report" (p.6). (**Caution:** *Make every effort to protect confidentiality and student's rights to privacy. If the student is seen prior to the collection of data, the SAS must obtain a signed release before collecting information from sources other than school records. See pages 116–122 for additional information on confidentiality.*

Step Two – Building Rapport. Program staff conducts an informal interview with the student. The initial interview is relatively short, about a 15–30-minute consultation and is an opportunity for the SAS to:

- Build rapport, demonstrate care and concern.
- Describe SAS role and explain program services including confidentiality and rights to privacy.
- Determine student's frame of mind, appearance, attitude, and willingness to participate.
- Check in to determine if there are issues that may be affecting the student's life in which s/he needs immediate assistance.

Conduct (if student is amenable) or make an appointment to administer a brief ATOD screening if the student is going to continue with services. Often step two is combined with step three, due to scheduling and limited class release time. The main priority is to make sure rapport is built prior to asking sensitive questions.

Step Three – Identify Risks and Needs. The third step in the screening process is *to gather, review and assess data* on the student related to the nature and severity of the student's problem behaviors and needs; prevalence or lack of risk and protective factors; social, emotional and behavioral issues; nature of the student's substance use history and severity of use; and the student's readiness to change. A sample Intake Form, under additional resources guides the SAS in collecting risks and needs data. Additional information regarding selecting screening instruments to compliment the intake form and screening process is also included in the additional resources section.

Assessing Risk and Protective Factors. The presence of risks, or lack of protective factors, is indicative of potential risk of substance abuse (Hawkins, et al., 1992) and serious emotional disturbance/mental health issues. SAS need to be aware of such issues as school related risks which include academic failure, disruptive classroom behavior, aggressive and/or violent behavior, poor school bonding (truancy, attendance), and affiliation with antisocial peers, or peers that use/abuse substances. Risk factors at home also affect the student's behavior such as ineffective parenting, lack of parental monitoring, a chaotic home environment, lack of significant relationship with a caring adult, and a parent/guardian that abuses substances, suffers from mental illness, or engages in criminal behaviors. Being aware of the multiple factors that influence a student's behaviors is critical to ensuring appropriate placement into services to

address identified needs (Hawkins, et. al. 1992; Robertson & Rao, 2003). *(Detailed information related to risk and protective factors is located in Additional Resources at the end of Section 1).*

Alcohol and Other Drug Use Screening. A central purpose of the SAPISP program is to intervene and reduce student substance use or delay onset of substances. Students referred to program services span a range from those who have not used to those who exhibit characteristics and behaviors that put them at risk of substance use. Other students may be experimenting with tobacco, alcohol, and marijuana, while some referred for services have progressed to heavier use level and are exhibiting signs of dependence (Deck, 2004).

All students referred to program services, are screened for ATOD use, which includes collecting information about the student's lifetime and recent history of substance use, and family use history. In Screening and Assessing Adolescents for Substance Use Disorders Treatment Improvement Protocol (TIP) Series 31 (1999), Winters states,

A screen should be simple enough that a wide range of health professionals can administer it. It should focus on the adolescent's substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning, and living situation. The client's awareness of her problem, her thoughts on it, and her motivation for changing her behavior should also be solicited" (p.8).

The ATOD screening process collects student self-reported data on substance use history, including lifetime, current (30 day), and severity of use.

Washington State requires all publicly funded substance abuse and mental health programs to use the Global Appraisal of Individual Needs Short Screen (GAIN SS) as the primary screening tool. SAS's use this tool along with an intake that includes a substance use history. The license to use the GAINSS is purchased by the state for all ESD's to utilize the GAIN SS. Coordinators train the SAS staff how to administer the GAIN SS.

The Global Appraisal of Individual Needs – Short Screener (GAIN-SS)³¹ Interviewer or self-administered screening questionnaire. Developer: Michael Dennis (2005). The GAIN-SS is a brief,

³¹ Source: Chestnut Health Systems, www.chestnut.org/li/gain.

Validity/Reliability: The 20 symptom Total Disorder Screener has high reliability (alpha=.86), and is correlated .94 with the 123 symptom General Individual Severity Scale (GISS) in the full GAIN scale (see www.chestnut.org/li/gain). Using a cut point of 3 or more on this scale had excellent sensitivity (91%) for identifying people with a disorder and excellent specificity (89%) for correctly ruling out people who did not have a disorder. In both cases, using a lower (1+) cut point would increase sensitivity further, but decrease specificity. The 5 item subscales have alphas of .73 to .78 and are correlated .87 to .92 with their respective scales in the full GAIN (i.e, 43 item Internal Mental Distress Scale, 33 item Behavior Complexity Scale, 16 item Substance Problem Scale, and 31 item Crime/Violence Scale). Within each sub screener, using a cut point of 1+ achieved over 90% sensitivity and 70% specificity (within the area) for both adults and adolescents. Using 3+ in the subscales provided 70% sensitivity and 90% specificity (within the area) for both adults and adolescents. Thus, the interpretative ranges are set at low (0), moderate (1-2) and high (3+) for the total and each subscale.

efficient behavioral health screening instrument for use in multiple settings. It can be interviewer- or self-administered in 5 to 10 minutes. The tool is available in two formats, items on one are written in “yes/no” format and collect information for “past year” occurrences. In the second format, questions use a regency response set to generate past month counts to measure change, past year measures for screening, or lifetime measures as covariates. The GAIN-SS is available in English and Spanish versions.

Description: Similar to the GAIN-Q, the Short Screener is a brief screening instrument used to identify various life problems among adolescents and adults in the general population. The instrument contains total scale (20-symptoms) and its 4 subscales (5-symptoms each) for internal disorders, behavioral disorders, substance use disorders and crime/violence designed to screen for people with clinical disorders among general populations of adolescents, young adults and adults. The subscales are based on a series of exploratory and confirmatory factor analyses of psychiatric symptoms and disorders among clinical samples. Scales:

- Internal Disorder Screener (IDScr) – one or more symptoms used to identify over 94 percent of people with depression, anxiety, suicide ideation, acute/post traumatic disorders, or other internal disorders.
- External Disorder Screener (EDScr) – one or more symptoms used to identify over 97 percent of people with attention deficit, hyperactivity, other impulse control disorders, conduct disorder (including antisocial personality disorder), aggression/violence, criminal activity or other external behavior problems.
- Substance disorder screener (SDScr) – one or more symptoms used to identify over 96 percent of people with abuse or dependence on alcohol or other drugs.
- Crime/Violence Screener (CVScr) – one or more symptoms used to identify over 91 percent of the people with physical conflict or criminal involvement.
- Total Disorder Screener (TDSr) – one or more of any of the above identifies over 99 percent of the disorders listed above.

Population: Adolescents (over 11); Adults

Stages and/or Continuum of Adolescent Substance Use. All adolescents progress through predictable stages of use, but all youth do not necessarily progress through all stages of substance use. Only a small proportion of youth will progress to the final stages (abuse/dependency) (Steinberg & Levine, 1990; Winters, 1999). There are several varying descriptions of the progression of adolescent substance use; each is relatively consistent with the others; however, terminology and description of stages may differ. To determine a student’s stage or where he/she is on the continuum of substance use, information is collected on recency (past 90 days) and severity of substance use. Severity ratings, as cited by Deck (2005), are adapted from the DSM-IV criteria and from Mueser (1995).³²

- *Never used.* The student has never used this substance.
- *Abstained.* The student has used this substance, but not in the past three months.

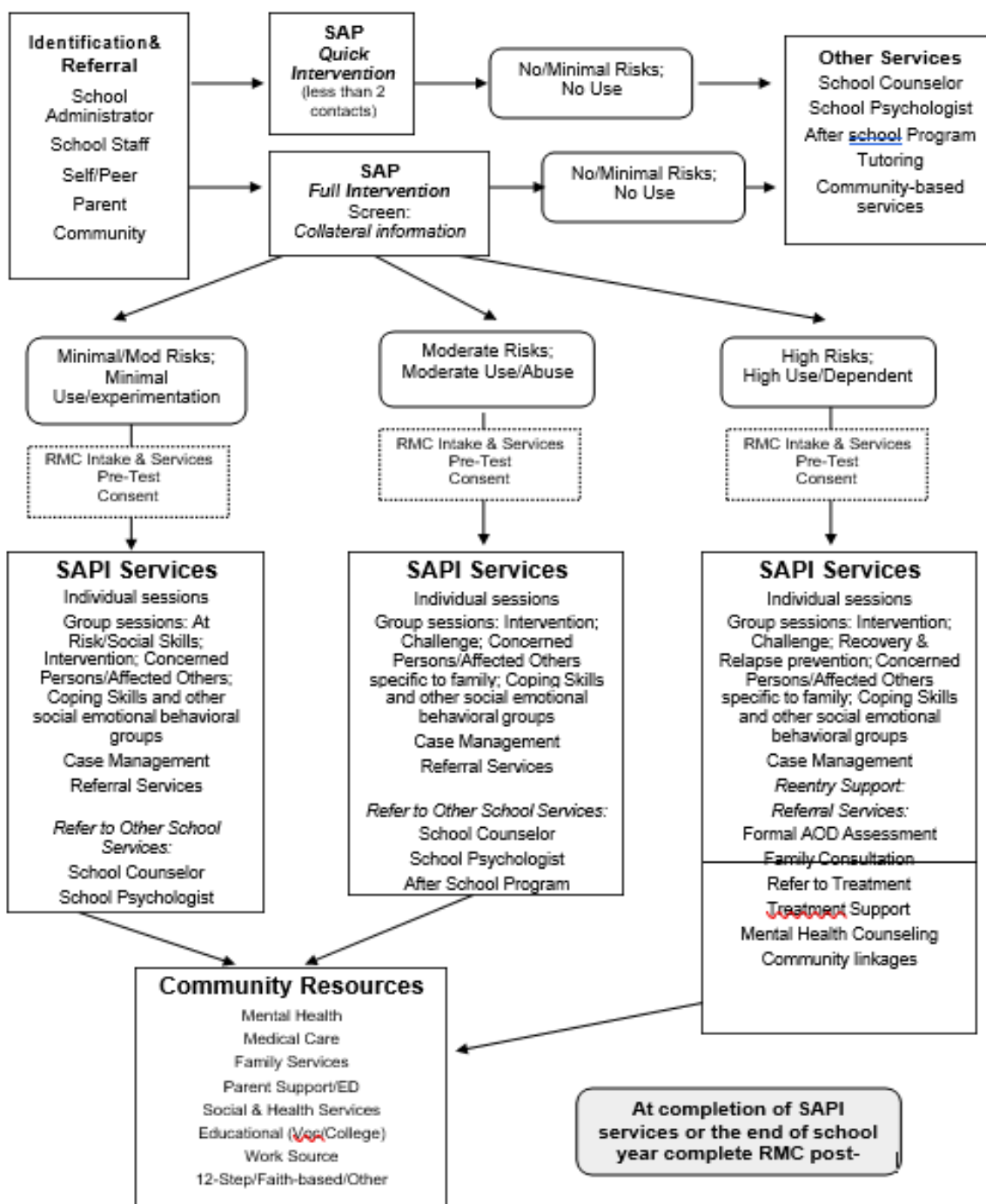
³² Deck, D. (2005). Washington State prevention and intervention services program. Data collection manual, p. 13. Office of Superintendent of Public Instruction. Olympia., WA.

- *Misused.* The student has used the substance in the past three months, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to the use and no evidence of recurrent dangerous use.
- *Abused.* The student has used during the last three months and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to the use and evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior problems. Problems have persisted for at least one month.
- *Dependent.* They meet the criteria for abuse, plus at least three of the following:
 - Greater amounts or intervals of use than intended.
 - Much of their time is spent obtaining or using the substance.
 - Frequent intoxication or withdrawal interferes with other activities.
 - Important activities are given up because of drug use.
 - Continued use despite knowledge of substance-related problems.
 - Marked tolerance.
 - Characteristic withdrawal symptoms.
 - Alcohol or other drugs are taken to relieve or avoid withdrawal symptoms.

Step Four – Intervention and Other Support Services. The final step is to *determine the best course of action and to develop placement decisions and referral recommendations for intervention* or other school and community-based service options based upon the findings of the screening process. The following suggested support service placement guideline assists program staff in determining placement using a standardized referral and services process (Figure 5.1). It is important to note that referral and service provision is not a static process but a cyclical one; students can move in and out of services, depending on need and success.

1. Students identified with **no to low risks and no use**, are referred to other school services such as the school counselor, and after school program, or tutor/mentor program.
2. Students identified with **low to moderate risks and minimal/experimental use** are enrolled in selective/indicated program services, referred to the appropriate SAS led educational support group, seen individually by the SAS, receive case management, and may be referred to other school and community based agencies based upon identified needs.
3. Students identified with **moderate risks and moderate use/abuse** are enrolled in selective/indicated program services, referred to the appropriate SAS led educational support group, seen individually by the SAS, receive case management, and may be referred to other school and community based agencies based upon identified needs.
4. Students identified with **high risks and high use/dependent** are enrolled in selective/indicated program services, referred to the appropriate SAS led educational support group, and seen individually by the SAS. Students receive case management, family consultation, and may be referred to other school and community-based agencies based upon identified needs. These students are also provided with re-entry support, upon returning from or while involved treatment.

Figure 5.1 SAPISP Decision Tree for Services



Understanding Confidentiality in SAPISP Programs

Maintaining student confidentiality is of utmost importance within the SAPISP setting. Program staff needs to be aware of not only school policies associated with disclosure of student related information but to federal and state regulations. The information outlines a process for avoiding implicit or accidental disclosure of a student's status as an individual referred for, diagnosed with, or treated for alcohol or other substance abuse in the Student Assistance Prevention-Intervention Services Program.

Confidentiality Regulation: Federal Regulations – 42 Cfr. Part 2

§2.1. Statutory authority for confidentiality of drug abuse patient records. The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act ([21 U.S.C. 1175](#)). That section as amended was transferred by Pub. L. 98–24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee–3. The amended statutory authority is set forth below:

SECT;290EE-CONFIDENTIALITY OF PATIENT RECORDS.

(a) Disclosure authorization.

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

Confidentiality: Questions and Answers³³

The need to maintain and uphold confidentiality regulations is an important task. In a question and answer format, the information below provides program staff with a clear understanding of how to avoid unintended disclosure of student information. *The information provided here does not substitute for legal counsel. In the event that question and/or issue arise regarding a student's right to confidentiality and privacy, seek the services of a competent professional.*

Unintended, implicit disclosure of student sensitive information can occur in a number of ways:

- The person disclosing the information is identified in the school and community as being a provider of referral, diagnostic or treatment services for alcohol or other substance abuse.
- Confirming that a student is a participant in the program, even if the person seeking confirmation appears to have the information independently.
- Sending a student a letter in an envelope indicating that the addressee is a client in the program.
- Faxing information or sending a letter to or about a student on program stationary.

³³ Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.

- In a message on an answering machine or voicemail.
- Disclosing sufficient information to identify a student who is in the program.
- Producing or identifying the student when police arrive with an arrest warrant, but without a proper court order.
- Failing to protest a search warrant when police do not have a proper court order.

The danger of unintended, implicit disclosure of a student's involvement in program services is somewhat lessened when the program staff providing the services is known in the school and community as providing a variety of services, such as general mental health counseling, anger management, social skills, curriculum delivery, tobacco cessation counseling, and student leadership activities.

At times, program staff needs to report information relating to a student in the program, but in doing so, the student's status as a program participant is indirectly disclosed by the mere fact that the staff member is known to exclusively provide substance abuse services. As described in more detail below, in certain circumstances program staff will need to report the information anonymously.

Even in circumstances where there are authorized consents or a legal basis for disclosure of a student's Participation in program services, take steps to ensure that accidental or indirect disclosure to unauthorized third persons does not occur, as described below.

Routine Matters (e.g. referral, attendance, taking student out of class)

Question: *How do I inform the principal or school counselor that a student was seen by program staff in pursuant to a referral?*

Answer: The consent form permits this type of disclosure. To avoid unauthorized disclosure to third parties, the information should be given in writing, on the form provided, with the warning against disclosure attached to the front of the reporting form, transmitted in a generic envelope or folded over and stapled.

Question: *How do I inform the attendance officer or principal that a student was at an appointment with me?*

Answer: The consent form permits this disclosure. To avoid unauthorized disclosure to third parties, the information should be given in writing, on the form provided, with the warning against disclosure attached to the front of the reporting form, transmitted in a generic envelope or folded over and stapled.

Question: *How do I get a student out of class for an appointment?*

Answer: Provide passes that do not identify the SAPISP as the destination.

Medical Emergencies.

Question: When may I disclose a specific diagnosis of substance abuse in a medical emergency?

Answer: The law permits the disclosure of a diagnosis to medical personnel treating the student, or another, when it is necessary for the medical treatment. This would include suicide attempts or threats, drug overdose, and tuberculosis reporting when a student is not taking medications. You must immediately document the disclosure, recording the name of the recipient and his or her affiliation with any health care facility, the name of the individual making the disclosure, the date and time of the disclosure and the nature of the emergency. If time permits, you should consult with your supervisor before making the disclosure.

Question: When the law permits me to disclose a diagnosis to medical personnel, may I tell anyone else about a diagnosis in a medical emergency?

Answer: No, you cannot reveal a diagnosis. But the consent form permits the disclosure of the fact that the student is a participant in the program to school administrators and the parents or guardian for the purpose of complying with school district policy concerning notification of medical emergencies involving students. When you notify them of the medical emergency, you must also transmit to them the warning against disclosing any information that would identify the student as a participant in the program (such as the fact that they obtained the information from program staff).

Question: What can I do when school district policy requires me to report or take other action in a medical emergency to protect a student or another person, but it is not necessary for medical treatment to disclose a student's diagnosis?

Answer: The consent form permits the disclosure of the fact that the student is a participant in the program to school administrators and the parents or guardian for the purpose of complying with school district policy concerning notification of medical emergencies involving students. The administrator may then report the medical emergency in accordance with district policy, but may not disclose the fact of the student's Participation in the program in doing so. You can report the emergency yourself if you do so without identifying your affiliation with the program. When you report the medical emergency to anyone permitted by the consent, you must also transmit to them the warning against disclosing any information that would identify the student as a participant in the program, unless they obtain consent.

Non-Medical Emergencies.

Question: When may I disclose the status of a student as a participant in the program in connection with: a) A crime or threat of crime on program premises or against program personnel? b) A crime or threat of crime elsewhere or against others? or c) Violation of school district policy regarding being on district premise or at district functions while under the influence of alcohol or drugs?

Answer:

- a) *Crime or threat of crime on program premises (against anyone) or against program personnel (anywhere).* The law permits you to report to law enforcement that a student is a participant in the program in the course of reporting that he or she has committed, or threatened to commit, a crime against anyone on the program premises or against program personnel on or off program premises. This applies to confessions of past crimes if they are within these circumstances. The consent form permits you to disclose the same information to school district administrators and the parents or guardians when required by district policy. In doing so, you may not disclose the program status of a victim or witness who is a participant in the program. You must give anyone to whom you made a disclosure the warning against disclosure without consent. If time permits, you should consult with your supervisor before making a disclosure.

- b) *Crime or threat of crime elsewhere or against others.* The consent form permits you to disclose the fact that the student is a participant in the program to school district administrators, and the parents or guardians when district policy requires you take action in cases of crimes or threats of crimes involving a student. The administrator may then report the crime or threat of crime accordance with district policy, but may not disclose the fact of the student's Participation in the program in doing so. You can report the crime or threat yourself if you do so without identifying your affiliation with the program. When you report the crime or threat to anyone permitted by the consent, you must also transmit to them the warning against disclosing any information that would identify the student as a participant in the program, unless they obtain consent. If time permits, you should consult with your supervisor before making any disclosure.

- c) *Violation of district policy concerning being under the influence of alcohol or drugs.* The consent form permits you to disclose the fact that the student is a participant in the program to school district administrators and the parents or guardians if district policy requires you to report when a student is under the influence of alcohol or drugs on district premises or at district functions. When you report the incident to anyone permitted by the consent, you must also transmit to him or her warning against disclosing any information that would identify the student as a participant in the program, unless they obtain consent. If the student's condition constitutes a medical emergency, then see the instructions pertaining to medical emergencies. If time permits, you should consult with your supervisor before making any disclosure.

Question: *What can I do to comply with State laws requiring reporting suspected child abuse or neglect?*

Answer: You may make a report and confirm a report in writing, but no more. Files may not be disclosed to any authority, including law enforcement, without consent or a proper court order.

Court Orders and Subpoenas

Question: *What do I do when I am served with a court order to disclose a student's records or a court order that accompanies a search or arrest warrant?*

Answer: Give a copy of the order to your supervisor to determine if it is proper. If he or she determines that it is a proper court order, then you may disclose the information described in the order.

Question: *What do I do if I am served with a subpoena?*

Answer: Give a copy to your supervisor. He or she may contact the student and seek his or her consent to release the subpoenaed information, or may contact the party that issued the subpoena to persuade the party to obtain a proper court order, or, if that fails, move to quash the subpoena.

Question: *What do I do if I am served with a search or arrest warrant without a court order?*

Answer: You must resist the warrants, but not to the point of using force. Contact your supervisor and try the following to avoid compliance:

- Produce a copy of the regulations and explain that you cannot cooperate unless they have a proper court order.
- Explain that your supervisor is contacting an attorney.
- Ask to contact the prosecuting attorney or commanding officer so that you can repeat your reasons for resisting without a proper court order.
- Try other appeals to reason.

If all of the above fail, do not forcibly resist. Allow the law enforcement officials to enter, but *do not point out the student or the records sought*.

Suggested SAS Protocol for Releasing Confidential Information³⁴

Federal and State law protects the confidentiality of participant records maintained by the Student Assistance Prevention-Intervention Services program. This means that the program may not disclose to anyone outside the program a participant's program status e.g. enrolled, participating, etc., or to disclose any type of communication between staff and participants. According to Federal and State law, confidentiality protections do not apply under the following circumstances:

- A student gives written consent to release information to a specific person or agency (Probation officers receives only a summary of progress toward goals).
- A court order, with special findings, requires disclosure.
- The disclosure is made in the course of reporting suspected child abuse or neglect as required by State law.
- If a participant is in danger of harming himself or herself or others, the program may notify the school administrator, counselor, parent/guardian, mental health professional, or law enforcement agency, as appropriate and necessary. This includes suicidal intent or late stage addiction constituting "imminent harm." Program staff will not disclose that a participant is involved in substance abuse services without written consent.

³⁴ Source: OESD 114 Student Services Center. Kristin Schutte, Director.

- The Program Director, in the course of carrying out his or her duties to administer the program and supervise staff.
- The disclosure is made to medical personnel in a medical emergency where disclosure of the diagnosis is necessary to treat the emergency.
- The disclosure is made to qualified personnel for research, audit or program evaluation.
- The disclosure is made in the course of reporting to law enforcement any crime committed by a participant at the program or against any program staff, or any threat of such a crime.

All participants in the program must sign the Confidentiality Notice and Consent Form. If a participant refuses to sign the form, services cannot be provided to the student or family. Each participant must read (or outline) and sign form both forms. If the child is under 13, a parent must also sign the forms. Provide a photocopy of each form along with a copy of RCW 18.130.180 (Unprofessional Conduct).

What can be shared with the Principal/Counselor without a Confidentiality and Release of Information forms signed?

- Name of students on caseload (which must be printed on Disclosure form).
- School behavior activity not related to substance using/abuse status.
- Type of services/groups provided to students without specifying names.
- CPS referral, suicide/homicide, weapon issues (follow local level protocols).

Any other information shared without a signed Release of Information is a breach of confidentiality regulations.

How to Share Additional Information: With a Release of Information signed by student and parents (when appropriate), the following information can be shared with the specific person identified:

- Information as indicated on the release form.
- Case consultation without releasing any diagnosis of student and family.
- Behavior contracts, case management, and family situations.

If a participant is willing to sign a Release of Information form to parent(s), school administration, counselor, or legal authorities, specify the name of each individual receiving the information. Do not use referent titles such as "administration" or "school counselor."

Participation on Student Assistance Teams (SAT): We want SAS to participate in SAT/teams; however, unless the Release of Information form includes the names of all team members, information regarding specific students and/or families may not be disclosed.

- Involvement in the SAT/teams can help generate referrals and gain information.
- SAS may case consult at any time regarding a child/family *if they have not previously met with the child or family or in general terms without being specific about a student on his/her caseload.*

Helpful Hints to Build Relations without a Signed Release:

- Assist teachers and building administrators by providing generic descriptions of a child coming from a difficult home environment.
- Provide global informational handouts related to classroom management, supporting challenging youth, and implementing behavior plans.

Sample Forms for Compliance with Confidentiality Regulations. The following pages provide a collection of sample forms and resource information for use within the SAPISP program when enrolling a student in selective and indicated services. The forms cover a variety of areas related to the internal referral process including a Referral Form, Sample Intake Form, Confidentiality Notice and Consent Form, Disclosure Statement and Consent Form, Consent for Exchange of Confidential Information, and staff feedback forms.

- Checklist for agency-based SAPISP programs to ensure forms comply with regulations.
- Confidentiality Notice and Consent Form.
- Disclosure Statement and Consent Form.
- Consent for Exchange of Confidential Information.
- Attendance document for School Administrator.
- Transmittal Form cover page.
- Parent letter regarding violation of the school district policy.
- Confidentiality Agreement for SAT members.
- Protection of Public Rights Amendment (PPRA): Model Notification of Rights.

Sample³⁵

SAPISP Confidentiality Forms Checklist for Agency-Based Program

√	Form	Purpose	Key Elements
	Consent to Seek Parental Permission for Student Participation in Program	To be used before the start of services to obtain participant's authorization to seek parental permission for student to participate in the program.	<ul style="list-style-type: none"> • Must comply with 42 C.F.R. § 2.31. • Advise participant that records are protected under federal and state laws and regulations; application for services are governed by 42 C.F.R. Part 2 and cannot be disclosed without written consent; consent may be revoked at any time except if already relied upon; consent expires on specific date, event, or condition. • Signed by participant.
	Parental Permission	To be used after receiving consent from participant, and before the start of services, to ensure parent's awareness that child of any age intends to participate in any aspect of the program.	<ul style="list-style-type: none"> • Include a description of program mission, goals, and services. • Provide notice regarding confidentiality of information. • Signed by parent/guardian.
	Disclosure Statement and Consent	To be used at the start of services to (a) provide mandatory disclosures, and (b) obtain consent for services.	<ul style="list-style-type: none"> • Must comply with chapter 18.19 RCW and WAC 246-810-310. • Provide list of the acts of unprofessional conduct in RCW 18.130.180. • Signed by both participant and P/IS professional. • Signed by parent/guardian if participant under 13.
	Federal Confidentiality Notice and Consent	To be used at the start of services to (a) provide notice of confidentiality rights, and (b) obtain consent for additional releases of confidential information that are critical to the success of the program.	<ul style="list-style-type: none"> • Organize form into two sections on (1) notice, and (2) consent. • Notice section must comply with 42 C.F.R. § 2.22. • Consent section should seek from participant consent for release of limited confidential information to school administrators and parents regarding Participation in program. • Consent section must indicate that anyone receiving information will be given written notice prohibiting re-disclosure without consent; consent may be revoked at any time except if already relied upon; and consent expires when participant is no longer a student in district.

³⁵ Source: Puget Sound ESD, Prevention Center, Kimberly Noel, Director

√	Form	Purpose	Key Elements
			<ul style="list-style-type: none"> • Signed by both participant and SAPISP professional. • Signed by parent/guardian if participant under 13.
	Consent for Exchange of Confidential Information	To be used to obtain consent either to send confidential information to other persons or to receive confidential information from other persons.	<ul style="list-style-type: none"> • Must comply with 42 C.F.R. § 2.31. • When seeking information, health care providers may require that consent complies with additional HIPAA Privacy Rule requirements. • Signed by participant. • Signed by parent/guardian if participant under 13.
	Transmittal Cover Sheet	To be used as a cover sheet anytime that confidential information is disclosed.	<ul style="list-style-type: none"> • Must include redisclosure language contained in 42 C.F.R. § 2.32.

Sample

Student Assistance Prevention-Intervention Services Program Confidentiality Notice and Consent Form³⁶

A. Notice of Confidentiality of Program Participant Records. Federal and State law protects the confidentiality of participant records maintained by this Student Assistance Prevention Intervention Services Program (the Program). Generally, this means that the Program may not disclose to anyone outside the Program that a participant attends the Program or disclose communications between staff and participants. Under Federal and State law, confidentiality protections do not apply in these circumstances:

Exceptions applicable to all Program participants:

- A participant gives written consent to release information to a specific person or agency. (Probation officers will receive only a summary of work done toward goals).
- A court order that includes special findings requires it.
- The disclosure is made in the course of reporting suspected child abuse or neglect as required by State law.
- When a person is in danger of harming themselves or others the Program may notify school administrators, counselor, parents/guardian, a Mental Health Professional, or law enforcement, as may be appropriate and necessary. This includes suicidal intent or late stage addiction constituting "imminent harm." Program staff will not disclose that a participant is being seen for substance abuse without written consent.
- The Program Director, in the course of carrying out his or her duties to administer the Program and supervise staff.
- The disclosure is made to medical personnel in a medical emergency where disclosure of the diagnosis is necessary to treat the emergency.
- The disclosure is made to qualified personnel for research, audit, or program evaluation.
- The disclosure is made in the course of reporting to law enforcement any crime committed by a participant at the Program or against any Program staff, or any threat of such a crime.

For substance abuse programs, federal law prohibits disclosure outside the Program that a participant is being seen in the Program for a substance abuse problem or disclosure of any information that identifies a participant as a person who has a substance abuse problem, except for the circumstances described above. Violation of this Federal law and regulation by the Program is a crime. You may report suspected violations to the appropriate authorities in accordance with Federal regulations. (See Federal laws 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 and Federal regulations 42 CFR, Part 2.). In all cases described above, except when written consent is given, the Program Director will be consulted before any disclosure is made. In all cases, the recipient of the disclosure will be informed that disclosure is not permitted without your written consent.

³⁶ Source: OESD 114 Prevention and Treatment Center, Kristin Schutte, Director

B. Consent for Release of Confidential Information. Because this is a school-based program offered in cooperation with your school district, you are asked to consent to the disclosure of limited information (including your status as a participant in the Program for substance abuse, if applicable) to school administrators and your parents or guardian under the following circumstances:

- The fact that you have complied with a referral to the Program (including completing or dropping out of the program) may be disclosed to a school principal or counselor for the purpose of informing them how your needs are being served.
- The dates and times of your attendance at the Program may be disclosed to a school principal or attendance officer for the purpose of verifying that you complied with the State school attendance laws and were properly absent from class.
- The fact that you are a participant in the Program may be disclosed to school administrators and your parents or guardians if Program staff are obligated to report a medical emergency in accordance with school district policy and procedures concerning notification of medical emergencies involving students.
- The fact that you are a participant in the Program may be disclosed to school administrators and your parents or guardians if Program staff are obligated to report any violations by you of school district policies, including those concerning the commission of a crime, or threat to commit a crime, on school premises or being on school premises or at school functions under the influence of alcohol or drugs.

Anyone receiving information allowed by this Consent will also be given written notice that they may not further disclose the information unless you give written consent.

You may revoke this Consent at any time except to the extent that action has been taken in reliance on it and, in any event, this Consent expires automatically when you are no longer a student in the School District in which you are currently enrolled.

C. Signature. I have read the Notice of Confidentiality Participant Records and the Consent for Release of Confidential Information and had them explained to me.

_____ Signature of participant/student	_____ Date
_____ Signature of parent/guardian*	_____ Date
_____ Signature of Specialist	_____ Date

* Required for students under the age of 13.

Sample³⁷

Consent for Exchange of Confidential Information

Student Name: _____ Date of Birth: _____

I hereby consent to the exchange of information described below by _____ [Agency Name] and
_____ [Name of Specialist].

Name: _____

Institutional Affiliation/Relationship: _____

Address: _____

Type of Information:

- Identifying information (e.g. name, birth date, SSN, dates admitted to/discharged from program)
- Emergency contacts
- Medical and medication information, including diagnosis
- Alcohol/Drug assessment, evaluation, diagnosis, treatment recommendations, and prognosis
- Results of urinalysis or other drug and alcohol tests
- Student's counseling experience
- Legal, social, educational, and vocational history
- Treatment history and progress
- Identified strengths of the family and student
- Current family stressors or challenges
- Discharge summary and recommendations
- Other _____

Purpose of Information:

- Access in emergency situations
- Exchange and verify client case planning information
- Access resources that best meets needs of the family
- Assist in appropriate treatment placements
- Brainstorm solutions to decrease family stressors
- Other _____

This consent is in effect until _____ but does not authorize the release of information relating to future care received more than 90 days after this date. This consent is subject to revocation, orally or in writing, at any time except to the extent [agency name] has already taken action in reliance on it. No disclosure may be made without specific authorization.

Student

Date

Parent/Guardian*

Date

* Required for students under the age of 13

³⁷ Source: OESD 114 Student Services Center. Kristin Schutte, Director

Sample³⁸

Attendance/Referral Feedback Form For a Student Assistance Prevention Intervention Program

The following is confidential information:

TO: _____

FROM: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Prohibition on Redisclosure

This information is disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

³⁸ Source: OESD 114 Student Services Center, Kristin Schutte, Director

Sample³⁹
Transmittal Cover Sheet

To: _____

PROHIBITION ON REDISCLOSURE

This information is disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

³⁹ Source: OESD 114 Student Services Center, Kristin Schutte, Director

Sample⁴⁰

Parent Letter

(Date)

(Parent's address)

Dear _____,

Your child, _____, has been referred to me for a violation of the school district policy. Unfortunately, I have been unable to contact you by telephone to discuss my role in your child's intervention.

Please feel free to contact me at _____ with any questions or concerns you may have. If I am not available, please leave a number and a time when I can reach you. I am happy to discuss how I might assist you with this discipline referral.

Sincerely,

Program Staff Name (Print Name)

⁴⁰ Source: OESD 114 Student Services Center, Kristin Schutte, Director

Sample⁴¹

Student Assistance Prevention-Intervention Services Program Confidentiality Agreement⁴²

As an administrator, counselor, and/or teacher, in connection with the SAPISP services, I agree to the following:

1. All files, charts, notes, and other written material, concerning students will be held in staff offices or former students will be secured when not being used.
2. All discussions concerning students will be held in staff offices or other places which assure privacy.
3. All information about students or former students will be kept confidential.
4. No privileged information about students or former students will be discussed with families and/or friends.
5. For privileged information, written or verbal, to be shared with agencies or professionals, written authorization will first be obtained from the student.

Signature

Student Assistance Specialist

Date

⁴¹ Source: OESD 114 Student Services Center, Kristin Schutte, Director

⁴² Source: OESD 114 Prevention and Treatment Center, Kirstin Schutte, Director

Sample

Protection of Pupil Rights Amendment (PPRA): Model Notification of Rights⁴³

The PPRA affords parents certain rights regarding our conduct of surveys, collection and use of information for marketing purposes, and certain physical exams. These include the right to:

- *Consent* before students are required to submit to a survey that concerns one or more of the following protected areas (“protected information survey”) if the survey is funded in whole or in part by a program of the United States Department of Education (ED):
 1. Political affiliations or beliefs of the student or student’s parent.
 2. Mental or psychological problems of the student or student’s family.
 3. Sex behavior or attitudes.
 4. Illegal, anti-social, self-incriminating, or demeaning behavior.
 5. Critical appraisals of others with whom respondents have close family relationships.
 6. Legally recognized privileged relationships, such as with lawyers, doctors, or ministers.
 7. Religious practices, affiliations, or beliefs of the student or parents.
 8. Income, other than as required by law to determine program eligibility.
- *Receive notice and an opportunity to opt a student out of:*
 1. Any other protected information survey, regardless of funding.
 2. Any nonemergency, invasive physical exam or screening required as a condition of attendance, administered by the school or its agent, and not necessary to protect the immediate health and safety of a student, except for hearing, vision, or scoliosis screenings, or any physical exam or screening permitted or required under State law.
 3. Activities involving collection, disclosure, or use of personal information obtained from students for marketing or to sell or otherwise distribute the information to others.
- *Inspect*, upon request and before administration or use:
 1. Protected information surveys of students.
 2. Instruments used to collect personal information from students for any of the above marketing, sales, or other distribution purposes.
 3. Instructional material used as part of the educational curriculum.

These rights transfer to from the parents to a student who is 18 years old or an emancipated minor under State law.

[School District will/has develop[ed] and adopt[ed]] policies, in consultation with parents, regarding these rights, as well as arrangements to protect student privacy in the administration of protected information surveys and the collection, disclosure, or use of personal information for marketing, sales, or other distribution purposes. **[School District]** will directly notify parents of these policies at least annually at the start of each school year and after any substantive changes. **[School District]** will also directly notify, such as through United States Mail or email,

⁴³ Source: Puget Sound ESD, Prevention Center, Kimberly Noel, Director

parents of students who are scheduled to participate in the specific activities or surveys noted below and will provide an opportunity for the parent to opt his or her child out of Participation of the specific activity or survey. **[School District]** will make this notification to parents at the beginning of the school year if the District has identified the specific or approximate dates of the activities or surveys at that time. For surveys and activities scheduled after the school year starts, parents will be provided reasonable notification of the planned activities and surveys listed below and be provided an opportunity to opt their child out of such activities and surveys. Parents will also be provided an opportunity to review any pertinent surveys. Following is a list of the specific activities and surveys covered under this requirement:

- Collection, disclosure, or use of personal information for marketing, sales, or other distribution.
- Administration of any protected information survey not funded in whole or in part by education.
- Any nonemergency, invasive physical examination or screening as described above.

Parents who believe their rights have been violated may file a complaint with:

Family Policy Compliance Office
United States Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5901

Record Keeping

Each project site determines what records are kept and how records are to be stored. It is recommended that the SAS maintain at a minimum referral, screening, group or individual attendance and topic log records, signed Confidentiality Notice and Consent Form, Disclosure Statement and Consent Form, Consent for Exchange of Confidential Information. ***A single copy of these forms, along with other significant records, are kept in the Student Assistance Prevention Intervention Services Program locking file cabinet for each student with these kept separate from student records.*** DBHR requires that records are kept for six years (WAC 275-19-170).

Close Out Procedures for Records

The following steps are to be used as a guide to assist with record keeping procedures once a student has completed services and records need to be transferred to the main ESD/School District office location. Note: According to WAC 275-19-170 records are to be kept in a locked filing cabinet located in a room that also locks.

Student records are to be closed-out when a student has moved out-of-state, graduated, or no longer need program services (this includes possibility of services needed in the future).

The SAS consolidates the following information for each student.

- List the student's name, ID number, date, and name of school on folder tab. Each folder should include the following (those items with an * may not be in every students file)
- A brief statement of the reason for file closure (see example below), and a list of groups attended. Signed and dated.
- Referral form *
- Confidentiality & Release forms/permission
- All releases*
- Screening tools i.e. intake, screening/pre-assessment tool (e.g. GAIN SS, GAIN Q, SASSI, or PESQ, drug log, etc.)
- Individual attendance records
- Referral recommendations *
- All CPS reports/documentation, Suicide No Harm contracts and Homicidal/Behavior contracts *

Sample Close Out Statement

The record for John Doe is being closed because he moved out of the district in March 2005. John Doe participated in the following groups during the 2004–05 program year: Insight and Recovery Support.

Or

The record for John Doe is being closed because he is graduating in June 2005. John Doe participated in the following groups during the 2004–05 program year: Insight and Recovery Support.

Sample SAPISP Forms

On the following pages is a collection of sample forms to assist the SAS with data collection, record keeping and to track student progress.

1. School staff referral form
2. Parent Permission Form
3. Sample Intake Form
4. Screening – Recommendation and Referral
5. Group Attendance Log (located in Section 8 Educational Support Groups)*
6. Individual Attendance Log*
7. Personal Progress Chart*
8. Student Outcome Plan*
9. Suggested Guidelines in Responding to Disciplinary Referrals

Other records may include correspondence from treatment agencies and community mental health or other community counseling agencies, CPS reports, suicide contracts, or juvenile justice probation information.

* Note: The Group Attendance Log, Individual Attendance Log Personal Progress Chart, and Student Outcome Plan are forms that the SAS can use to document progress. It is up to the Project Coordinator and/or Supervisor to determine what level of progress to record.

Sample

Student Assistance Prevention-Intervention Services Program School Staff Referral Form

Date of Referral _____ Person Reporting _____
Student Name _____ Grade _____ Age _____
Homeroom Teacher _____

Areas of Concern (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> No interest in school and poor academic performance | <input type="checkbox"/> Threats toward others |
| <input type="checkbox"/> Frequent absence/tardiness | <input type="checkbox"/> Atypical behaviors (lack of attention to hygiene, grooming, dress) |
| <input type="checkbox"/> Sudden or extreme behavior/attitude change or appearance | <input type="checkbox"/> Unusual risk-taking behaviors |
| <input type="checkbox"/> Withdrawn or feelings of isolation and/or being alone | <input type="checkbox"/> Aggressive/hostile behaviors |
| <input type="checkbox"/> Detachment/lack of bonding | <input type="checkbox"/> Patterns of impulsive and chronic hitting, intimidation, and bullying behaviors |
| <input type="checkbox"/> Feelings of being picked on or persecuted | <input type="checkbox"/> History of disciplinary problems |
| <input type="checkbox"/> Being a victim of violence | <input type="checkbox"/> Delinquent/criminal activity |
| <input type="checkbox"/> Uncontrolled anger | <input type="checkbox"/> Unusual interest/preoccupation with weapons |
| <input type="checkbox"/> Excessive feelings of isolation and being alone | <input type="checkbox"/> Expression of violence in writings or drawings |
| <input type="checkbox"/> Suicide threats/self-mutilation | <input type="checkbox"/> Suspected substance abuse |
| <input type="checkbox"/> Family substance abuse or violence | |

Please note any additional concerns or pertinent information regarding this student's behavior:

Sample Parent Permission Student Assistance Prevention-Intervention Services Program⁴⁴

Mission and Goals: The SAPISP provides a comprehensive, school-based approach for the prevention, identification, intervention, and support services for secondary schools. The program is successful due to the collaborative efforts among students, parents, schools, and community resources. The program is designed to:

1. Reduce student risk for alcohol, tobacco and other substance abuse;
2. Strengthen healthy attitudes, positive decision-making skills and provide clear standards for behavior;
3. Provide referral and support services for students and families;
4. Provide education for parents, schools and community on ways to support the social/emotional health of our youth; and
5. Assist students to achieve academic and social success.

Program services include:

- ATOD Education classes for students and/or parents
- Classroom presentations/education
- Consultation for parents and Staff
- Youth Empowerment activities, cross-age education, youth led schoolwide prevention events
- Social Skills, educational support groups, and social emotional learning
- Support for youth with friends that use
- Referrals to community services
- Screening for high risk behaviors
- Tobacco Cessation education and support
- Case management with school team
- Informational workshops

Your child has expressed interest in and/or has been invited to participate in one or more aspects of this program. All services are based on best practices and provided by a qualified professional with youth/school-based services experience. This program is available at NO COST through district, state, and federal funding. Federal and state law protects the confidentiality of participant records maintained by the SAPISP Program.

In an effort to measure the benefits of services on students and to continually improve practices, your child may be asked to provide information in the form of a questionnaire both at the beginning and at the conclusion of services regarding: attitudes and behaviors related to substance abuse, school experience, and this program. Parents must give consent before their

⁴⁴ Source: Puget Sound ESD 121, Prevention Center, Kimberly Noel, Director

children can participate in these questionnaires, pursuant to the Protection of Pupil Rights Amendment ("PPRA").

By signing below, you are agreeing to your youth's participation in one or more of the above services. In addition, you are consenting to allowing the program to administer the questionnaire for program evaluation purposes.

This consent expires at the end of the 2005–06 school year.

Signature

Printed name

Student's name

Date

THANK YOU FOR YOUR COMMITMENT TO HELP OUR PROGRAM. TOGETHER WE ARE INVESTED IN SUPPORTING AND STRENGTHENING STUDENT SUCCESS!

Sample Intake Form

1. Student ID #: _____ 2. School: _____ 3. Enrollment Date: _____

Demographic Information

4. Student Name (Last, First, MI): _____

5. Gender: (circle one) _____ 6. DOB: (mm/dd/yyyy) _____ 7. Age: _____
a. Female c. Transgender (ID as female)
b. Male d. Transgender (ID as male)

8. Race: (circle one) _____ c. Asian F. Hispanic, Latino, or Chicano
a. White/Caucasian d. American Indian/Alaska Native g. Multi-racial (specify) _____
b. Black/African American e. Native Hawaiian/Pacific Islander h. Other (specify) _____

9. Living Arrangement (circle one) d. Mother and stepparent h. Grandparent(s)
a. Both parents e. Father and stepparent i. Other relative (specify) _____
b. Mother only f. Mother and partner j. Foster care
c. Father only g. Father and partner k. Homeless
i. Other (specify) _____

10. Address: _____ 11. City: _____ 12. State: ____ 13. Zip: _____

14. Home Phone: _____ 15. Cell Phone: _____ 16. Work Phone: _____

17. Email: _____

18. Parent/Responsible Adult (Last, First, MI): _____ 19. Daytime Phone: _____

20. Responsible Adult Address: _____ 21. City: _____ 22. State: ____ 23. Zip: ____

24. Responsible Adult's Employer: _____ 25. Work Phone: _____

26. Student's Employer: _____ 27. Work Phone: _____

28. Emergency Contact (Last, First) (different from #18): _____

29. Emergency Phone: _____

School/Education History

30. Last School Attended (name, city, state): _____

31. Last Date Attended (mm/dd/yyyy): _____

32. Highest Grade Completed: ____ 33. On Track to Graduate: 34. Ever held back or flunked:
a. Yes ____ b. No ____ a. Yes (# of times) __ b. No

35. School Services (circle all that apply)

a. Regular Classroom d. Gifted/Honors g. Alternative School
b. Bilingual Education e. Home/Hospital h. Family Support/RTL
c. Title I/LAP f. Special Education g. Tutor

36. Current Enrollment Status: 37. Attendance: (most recent sem.) 38. Suspension/Expulsion History:

a. GED Prep a. Excellent, no unexcused absences a. 1 time
b. Enrolled full-time b. Good, few unexcused absences b. 2–3 times
c. Enrolled part-time c. Some partial day unex. absences c. 4–5 times
d. Suspended d. Some full day unex. absences d. 6–7 times
e. Expelled e. Truancy petition/equivalent or
withdrawn e. 8 or more times
f. Never suspended/expelled

39. Academic Performance (most recent semester): c. 2.0–3.0 (mostly B's and C's, no F's)
a. Honor student (mostly A's) d. 1-0–2-0 (mostly C's and D's, some F's)
b. Above 3.0 (mostly A's and B's) e. Below 1.0 (some D's and mostly F's)

Juvenile Justice History

40. Juvenile Justice Status:

(circle all that apply):

- a. On probation
- b. On diversion
- c. Other (specify) _____

Reports to: _____

41. Criminal History:

(circle all that apply):

- a. Against person offense/arrests (specify) _____
- b. Property offenses/arrests (specify) _____
- c. Drug/alcohol offenses/arrests (specify) _____
- d. Other offenses/arrests (specify) _____
- e. None

42. Age of first offense: _____

43. Times in secure confinement: _____

Personal History

44. In your lifetime, have you ever been ...

- a. physically abused?
- b. sexually abused?
- c. Emotionally abused?
- d. involved with CPS/ICW?

45. Mental Health Diagnosis

- a. Yes (specify) _____
- b. No.
- c. Unknown

46. Past/Current AOD Assessment

- a. Yes (specify agency) _____
- b. No
- c. Unknown

47. Sexually active? Y N

48. Pregnant? Y N

49. Parent? Y N

50. Extracurricular Activities

- a. Currently involved? If yes, specify _____
- b. Previously involved? If yes, when _____

51. Student Self-assessment of Problem: _____

52. Peer Behaviors (past 30 days):

- a. % of friends who used any drugs _____
- b. % who got drunk (5 or more drinks) _____
- c. % of friends who worked full-time _____
- d. % involved in illegal activity _____

Family Bonding/Attachment

53. Family Relationships:

	Age	Rating	Current/Past Substance Abuse	
		(1=poor / 10-excellent)	Yes	No
a. Name _____	Age ____	Rating ____	Yes	No
b. Name _____	Age ____	Rating ____	Yes	No
c. Name _____	Age ____	Rating ____	Yes	No
d. Name _____	Age ____	Rating ____	Yes	No

ATOD Use History

54. In your lifetime, have you ever used any alcohol, marijuana, hallucinogens, amphetamines, cocaine/crack, inhalants, or other drugs?

- a. Yes
- b. No (if No, skip to question 60)

Severity of Use. The following section asks questions about your specific drug use. Please be honest about your drug use, if any.

Drug used	Age of first use	Last time used (days)	In past 90 days, how many days did you use?	What was the most you had in one day	What was the least you had in one day?	How much do you normally use?	How often do you use?
a. Tobacco							
b. Alcohol							
c. Marijuana							

Drug used	Age of first use	Last time used (days)	In past 90 days, how many days did you use?	What was the most you had in one day	What was the least you had in one day?	How much do you normally use?	How often do you use?
d. Amphetamines							
e. Heroin							
f. Ecstasy							
g. Hallucinogens							
h. Rx drugs							
i. OTC drugs							
j. Other							
J, Other							

56. Has your alcohol/drug use ever caused you problems at home or at school?

Yes No

57. Have you ever dealt drugs?

Yes No

58. Do you think you may have a problem with alcohol, marijuana, or other drugs?

Yes No

59. Do you want help with your drug use?

Yes No

Family Use History

60. Do you ever worry about your mom's or dad's drinking, use of medication, or use of drugs?

Yes No

61. Do you wish your mom or dad drank less or used less medication or used fewer drugs?

Yes No

62. Do you wish your mom or dad didn't drink at all, didn't use medication, or didn't use any drugs?

Yes No

63. What make you worry or wish? _____

Other Information

64. Reason for Referral (circle all that apply)

- a. Possible ATOD use
- b. Behavior/Peer Relations
- c. School Problems (academic performance, attendance)
- d. Home/neighborhood issues
- e. Mental Health issues

65. Previously enrolled in SAPISP program?

- a. Yes (specify) _____
- b. No

66. Parent involved in process?

- a. Yes Called _____ Family conference _____ Info provided _____ Release signed to parent _____
- b. No

67. Intervention Group Completed

- a. Yes
- b. No, if not reason _____

Sample⁴⁵
Screening Recommendations and Referral

_____ has completed an Alcohol and Other Drug Screening.
Name

Based on this process, I _____ am making the following
Student Assistance Specialist
recommendations:

_____ No further services are necessary at this time.

_____ Referral to an Educational Support Group

_____ Further adolescent and family educating/counseling
_____ Social Skills _____ Challenge _____ Recovery
_____ Affected/Concerned others _____ Other

_____ Monitor Urinalysis for Abstinence

_____ Referral for alcohol and other drugs assessment to determine necessary treatment needs for Outpatient, Intensive Outpatient, or Inpatient.

Agency referrals:

1. _____
2. _____
3. _____

Additional Counselor Comments:

Student Assistance Specialist

Date

Phone

PROHIBITION ON DISCLOSURE

This information is disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

⁴⁵ Source: OESD 114 Prevention and Treatment Center, Kristin Schutte, Director.

Sample⁴⁶ SAPISP Individual Attendance Log

Student Name: _____ ID # _____

School: _____ School Year: _____

Status: Active _____ *Closed Code _____

DATE	TOPIC CODE(S)	DATE	TOPIC CODE(S)

Topic Codes

- I = Intake
- CU = Consequences of use
- DUH = Drug use history

- SS = Social skills
- CO = Concern for other's use
- SA = Self-assessment

- RS = Recovery support
- RU = Reasons for use
- O = Other

Closed Codes*

- M = Moved/transferred
- A = Alt. school
- C = Completed
- O = Other/unknown

- Q = Quit program
- D = Dropped out
- G = Graduated

- S = Suspended/Expelled
- JD = Juvenile Detention
- E = End of school year

⁴⁶ Source: OESD 114 Prevention and Treatment Center, Kristin Schutte, Director

Sample⁴⁷ Personal Progress Chart

Name: _____ Date: _____

Address: _____

Phone Number: _____ Cell: _____

Grade: _____ Age: _____

Parent: _____

Evaluation Date: _____ Location: _____

With: _____ Completed: _____

Recommendations: _____

AA Meetings Requested: _____ Completed: _____

Problem	Solution	Goal	Outcome

Student Assistance Specialist: _____

Comments: _____

⁴⁷ Source: Puget Sound ESD Prevention Center, Kimberly Noel, Director

Sample⁴⁸ Student Outcome Plan

Student Assistance Specialist: _____ Date: _____

District: _____ Building: _____ Review Date: _____

Student: _____ Grade Level: _____ Review Date: _____

(Use code number)

Counseling:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Challenge |
| <input type="checkbox"/> At Risk/Social Skills | <input type="checkbox"/> Intervention (Insight) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Affected Others | <input type="checkbox"/> Recovery Support | |

Description of Intervention Goals: (<i>Establish at least two goals</i>)	Academic Goals: (<i>Establish at least one goal</i>)
Goal 1	Goal 1
Goal 2	Goal 2
Goal 3	Goal 3
Objectives for Meeting Goals	Objectives
Objective 1	Objective 1
Objective 2	Objective 2
Objective 3	Objective 3

⁴⁸ Source: OESD 114 Prevention and Treatment Center, Kristin Schutte, Director; Puget Sound ESD Prevention Center, Kimberly Noel, Director

Suggested Guidelines in Responding to Disciplinary Referrals⁴⁹

The following provides a guideline for steps that program staff can take in response to student violation of drug policies and subsequent disciplinary referrals to the Student Assistance Program (OESD 114, 2002).

Suggested Protocol

- Once a referral is received from an administrator, make a serious attempt to contact and involve parents in the intervention process prior to meeting with the student. Make two attempts to contact the parents by telephone, leaving a message regarding how and when they can return your call. If there is no response after two attempts, send the parent letter. **Due to federal confidentiality laws, technically we can only leave our name, and contact information. No information regarding the student’s ATOD referral can be left in the phone message or included in a letter. In a phone message, the SAS might say, “I am the Student Assistance Specialist and your (child’s name) was referred to me.”**

Research has indicated that a child is less likely to use alcohol/drugs when a parent:

- Is positively involved with his/her child.*
- Monitors his/her behavior.*
- Uses effective discipline (i.e. setting limits/boundaries that are consistent and clear).*

- As part of a face-to-face meeting or phone conversation, explain to the parent your process for screening, referral and the disciplinary procedures. Use the parent questionnaire as a guide to conduct an interview regarding the parents’ concerns related to their child’s potential ATOD use. Provide the parent with a list of signs and symptoms, as well as educate the parent on communication and monitoring skills to support his/her child.

- Following the meeting one or more of the processes may occur:

Scenario 1	Scenario 2
Following parent meeting you meet with the student individually and begin the intervention by getting to know the student and completing the intake process.	Following parent meeting you meet with the student in Insight group and begin the intervention process through the insight group.
Determine if the student is appropriate for an in-school intervention program (TEG, ATOD Education, or Insight) or needs to be referred to an outside agency for completion of the intervention (i.e. Intervention) or both.	Determine if the student is appropriate for ongoing in-school intervention support or needs to be referred to an outside agency for completion of the intervention (i.e. Intervention) or both.
If the student is appropriate for in-school intervention—complete the program with the student	Upon completion of the intervention, make additional recommendations to the referring administrator.
Upon completion of the intervention, make additional recommendations to the referring administrator.	Meet again with the parent(s) and the student to discuss any further recommendations.

⁴⁹ Source: OESD 114 Student Services Center. Kristin Schutte, Director

Additional Resources

Being Specifically Alert to Substance Abuse Indicators⁵⁰

The first part of the article can be found on page 103 of the program manual in the Internal Referral Process section.

Amphetamines (stimulants)

Excessive activity	Rapid speech
Irritability	Appetite loss
Anxiety	Extreme moods and shifts
Erratic eating and sleeping patterns	Fatigue
Disorientation and confusion	Increased blood pressure and body temp.
Increased respiration	Increased and irregular pulse
Tremors	

Cocaine (stimulant, anesthetic)

Short-lived euphoria followed by depression	Nervousness and anxiety
Irritability	Shallow breathing
Fever	Tremors
Tightening muscles	

Inhalants

Euphoria	Intoxicated look
Odors	Nausea
Drowsiness	Stupor
Headaches	Fainting
Poor muscle control	Rapid heartbeat
Anemia	Choking

Cannabinoids (e.g., marijuana, hash, THC)

Increased appetite initially	Decreased appetite with chronic use
Euphoria	Decreased motivation for many activities
Apathy, passivity	Decreased concentration
Altered sense of time and space	Inappropriate laughter
Rapid flow of ideas	Anxiety; panic
Irritability, restlessness	Decreased motor skill coordination
Characteristic odor on breath and clothes	Increased pulse rate
Droopy, bloodshot eyes	Irregular menses

Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

Extreme mood swings	Poor concentration
Confusion	Insensitivity to pain
Drowsiness/decreased respiration	Slow, shallow breathing

⁵⁰ Excerpt from: Resource Aid Packet on Substance Abuse. UCLA Center for Mental Health in Schools, Dept. of Psychology, PO Box 951563, Los Angeles, CA 90095 pp 37-39. Available at: <http://smhp.psych.ucla.edu/pdfdocs/Substance/substance.pdf>

Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

Decreased motor coordination	Itchiness
Watery eyes/pinpoint pupils	Lethargy
Weight loss	Decreased blood pressure
Possible needle marks	As drug wears off, nausea and runny nose

Barbiturates, sedatives, tranquilizers (CNS depressants)

Decreased alertness	Intoxicated look
Drowsy	Decreased motor coordination
Slurred speech	Confused
Extreme mood swings	Erratic eating and sleeping patterns
Dizzy	Cold, clammy skin
Decreased respiration and pulse	Dilated pupils
Depressed mood state	Disinhibition

Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)

Extreme mood alteration and intensification	Loss of sense of time, place, person
Decreased communication	Panic and anxiety
Paranoia	Extreme, unstable behaviors
Restlessness	Tremors
Nausea	Flashbacks
Increased blood pressure	Impaired speech
Impaired motor coordination	Motor agitation
Decreased response to pain	Watery eyes
Altered perceptions of time, space, sights, sounds, colors	

Section 6

Considerations for Vulnerable, Greater-Risk Populations

Introduction

This section was written to raise the awareness of Student Assistance Specialist (SAS) and Project Coordinators about identified populations/groups/individuals that have shown to be at high risk of developing a behavioral health problem. The bio-psychological-social make up, social-environment and upbringing, and/or genetic predisposition appear to have an impact as to what makes these populations/groups/individuals more vulnerable and at greater risk for substance abuse problems.

In addition, the Substance Abuse and Mental Health Administration Services in 2011 action plan for 2011-14 identified eight Strategic Initiatives. The following Strategic Initiatives align with the vulnerable-greater-risk populations/groups/individuals:

Strategic Initiatives # 1: Prevention of Substance Abuse and Mental Illness

Goal 1.3 – Prevent suicide and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indian and Alaskan Native (p. 8).

Strategic Initiatives # 2: Trauma and Justice

Goal 2.3 – Reduce the impact of trauma and violence in children, youth and families (p. 8).

Strategic Initiatives # 3 Military Families

Goal 3.2 – Improve the quality of behavioral health-focused prevention, treatment and recovery support services by helping providers respond to the needs within the military family cultures.

Goal 3.3 – Promote behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health and prevent suicide (p.9).

Strategic Initiatives # 8 Public Awareness and Support

Goal 8.1 – Increase public understanding about mental and substance abuse disorders, the reality that people recover and how to access treatment and recovery supports for behavioral health conditions.

Goal 8.5 – increase social inclusion and reduce discrimination (p.12).

To address the above Strategic Initiatives from school-based SAPISP model six vulnerable-greater-risk population/groups/individuals were identified: mental health (includes suicide risk factors and adverse childhood experiences), children from military families, children from substance abusing parents, LGBTQ and Native American. A brief overview on each population/groups/individuals about the risk and statistical facts, special considerations and strategies is provided. This section is by no means intended to provide SAS with a complete guide of "how-to's" instead, links to websites, suggested curriculum and books are provided to assist in further professional development

Mental Health (Youth with Serious Emotional Disturbances)

Overview

The mental health needs of many youth go unmet because children and adolescents are unable to access appropriate high-quality mental health services. Recent research has shown evidence that school-based mental health programs improve educational outcomes by decreasing absences, reducing discipline referrals, and improving test scores. Identifying mental health problems early and providing appropriate services are especially important in improving academic achievement and overall student well-being (Safe Schools Health Students, 2009).

The Substance Abuse Mental Health Services Administration (SAMHSA) describes mental health problems as "... health conditions involving changes in thinking, mood, and/or behavior ... associated with distress or impaired functioning. When they are more severe, they are called mental illnesses. These include anxiety disorders, attention-deficit/hyperactivity disorder, depressive and other mood disorders, eating disorders, schizophrenia, and others. When these occur in children under 18, they are referred to as serious emotional disturbances (SEDs)".¹

According to a report from Oregon Public Health Division (2006):

- Epidemiological studies suggest that 12 to 30 percent of United States school-age children and youth experience at least moderate behavioral, social, or emotional problems.
- Over half of the adolescents in the United States who fail to complete their secondary education have a diagnosable psychiatric disorder.
- High depression scores are associated with low academic achievement, high scholastic anxiety and poor peer and teacher relationships.
- Anxiety disorders are associated with drug use and dependence, suicidal behavior and a reduced likelihood of attending college.
- Teens who have made a suicide attempt in the previous twelve months showed significantly lower levels of school performance and school connectedness than non-attempters.
- Adolescents with a six-month diagnosis of alcohol or drug abuse/dependence were found to have poorer school performance.
- Moderate substance use and/or violence/delinquency were associated with test scores a full level below scores of groups of students not involved in these behaviors.

Special Considerations⁵¹

Grade-school children with serious emotional disturbances have the highest rates of school failure because of the discrimination and stigma associated with these disorders. Fifty percent of these students drop out of high school, compared to 30 percent of all students with disabilities. The situation gets worse as the students get older: college-age students are especially

⁵¹ Excerpt retrieved from (4/2012) <http://promoteacceptance.samhsa.gov/topic/education/default.aspx>.

vulnerable to mental illness; many psychiatric disorders first emerge in the late teens or early twenties.

Not only do students with mental health problems experience difficulties but their teachers do, too. It can be frustrating to teach such students who have mental illnesses not only because of their challenges in learning but also due to the impact of their behaviors on the rest of the class. Mental health awareness by everyone in the classroom may increase acceptance and understanding of people with mental illnesses, decrease the negative attitudes that are oftentimes attached to mental health problems, and lead to treatment for youth with mental health disorders.

Suggested Strategies and Resources

Activities geared towards mental health promotion in schools are intended to support enhanced integration, coordination, and resource sharing among education, mental health, and social services providers. To support students identified with Serious Emotional Disturbances, at a minimum school-based student assistance programs should consider including the following activities:

- Training and consultation to school personnel related to childhood mental, social, and emotional issues.
- Procedures for early identification, internal referrals and linkages to the local public mental health agencies for at-risk children and adolescents and their families. Services need to include assessment, early intervention and/or treatment as needed on or off school grounds.
- Supportive services to families in order that they may fully participate in the educational, social, and healthy development of their children.
- Policies and procedures, as needed, to ensure enhanced communication and information sharing across service systems (such as common referral or intake forms).

Mental Health

Warning Signs for Youth Suicide⁵²

Most suicidal young people don't really want to die; they just want their pain to end. About 80 percent of the time, people who kill themselves have given definite signals or talked about suicide. The key to prevention is to know these signs and what to do to help.

If a friend or someone you know mentions suicide, take it seriously. If he or she has expressed an immediate plan or has access to a gun or other potentially deadly means, do not leave him or her alone. Get help immediately. Seek out a school counselor or psychologist, family physician, suicide prevention or crisis line, or a friend to help.

- Contact 911 if you believe someone is in immediate danger of hurting themselves.
- Contact a mental health professional or call **1-800-273-TALK(8255)** or **www.suicidepreventionlifeline.org** for a referral should you witness, hear or see anyone exhibiting any one or more of the below warning signs.

Watch for these signs. They may indicate someone is thinking about suicide. The more signs you see, the greater the risk.

- A previous suicide attempt
- Current talk of suicide or making a plan
- Strong wish to die or a preoccupation with death
- Giving away prized possessions
- Signs of depression, such as moodiness, hopelessness, withdrawal
- Increased alcohol and/or other drug use
- Hinting at not being around in the future or saying good-bye

These warning signs are especially noteworthy if there has been:

- A recent death or suicide of a friend or family member
- A recent break-up with a boyfriend or girlfriend, or conflict with parents
- News reports of other suicides by young people in the same school or community

Other key risk factors include:

- Readily accessible firearms
- Impulsiveness and taking unnecessary risks
- Lack of connection to family and friends (no one to talk to)

⁵² Retrieved 4/12/2012 from KING5.com Posted on April 11, 2012 at 1:19 PM. *Source of information obtained from K5 News from: Washington State Department of Health and www.yspp.org*

Risk Factors for Suicide⁵³

Psychiatric Disorders

At least 90 percent of people who kill themselves have a diagnosable and treatable psychiatric illnesses, such as major depression, bipolar depression, or some other depressive illness, including:

- Schizophrenia.
- Alcohol or drug abuse, particularly when combined with depression.
- Posttraumatic Stress Disorder, or some other anxiety disorder.
- Bulimia or anorexia nervosa.
- Personality disorders especially borderline or antisocial.

Impulsivity

Impulsive individuals are more apt to act on suicidal impulses.

Past History of Attempted Suicide

Between 20 and 50 percent of people who kill themselves had previously attempted suicide. Those who have made serious suicide attempts are at a much higher risk for actually taking their lives.

Genetic Predisposition

Family history of suicide, suicide attempts, depression or other psychiatric illness.

Neurotransmitters

A clear relationship has been demonstrated between low concentrations of the serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) in cerebrospinal fluid and an increased incidence of attempted and completed suicide in psychiatric patients.

Terminology, Classroom Challenges, and Strategies⁵⁴

Anxiety Disorder: Has an excessive, irrational dread of everyday situations that has become disabling. Has overwhelming anxiety and feelings of extreme self-consciousness in everyday social situations. Shows intense fear of being watched or judged by others.

Possible Challenges in the Classroom: Distracted by things beyond the classroom – e.g. excess worry about family, friends, health, etc. Inability to focus. Often times preoccupied and may need to have information repeated. In severe cases, student may exhibit signs of panic for

⁵³ Retrieved 4/12/2012 from KING5.com Posted on April 11, 2012 at 1:19 PM *Source of information from K5 News from:* Source: [American Society for the Suicide Prevention](#)

⁵⁴ Excerpt from: Hertel, R., Johnson, M., Kincaid, S. O., & Wolpaw, R. (2009). Heart of learning and teaching: Compassion, resiliency, and academic Success (p.140-144). Olympia, WA: Office of Superintendent of Public Instruction - Compassionate Schools.

unknown or unperceived reasons. May even result in physical symptoms such as pounding heart, weakness, sweatiness, or dizziness.

Classroom Strategies:

- Talk with the student during times of distress.
- Present calmly to student.
- Use low volume tones.
- Listen and encourage the student to see the school counselor, if warranted.
- Do not force student to talk during class by calling on him or her.
- Foster an environment of respect so student may slowly gain comfort interacting with peers.

Attention Deficit Hyperactivity Disorder (ADHD):

Hyperactive Symptoms include constant motion, fidgeting, difficulty with quiet tasks, and trouble sitting still. Impulsive Symptoms include interrupting conversations, blurting out answers, acting without regard for consequences, and impatience. Inattention. Easily bored, confused and distracted. Appear to daydream. Forgetfulness. Slow moving.

Possible Challenges in the Classroom:

Difficulty paying attention during class. Disruptive behavior. Often distracts other students. Inability to self-regulate. Easily sidetracked. Frequently daydreaming. Certain events, situations, or health conditions may cause temporary behaviors that seem like ADHD.

Classroom Strategies:

- Structure, structure, structure.
- Early intervention before behavior escalates.
- Stand in close proximity to student if they are having trouble focusing.
- Medication monitoring by school nurse.
- Short lessons to encourage focus on work.
- Provide family support and social and emotional learning.

Autism Spectrum Disorders (ASD), including Asperger's:

Has difficulty communicating with others. May exhibit repetitious behaviors, such as rocking back and forth, head banging, or touching or twirling objects. Has a limited range of interests and activities. May become upset by a small change in the environment or daily routine. Severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. Has difficulty reading people and situations.

Possible Challenges in the Classroom:

Social etiquette is often inappropriate. Social etiquette skills include how to comfortably join and exit a group of peers; good sportsmanship; good host behavior during get-togethers; changing bad reputations and owning up to a previously bad reputation; and handling teasing, bullying and arguments. May be a target for bullying or other harassment. Challenges with any kind of intimacy and relationship development.

Classroom Strategies:

- Often receiving specially designed instruction through an IEP.
- Dietary interventions.
- Teaching of social interaction skills. May also need greater one-on-one attention and help from a teacher.
- Provide personal space for student.
- Little routine change and a structured class.
- Break assignments into small steps.

Bipolar Disorder (Manic Depression):

Changes in mood from being extremely irritable or sad to overly silly and elated.

Manic Symptoms include distractibility, increase in talking, great increase in energy, repeated high-risk behavior, severe mood changes, unrealistic highs, and not allowing interruptions.

Depressive symptoms include persistent sadness, decreased interest in activities, frequent complaints of physical illness, irritability, and low energy levels. Shifts in not only mood, but also energy level and ability to function.

Possible Challenges in the Classroom:

Disruptive behavior or anger towards others for what seems to be no reason and with no provocation. Teachers may have trouble gauging when mood swings may occur and have little chance of dispelling them. Medication frequently prescribed if diagnosed.

Classroom Strategies:

- Allow student to work on a creative or interesting assignment.
- Have an aide work one-on-one with the child.
- Allow the child to work in a study carrel.
- IEP to address accommodations to emphasize strengths, assets of student.
- Possible medication monitoring by school nurse.

Borderline Personality Disorder (BPD):

A serious personality disorder characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. Extremes of mood occur. Attention seeking and often dramatic.

Possible Challenges in the Classroom:

This disorder disrupts individuals' sense of self-identity. Bouts of aggression may lead to issues with other students and teachers. Potential substance abuse. Poor boundaries. Issues of other students often become their own. Intense bouts of anger, depression, and anxiety that circulate through their daily lives. Often seeks to create a reaction in other students.

Classroom Strategies:

- Watch for signs that warn for something greater than a mere temper tantrum or bad day—over a prolonged period of time.
- Be very consistent and stable, not reacting to the student's provocation.

- Know who they are even when they are struggling with their own identity.
- Pay attention to signs of substance abuse and notify counselor if that is the case.

Depression:

Difficulty with relationships. Frequent complaints of physical illness. Frequent sadness or crying. Low energy, Low self-esteem. Persistent boredom. Poor concentration. Thoughts of suicide. Loss of interest in activities that were once enjoyable.

Possible Challenges in the Classroom:

Unwilling to participate in class activities or even pay attention. 'Empty' feeling may lead to students disregard for anything and lead to disassociation with what is happening in the classroom.

Classroom Strategies:

- Offer support.
- Be there for students to talk to if they need to.
- Make sure counselors know that there is something going on with the student so they can best help.

Eating Disorders:

Severe disturbances in eating behavior, such as extreme reduction of food intake (Anorexia Nervosa) or purging (Bulimia) accompanied by feelings of extreme distress or concern about body weight or shape. Frequent trips to the restroom.

Possible Challenges in the Classroom:

Preoccupied with food intake. May refuse snacks or overindulge. Obsessive about body image. May exhibit excessive weight loss or gain. Often quiet and depressed. Changes in weight are not always apparent (especially with Bulimia).

Classroom Strategies:

- Careful observation.
- Refer to school counselor for appropriate follow up. Do not expect the student to "admit" to the problem. Behavior is often very secretive.

Fetal Alcohol Syndrome:

Difficult to diagnose. Some symptoms are physical such as low birth weight; small size; small eyes; flat cheeks and nose; thin upper lip; shaking and tremors; sight and hearing problems; heart defects; joint defects, and a small, abnormally formed brain. Other symptoms include eating and sleeping difficulties; delayed speech; ADHD; an undeveloped conscience; lower IQ; poor coordination; behavior problems; impulsivity; and difficulty getting along with other students. May develop drug or alcohol dependency, anxiety disorders, and trouble controlling explosive anger.

Possible Challenges in the Classroom:

Disruptive, out of control, inciting negative behavior in other students. Very short-term memory for instructions. Talking in the classroom. May appear as if they are simply disinterested in the material and are choosing to disengage. Difficulty in retaining what is learned.

Classroom Strategies:

- Assess the student's needs by reviewing the student's academic history through report cards and by speaking with the parents.
- Record the adaptations and/or modifications that will be used to support the student.
- Observe students' skills and productivity in the classroom.
- Extra patience, attention and help.
- Lessons need to be shorter in duration and actively seek to gain the attention and interest of the students.
- Use nonverbal cues.
- Prioritize the student's needs from most to least important.

Obsessive Compulsive Disorder (OCD):

Recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions).

Possible Challenges in the Classroom:

Student may be plagued by persistent, unwelcome thoughts or images or by the urgent need to engage in certain rituals. May be obsessed with germs, dirt, and washing their hands. They may be filled with doubt and feel the need to check things repeatedly.

Classroom Strategies:

- Interact with student one-to-one.
- Do not draw attention to behaviors.
- Refer to school counselor for potential referral for mental health services.
- Listen and encourage.
- Be aware of how much the student can comfortably handle.

Oppositional Defiant Disorder (ODD):

Throwing repeated temper tantrums. Excessively arguing with adults. Actively refusing to comply with requests and rules. Deliberately trying to annoy or upset others or being easily annoyed by others. Blaming others for their mistakes. Frequent outbursts of anger and resentment. Seeking revenge. Swearing or using obscene language. Many children with ODD are moody, easily frustrated and have low self-esteem.

Possible Challenges in the Classroom:

Anger towards the teacher for what may appear to be no rational explanation. Leads to student focusing on those feelings rather than the schoolwork and may disregard anything the teacher has to say relevant to schoolwork itself.

Classroom Strategies:

- Students do respond to praise and should be given some flexibility; they also need limits and consequences.
- Consequences should be appropriate and meaningful, something they want to avoid. Choose consequences wisely.
- Separate actions from students and understand that their hostility is not personalized toward you.
- Family support.
- Social and emotional learning.

Post-Traumatic Stress Disorder (PTSD):

An anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.

Possible Challenges in the Classroom:

May appear distracted or daydreaming in the classroom. Expresses fear and may speak of memories of the event in the class. Student may appear detached and be easily startled.

Classroom Strategies:

- Maintain a calm environment.
- Listen if the student chooses to talk about the event, being careful to terminate conversation if any anxiety begins to develop.
- Refer to a counselor for community mental health treatment.

Substance Abuse:

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile). Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct). Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with friends and family about consequences of intoxication, physical fights).

Possible Challenges in the Classroom:

Repeat absences. Poor work performance [Disruptive and defiant. Disengaged. Sleeping in class]. Substance-abuse related suspensions or expulsions.

Classroom Strategies:

- Refer to a Student Assistance Specialist or other personnel for a substance abuse screening and potential referral for substance abuse treatment.

Mental Health (Adverse Childhood Experience)⁵⁵

There is nothing new about the presence of children affected by trauma in schools. What is new is our knowledge of the problem's pervasiveness and its effect on school performance. Studies funded by the Center for Disease Control (Felitti et al, 1998) and the United States Justice Department (Snyder, H. & Sickmund, M., 2006) indicate the significant percentages of American students and their families who live in a culture of isolating familial and societal violence including, but not limited to, domestic abuse, rape, homicide, gang violence, drug and alcohol abuse and related violence, physical, emotional, and sexual abuse, mental health issues, and loss due to suicide. Take for example the Adverse Childhood Experiences (ACEs) study. Dr. Vincent Felitti (Kaiser Permanente, California) and Dr. Robert Anda (CDC) began by asking over 17,000 adults, who were members of a Health Maintenance Organization, about their childhood experiences (see below). Then, using health records and assessments, they developed an understanding of how these ten ACEs affected the health of the people in the group over their life spans. Their survey tool was a sophisticated one. People were asked: "Sometimes physical blows occur between parents. While you were growing up, in your first 18 years, how often did your father (or stepfather) or mother's boyfriends do any of these things to your mother (stepmother): Push, grab, or throw something at her? Kick, bite, hit her with a fist or hit her with something hard? Hit her repeatedly over at least a few minutes? Threaten her with a knife or gun or injure her with a knife or gun? (For more on the ACEs study visit <http://www.acestudy.org/> and <http://www.cdc.gov/nccdphp/ace>).

Adverse Childhood Experiences (ACEs) as defined by Felitti & Anda (2009)

- Child physical abuse
- Child sexual abuse
- Child emotional abuse
- Emotional neglect
- Physical neglect
- Mentally ill, depressed, or suicidal person in the home
- Drug addicted or alcoholic family member
- Witnessing domestic violence against the mother
- Loss of a parent to death or abandonment, including abandonment by parental divorce
- Incarceration of any family member for a crime

Note: Other categories of ACEs have been studied in subsequent research.

The prevalence of adverse childhood experiences across this group as a whole was remarkable. For example, 28 percent had been abused physically as a child, 17 percent had a mentally ill, depressed or suicidal person in the home, and 27 percent had a drug addicted or alcoholic

⁵⁵ Excerpt from: Hertel, R., Johnson, M., Kincaid, S. O., & Wolpow, R. (2009). Heart of learning and teaching: Compassion, resiliency, and academic success (p.140–144). Olympia, WA: Office of Superintendent of Public Instruction - Compassionate Schools. Olympia, WA

family member. The researchers made an especially significant finding: the greater the number of ACEs, the greater the risk for an array of poor physical, mental and behavioral health outcomes for patients across their life spans. In scientific terms, there was a direct “dose-response” relationship between ACE’s and serious health issues.

We cannot draw a straight line between ACEs and outcomes. However, we do know that the higher the ACEs score in a given population, the greater the probabilities of the following co-occurring conditions: More than 75 percent of the 17,500 adults who participated in the ACEs study were college graduates, doing well enough economically to be employed and provided quality health insurance. Despite the traumatic hurricanes in their lives, they were able to succeed. Will the same be true for students who are seeking solace in our classrooms? What role can we play to support our students through these storms?

- Alcoholism and alcohol abuse.
- Chronic obstructive pulmonary disease and ischemic heart disease.
- Depression.
- Fetal death.
- High risk sexual behavior.
- Illicit drug use.
- Intimate partner violence.
- Liver disease.
- Obesity.
- Sexually transmitted disease.
- Smoking.
- Suicide attempts.
- Unintended pregnancy.

ACEs and School Performance Those of us who work in the schools already know, intuitively, that there is a dose-response relationship between adverse childhood experiences and student learning. Several studies (Delaney-Black et al, 2002; Sanger et al., 2000; Shonk & Cicchetti, 2001), including one conducted here in Washington (Grevstad, 2007), reveal that students dealing with trauma and trying to play chess in hurricanes ...

- Are two-and-one-half times more likely to fail a grade.
- Score lower on standardized achievement test scores.
- Have more receptive or expressive language difficulties.
- Are suspended or expelled more often.
- Are designated to special education more frequently.

Recommended Books/Manuals:

Boesky, L. (2007). *WHEN to WORRY How to Tell if Your TEEN NEEDS HELP and What to Do about it*. New York, NY: American Management Association. www.amacombooks.org.

Levine, P. A. & Kline, M. (2007). *Trauma through a child's eyes: Awakening the ordinary miracle of healing*. Berkeley, CA: North Atlantic Books.

O'Connell, M., Boat, T., and Warner, K. (2009). *Preventing mental, emotional, and behavioral disorders among young people*. National Academy of Sciences. Available at http://www.nap.edu/catalog.php?record_id=12480

Hertel, R., Johnson, M., Kincad, S. O., & Wolpow, R. (2009). *Heart of learning and teaching: Compassion, resiliency, and academic success*. Olympia, WA: Office of Superintendent of Public Instruction - Compassionate Schools.

Websites

National child trauma stress network <http://www.nctsnet.org>

Substance Abuse and Mental Health Services Administration <http://www.samhsa.gov>

Military Children and Families

Overview

Military-connected students are children in P–6 schools, adolescents in middle and high school and students who are adolescents or young adults in trade schools, or Institutions of Higher Education (2- or 4-year schools) that are official dependents of a Military Service member. A military-connected student has one degree of separation from their military sponsor; the connection may be biological, because of an adoption, through foster parenting or within loco parentis authorization.

The Military Child Education Coalition (2012) reports there are currently 2,000,000 military-connected students whose parents are active duty, members of the National Guard or Reserves or Veterans of the United States Military. Statistically, 1,381,584 of the military-connected students are 4–18 years old. Over 80 percent of these children – 1,105,267 students – attend P–12 public schools and almost every school district in this country has military-connected students. Approximately 10–12 percent of military-connected students are served in special education programs. There are an additional 144,191 military-connected students age 19–23.

The United States National Center for Educational Statistics (2009) research shows that approximately 70 percent of youth attend college or university, which, equates to 100,934 military-connected students enrolled in postsecondary education in 2009. In addition, since the onset of Operation Enduring Freedom (OEF) in 2001, over 3,700 military children (under the age of 18 years old) have lost a Service Member parent and over 41,000 have experienced a parent who was wounded, injured or ill (Defense Manpower Data Center, 2011)

Special Considerations

Children's adjustment to deployment varies by a number of factors including, but not limited to, age, developmental stage, family composition, length and number of deployments and other individual and family factors. Parental combat deployment has an effect on both the child, as well as, the at-home parent both during and following the deployment (Lester, P. et al, 2010). Research has shown that children of deployed parents face significant difficulty with overall adjustment, including "externalizing" behaviors (aggression, noncompliance), and "internalizing" behaviors (depression, anxiety, irritability). Young children may exhibit regression in developmental milestones, such as bedwetting and thumb-sucking) while older school aged children may show decline in academic performance and increase in depression and behavioral problems in response to emotional stress (Department of Defense, 2010). Although all children are impacted in some way by the deployment of a parent or loved one, the literature suggests that young children (infants and preschoolers) are still the most impacted by parental deployment.

A RAND Study (2008) confirmed that recent and frequent Operation Enduring Freedom and Operation Iraqi Freedom deployments have a negative impact on child and adolescent behavior and mental health outcomes. Children indicated that they experienced significant difficulties

with readjustment when a parent was both deployed and returned from a deployment. Children endorsed having difficulty interacting with peers and teachers who had limited understanding of what their deployment experiences were like. In addition, Reserve Component children felt less connected or networked with people who understood military life and shared similar experiences. They reported little opportunity to spend time with other children from military families and felt that teachers did not understand their experiences.

A Department of Defense survey (2008) examined the impact of deployments on children by surveying a representative sample of over 13,000 military spouses across all branches of the service and the Reserve Component. Findings indicated that the children of active duty and reserve component families experienced greater difficulty and experienced a higher incidence of anxiety and behavioral problems during the deployment of a parent. In addition, in each case, over a quarter of those families felt that their child(ren) coped “poorly” or “very poorly” during that time.

Regardless of any difficulties in coping all Military-connected students face the following challenges:⁵⁶

- Separations from a parent or caregiver due to deployments.
- High mobility rates – active duty families move every two to three years (This is approximately three times more often than the civilian population. Students often experience six to nine moves during their P-12 school education).
- Academic and social challenges attributed to frequent school changes, deployment of a parent(s), return of a deployed parent, injury to or death of a parent.
- Difficulties qualifying for, receiving, or continuing special needs services due to differences in regulation interpretations, testing required to enroll in or receive special needs services, and resource availability in school districts.
- Understanding and interpreting new school regulations and policies.
- Elevated stress – making new friends and finding a new peer group in a new school; adjustment to a new school, community, and home.
- At-risk for depression, anxiety and other risk-taking behavioral (including substance use/abuse) due to relocation, deployment of a parent(s), etc.
- Adjusting to curriculum and instructional methods or school climate/culture that may differ from school to school.

Suggested Strategies for Intervention and Support

Preventative interventions for military connected students should be geared toward increasing understanding and support of the unique challenges faced by military children and youth. In addition, they should seek to increase knowledge, coordination and resource sharing among education, social service and military affiliated professionals. To effectively support military connected students and their families, school-based SAS should consider the following strategies:

⁵⁶ Excerpt retrieved from (4/2012): <http://www.k12.wa.us/OperationMilitaryKids/>. Tough Topics Series Learning and Teaching Support Issue 1: Supporting Military Children During Deployment.

- Take time to foster your individual knowledge, awareness and understanding of the experiences and military-connected students by attending workshops on military culture. Actively engage with military organization to identify support services offered at the local level that might be appropriate for referrals.
- Initiate/co-facilitate a military educational support group with school counselors (other school-based professionals) to assist students in dealing with the unique stressors as well as identifying the benefits of being a military-connected youth;
- Create a safe environment in the SAPISP setting that is responsive to the social, emotional and learning needs of military connected students;
- Focus on military-connected students in the school and seek to establish a safe, Supportive learning environment considerate of the military culture and the impact of multiple deployments of youth.

ADDITIONAL RESOURCES

Websites:

- SBH Web Site <http://brainhealth.army.mil/SBH/default.aspx> Military Child Education Coalition <http://www.militarychild.org/>
- Operation: Military Kids <http://www.operationmilitarykids.org/public/home.aspx> Military Kids Connect <https://www.militarykidsconnect.org/>
- I AM A Military Kid Curriculum <http://i-am-a-military-kid.wikispaces.com/> Military One Source <http://www.militaryonesource.mil>

Children of Substance Abusing Parents (COSAP's)

Overview

There are more than 11 million children of substance abusing parents (COSAP's) under the age of 18 in the United States. Countless others are affected by alcoholic or drug abusing parents, siblings, and or other caregivers. In 2001, more than 6 million children lived with at least one parent who abused or was dependent on alcohol or an illicit drug. Science shows that children in families affected by substance abuse are at increased risk for illness, injury, emotional disturbances, educational deficits, behavioral problems, and alcohol abuse later in life. Some face physical abuse or neglect. More often, they experience shame, confusion, or a vague sense that they are somehow to blame for the difficulties (SAMHSA, 2004).

All too often alcoholism and other drug addictions become a family legacy. More than fifty percent of today's addicted adults are children of substance abusers, and there are millions challenged by other problems that result from alcoholism or drug addiction in their families. It is essential to spare children from unnecessary years of silence, shame, and suffering caused by parental addiction. Through effective prevention measures, professionals in the school-based setting can play a major part in this process. Individually and collectively, they can be a voice and steadying force for children who can't always speak for themselves. The tools these professionals can use to encourage this process include age-appropriate information, skill building, and the bonding and attachment derived through healthy relationships.

Special Considerations

According to American Academy of Child and Adolescent Psychiatry (2011), one in five adult Americans have lived with a substance abusing relative while growing up. These children are in general at greater risk for having emotional problems than children whose parents are not addicts. Substance abuse runs in families, and children of addicts are four times more likely than other children to become substance abusers themselves. Compounding the psychological impact of being raised by a parent who is suffering from addiction is the fact that most children with such parents have often experienced some form of neglect or abuse.

A child being raised by a parent or caregiver who is suffering from addiction may have a variety of conflicting emotions that need to be addressed in order to avoid future problems themselves. They are in a difficult and lonely position because they cannot go to their own parents for support. Some of the feelings can include guilt, anxiety, embarrassment; inability to have close relationships; confusion; anger; and depression.

Although COSAP's try to keep the addiction a secret, teachers, relatives, other adults, or friends may sense that something is wrong. Teachers and caregivers should be aware that the following behaviors may signal a drinking or other drug problem at home:

- Failure in school; truancy; lack of friends; withdrawal from classmates; delinquent behavior, such as stealing or violence; and frequent physical complaints, such as

headaches or stomachaches; abuse of drugs or alcohol; aggression towards other children; risk taking behaviors; and depression or suicidal thoughts or behavior (National Association of Children of Alcoholics 2001)⁵⁷

- Some COSAP's may cope by taking the role of responsible "parents" within the family and among friends. They may become controlled, successful "overachievers" throughout school, and at the same time be emotionally isolated from other children and teachers. Their emotional problems may show only when they become adults. It is important for relatives, teachers and caregivers to realize these children and adolescents can benefit from educational programs and social skill-building support groups specifically targeting the unique needs of children of substance abusers. In fact, offering these programs in the safety of the school setting can be extremely helpful and highly effective.

Suggested Strategies for Intervention and Support

Early intervention is important in preventing more serious problems for children of substance abusers; including reducing risk for future substance use/abuse themselves. It can also help them to understand they are not responsible for the substance abuse problems of their parents and that they can receive help even if a parent is in denial and refusing to seek help. To effectively support COSAP's in the school setting SAS's should consider utilizing the following strategies:

- Conducting educational support groups to teach life skills including feeling identification, problem solving, decision making, communication skill, etc. necessary to help students cope with the day-to-day challenges encountered;
- Frequently reminding COSAP's of the "Seven Cs including I didn't CAUSE it; I can't CURE it; I can't CONTROL it; I can help take CARE of myself by COMMUNICATING my feelings; Making healthy CHOICES; CELEBRATING me (Moe, J. 2007).⁵⁸
- Educating and giving students the basic information about use and abuse of alcohol and other drugs to increase their awareness and assist them in making healthy choices in the future.
- Listening to what COSAP's are saying. Giving them focused attention with plenty of eye contact. Showing them you genuinely care through your consistency in thought, word, and deed.
- Observing/watching for nonverbal forms of communication. Being aware of facial expressions, body language, and the manner in which students respond to others both positively and negatively. In many cases the actions of COSAP's can speak much louder than their words.
- Validating and letting them know you hear and understand what they are communicating. Acknowledging what is said, asking questions to show concern and reflecting in a nonjudgmental manner the feelings that are shared. Recognizing and holding them accountable for their behaviors both positive and challenging.

⁵⁷ Children of Alcoholics: A Kit for Educators; National Association of Children of Alcoholics (NACoA); <http://www.nacoa.org/>

⁵⁸ Teachers Can Make A Tremendous Difference by Jerry Moe, M.A. from Children of Alcoholics: A Kit for Educators; National Association of Children of Alcoholics (NACoA); <http://www.nacoa.org/>

- Empowering and helping COSAP's see there are safe people in their lives that they may turn to for support and guidance. Safe people are those that truly care and aren't harmfully involved in active addiction themselves. Safe people may be recovering parents, siblings, other relatives, neighbors, teachers, ministers, coaches, and counselors.

Recommended Books/Manuals

Black, C. (2002). *It will never happen to me: Growing up with addiction as youngsters, adolescents, adults*. Second edition. City Center, MN: Hazelden Publishing.

Black, C. (1979). *My dad loves me, my dad has a disease: A child's view: Living with addiction*. Washington, DC: Mac Publishing.

Fleming, M. (1992). *101 support group activities for teenagers affected by someone else's alcohol/drug use*. Second edition. City Center, MN: Hazelden Publishing.

Leite, E & Espeland, P. (1984). *Different like me: A book for teens who worry about their parents' use of alcohol/drugs*. City Center MN: Johnson Institute/Hazelden Publishing.

Moe, J. (1989). *Kids' power: Healing games for children of alcoholics*. Deerfield Beach, FL: Health Communications, Inc.

Typpo, M. & Hastings, J. (1994). *Elephant in the living room*. City Center, MN: Hazelden.

Manuals/Kits:

Children of Alcoholics: A Kit for Educators(2001); National Association of Children of Alcoholics (NACoA); <http://www.nacoa.org/>

Children of Alcoholics: A Guide to Community Action(2004); United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; <http://www.samhsa.gov/>

Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

Overview⁵⁹

Precise prevalence rates of substance use and abuse by LGBTQ individuals is difficult to calculate because the inability to collect reliable information on the size of the LGBTQ population, as well as the lack of information from alcohol and drug abuse studies to collect information about sexual orientation. Additionally, the LGBTQ community differs from other minority groups in that LGBTQ persons do not come from a common geographic area or have certain physical characteristics in common.

Studies indicate that, when compared to the general population, LGBTQ individuals are more likely to use alcohol and drugs, have higher rates of substance abuse, and are more likely to continue heavy drinking into later life. Specific to LGBTQ youth, most of the available research has focused on lesbian and gay adolescents. In a study among a multi-ethnic group of self-identified lesbian, gay and bisexual youth, 93 percent of females and 89 percent of males reported using licit or illicit substances, with alcohol the most popular licit drug and marijuana the most popular illicit drug.

Special Considerations

LGBTQ youth use alcohol and drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mood disorders. However, LGBTQ youth may be more vulnerable as a result, they may use alcohol and drugs to deal with stigma and shame, to deny same-sex feelings, or to help them cope with ridicule or antigay violence.⁶⁰ According to the 2009 National School Climate Survey:⁶¹

- Nearly 9 out of 10 LGBTQ youth (84.6 percent) said they'd experienced harassment in school in the past year because of their sexual orientation.
- Nearly two-thirds (63.7 percent) experienced harassment because of gender expression.
- Almost two-third (61.1 percent) said they felt unsafe at their school because of their sexual orientation.

Specific stresses for LGBTQ youth include:⁶²

1. LGBTQ youth have the same developmental stresses as their heterosexual peers; however, they also face the stigma attached to being gay. This additional stress puts them at greater risk for substance abuse, continued heavy drinking into later life, unprotected sex, increased psychological distress and suicidal ideations.

⁵⁹ Excerpt from US Department of Health and Human Services (2001). Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.

⁶⁰ Ibid

⁶¹ Retrieved from <http://www.glsen.org/cgi-bin/iowa/all/library/record/2730.html>. GLSEN (Gay, Lesbian, Straight Education Network).

⁶² Excerpt from: US Department of Health and Human Services (2001). Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.

2. LGBTQ youth face the stigma attached to being gay and are far more likely to be victims of bullying. These youth must adapt to living in a hostile environment and learn how to find positive environments.
3. Homelessness is a particular concern for LGBTQ youth, because many teens may run away as a result of harassment and abuse from family members or peers who disapprove of their sexual orientation. Others may be thrown out of the home when their parents learn they are gay.
4. Like their heterosexual counterparts, homeless LGBTQ youth are at greater risk of physical health, mental health, and social problems.

Suggested Strategies for Intervention and Support⁶³

Interventions with LGBTQ youth should address their social environment, sexual identity, stage of coming out, support network, and knowledge of safer sex practices. The following is a brief list of do's and don'ts when working with LGBTQ youth.

DO's

- Do create a safe environment for LGBTQ students, including affirming a confidential setting and Supportive attitude.
- Do provide a Supportive adult relationship.
- Do consider peer influences for support (such as a Gay Straight Alliance)
- Do read about LGBTQ youth and get to know resources available and how to access them.
- Do review forms to ensure inclusive language.
- Do have LGBTQ-friendly literature and available in visible places.
- Do seek training to increase knowledge and understanding relative to LGBTQ.
- Do connect with existing community initiative.

DON'Ts

- Don't label.
- Don't pressure a client to come out. Respect where they are in the process and their need to feel safe.
- Don't ignore significant others.
- Don't interject personal feelings into conversations, but follow the clients lead. For example, "Youth must be angry your parents don't accept you," or "it must be hard being lesbian."

Additional Resources

Websites

OSPI Safety Center <http://www.k12.wa.us/SafetyCenter/LGBTQ/default.aspx>

A state resource designed to increase the educational community's understanding of the challenges lesbian, gay, bisexual, and transgender and questioning youth face in school.

⁶³ Retrieved from (6/2012): <http://www.welcomingschools.org/resources/>. Welcoming Schools Guide.

GLSEN (Gay, Lesbian, Straight Education Network)

www.glsen.org/cgi-bin/iowa/all/home/index.html - a national organization for educators and student who want to crate schools where differences are respected.

Seattle Counseling Services (includes regional support centers). <http://seattlecounseling.org>

Seattle LGBT Commission. <http://www.seattle.gov/LGBT/resources.htm>.

The Pride Foundation (serving Northwest). <http://www.pridefoundation.org/youmatter/>.

National Coalition for the Homeless (including LGBTQ youth). <http://www.nationalhomeless.org>.

The Sexual and Gender Minority Youth Resource Center (serving SW Washington and Portland area) <http://smyrc.org/node/62>.

United States Department of Health and Human Services, (2001). A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.

Office of Juvenile Justice and Delinquency Prevention: Understanding and Overcoming Challenges Faced by LGBTQI Youth in Schools and Communities webinar.

Native American Youth

Overview⁶⁴

It is well documented that alcohol and illicit drug use problems are a critical issues among American Indian youth. Recent reports have shown higher rates of substance use among American Indians or Alaska Natives compared with persons from other racial/ethnic groups. Among American Indian or Alaska Native youths aged 12 to 17, the rates of past month cigarette use, binge drinking, and illicit drug use were higher than those from other racial/ethnic groups. Research has shown associations with risk and protective factors and substance use among American Indian or Alaska Native youths compared with youths in other racial/ethnic groups.

Special Considerations⁶⁵

In 2008/09, American Indian students accounted for 1.2 percent (585,884) of all K–12 students (49,265,572) in the United States. A larger percentage of American Indian or Alaska Native youths perceived moderate to no risk of substance use compared with youths in other racial/ethnic groups. For example, 47 percent of American Indian or Alaska Native youths believed there was moderate to no risk in smoking one or more packs of cigarettes per day compared with only 36 percent of youths in other racial/ethnic groups. Additionally, American Indian or Alaska Native youths were less likely to have participated in two or more youth activities than youths in other racial/ethnic groups. A smaller percentage of American Indian or Alaska Native youths attended religious services on a regular basis than youths in other racial/ethnic groups. Fewer American Indian or Alaska Native youths also agreed that religious beliefs are a very important part of their lives compared with youths in other racial/ethnic groups. In Indian communities, alcoholism is a multi-generational issue. Alcohol abuse frequently co-exists with other problems such as stress related acting out, cultural shame and depression.

Larger percentage of American Indian or Alaska Native youths do not perceive strong parental disapproval of youth substance use compared with youths in other racial/ethnic groups. Other important risk factor for Native American youth is poor school performance and the belief that the majority of their peers are using cigarettes, alcohol, or illicit drugs.

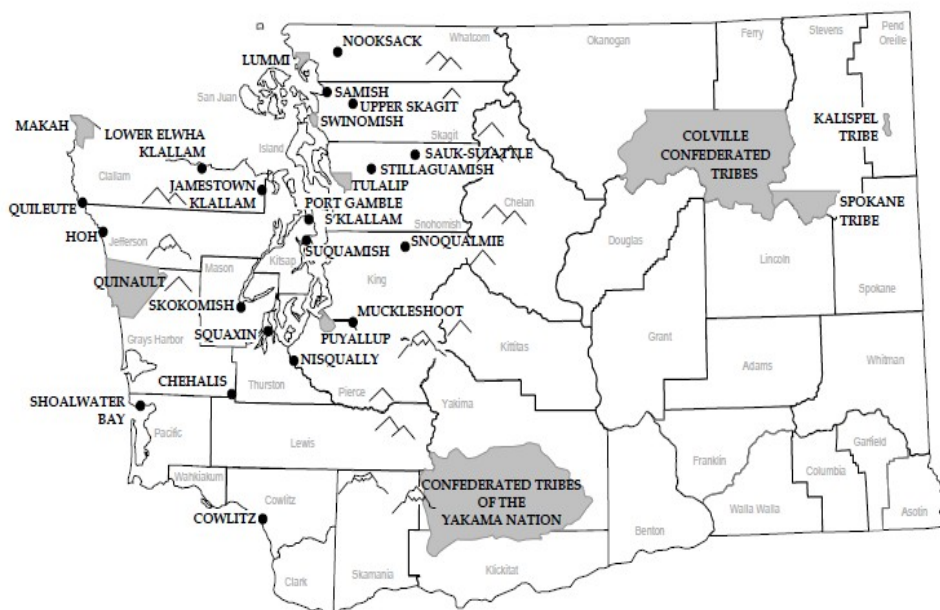
Where are Washington Tribes Located?

The map in Figure 1 below provides the name and location of each Native American Tribe in Washington State. (DSHS webpage, retrieved June 2012).

⁶⁴ Excerpt retrieved (6/2012) from: <http://samhsa.gov/data/2k4/AmIndianYouthRF/AmIndianYouthRF.htm>. The National Survey on Drug Use and Health Report.

⁶⁵ Ibid

FEDERALLY RECOGNIZED TRIBES OF WASHINGTON STATE



Suggested Strategies for Intervention and Support⁶⁶

- Take time to foster your individual knowledge, awareness and understanding of the experiences of Native American students by attending workshops on tribal culture. Actively engage with tribal organizations to identify support services offered that might be appropriate for referrals.
- Create a safe environment in the SAPISP setting that is responsive to the social, emotional and learning needs of Native American students. Use examples that are relevant to their lifestyles.
- Allow for one-to-one help, building to small group.
- Vary delivery method, including visual, auditory, tactile, and kinesthetic.
- Allow wait-time for responses and be aware some individuals may not be direct when they ask questions.

ADDITIONAL RESOURCES

Information factsheets and curriculum

The People (12/30/2008). *From Where the Sun Rises: Addressing the Educational Achievement of Native Americans in Washington State*. Section 3, p. 27.

⁶⁶ Excerpt Retrieved (6/2012) from: <http://literacynet.org/lp/namericans/strategies.html>. Strategies for Teaching Native Americans

Since Time Immemorial: Tribal Sovereignty in Washington State – a curriculum developed as a result of House Bill 1495, which officially recommended inclusion of tribal history in all common schools.

Websites

OSPI Indian Education Office <http://www.k12.wa.us/IndianEd/default.aspx>

Governor’s Office of Indian Affairs <http://www.goia.wa.gov/>

Washington State University College of Education, Native Teaching and Learning
<http://education.wsu.edu/nativeclearinhouse/>

Section 7

Student Assistance Team: Problem Solving and Case Management

Introduction

The SAT is comprised of administrators, teachers, SAPISP staff, school counselor, school nurse, social worker, and other interested school staff members, as needed. The most important part of forming a team is ensuring the team consists of individuals who choose to work as members of the team *AND* who are concerned about the overall welfare of the student body.

Response to Intervention (RTI) is being used across the country, including Washington State and encouraged by the federal government. The New Mexico Public Education Department, Quality Assurance Bureau program manual (2009) explains, "RTI as a multi-level prevention system to assist schools to ensure success for all students, and provide early assistance to students who are experiencing academic and/or behavioral challenges, or need opportunities for advanced learning. It is a continuum of schoolwide support that seeks to maximize the odds of student success and contributes to overall comprehensive school improvement efforts." (p.6)

This is a multi-level prevention system has "at least three tiers where the academic and/or behavioral interventions change, or become more intense, as student needs are addressed in each successive tier ..." (Ibid, p.6). The primary prevention level includes high quality core instruction. The secondary level includes evidence-based intervention(s) of moderate intensity. The tertiary prevention level includes individualized intervention(s) of increased intensity for students who show minimal response to secondary prevention (RTI 4success.org). The term *three-tier model of intervention* is borrowed from public health triage models that focus on levels of treatment based on need. Simply put, it is a model consisting of three well-defined and separate processes running on different levels within a system. The different tiers represent a change in how something is done or how supports are delivered. The RTI framework mirrors the three-tiered intervention model established by Center for Substance Abuse Prevention (CSAP), referred to in the introduction section of this manual, and also is adopted from the public health model.

RTI interfaces with Schoolwide Positive Behavioral Supports (SW-PBS), which aligns with the CSAP three-tiered approach as well. SW-PBS is described as:

Systematic strategies to promote positive student behavior through data-based decision making, providing an outstanding framework from which to enhance mental health promotion and intervention. Foundational to this work is a 'shared agenda' in which families, schools, mental health systems, and other youth serving community systems are working together to build a full continuum of multi-tiered programs and services for students and

their families in general [substance abuse, behavioral health] and special education . These programs and services reflect integrated strategies to promote student wellness and success in school and reduce both academic and nonacademic barriers to learning and school success. SW-PBS has developed a three-tiered model of providing services reflecting the social and behavioral component of RTI and consistent with a public health approach to school mental health promotion and intervention. Services reflecting the social and behavioral component of RTI and consistent with a public health approach to school mental health promotion and intervention (Barrett & Eber, 2012, p.1).

The SAS role is to interface with the RTI/SAT(SAT) by assisting in reviewing and providing information about referrals generated where substance abuse and other SEBH, issues are of concern. The SAS is a participating member of the Student Assistant Team and the team works together to identify intervention needed at tier 2 and 3 and prioritize referrals. The benefits of a team approach include:

- Improving the quality of intervention strategies by utilizing the skills and experiences of individual team members.
- Sharing the burden of responsibility for decision making that impacts the lives of students.
- Increasing the capacity of the school staff to handle student problems.
- Increasing the accountability of the school's system of identifying and referring students experiencing difficulty.

Importance of a Team⁶⁷

Teams consist of individuals with different skills, knowledge and interest coming together for common purposes – student advocacy – and work collaboratively. A team is not the same as a “group of people.” Teams have a commitment to a common purpose and are willing to build cohesiveness to accomplish their goals. The combined energy of individuals when applied in a team effort is potentially much greater than the sum of energies expended by individuals working on their own, or even loosely allied as a group. A few reasons why teams are effective:

- Local school teams are best suited to address local problems.
- People are more invested in solutions they helped to develop.
- Teams create a momentum that individuals alone do not.
- Team goals give continuity when individuals leave or are added.

Factors contributing to SAT success:

1. Administrative support
2. Regularly held student assistance team meetings
3. Student assistance team manager with some release time
4. Early parent involvement
5. Using team meeting roles
 - Team skills; e.g., active listening

⁶⁷ Adapted from: Student Assistance Services Program Guide. Indiana Department of Education. Available at www.doe.state.in.us/sservices

- Written agenda
 - Consensus decision making
 - Ground rules
6. Clear referral process
 - Staff, students, and parents aware of the process
 - Focus on observable behavior
 7. Credibility of the SAPISP process among staff, students, and parents
 8. Team sharing information appropriately
 9. High level of involvement of staff beyond student assistance team members
 10. Written policy to address students "at risk" and consistent implementation of the policy to all students
 11. Ongoing training of all staff
 12. Planning, implementing, evaluating, and refining

How Student Assistance Teams Function

Teams come together to determine the best ways to address various student problems. The team will need to determine how they can best function together as a unit.

Here are a few tips on team functioning:

1. Seek out a cross-representation of individuals, including professional and nonprofessional staff, relevant ethnic and cultural groups.
2. Identify the contributions of members to the team and define the role that each team member is expected to play.
3. Define the purpose and priorities of the team and continue to redefine these as necessary as in pursuit of goals.
4. Establish guidelines about meetings and their structure including time, place, length, interval between, who chairs, takes minutes, etc.
5. Describe how decisions are made with a solution-focused criteria (consensus decision making carries the strongest message, but may involve working through some "rough spots" on the path to consensus).
6. Anticipate potential problems (opposing philosophical positions, for example), think in advance about possible strategies for dealing with potential problems, or at least know how to allow extra time to work through them.

Suggested Program Operations

The following provides program coordinators and SAS with suggested guidelines to use in forming a SAT. In addition, the section includes information on specific roles and task for team members, team maintenance, and case management procedures.

Roles and Duties

In general, the SAT meets regularly to review referrals and data generated by school faculty and on occasion from other students, parents, or community members regarding students of concern. The team meets to review the needs of referred students and to develop individual intervention plans. In most cases, the SAS case manages the referrals specific to his/her students

identified with substance abuse and other behavioral health issues as applicable. This includes screening, referral monitoring, case managing, evaluating students' progress, and reports back to the team (within confidentiality guidelines). Some SATs will appoint one of the team members to serve as the case manager and responsibilities are shared among the team members. Although, there will be crisis referrals where immediate action is required by the SAS as well as referrals where a brief consultation is sufficient, the majority of referrals will be taken to the team for consideration and action.

For teams to function effectively, specific roles can be assigned to members to expedite the review of materials, assist in the documentation of interventions and the individual student plan, provide measures for keeping team members focused on the discussion, and serve as a record of the meeting. If there is not an established SAT in the school, then the following roles and functions are important to the SAS establishing a team:

SAS

- Works with school administration/leadership to determine if SAS should link with an existing team (such as RTI) or stand alone.
- Presents SAT concepts to school administration/leadership to obtain approval and buy-in.
- Recruits team members.
- Schedules meeting and logistics.
- Coordinates function of team.
- Gathers initial data for meeting.
- Completes student profile sheet.
- Gathers additional data after first meeting.
- Talks with school staff.
- Consults with community resources.
- Contacts parents.
- Report's findings and updates to the team.

SAT Facilitator

- Listens, summarizes, maintains, open and balanced conversational flow.
- Protects individuals from personal attacks.
- Focuses discussion on topics.
- Checks out participants' involvement.
- Clarifies, encourages, and guides group process.
- Keeps meeting content focused on solutions.

SAT Recorder

- Records group discussion and decisions that are made.
- Places information on a flip chart, erasable board, or overhead.

SAT Timekeeper

- Keeps the group on time and informs members when a transition will occur.

- Keeps members on task.

SAT Participants

- Stay actively involved in discussion.
- Monitor the recorder.

SAT members receive ongoing training to provide them with the knowledge and skills that allow them to effectively carry out their roles and functions in the prevention and intervention of barriers that place students at risk within the school or community.

SAT Member Tasks

Members work interdependently in order to achieve agreed upon program goals, including promoting the philosophy of the SAPISP; promoting program services through planning and implementing appropriate in-service training to staff and community professionals; and facilitating the inclusion of students, staff, parents, and community members in prevention activities. Additional duties may include:

- Attending training sessions and SAT meetings regularly.
- Being responsible for individual team tasks.
- Contributing to solution-focused problem solving.
- Contributing to the healthy maintenance of team.
- Maintaining confidentiality and the integrity of the team.
- Being familiar with the Ethical Guidelines and Standards of Practice.

Pre-Meeting Tasks

The team leader will need a preliminary file or case for presentation to the team. If there is not an established team the SAS would take on this role and function. Pre-meeting task include, but are not necessarily limited to:

- Reviewing the student's cumulative records.
- Reviewing attendance records and any legal records, if accessible.
- Sending an information referral form out to other staff who instruct the student to gather other information (see attached form).

Specific to the needs of the SAS, these three activities should provide sufficient data for the SAS and/or the team to determine if next steps such as an initial screening with the student conducted by the SAS, and referral and/or parent notification are warranted or referral to other school staff. When the referral from the SAT is to the SAS the preliminary information should be recorded on a student profile sheet kept in a confidential SAPISP file separate from student records (see sample student SEBH check off list form in additional resources section).

Team Meeting

Team members should come to meetings prepared to collaborate and work towards solutions. It is important to be on time and available for the entire meeting. Each team member must read all documentation thoroughly to acquaint themselves with the student. The referring teacher

may be present to answer questions and to take an active role in the meeting. The team begins the case conceptualization process and develops the individual student plan.

If the SAS is the leader of the team and not part of an established RTI/SAT. The SAS facilitates the meeting acting as the case manager and reviews with the team previously discussed cases and newly referred cases. The SAS has overall responsibility of assuring that the individual student plan is implemented if the student falls under the SAPISP services. The SAS reports the progress of the plan back to the team with broad brush details **without breaching student confidentiality**. The team determines whether to continue with the initial plan, develop additional assessment/intervention strategies (based on RTI model), or to close the case.

Another option for the SAT is to develop a case management process. In a case manager system, members take turns in assuming the responsibility of implementing individual student plans. The designated case manager reports the progress of the plan back to the team at determined intervals. The team determines whether to continue with the initial plan, develop additional assessment/intervention strategies, or to close the case. Within such a framework, team members share responsibilities before, during, and after a team meeting.

It is important for the team to orient any "guest" who may attend a meeting. These guests are most likely to be the referring teacher or parents but may include other school staff and community personnel (e.g., probation officers). This orientation should include an explanation of the team meeting process and roles and an emphasis on the confidentiality of the deliberation.

Student Assistance Teams Procedures

Upon receipt of a referral (specific to substance abuse and emotional/behavioral health issues), gather information and note any teacher request for assistance. Discuss concerns, brainstorm ideas for assisting the student and classroom management strategies/techniques that may be helpful for teachers. When meeting with the parents, share concerns, gather additional information, explain the purpose of the Student Assistance Team—i.e., a solution focused problem-solving team for students, parents, and faculty. Finally, develop the action plan based upon the input from the team, parents, and other sources.

Meet with teachers and provide list of possible suggestions for classroom management techniques and strategies for working with referred students (see vulnerable youth section for information and resources). The team at a minimum reviews and monitors student plans at least monthly, and every two months conducts ongoing conversations with the student, parents and faculty to discuss and review progress. If at any time during this process there is an indication for the need to rule out learning challenges and/or emotional challenges that are beyond the scope of the SAT or if after continuous efforts to assist the student there is no improvement, then a referral to other school or community-based agencies is considered.

Documentation

The SAS is responsible for the maintenance of team records as applicable to the students referred to the SAS. If the SAS establishes the team and the team is not part of the SW-PBI or

RTI then the SAS also keeps on file an attendance list of team members present at each meeting, having confidentiality agreements signed, and filing student referral information (as described in section 5 Internal Referral Process). All team members sign the confidentiality agreement and follow the confidentiality guidelines including not sharing information with other colleagues or absent team members outside of the team meeting. Under the strictest confidentiality guidelines, student's substance abuse diagnosis or history cannot be shared without a release signed by the student. If he/she is under the age of 13 the parent must also signed. Release to the team needs to include the nondisclosure statement.

Schools are encouraged to have only objective comments and observable behaviors documented on the referral forms. The team should document only the intervention or assessment plan chosen by the team. It is not necessary to document group comments. *A single copy of these forms, along with other significant records, are kept in locking SAPISP file separate from the student's regular school records (see Section 5 Internal Referral Process regarding Record Keeping).*

Team Maintenance

The team will be dealing with highly sensitive issues related to students, families, and communities. To help provide longevity and prevent "burnout" of team participants, it is important for team members to practice healthy communication and to support one another. Team maintenance techniques along with benevolent and realistic attitudes and goals are encouraged. Team maintenance can be as simple as "checking-in" with each member at the beginning and end of meetings, to more formal retreats and planned team outings (*see sample Team Maintenance Evaluation in resource section*). Celebration of successes when they occur, and especially at the end of the school year, can bring a sense of accomplishment to a difficult job.

Each individual team member is challenged to examine his/her personal boundaries and reasons for choosing to participate on the Student Assistance Team. It is important to recognize that over-commitment to the team and unrealistically high expectations for success can lead to burnout. The following behaviors may reflect burnout:

- Coming to meetings unprepared.
- Arriving to meetings late and/or leaving early.
- Being preoccupied during the meetings.
- Acting defensively.
- Limited problem solving (feeling stuck).
- Expressing feelings of hopelessness or blaming.

When members begin to develop a pattern of such behaviors, the team must address the underlying issues and resolve any conflicts that are interfering with team cohesion and effectiveness.

The current atmosphere within schools places an enormous pressure upon teams to be accountable to the school staff, students, and families. SAT members are seen as leaders in

setting the tone in the way problems are addressed within the school. Working together is essential to the team process, and the team must be a model for the school to emulate.

Case Management

To engage and keep students involved in intervention services and to ensure a higher level of follow through, case management is a part the comprehensive SAPISP model. Case management is designed primarily to:

- Engage and prevent the student from dropping out of the recommended SAPISP services.
- Overcome barriers to active Participation.
- Identify appropriate services and treatment needs, if necessary.
- Provide links to needed services – school and community-based.
- Monitor student progress.
- Provide motivational enhancement.
- Encourage Participation in other community-based support groups.

The SAS, along with the SAT, has primary responsibility for engaging the student in program services and preventing the student from dropping out. The SAS addresses a broad and comprehensive array of barriers to services and achievement of intervention goals. As barriers arise, the SAS develops alternative or creative strategies for achieving desired outcomes.

The following are helpful guidelines to assist the team with effective case management (Project Care www.projectcare.org, 2005).

1. Is this an appropriate SAPISP referral? If not, then to whom should the student be referred?
2. What is documented as **observable** behavior? Is more information needed? Who might provide that information?
3. What action is appropriate?
 - a. How urgent is the situation?
 - b. How can the team encourage parent involvement?
 - c. What is the scope of the problem?
 - What in-school resources and/or services could be offered to support the student?
 - What community resources would be available and appropriate for this situation?
 - Is it appropriate to involve the liaison in this case?

If the SAT shares responsibility for case management, the team's case management questions may also include:

1. Which team members can serve as effective resources for this student?
 - a. Who will be the case manager?
 - b. Who will call the parent?
 - c. Which two (2) team members can meet with the parent?

An important responsibility of the SAS is engagement; program staff provides motivational support for the student and assists the youth to overcome barriers or resistance to program

Participation. The SAS uses marketing (sales) and motivational skills at each stage of the process – from referral through completion of program services.

Beginning with the student's most critical needs, the case manager provides links to services. The case manager must also teach families how to acquire services so they will have that knowledge when the support of the case manager is no longer available. Once referrals are made, the case manager is responsible for monitoring the progress of the adolescent and his or her family (e.g., checking whether the family members are keeping their appointments and whether their treatment plan is effective). For the case manager to release information to the referral agencies in accordance with Federal and State regulations, the adolescent and family must sign a release form.

Throughout the intervention process, the SAS must provide support to overcome barriers to the successful completion of intervention services. Program staff must be persistent and assertive to overcome barriers that prevent the student from receiving needed services. Prompt intervention when obstacles arise (e.g., transportation) helps decrease the dropout rate and increase positive outcomes. Program staff should also link students to community support groups or initiate a peer-led support group.

For SAS to provide effective linkages to community services for students and their families, they must establish positive working relationships with other service providers in the area. Strategies developed for establishing relationships with external referral sources, are outlined in Section 9 – Cooperation and Collaboration. Resource lists of help lines or hotlines and community-based agencies should be useful for identifying local service agencies.

Monitoring the Student's Progress

The SAS monitors the student's progress by following up on referrals made, ensuring that the student is keeping their appointments and that their needs are being met. The SAS must also periodically monitor the intervention plan of the student to make sure that the plan is effective and to make modifications as necessary.

Additional Resources



Development of an Interconnected Systems Framework for School Mental Health⁶⁸

(a work in progress) Revised: February 2012

Susan Barrett and Lucille Eber, National PBIS Center Partners; and Mark Weist, University of South Carolina (and Senior Advisor to the University of Maryland, Center for School Mental Health)

Context

Over the past two decades, there has been a great deal of attention on the development of models for mental health in schools, including social emotional learning, schoolwide prevention systems and more timely and effective treatment options for youth with more intensive mental health challenges. Leaders from two national centers with compatible approaches to this issue, the National PBIS Center and the Center for School Mental Health (at the University of Maryland) are working collaboratively to establish a framework inclusive of the experiences and knowledge of both national centers. This draft concept paper, a work in progress, is one step towards the development of an interconnected framework for communities and schools to use as they work in partnership to build more responsive and effective systems that connect mental health and schools.

During the next 18 months, we have been sharing this draft framework and concept paper through national meetings, conferences and learning communities to solicit feedback, including examples that align with the framework's guiding principles as we finalize a brief monograph. The goal was to obtain broad input from stakeholder groups as well as to promote a dialogue to operationalize the concept of an interconnected systems framework inclusive of mental health and education and guided by youth and families. The Centers would like to recognize and extend appreciation to the contributions of the Illinois Children's Mental Health Partnership (ICMHP), represented by Colette Lueck and Lisa Betz from the Illinois Department of Human Services Division (I-DHS) of Mental Health who developed the initial framework, key components and interconnected systems visual.

⁶⁸ Retrieved (5/21/2012) from www.pbis.org/common/pbisresources/publications/ISF_rev. Reproduced with permission from Positive Behavior Interventions and Supports Organization.

Background

Innovations in education and in child and adolescent mental health are growing rapidly; for example, in relation to Response to Intervention (RTI), and the related development of Schoolwide Positive Behavior Support (SW-PBS) in education, and the move to strong Family Engagement and Empowerment, and Systems of Care within mental health. Importantly, innovations in these systems are increasingly linked together through school mental health (SMH) programs and services. SW-PBS has pioneered systematic strategies to promote positive student behavior through data-based decision making, providing an outstanding framework from which to enhance mental health promotion and intervention. Foundational to this work is a 'shared agenda' in which families, schools, mental health systems, and other youth serving community systems are working together to build a full continuum of multi-tiered programs and services for students and their families in general and special education. These programs and services reflect integrated strategies to promote student wellness and success in school and reduce both academic and nonacademic barriers to learning and school success. SW-PBS has developed a three-tiered model of providing services reflecting the social and behavioral component of RTI and consistent with a public health approach to school mental health promotion and intervention. The intent of this brief concept paper and figure (attached) is to promote enhanced collaboration toward system integration among families, youth serving agencies, and initiatives that connect to schools. It is believed that this enhanced collaboration will improve program efficiencies, further enhance data-based decision making, increase the likelihood of evidence-based promotion and intervention, improve student, and school-level outcomes, and boost policy support for school mental health.

Figure 1 amplifies key themes in this *Interconnected Systems Framework for School Mental Health*. Guiding principles for this Interconnected Systems Model include:

1. Programs and services reflect a "shared agenda" with strong collaborations moving to partnerships among families, schools, and mental health and other community systems.
2. The three-tiered Figure 1 represents systems and progress monitoring features of the multi-tiered Interconnected System Framework.
3. At all three tiers, programs and services are for students (and their families) in special and general education, with close collaboration between these two systems within schools.
4. Tier 1 represents systems that support ALL youth; Tier 2 represents systems that additionally support some students (typically 10-15 percent) and Tier 3 represents systems that provide an additional level of support to a few youth (typically 1-5 percent).
5. Tier 2 and Tier 3 interventions are anchored in Tier 1 interventions and are natural extensions or scaled-up versions of Tier 1. For example, students who do not sufficiently respond to SW-PBS Tier 1/universal interventions receive preventive and Supportive interventions at Tier 2, and students whose problem behavior persists despite Tier 1 and Tier 2 intervention, receive intervention at Tier 3.
6. The three tiers represent system structures for providing interventions-- the tiers do not represent youth.
7. At all three tiers of programs and services, emphasis is on data-based decision making and on the implementation of evidence-based promotion and intervention.

8. There is strong training, coaching and implementation support for all efforts.
9. All aspects of the work are guided by youth, families, school and community stakeholders with an emphasis on ongoing quality assessment and improvement.
10. The functioning of school teams is critical to all efforts and are emphasized and supported strongly.
11. Prevention is an underlying principle at all 3 tiers with Tier 1 focused on preventing occurrences of problems, Tier 2 preventing risk factors or early-onset problems from progressing, and Tier 3 reducing the intensity and duration of symptoms. Prevention is aligned conceptually and operationally to promotion of health, mental health and wellness. For example, a Tier 3 (individualized) intervention to reduce anxiety, promotes health and wellness and increases that student's Participation in programs and activities in Tiers 1 and 2.
12. Interventions across the 3-tiered model are not "disorder" or "diagnosis" specific but rather are related to severity of emotional and behavioral challenges that may be present (with or without mental health diagnosis or special education identification). As part of ongoing quality assessment and improvement efforts, there is appropriate caution about labeling students, and training and increased understanding of the impacts of such labeling.

The Three Tiers Defined

Tier 1/Universal: Interventions that target the entire population of a school to promote and enhance wellness by increasing pro-social behaviors, emotional wellbeing, skill development, and mental health. This includes schoolwide programs that foster safe and caring learning environments that engage students, are culturally aware, promote social and emotional learning and develop a connection between school, home, and community. Data review should guide the design of Tier 1 strategies such that 80-90 percent of the students are expected to experience success, decreasing dependence on Tier II or III interventions. The content of Tier 1/Universal approaches should reflect the specific needs of the school population. For example, cognitive behavioral instruction on anger management techniques may be part of a schoolwide strategy delivered to the whole population in one school, while it may be considered a Tier 2 intervention, only provided for some students, in another school.

Tier 2/Secondary: Interventions at Tier 2 are scaled-up versions of Tier 1 supports for particular targeted approaches to meet the needs of the roughly 10-15 percent of students who require more than Tier 1 supports. Typically, this would include interventions that occur early after the onset of an identified concern, as well as target individual students or subgroups of students whose risk of developing mental health concerns is higher than average. Risk factors do not necessarily indicate poor outcomes, but rather refer to statistical predictors that have a theoretical and empirical base and may solidify a pathway that becomes increasingly difficult to shape towards positive outcomes. Examples include loss of a parent or loved one, or frequent moves resulting in multiple school placements or exposure to violence and trauma. Interventions are implemented through the use of a comprehensive developmental approach that is collaborative, culturally sensitive and geared towards skill development and/or increasing protective factors for students and their families.

Tier3/Tertiary: Interventions for the roughly 1-5 percent of individuals who are identified as having the most severe, chronic, or pervasive concerns that may or may not meet diagnostic criteria. Interventions are implemented through the use of a highly individualized, comprehensive and developmental approach that uses a collaborative teaming process in the implementation of culturally aware interventions that reduce risk factors and increase the protective factors of students. Typical Tier 3 examples in schools include complex function-based behavior support plans that address problem behavior at home and school, evidence-based individual and family intervention, and comprehensive wraparound plans that include natural support persons and other community systems to address needs and promote enhanced functioning in multiple life domains of the student and family.

Next Steps: Establishing Demonstration Sites: We are working with several states and districts across the country who are in the process of developing critical collaborative and sustainable strategies for establishing an interconnected systems framework. These sites have identified key stakeholders representing mental health and educators and have embarked in a collaborative teaming process. We are examining current conditions, assessing systems features and selecting the best tools to track progress and fidelity. Facilitation guides will also broaden our understanding of the roadblocks and challenges that impede the process of integration.

Building Interconnected Systems: Examples of the Work in Progress: In the current environment of limited resources and increased student exposure to risks that represent potential barriers to learning, it is critical that schools make efficient use of their own resources and garner the support that they need to effectively facilitate student performance. Braiding community resources into school environments using a three-tiered public health approach provides a structured but responsive tool for collaborative planning to maximize the effect of interventions.

We are gathering examples from the field to demonstrate how schools, districts and communities are re-designing the way they approach a fully integrated process.

Example 1: A District-Level Re-Design: The "old approach" used by the district:

- Each school works out their own plan for involving community mental health staff.
- One community Mental Health clinician is housed in a school building 1 day a week to "see" students.
- The clinician does not participate in school teams and operates in relative isolation.
- No data are used to decide on or to monitor interventions.
- There is no systematic evaluation, instead "intuitive" monitoring of efforts. The "new approach" used by the district.
- District has a plan shaped by diverse stakeholders for promotion of learning, positive behavior and mental health for students, and a "shared agenda" is real in individual schools, with staff from education, mental health and other child serving systems working closely together and with youth and families for developing and continuously improving programs and services at all 3 tiers, based on community data as well as school data.
- There is "symmetry" in leadership among staff from education and mental health systems in leading and facilitating activities at all three tiers.

- Personnel from Mental Health agency assists school district clinicians with facilitating some Tier 2 and Tier 3 interventions including some small group interventions, function-based behavior plans and wraparound teams/plans.

Example 2: Planning for Transference and Generalization: A middle school implementing schoolwide PBIS had data that indicated an increase in aggression/fighting between girls. A local community agency had staff trained in the intervention, Aggression Replacement Training (ART) and available to lead groups in school. This evidence-based intervention is designed to teach adolescents to understand and replace aggression and antisocial behavior with positive alternatives. The program's three-part approach includes training in pro-social skills, anger management, and moral reasoning. Agency staff worked for nine weeks with students for six hours a week; group leaders did not communicate with school staff during implementation. Discipline referrals for the girls dropped significantly during group. At the close of the group there was not a plan for transference of skills (e.g., training school staff on what behaviors to teach/prompt/reinforce), which resulted in a reversion to higher levels of referrals for aggressive behaviors among girls. The school's PBIS Secondary Systems Team reviewed data and regrouped by meeting with ART staff to learn more about what they could do to continue the work started with the intervention. The team pulled the same students into groups led by school staff with similar direct behavior instruction and developed transference strategies, which resulted again in reductions in referrals for aggressive behavior by girls.

Example 3: Tiers Working Together: In an example of a school/community agency partnership, a middle school, and a community Mental Health agency collaborated to help students at risk be more successful in school. Seventeen middle school students received additional support via a social/academic instructional group (a Tier 2/secondary intervention) taught by staff from the community Mental Health agency partnering with the school. Student need for assistance was determined based on data showing five or more office discipline referrals (ODRs) for disruption, or noncompliance. The students met during lunch with a group leader to learn effective skills in communication, problem-solving, how to work cooperatively, and set goals. A comparison of ODRs before and after the intervention showed, overall, the students experienced a 48 percent decline in referrals. Furthermore, a post-test measure indicating the influence of the intervention on the students' attitudes revealed that 60 percent of the participants changed their belief that fighting was an effective way to handle their anger.

Example 4: Community Clinicians Bringing in Augmenting Strategies: A school located near an Army base had a disproportionate number of students who had multiple school placements due to frequent moves, students living with one parent and students who were anxious about parents as soldiers stationed away from home. These students collectively received a higher rate of office discipline referrals than other students. The school partnered with mental health staff from the local Army installation, who had developed a program to provide teachers specific skills to address the particular needs students from military families. Teachers were able to generalize those skills to other at-risk populations. As a result, office discipline referrals decreased most significantly for those students originally identified as at risk but also for the student body as a whole.

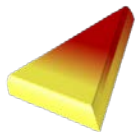
Example 5: Systems Collaboration and Cost Savings: A local high school established a mental health team that included a board coalition of mental health providers from the community. Having a large provider pool increased the possibility of providers being able to address the specific needs that the team identified using data, particularly as those needs shifted over time. In one case, students involved with the Juvenile Justice System were mandated to attend an evidence-based aggression management intervention. The intervention was offered at school during lunch and the school could refer other students who were not mandated by the court system, saving both the school and the court system time and resources and assuring that a broader base of students was able to access a needed service. As a result of their efforts, the school mental health team was able to re-integrate over ten students who were attending an off-site school, at a cost savings of over \$100,000.

Links to Additional Resources:

www.schoolmentalhealth.org <http://www.nwi.pdx.edu/> www.sharedwork.org <http://www.ideapartnership.org/> <http://cecp.air.org/> <http://csmh.umaryland.edu/> <http://smhp.psych.ucla.edu/http://www.pbis.org/> <http://rtckids.fmhi.usf.edu/sbmh/default.cfm>

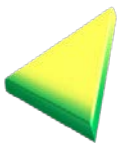
Figure 1. Interconnected Systems Framework for School Mental Health

Tier 3: Intensive Interventions for Few—*Individual Student and Family Supports*



- Systems Planning team coordinates decision rules/referrals for this level of service and progress monitors
- Individual team developed to support each student
- Individual plans may have array of interventions/services
- Plans can range from one to multiple life domains
- System in place for each team to monitor student progress

Tier 2: Early Intervention for Some—*Coordinated Systems for Early Detection, Identification, and Response to Mental Health Concerns*



- Systems Planning Team identified to coordinate referral process, decision rules and progress monitor impact of intervention
- Array of services available
- Communication system for staff, families and community
- Early identification of students who may be at risk for mental health concerns due to specific risk factors
- Skill-building at the individual and groups level as well as support groups
- Staff and Family training to support skill development across settings



Tier 1: Universal/Prevention for All—*Coordinated Systems, Data, Practices for Promoting Healthy Social and Emotional Development for ALL Students*

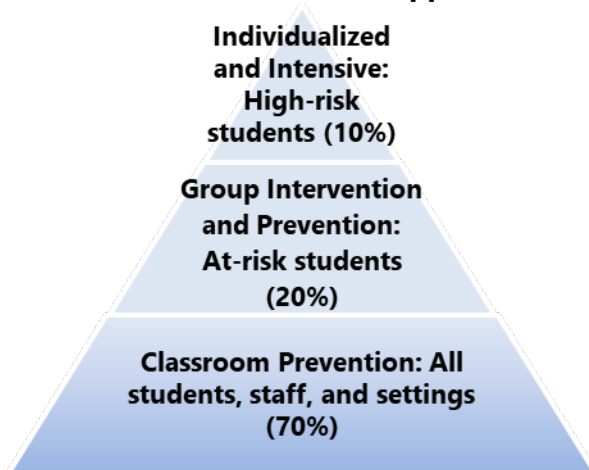
- School Improvement team gives priority to social and emotional health
- Mental Health skill development for students, staff, families and communities
- Social Emotional Learning curricula for all students
- Safe & caring learning environments
- Partnerships between school, home and the community
- Decision making framework used to guide and implement best practices that consider unique strengths and challenges of each school community

Note: In the three-tiered described interventions and support above, the document refers to mental health and social and emotional supports. SASPISP interventions and supports also include behavioral health issues, including substance abuse, in all three tiers.

Three-Tiered Approach to SBH⁶⁹

Program services should reflect a three-tiered approach as presented below.

Tier 1 services involve helping to improve the **school environment**; For example, assuring that all places within schools are safe, reducing student bullying, taking actions to promote positive and nurturing interactions among students and staff, and implementing **systems of Positive Behavior Intervention and Support (PBIS)**.

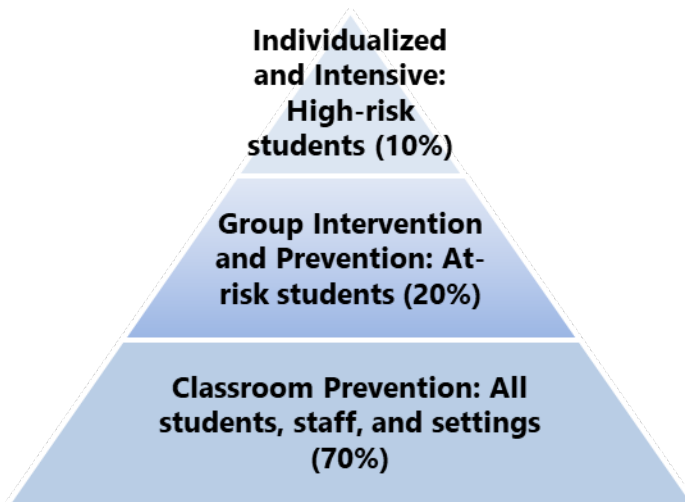


Ideally, the school is implementing PBIS as supported by most states and local school districts in the United States. Since there is very strong complement between PBIS and SBH, it is appropriate for SBH leaders to pursue PBIS connections for the schools, and for SBH clinicians to help support its implementation. Please note that PBIS is a social/behavioral strategy for **Response to Intervention** (a dominant theme within the current United States educational system focused on tailoring interventions to student needs based on evaluation of progressively implemented interventions), with **major emphasis on a multi-level prevention system, systematic screening of youth for early problems, active progress monitoring, and data-based decision making**. This has been shown to be more effective than a static testing approach. Tier 1 services are meant to be helpful to all students. For Military schools developing **programs to ameliorate deployment-related stress are of the highest importance**, and the CAF-BHO will assist installations in selecting and implementing these programs.

Tier 2 services are focused on **students showing early signs of behavioral problems or demonstrating signs and symptoms of risk** and could be applicable to all students given a major negative event affecting the whole school such as large-scale deployments or the death of Soldiers. Tier 2 services include **focused assessment and intervention services** (e.g., for up to a few sessions), implementing **Supportive and evidence-based group interventions**, and

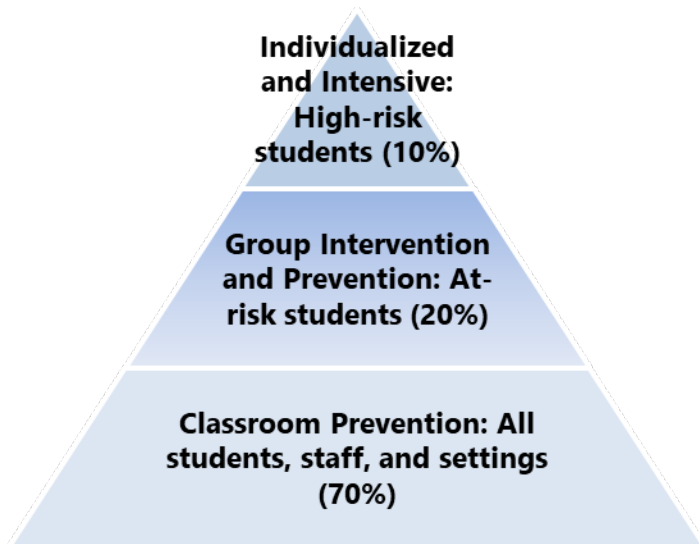
⁶⁹ Excerpt from: Child, Adolescent and Family Behavioral health Office, United States Army Medical Command, and Office of the Surgeon General United States Army (10/2011, revised ed.). Available at <http://brainhealth.army.mil/SBH/>

working collaboratively with educators in promoting positive behavior and managing negative behavior.



Tier 3 services provide behavioral health **treatment for students and their families presenting more serious emotional/behavioral challenges**. SBH staff offer more intensive assessment and diagnostic evaluation, and treatment. This may include individual, group and/or family therapy with close case management.

In general, SBH staff should emphasize Tier 3 and Tier 2 services targeted to Military Families with adherence to procedures that meet accreditation requirements of the MTF. However, SBH staff may provide consultation services to school staff, focused on general issues or strategies to assist students and promote behavioral health for all students. SBH staff should also be available to assist students and Families in connecting with other services. For example, for **nonmilitary Families** this would include services offered within the school, and through the local community behavioral health agency. For Military students and Families, this would include services offered through Child Development Centers, Child and Family Assistance Centers, and through Army Community Services. In addition, SBH staff represents a resource for school staff; for example, in providing guidance on coping with stresses of Military life, promoting the use of wellness strategies, etc.



SBH programs should utilize evidence-based curriculum and practices in the direct services being provided to students and Families in all three tiers of the prevention/intervention model illustrated above. To learn more about evidence-based practices, please visit the Substance Abuse and Mental Health Services Administrations (SAMHSA's) National Registry of Evidence-based Programs and Practices (NREPP). This helpful website is an online registry of reviewed behavioral health and substance abuse interventions that have been determined to have quality research supporting the intervention and can be readily disseminated. The registry can be found at <http://nrepp.samhsa.gov/>. The CAF-BHO will be providing training to installations in modularized CBT interventions.

Examples of Prevention and Wellness Groups:

- Classroom Based Deployment Group (coping with deployment and reintegration)
- Buddy lunches and Brigade Basketball – positive mentoring of students from the Soldiers from an adoptive brigade.
- Understanding and Combating Bullies
- Common Sense Parenting; 1-2-3 Magic; SOS Help for Parents
- "Copier Chats" – posting info for teachers around the copiers and quick chats about symptoms of disorders or common challenges for Military children.
- Brown Bag series – symptom and intervention specific support
- "Ask a Doc" coffee hours
- Health and Fitness groups; Crafting Club; Child-Parent playtime
- Campaign of Kindness – Filling someone else's bucket today (how can you give to others in your day and make a positive contribution)

Triage Team

The SBH team and school will need to establish a **Triage Team** to discuss students referred for evaluation and treatment of behavioral health issues. The team should be chaired by either the SBH clinician assigned to the school or by a SBH professional, such as the school psychologist, counselor, or social worker. The Triage Team should meet weekly to discuss the referred

students, progress being made, changes in treatment plans, and other behavioral health issues pertinent to the school. A lay component of the Triage Team is **monitoring outcomes and ensuring ongoing performance improvement**. The Triage Team will work with other teams in the school (e.g., PBIS, Student Support and School Advisory Team) and will also assess and monitor staff, family and student relations, and issues related to community and Military life.

Student Assistance Prevention Intervention Services Program School Staff Referral Form

Date of Referral _____ Person Reporting _____
Student Name _____ Grade _____ Age _____
Homeroom Teacher _____

Areas of Concern (please check all that apply)

ATOD-related Issues

- Suspected alcohol use
- Suspected marijuana use
- Suspected tobacco use
- Suspected other drug use

School-related Issues

- Poor academic performance
- Poor attendance/frequently tardy
- Low commitment
- Disruptive school behavior
- History of disciplinary problems

Behavior/Peer Relations

- Aggression/fighting
- Anger/Lack of control
- Poor Social Skills
- Association with antisocial peers
- Gang involvement/behavior
- Inappropriate dating behaviors
- Patterns of impulsive and chronic hitting, intimidation and bullying behaviors
- Threats toward others

Mental Health Issues

- Anxious, depressed, withdrawn
- Low self-esteem
- Other mental health needs
- Grief/loss
- Excessive feelings of isolation and being alone
- Suicide threats/self-mutilation

Home/Community Issues

- Substance use by others

- Relations with parent/guardian
- Physical/sexual/emotional abuse
- Legal problems
- Grief/Loss
- Basic Needs-School-related Issues
- Poor academic performance
- Poor attendance/frequently tardy
- Low commitment
- Disruptive school behavior
- History of disciplinary problems

Other

- Atypical behaviors (lack of attention to hygiene, grooming, dress)
- Unusual risk-taking behaviors Delinquent/criminal activity
- Unusual interest/preoccupation with weapons
- Expression of violence in writings or drawings
- Being a victim of violence

Please note any additional concerns or pertinent information regarding this student's behavior.

SAT Meeting Attendance Record

Date	Date	Date
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name

Date	Date	Date
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name
Name	Name	Name

Sample Team Maintenance Evaluation⁷⁰

Directions: Effective teams take time to monitor the process and results of each of their meetings. Please respond to the following questions, then, as a team, discuss your comments.

1. Write down three (3) words to describe how you feel about this meeting.

2. How would you rate the effectiveness of this team to work together?

Low 1 2 3 4 5 High

3. How satisfied are you with the results of this meeting?

Low 1 2 3 4 5 High

4. Did you feel that your opinions were heard during the meeting? Why or why not?

5. What suggestions do you have to improve the next meeting?

⁷⁰ Source: Project CARE SAP Training Workbook • www.projectcare.org.

Practice Notes:⁷¹

Managing Care, Not Cases

Common terminology designates those whom professionals work with as “cases.” Thus, considerations about making certain that clients connect with referral resources often are discussed as “case monitoring” and efforts to coordinate and integrate interventions for a client are designated “case management.”

Given that words profoundly shape the way people think, feel, and act, some professionals are arguing for use of the term “care” in place of “case.” Such a move is in keeping with the view that care is a core value of helping professionals. It also is consistent with the growing emphasis on ensuring that schools are “caring communities.” For these reasons, it seems appropriate to replace the term case management with that of management of care.

Management of care involves (1) initial monitoring, (2) ongoing management of an individual's prescribed assistance, and (3) system's management. As with any intervention, these activities must be implemented in ways that are developmentally and motivationally appropriate, as well as culturally sensitive.

Initial Monitoring of Care

Stated simply, monitoring of care is the process by which it is determined whether a client is appropriately involved in prescribed programs and services. Initial monitoring by school staff focuses on whether a student/family has connected with a referral resource. All monitoring of care requires systems that are designed to gather information about follow-through and that the referral resource is indeed turning out to be an appropriate way for to meet client needs. When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide.

Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Ongoing Management of Care

At the core of the ongoing process of care management are the following considerations:

- Enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions.
- Adequacy of client involvement.
- Appropriateness of intervention planning and implementation, and progress.

Such ongoing monitoring requires systems for:

- Tracking client involvement in interventions.

⁷¹ Center for Mental Health in Schools at UCLA. (2003). School-Based Client Consultation, Referral, and Management of Care.

- Amassing and analyzing data on intervention planning and implementation.
- Amassing and analyzing progress data.
- Recommending changes.

Effective Care Management is based upon:

- Monitoring processes and outcomes using information systems that enable those involved with clients to regularly gather, store, and retrieve data.
- The ability to produce changes as necessary to improve quality of processes.
- Assembling a "management team" of interveners and clients and assigning primary responsibility for management of care to one staff member or to several staff who share the role.
- Assuming a role that always conveys a sense of caring and a problem-solving orientation and involves families as empowered partners.
- Facilitation of self-determination in clients by encouraging Participation in decision- making and team reviews (particularly when clients are mandated or forced to enroll in treatment).
- Meeting as a management teams need to meet whenever analysis of monitoring information suggests a need for program changes or at designated review periods.

A few basic guidelines for primary managers of care are:

- Write up analyses of monitoring findings and recommendations to share with management team.
- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when.
- Set-up a "tickler" system (e.g., a notation on a calendar) to remind you when to check on whether tasks have been accomplished.

Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

Section 8

Educational Student Support Groups (Selective and Indicated)

Introduction

Research shows that daily or weekly contact with a student greatly increases protective factors and reduces risks (Bond and Hauf, 2004; Dusenbury and Hansen, 2004). One of the most effective approaches for weekly contact is the provision of school-based educational support groups. Student Assistance Specialist (SAS) trained in the dynamics of group process facilitate support groups. These support groups are educational, curriculum-based, student-centered, and solution-focused discussion groups. Educational support groups are not unstructured rap sessions nor therapeutic in nature. In the SAPISP, educational support groups are beneficial for several reasons:⁷²

- **Time and cost efficiency.** Since several children participate in support groups at once and focus on common concerns, the group format may be more time efficient than one-on-one counseling. Further, not all schools can afford school counselors, social workers, and/or psychologists. In any case, these professionals are burdened with ever-increasing caseloads. Support groups facilitated by trained professionals can ease the counseling burden and broaden the range of services, especially in small, rural communities.
- **Breaking the isolation** of participants when they meet, talk to, and work with other students and a caring adult to solve similar problems.
- **Appropriate emphasis on information.** COAs and children from other disrupted family environments have a lot to learn about how their family problems affect them. Support groups provide a safe, positive environment in which information can be learned.
- **Safety and protection.** Group members offer each other ideas and experiences on how to stay safe at home and on the streets.
- **Healthy relationships.** The relationships developed in support groups can serve as guidelines for developing healthy relationships outside of group.
- **Respect.** Participants learn and model how to give and receive respect from their facilitators and peers. This may be a new and affirming experience for them.
- **A positive peer and community environment.** Although support groups generally take place during one period, one day a week, participants may gather outside of group for recreation or volunteer activities.
- **Validation of their own experiences.** Group feedback helps participants do a “reality check” and gain perspective on how others’ behavior affects them. By seeing how their peers are affected by family situations, participants are better able to understand their own.

⁷² Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.29-30). Substance Abuse and Mental Health Services Administration. Rockville, MD.

- **Absolution of blame.** Support groups provide an opportunity for students to hear often, and from many different sources, that they are not the cause of their parent's addiction or other family problems.
- **Inclusion**⁷³ Regardless of whether their concern is with their own alcohol/drug issues experience or with another's, most children and adolescents have been forced to deal with these problems in isolation. Most feel that they are the only ones who feel the way *they* do, that no one else has similar problems, and that others would judge them harshly if they knew. The strength of the "no talk rides" and society's general unwillingness to be open about family alcoholism *leads* most affected children to think they are the only ones facing such problems. Few young people who are abusing alcohol or other drugs discuss their pain with each other. The student in treatment also often feels isolated and "different," convinced that no one else could possibly share his problems. One of the things which the brief, problem-focused group accomplishes better than anything else is allowing students to discover that they are not alone. Students discover that they are not alone in feeling guilty for causing their parent's drinking, in feeling confused and scared about their own drug experiences, or about their struggle to stay straight. The feeling of isolation diminishes immediately upon entering the group room for *the* first time and disappears entirely as the group develops.

Implementing Support Groups in the School Setting

Support groups are seen as an effective and practical way to provide support to young people who are struggling with their own SEBH issues including substance abuse, lack competent, caring adults in their lives due to chemical dependency, marital strife, abuse, neglect, abandonment and various other problems. School-based educational support groups provide healthy relationships with the adult group leader and the children/youth in the groups. "People of all ages but especially young people need support when attempting to understand and change their behavior. Most get support from their immediate or extended family. However, millions of children lack Competent, caring adults in their lives due to alcoholism, parental marital conflicts, abuse, abandonment, and other problems" (Center for Substance Abuse Prevention, 2007, p. 27).

Support Groups Are Efficient⁷⁴

A primary reason for implementing ATOD-related support groups has to do with the fact that drug abuse and related problems *are* extremely resistant to change. Whether they are recovering from chemical dependency, are struggling with their own drug abuse, or are dealing with the stress of living with a chemically dependent family member, the promotion of healthier and more constructive behaviors in students requires considerable education, illustration, and support. Changing resistant behavior requires an environment that is safer and more Supportive of change than that provided by a student's routine associations with other students, family members, and even staff members.

⁷³ Reprinted by permission from "When Chemicals Come to School." p. 174–175. Copyright 1993 by Gary L. Anderson, S68 W20707 Stonecrest Rd., Muskego, WI 53150

⁷⁴ Ibid

One of reasons why constructive change is difficult is that the behavior required is both new and risky. Thus, from a more *pragmatic* standpoint, whether the issue is confronting a family member with a drinking problem, expressing *a* feeling, or resisting peer pressure, the group provides an opportunity for students to *experiment with and practice new behavior in group before trying* it out in the "real world." Enlisting the ideas and suggestions of group members also *provides* the student with many realistic alternative behaviors that he would typically have been unable to come up with by himself.

According to the Center for Substance Abuse Prevention (2007) "Support groups are neither "rap" nor therapeutic groups, but are age-appropriate, curriculum-based, solution-focused student discussion groups. The goal of such groups is to provide education and support behavior change." "Research shows that daily or weekly contact with a caring, concerned adult greatly increases protective factors and reduces risk factors in youth." (p.28)

Support Groups Are Developmentally Appropriate

Most drug-related behavior occurs within and is supported by a fairly strong and cohesive peer group that does not readily sanction individual independence, even if the adolescent is developmentally equipped to resist peer group pressures. For the children of alcoholics, the family represents a "group" setting which is even more intense and less accepting of changes that can involve the open recognition of an ATOD problem, violation of the "no talk rules," or the reduction of enabling behavior by the affected child or adolescent. The support group, made up of other children or adolescents facing similar problems and tasks, thus provides a developmentally appropriate context within which to discover, examine, and experiment with change and still do so in an environment that is both emotionally "safe" and made up of one's peers.

Similarly, students struggling with their own chemical abuse are not responding to "*peer pressure*" to use drugs so much as *they* are responding to an intense need to belong and to avoid behavior that would precipitate rejection by their *peers*. Groups focusing on drug abuse provide a controlled and directed peer setting within which individual students can examine "peer pressure" and ways of rejecting drugs that are based on affirming positive aspects of themselves and that do not involve rejecting other *adolescents* as people. Groups provide opportunities to explore such issues and practice behaviors to a degree that one-to-one counseling relationships do not provide as readily.

Finally, groups are *even* more developmentally appropriate for the recovering student who is faced with internal pressures to return to chemical abuse, and an external family, school, and peer environment that at best often does not understand the magnitude of the task of staying straight. At worst, the environment actively promotes the return to chemicals. For these students more than others, the support group provides an environment of peers who are struggling with the same issues.

Support Group Composition

It is important to be sensitive to group make up or composition. Grouping students will like issues and risk factors are important (i.e. not combining those harmfully involved with substances with those who are experimenting or those at potential risks ATOD use and other SEBH issues. It is critical that placement is based upon identified student risks and needs and that groups are appropriately mixed (Einspruch & Deck, 1999). Anderson (1993) notes that close attention must be paid when making group placement decisions. He states: "Among those students affected by their own chemical abuse, a distinction must also be made between those who are diagnosed as chemically dependent [and serious emotional disturbances and who have been or are involved in a treatment program and those students who are not chemically dependent or who have not yet been diagnosed as such. This division is necessary on both theoretical and practical grounds. First, drug abuse differs conceptually as well as clinically from drug addiction or dependency. Secondly, the "recovery" issues for students in each group will consequently differ significantly. Abstinence, for example, is the prevailing treatment goal for dependent youth, whereas it is not a lifetime necessity for nondependent youth."

The distinction between "recovering" and other drug-involved youth also makes sense for the school from a procedural point of view. There will be many students who may in fact be chemically dependent but who have not yet been so diagnosed through referral to assessment agencies... [A] use-focused group is often the device by which the school can gather enough meaningful information about a student's drug involvement to justify as well as bring about a successful referral. Moreover, it would be highly inappropriate to mix students who have elected a use-focused group in lieu of suspension with students who have returned to the school from a treatment program (p. 180).

SAP Support Group Limitations

Anderson (1993) notes that establishing the intended target group (i.e., recovering students, affected others, etc.) as well as identifying goals and objectives for achievement in the support group setting is an essential step in the planning process. Generally, the intent of educational support groups should be "to improve rather than cure" (p. 210), and it is important to distinguish "support groups" from "therapy." SAPISP support groups have two general goals: 1) "to promote, enhance, or maintain students' abilities to cope healthfully and constructively with ATOD-related problems in themselves and/or others, and 2) to enable students to make use of those resources available in the environment, where the 'environment' is the group, the school the family, or the community" (p. 210).

Two critical strategies to address personal change within a group setting is to allow students to define their own ATOD use as a problem and then to provide them with the knowledge, skills, competencies, and support needed to modify their substance use with reduction of use and abstinence as the main goal (Einspruch & Deck, 1999). Suggested topics for social, emotional behavioral health, including substance abuse groups may include information about the continuum of substance use experience, personal communication skills, the consequences of substance use or other social, emotional, behavioral problems, alternatives/solutions to problem behaviors, peer pressure, and decision making.

Einspruch and Deck (1999) conducted research on the effectiveness of SAPISP support groups intended to provide early intervention to substance using adolescences. Based upon their findings, they make the following recommendations as a means of increasing the likelihood of obtaining positive outcomes for students participating in peer support groups (p. E-13):

1. Groups should be based on specific activities designed to enhance skills rather than simply be a time for students to interact with each other in an unstructured environment that promotes the sharing of deviant norms.
2. The adult group facilitator needs to directly address substance use behaviors and should deliver a clear message that substance abuse is unacceptable, while still nurturing the trust and respect of the participating students.
3. Careful consideration should be given to the membership composition of early intervention peer support programs (e.g., whether new and more experienced substance users should be in the same group or whether new users and highly deviant users should be placed in the same group).

See additional resources for more information on the role of the Support Group Facilitator and Leaders guidelines from Center for Substance Abuse Prevention (2007), *Help is Down the Hall a Handbook on Student Assistance* (chapter 4).

Washington State's SAPISP Support Groups Offerings

Washington State's SAPISP model has four standard student support groups: 1) At Risk/Social Skills; 2) Intervention; 3) Children from Substance Abusing Parents (COSAP); and, 4) Recovery Support. Additional groups may include tobacco education/cessation, ATOD education, anger management, friendship group, gang/violence intervention, or bully/victims.

The following pages provide information on logistics, effective practices in group set up, information on the stages of group development, goals, and objectives for the four standard educational support groups and suggested resource list of curriculum/materials for group activities. Group facilitation skills, practice and theory as well as other support group contents other than the four standard groups are not covered in the Washington State SAPISP manual.

Group Logistics⁷⁵

The information below describes the logistical details to address before beginning a group in order to meet the needs of each particular school setting. These seemingly "minor" details can have enormous positive or negative impact on the character and success of a group.

Space: The meeting place should provide auditory and visual privacy with enough room for students to move around comfortably. A blackboard, bulletin board, or other writing/drawing surfaces are available. Desks and chairs are not necessary; if there is a rug and pillows, students can sit comfortably on the floor. Student behavior problems will be minimized if the space does not include enticing materials or equipment that is off-limits to the students (e.g. audio-video

⁷⁵ Adapted in part from: Kids Like Us Everywhere KCDASAS Prevention Program, Seattle, WA

equipment, sports equipment, etc.). *It is important to have this space reserved for the group on a regular and ongoing basis.*

Group space should protect personal privacy. It is important to hold group sessions in areas in which information cannot be overheard – students should feel comfortable sharing intimate feelings. It is equally important that SAS's not confuse privacy with confidentiality. According to Anderson (1993), "Group confidentiality protects what is said and done in group, *not* the fact that a student is in a support group" (p.212). Holding groups in secretive or out-of-the-way places may only serve to reinforce students' secrecy and shame associated with substance related problems. As long as issues of privacy are adequately addressed, locating support groups in common areas sends a message of acceptability to participating students.

Accessibility: Group membership and meeting space should be accessible to any student in the targeted student population. When forming groups, consider the special needs of students to prevent discrimination.

Time Scheduling: School personnel and the SAS establish the specific timing of groups well in advance of the initial group session. Groups need to meet regularly to alleviate students' anxiety or uncertainty about the meeting time and place. Predictability is assured with a regular meeting time; however, this may be difficult for the teacher and student if a student consistently misses a particular subject; a suggested solution is to plan a rotating group schedule (1st period one week, 2nd period the next, etc.). Group leaders need to know about special events, which may interfere with group times to make alternative plans in advance. Anderson (1993) recommends that group sessions be held during the regular school day to alleviate issues associated with transportation, extracurricular activities, or parental consent. In addition, doing so sends a message to both students and staff that SAPISP services are a significant component of the school system.

Getting Students To and From Group: Procedures need to be defined as to how: 1) students are to be excused from class; 2) students get to the group location; 3) attendance is recorded; 4) students return to class; and, 5) teachers and students deal with problem times (e.g., when testing is going on in the classroom or where the class has field trips planned).

Rules: Leaders should follow existing building rules and disciplinary procedures. SAS's should be aware of specific expectations and disciplinary procedures of each of the teachers from whom the students come and coordinate group expectations as much as possible with the classroom and building rules. *Remember*, the school staff member acting as co-leader has existing authority and should be comfortable exercising this authority when necessary.

Confidentiality. Prior to the start of groups, students are informed of the SAS's responsibilities regarding confidentiality including being a designated reporter of child abuse/neglect and sexual abuse under state statutes and staff's requirement to comply with state laws and to follow school procedures for reporting such cases. SAS are expected to safeguard student confidentiality and disclosure of information within the group setting. Exceptions to this general

policy need to be reviewed with the student and the group. (For additional information, see Confidentiality, page 123).

Parental Information and Consent. For students under the age of 13, parent permission is required prior to group Participation. In this case, a letter is sent to the parent/guardian, seeking written permission for their child to participate in a support group. For students over the age of 13, consent may be passive or active and is determined by school policies and the program supervisor. *Note of Caution: Some schools and SAPISP require active and/or passive parent consent regardless of the student's age.*

Group Preparation and Set Up

The overall goal of SAPISP is to improve not “cure” the identified problem behaviors or needs of referred students. Student support groups are one element of a comprehensive approach to helping students, with these viewed as one of many components linking students to other sources of support—school and community-based.

Pre-Group Screening: It is recommended that all students are screened as outlined in *Section 5 Internal Referral Process* and provided with an orientation interview prior to group placement. The orientation interview has a variety of purposes it allows staff to:

- Make appropriate placement decisions.
- Explain the group process and review with the student the group goals, purpose, rules, expectations and requirements.
- Determine if the student can make a commitment to participate in group.
- Assist the student in identifying his/her own goals/needs for group.
- Determine appropriate group material.

Consideration must also be given to compatibility of group members, including ethnic minorities and diverse populations. Finally, it is important that group members and the facilitator have a reasonable chance of successfully working together.

In addition, during the pre-screening/orientation interview that SAS will want to explore the following with the student (Anderson, 1993, p. 213):

1. What brings the student to the group? Is the group the student's idea or someone else's?
2. Is the student motivated to make changes in the direction of improvement?
3. Will this student be "alone" in the group? Is the student compatible with others already selected or already in the group?
4. Does the student understand the purpose for and expectations of the group?
5. Is this the student's first group experience?
6. Does the student possess the personal strengths and social and verbal skills necessary to be in this group at this time?

Goal Orientation: Defining the targeted objectives for students is another critical planning step in the group process. The specific goals, objectives, and outcomes of support groups depend upon the focus and topic addressed. The goals of most student support groups are⁷⁶:

- To provide accurate information in a safe, confidential setting where students can ask questions and get clarification.
- To clarify and define how others' behavior affects the child.
- To provide children with a framework to understand what they experience at home
- To validate their emotions and emotional experiences.
- To address problems by utilizing appropriate problem-solving skills, clarifying options, identifying support resources, and connecting to support systems outside group.
- To provide and support healthy relationships.
- To assess and respond to child protection issues.
- To separate the person from the problem behavior.
- To refer to additional services, such as a formal assessment, family counseling, tutoring, and so forth.

Outcomes of Participation in student support groups may include, but are not limited to:

- Improved attendance.
- Improved academic achievement.
- Decreased denial, confusion, and isolation.
- Improved social skills and sense of belonging.
- Increased self-esteem.
- Increased coping skills.
- Ability to discriminate between safe and unsafe people.
- Hope.

Anderson (1993) notes that for any group, outcomes should generally address three areas: 1) improvement in personal and interpersonal functioning; 2) improvement in academic performance (grades, attendance, classroom conduct); and 3) improvements in specific ATOD-related indicators (perception of risk, reduction/abstinence, coping skills, etc.). When establishing group goals, program staff should consider the overall aim of the support group – “to improve rather than cure” – and establish goals that can be realistically achieved given the limited timeframe, number of participants, or other extenuating factors.

Group Rules: Establish rules with student input at the first session (It is recommended that students agree in writing to group goals and rules). Existing school rules must be followed. At a minimum, rules should include maintaining confidentiality, dealing with absences, class release/return, not coming to group under the influence (no ATOD use for students participating in Recovery Group), and discussion with the facilitator and/or the group prior to a student ending group Participation. Most importantly, student statements or nonverbal cues that could

⁷⁶ Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.29). Substance Abuse and Mental Health Services Administration. Rockville, MD.

be seen as supporting ATOD use, or enabling, need to be confronted immediately and consistently.

Structure: Effective SAPISP groups are those in which the student makes a formal commitment to attend all sessions and requires a certain level of engagement and Participation. As previously stated, effective groups are not loosely defined "rap," or "drop-in, drop-out" sessions. Even in groups considered to be more "maintenance" oriented such as Recovery, students should make a commitment to attend an agreed upon number of consecutive sessions. Facilitators need to establish a set group structure and follow content as outlined for the established SAPISP groups (see page 228). Students should be supervised at all times prior to, during, and after the group session.

Time Limited: All groups need to have an established number of sessions (average 8–10) provided over a time limited period. Group/personal goals are evaluated as being achieved/effective by the individual student, the group as a whole, and the facilitator prior to any consideration of additional sessions. Students who want, or are in need of, continuing services can negotiate new goals for the second group offering. For example, a youth who completes Intervention group and is identified as having a difficult time abstaining and is resistance to treatment but open to support maybe referred to an ongoing support group. The new group establishes a set of goals different from the original group such as staying sober, coping with peer pressure, seeking community support, etc.

Frequency/Intensity: Typically, student support groups meet weekly; however, depending on the group focus, targeted audience, and identified student outcomes group scheduling may be flexible. For instance, some groups such as COSAP may meet twice weekly to assist students who are coping with stressful family situations or Recovery, daily for ongoing support. Another example is adapting meeting times to coincide with the school's schedule such as meeting twice a week for 25 minutes in order to adapt to shorter class periods. Optimally, groups should be on an established predictable schedule over the course of several weeks and staggered so that the student does not miss the same class period over the 10–12 weeks of group sessions. After 12 sessions it is recommended students who want to continue services that "new" group goals are discussed and established before continuing with a support group. Follow-up one-on-one on occasion is recommended to check in on the students periodically.

Size: Ideally, group range in size from six to eight members, although larger or smaller groups are possible – a group is two or more participants. Larger groups may require one or more facilitators with goals and expectations adjusted to accommodate group size. Larger groups are less likely to have personal interaction and tend to be more didactic and discussion focused whereas smaller groups allow for a higher level of personal engagement by participants and can focus more on process.

Closed versus Open Groups: Most often groups are closed rather than open enrollment, which means that students start and end the group together. The advantage of closed groups is the continuity and relationship building that takes place among group members. Closed groups

allow students to spend dedicated time together without interruption to the group process which is often caused by entry of new group members or others leaving in open group settings. One major disadvantage of closed groups is that students referred to a group must wait until a new group begins. (Anderson, 1993)

Educational in Nature: Student support groups are educational, focus on providing participants with life skills/coping skills, with structured goals and objectives achieved through curriculum-based content, and are time limited. Students needing open ended, unstructured treatment or therapy groups should be referred to the appropriate agencies for those services.

Labeling Groups and Anonymity: For purposes of the manual, student support groups have been named according to their focus i.e. at-risk, Intervention, Children from Substance Abusing Parents/Affected Others, and Recovery Support. However, to protect confidentiality, actual groups should have a neutral name, for example, Orange, Yellow or Green group, or Group 1, 2 or 3. Forms, such as parent permission slips, progress reports on discipline students, and hall passes should also use neutral group names. (Sample forms are located at the end of this section).

Credit Options: Explore options to enable students to receive credit for group Participation. Sometimes student support group Participation can be integrated within a regular health or communication class without jeopardizing confidentiality concerns.

Educational Support Groups vs. Therapy Groups

Educational support groups are different from therapy groups in a variety of ways. School-based substance prevention-intervention educational groups are content specific, curriculum-based, and focus on life/coping skills. Conversely, therapeutic groups aim to solve personal problems, and are resolution focused. In support groups, the SAS provides a Supportive group environment and validates, educates and empowers the students served. Whereas a therapist may be Supportive, s/he also diagnoses, establishes a treatment plan and confronts, and probes the client. School-based educational groups are time limited, whereas therapy groups/sessions are determined by patient’s progress or insurance coverage (Lemerand, 1993).

Claudia Black⁷⁷ has articulated the comparison of educational support groups to therapy groups in the following chart:

Educational Groups	Therapy Groups
Focus on life skills/coping skills	Solve personal problems
Education	Resolution
Support/Safety Net	May be Supportive but also include

⁷⁷ Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook.(p.36). Substance Abuse and Mental Health Services Administration. Rockville, MD.

Educational Groups	Therapy Groups
	confrontation and probing
Educational goals and objectives are achieved through curriculum-based content/activities	Individualized treatment plan, use of therapeutic activities; however, process is always more important than content
Building protective factors	Probing; addressing impact of risk factors; may focus later on building protective factors
Conducted by trained facilitators. Caring. Knowledgeable about child development and specific issues. Have "health" to give.	Conducted by trained therapist
LOVEE driven: (Listen, Observe, Validate, Educate, Empower)	Psychological theory and diagnosis driven
Time limited (6–12 weeks)	Length of treatment driven by treatment process and patient's progress, or insurance coverage

Critical Educational Support Group Components

To be effective educational support groups need to address certain skills found to be critical to preventing substance use, including empathy, social/problem solving, anger management or impulse control, communication, stress management and coping, media resistance, Assertiveness, and character development. Support groups are most effective when they (CSAP, 2002):

- Reach students during non-school as well as school hours.
- Use age and culturally appropriate, interactive teaching materials.
- Combine social and thinking skills instruction with resistance skills training.
- Include an adequate "dosage" of at least 8 to 12 sessions per year.
- Include peer education components that are led by students.

Group Formation

There are many theories on developmental systems. Weber (n.d.) explores developmental issues in a way that allows for continual change within the group process and argues that all groups go through several stages of development to reach competence – Forming, Storming, Norming, Performing. Weber's view, consistent with student assistance programs, maintains that *activities elicit behavior*. Weber notes that since the group is continually experiencing activities, the potential for new behaviors is always present. The group may leap forward to an advanced stage, or it may go back to an earlier stage. He states:

Groups may proceed through the [four] stages quickly or slowly; they may fixate at a given stage; or they may move quickly through some and slowly through others. If they do indeed complete all [four] stages, however, and have sufficient time left in their life together, they will again re-

cycle through the stages. This additional development will lead to deeper insight, accomplishment, and closer relationships. (p.1).

Groups will generally grow to a stage that can be somewhat relied upon, though it will revert depending on how it responds to significant challenges. Those challenges can be called "pinch points" or "crunch points," the pinch growing to a crunch if the group fails to deal with the challenges. Weber's group process theory builds upon the stages developed by Tuckman (1965), Schutz (1971) and Bion (1961), those stages are: *Forming*, *Storming*, *Norming*, *Performing*, and *Transforming*.

Forming: When groups form – or are in their infancy or childhood stage – members are scrambling for leadership and trying to establish a leader. There is confusion, anxiety, and willingness to please, along with solid glimpses into what the group will be like. This is an important time for the group to achieve something for they may be more willing to please each other and the leader at this stage than they will be during the *Storming* stage. Those solid immediate first achievements will be important building blocks to later group processes.

Storming: Others call this the control stage or "adolescence." Weber (n.d) describes it as "possibly the most difficult stage to tolerate in either persons or groups." (p.3). Alliances between members have formed sufficiently to generate negative behavior and power struggles begin to take place. Real testing of the leader begins as members overtly challenge or covertly undermine those in leadership positions. It is truly an all-out get-to-know-you time. Group members are asking through their behavior: *Is this group safe? Am I going to like what I am doing? Can these leaders handle us?* Members are essentially reacting to the situation, with very little initiative or independence exhibited. It is important to continue to deal with the uses of achievement and negotiation, giving group members the solid experiences that will help them move on to the next stage.

Norming and Performing: During its adulthood, the group operates as a unit, taking pride in what it is doing, and using its own strengths. The group is also moving away from its dependency on the leaders, taking initiative, and experiencing pride in group accomplishments. They are more able to confront each other in terms of goals and behavior and group norms are established. Group members begin to develop affection for each other and self-disclosure increases as the group moves toward intimacy. The group is ready to address its goals and to work together collaboratively. Through these stages the group has established its own identity and the group feels balanced, harmonious and healthy.

Transforming (also known as "termination"): Transforming is what a group must do when it has accomplished its goal or has run out of time. This is the change/transition phase. According to Weber (n.d.), there are two choices, 1) to Redefine, start again with a new agenda, purpose, and time period, or 2) to Disengage/Terminate. "The group must decide on its future, or it will proceed down a frustrating, unfulfilling path" (p.4). In this stage, members will feel a range of emotions (anger, fear, despair, acceptance), and there may be issues of loss and grief associated with the group terminating. However, Weber (p.4) notes,

Not uncommonly, groups will attempt to define ways of retaining contact after separation in an effort to escape the pain of disengagement. But failure to disengage, to recognize that the life of the group, as its members have experienced it, has come to an end, will only lead to a hollow, unfinished feeling in the future as a person must face the inevitability of leaving this life, members must realize that groups too must die. But if nourished, the spirit or experience can live on.

These developmental stages can help program staff to decide on intensity and specific tasks of groups activities. Tasks that require a high degree of initiative and responsibility should be reserved for the *Norming/Performing* stage. Tasks that must be watched closely through narrow parameters should be slotted into *Forming* and *Storming*. It is important to remember that groups will recycle through the process, in other words, "two steps forward, one step back." A group will move to a level, but may encounter difficulties, which force them to a previous level. If the difficulties are addressed, the group will grow in a normal "zig-zag" kind of fashion. If difficulties are not addressed, the group is at risk of falling apart.

Stages of Change⁷⁸

Prochaska and DiClemente's (1982) *Stages of Change* theory has been conceptualized for a variety of problem behaviors and is utilized as a foundational approach in Washington State's SAPISP model. The five stages of change are *pre-contemplation*, *contemplation*, *preparation*, *action*, and *maintenance* (figure 8.1).

- *Pre-contemplation* is the stage at which there is no intent to change behavior in the foreseeable future. Many individuals in this stage are unaware or under aware of their problems.
- *Contemplation* is the stage in which individuals are aware that a problem exists and are seriously thinking about overcoming it but have not made a commitment to take action.
- *Preparation* is the stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.
- *Action* is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. *Action* involves the most overt behavioral changes and requires considerable commitment of time and energy.
- *Maintenance* is the stage in which individuals work to prevent relapse and consolidate the gains attained during *Action*. For addictive behaviors this stage extends from six months to an indeterminate period past the initial action.

Figure 8.1: Stages of Change Model⁷⁹

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current

⁷⁸ Retrieved from <http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm>.

⁷⁹ Retrieved from http://www.cellinteractive.com/ucla/physician_ed/stages_change.html

Stage of Change	Characteristics	Techniques
		behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help student identify social support Verify that student has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

Standard Support Groups⁸⁰

The following pages provide detailed information about the four statewide SAPISP educational support groups including group goals and objectives, targeted student population and topical areas of discussion. After the support groups standards is a set of sample forms for the SAS to use in the implementation of groups.

1. Group signup sheet – students complete the form following a classroom presentation to indicate interest in group Participation.
2. Group Attendance log – a record of student’s weekly attendance and topics covered during group.

⁸⁰ NOTE: The information in this section was compiled in conjunction with the assistance and hard work of Martin Fleming, author and Intervention Specialist; Kim Beeson, Prevention Center Director, PSESD, Sandy Mathewson, Prevention Center Director, ESD 112, Randy Town, Coordinator of Alcohol and Drug Programs, ESD 105; and Kristin Schutte, Director, Services Center, OESD 114.

At Risk/Social Skills Group

Washington State Primary Group #1

At Risk/Social Skills Group: Prevention-oriented support groups typically focus on students who have been identified as being at risk for substance use due to risk factors or lack of protective factors and other social, emotional behavioral problems, but have not yet started. Examples include students who lack commitment to school, exhibit low impulse control, angry/rage issues, are alienated from peers or experience peer conflicts, suffer from low self-esteem. Experience shows that it is important to reach these students before they begin to use mood-altering chemicals rather than after. With this goal in mind, prevention-oriented groups can take many forms: social skills group, self-esteem group, making friends group, etc. While it is difficult to create an inclusive list of group goals for prevention groups, here are some of the more fundamental goals common to these groups:

1. Social/Communication skills.

Often times what places students at risk is their lack of meaningful connection with peers. This deficit typically stems from a lack of social skills resulting in being avoided or even shunned by other students. In order to correct this, we must teach these at-risk students skills that include:

- Refusal and managing peer pressure
- Coping, problem solving, and managing conflict
- Making friends/friendship skills
- Self-awareness and identification of emotions
- Listening and paraphrasing
- Knowing when and how to ask for help

2. Information related to risks of ATOD use

Since these students are at-risk for substance use due to SEBH issues and risk or lack of needs to be backed by age-appropriate information concerning health risks related to use by covering topics such as:

- Health implications associated with using ATOD
- Risk factors/vulnerability
- Legality issues
- The progression and dynamics of physical and psychological addiction. As applicable
- Heredity and its role in development of the disease
- Gaining accurate information on disease-related behaviors including black-outs, co-dependency, and enabling

3. Affective skills

Since alcohol and other drugs are often turned to because of emotional discomfort, another valuable goal for this group relates to providing students skills they can use to identify and manage their emotions. This skill set includes:

- Identifying emotions
- Creating a vocabulary for a variety of feelings

- Learning effective methods for coping with anger

4. Developing a Success Plan

- Steps for academic success
- Developing good study habits
- Establishing and building trust with others
- Anticipating and making plans to avoid “risky” situations with regard to drug use
- Developing healthy recreation/activities

5. Meaningful connections and experiences

Where young people are concerned, perhaps one of the most effective strategies for preventing alcohol and other drug use is to connect them with meaningful and healthy alternatives.

Troubled students search for someone they can talk to; bored students are looking for something to do with their free time. A prevention-oriented group can greatly help in this area by:

- Identifying and acquiring mentors
- Promoting constructive and positive activities
- Action plans for meeting personal goals

Intervention Group

Washington State Primary Group #2

Intervention Group: An essential mission of Student Assistance Programs is to prevent the escalation of potentially serious problems. The Early Intervention Groups are a type of student assistance support group for teens in trouble because of their tobacco, alcohol, marijuana, or other drug use, or aggressive/violent [and other SEBH problem] behavior. The SAT often works with school administrators to offer this group experience as a positive alternative to out-of-school suspension. While some students self-refer to this group, students are typically identified and referred to early intervention groups due to a school policy violation. Occasionally, however, a knowledgeable parent or friend will express a concern and ask the student assistance counselor to help (CSAP, 2007, p. 39).

The goal of early intervention groups is to help these young people gain insight into what is going on in their lives at the time and to understand the impact alcohol, tobacco, and other drugs and other negative behaviors have on their mental and physical well-being. Teens consider the consequences of their actions and make a decision about changes they need or want to make. Through the time spent with these students, facilitators can make informal assessments of the level of alcohol and drug use among participants and may refer students to special services outside of school, including addiction assessment, counseling, and other support groups, such as the family issues group. With the information and support participants gain in group, they can equip themselves to make decisions about what changes they need to make in their lives and how to access help in school or in the community (CSAP, 2007, p. 39).

Students in this category, range from those just beginning to experiment with mind-altering substances to students whose extensive chemical use warrant an in-patient intervention setting. The support group may attempt to span this entire continuum or narrow its focus to those who are experimenting and at high risk. **It is important to try and group those with more severity of use together and separate from those with less serious issues. If this is not an option, the SAS should guide the discussions and have little or no self-disclosure of ATOD use or other SEBH issues from the students. Also, if students are only referred for tobacco offense and have no other drug use history the groups should be conducted separately.**

Typical names for this support group include Insight or Choices group. A second phase intervention group is known as a Challenge group. This group is for students who need further intervention “care-formation” motivation and support to address their substance abusing behavior. The fundamental goal is similar to the insight/challenge; however, may include motivation to go to a community treatment or mental health agency.

The following five fundamental goals should be addressed in this group.

1. Information

While most group members will consider themselves well-versed in drug pharmacology, much of it is misinformation – e.g., marijuana is only an “herb” not a real drug. One of the major goals for this group should be to set the record straight about mind-altering chemicals and how they affect a user’s life. Examples of this goal include:

- Physical and psychological addiction process
- Drug classifications
- Drugs ad effects on the physical body
- Long-term implications for drug abuse
- Implications of use on the brain

2. Self-Assessment

After being given information about drugs and the dynamics of addiction, the curriculum should create opportunities for self-reflection. These students need to take a hard look at their drug-related behavior and the impact that it is imparting on their lives. Examples of this goal include:

- Self-assessment tied to a continuum of use, abuse and dependence
- Personal understanding of drug-using behavior and its consequences
- Relationship between academic performance and drug use

As applicable

- Self-assessment/reflection on anger/aggressive or depression (or other SEBH problems) and impact on self and others

3. Interpersonal skills

It has been said that drugs are a people substitute. This being the case, group members need to develop skills in the arena of understanding and expressing feelings. By developing quality

relationship with others, they will begin to get their needs – needs that were previously approached through drug use – met in much more positive manner.

- Self-awareness and identification of emotions
- Understanding of personal defenses
- Coping strategies and calming down techniques
- Communication (refusal, Assertiveness, and collaborative) and listening skills

4. Motivate group members to stop using drugs change negative behaviors

This goal is sometimes so basic it gets overlooked. A strong “no-use” and “quit now” message and as applicable other SEBH positive behavior reinforcement should be woven throughout the group curriculum. In addition to educational strategies, group policies and rules can be created to help satisfy this goal. Examples include:

- Abstinence, positive behavioral management contracts/commitments
- Rewards for “clean” time and/or positive behaviors, choices and actions
- Consequences for ATOD use incident or other unhealthy behaviors

As applicable

- Urinalysis.

5. Develop meaningful connections and experiences

Many group members turn to alcohol and other drugs because they are bored and have only limited avenues for constructive activities. Others with SEBH issues including substance abuse don’t have any meaningful connections with adults who can serve as role models and mentors. This goal area focuses on helping students learn how to successfully meet this need. Goal examples include:

- Identifying and linking students to constructive and positive activities
- Action plans for meeting personal goals
- Identifying and acquiring mentors
- Linkages to other community resources such as Work source, Job Corp, Red Cross, or Volunteer programs

6. Developing a Success Plan

- Steps for academic success
- Developing good study habits
- Establishing and building trust with others
- Anticipating and making plans to avoid “risky” situations with regard to drug use
- Developing healthy recreation/activities

Children from Substance Abusing Parents or Affected Others Group Washington State Primary Group #3

COSAP/Affected Others Group: These groups specifically target students who are impacted by someone else’s substance abuse/use. Students are usually from a chemically

dependent/substance abusing home environment – parents, relative or siblings (COSAP's). But can also be impacted by a friend's use as well – affected others. It is recommended the groups are kept separate because the issues of family are very different than concerns for a friend. A COSAP group may include students impacted by parental or sibling mental health issues. Groups offer students a safe, Supportive environment in which participants learn to cope and to understand that they are not alone through interaction with others like them.

Typical names for this type of group include children of substance abusing parents, concerned persons, affected others or family issues. It is suggested that the group name "children of from substance abusing parents" be avoided due to the stigmatization that occurs as well as the implied diagnosis of the parent. The title "Concerned Persons" or Affected Others has become something of a national standard for this support group. The following four fundamental goals should be addressed:

1. Information about family chemical dependency and if applicable mental health

Young people experiencing family members with drinking or other drug problems or other mental health issues need appropriate information to make sense of often bizarre experiences. Instead of relying on misinformation given to excuse drinking behavior, or, in the absence of information, trying to make sense of it themselves, we can provide the facts. Regardless of what else the group accomplishes, this is the first step – arm them with knowledge. Examples of this goal include knowledge of:

- Disease concept – including the 4 C's did not cause, cure, control but can cope
- Blackouts
- Rules and roles within the family
- Codependence and enabling

Group lessons/activities need to teach these students⁸¹

- **An Understand that they are not alone.** Others share their experiences and understand their feelings.
- **Validate their perceptions and interpretations of their experiences.** Families in crisis send mixed messages to children, and they need help sorting out the confusion. In an educational support group, they learn that they are reacting to adults who may downplay or ignore the severity of their own problems, deny that certain events ever took place, and behave inconsistently.
- **Gain perspective on how their parents' alcohol or drug use, or other behavior, affects them.** For instance, children from alcoholic families often fall into predictable, unhealthy patterns of behavior. Some become overly responsible to compensate for the irresponsibility of a parent, while others act out to get attention from an otherwise inattentive parent.
- **Shed blame.** Children learn that they are not at fault for the alcoholism, drug addiction, divorce, marital problems, neglect, and physical or sexual abuse in their families.

⁸¹ Taken from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.41). Substance Abuse and Mental Health Services Administration. Rockville, MD.

- **Separate the parent from the problem behavior.** For instance, alcoholics or drug addicted parents may be very caring, concerned people when they are not drinking or using; or a depressed, neglectful father may be capable of nurturing when his depression passes. Participants learn that a parent's drunkenness or other behaviors do not mean that their parent does not love them. Most importantly, they learn that they are valuable and that they are not responsible for fixing what is wrong at home.
- **Find hope.** Participants learn that alcoholism is a disease from which their parents can recover. Children from families experiencing a divorce will learn that the initial turmoil will eventually reach a more stable and tolerable resolution.
- **Understand the risks related to drugs and alcohol use.** Participants, especially children of alcoholics, learn that they are at high risk for becoming dependent on alcohol or other drugs and unhealthy relationships.

2. Coping and Social Skills

Another important goal area focuses on helping young people develop the skills to interact constructively with the world around them. Preliminary goals include a skill set often coined "survival skills," such as how to refine to ride home with an intoxicated parent. Examples include:

- Learning how to take care of themselves – doing positive things, playing and engaging in activities vs. worrying or taking responsibility for others
- Physical safety when with a chemically impaired/mentally ill adult/sibling
- Communication (self-assertion refusal, conflict resolution) skills
- Problem solving skills
- Relationship-building (i.e. what is friendship, trust and safety)
- Identifying other positive peer and adults supports

In addition, assisting the students to **cope with their daily lives.** "Because of the stress in the family, even minor tasks such as getting to school on time may be very difficult for some participants. They learn that they will not be pitied or allowed to perform below their potential. Rather, they learn ways to get support to accomplish routine or simple tasks, and move forward, helping them to build a sense of self-efficacy" (CSAP, 2007 p. 41)

3. Identify and express emotions

Young people with chemically dependent parents (and mental illness) have many experiences that give a rise to painful feelings, fortunately, a support group can become a safe place to identify, express and work through a variety of painful and confusing emotions. This goals area includes:

- Expressing emotions especially anger. "Many participants may be very angry with their parents. This anger tends to be expressed in destructive and inappropriate ways. Participants use the safety of the group environment to express their anger appropriately (CSAP, 2007, p. 41)
- Developing a feelings vocabulary
- Learning that they are not the only ones with this struggle
- Experiencing unconditional acceptance

4. Strengthen resources

Students' support group experience has specific time limits, but their lives and struggles will continue. With this in mind, another important goal of this support group is to focus on connecting them with other resources that are both practical and ongoing. This includes resources such as:

- Supportive school staff and peers
- community-based counselors/therapists
- Ala-teen and other community or church groups
- Mentors

5. School Success Planning:

- Steps for academic success if struggling
- Skills – being an adolescent (play, peer/friendships, and involvement in community)
- Establishing and building trust with others
- Anticipating and making plans to avoid “risky” situations with regard to drug use

Recovery Support Group Primary Group # 4

Aftercare/Recovery Support Group: Research indicates that students returning to the school environment following treatment services are much more likely to remain abstinent if provided with school-based recovery support groups. Support groups are important during this critical juncture between relapse and recovery when recovering adolescents are in most need of support to sustain their abstinence. Such groups provide students with strategies to cope with peer pressures, to avoid slippery/risky places, and get support for staying clean and sober. Reinforcing ATOD no use and positive behavioral patterns provides a continuation of lessons learned during outpatient treatment/intensive outpatient treatment or intervention groups.

Recovery support groups range from a brief 15-minute check in or monitoring, daily or weekly, to longer weekly sessions (45-50 minutes). Usual intended outcomes for these groups include addressing student needs and potential for relapse. Assist the student in creating Supportive networks – both within and outside of the school environment – to maintain long-term lifestyle changes addressing ATOD use.

Students who have stopped using chemicals either on their own or by completing some type of intervention program will need assistance. And they need assistance at school because school is often a place with many opportunities to obtain drugs or interact with other students who might dissuade them from their abstinence goals. It is important to note that this school-based support group is not intended to take the place of a community-based aftercare program. With this in mind, it is suggested that the support group not be named “Aftercare” group, but rather a Recovery group, or similar title. The four fundamental goals areas for Recovery support group are:

1. Alcohol and other drug abstinence

First and foremost is sobriety for these newly recovering students. The support group can assist these students in maintaining their sobriety by:

- Promoting abstinence
- Create a drug-free check-in
- Group membership/friendship with abstinence
- Identifying triggers/relapse cues

2. Life Skills

Many newly recovering young people do not have skills that others take for granted, while other students were developing specific life skills, group members developmental growth was interrupted as these youth focused on their drug use. Life skills goals can include:

- Following through on tasks
- Self-asseRTIon
- Study habits
- Job interviewing

3. Develop a support system with other students who don't use drugs

The hallmark of being a teenager is inclusion with peers. It is crucial that we help these group members find new and healthy peers. We can address this goal area by covering the following topics in the curriculum:

- Identifying quality peers
- Building new relationships (non-using friends)
- Asking for help
- Acquiring mentors

4. Coping and communication skills.

Often student who are addicted to alcohol or other drugs used to feel comfortable/cope in social settings or to cope with emotions/feelings. This being the case, group members need to develop skills in the arena of understanding and expressing feelings. By developing quality relationship with others, they will begin to get their needs – needs that were previously approached through drug use – met in much more positive manner

- Feeling identification, expressing emotions appropriately
- Dealing with life issues without chemicals
- Working together as a member of a group to solve problems
- Developing listening skills
- Encouraging others

5. Recovery/Success plan

- Steps for attendance and academic success
- Developing good study habits
- Establishing and building trust with others
- Anticipating and making plans to avoid "risky" situations with regard to drug use
- Developing drug-free recreation and social activities

6. Strengthen links with community resources

A group member's recovery program cannot be limited to what the school provides. Rather, these students need to develop connections within the community that will help ensure their continued sobriety during the summer months, as well as after graduation. Goal examples include:

- Involvement in 12-step programs, such as Alcoholic Anonymous.
- Aftercare programs.
- Community-based counselors and therapists.
- Employment opportunities.
- Recreational programs.

Forms

Group Sign-up Sheet

Name _____ Grade _____

I am interested in participating in the following groups (please check all that apply):

- At-Risk/Social Skills:** Support for students who have been identified as being at “high- risk” for substance use but have not yet started
- Intervention:** Support for students who are experimenting or using alcohol and/or other drugs and want to learn about the harmful effects of substance use
- Challenge:** Support for students maintaining abstinence or to motivate a student to attend Intervention if needed.
- Concerned/Affected Others:** Support for students who are concerned about someone else’s use of alcohol and/or other drugs
- Recovery Group:** Support for students who have quit using alcohol and other drugs
- I am not interested in participating in a group at this time*

Group Session Summary/Lesson Plan

SAPISP Services are Linked to Enhancing Academic Success

The work of the Student Assistance Specialist is closely linked to creating a readiness for students to learn and achieve academic success. Through educational support groups, SAPISP activities not only reduce barriers to learning, but also compliment the academic grade level expectations (GLE) addressed by classroom teachers.

At a minimum, all educational support group sessions address the following objectives:

- ✓ Provide ATOD education designed to increase perception of harm.
- ✓ Decrease ATOD use, and
- ✓ Increase student achievement.

Complete the following information for each educational support group session.

Name of Group: _____ Date: _____

Session Topic: _____

Brief Description: _____

For this lesson, check the content areas that you addressed (check all that apply):

- Reading
- Writing
- Communication
- Math
- Science
- Social studies
- Art

For this lesson, check the following topics you assigned or discussed (check all that apply):

- Attendance
- Homework
- Grades
- Time management
- Classroom management/teacher conflicts
- Other school related topics

Section 8

Educational Student Support Groups (Selective and Indicated)

Introduction

Research shows that daily or weekly contact with a student greatly increases protective factors and reduces risks (Bond and Hauf, 2004; Dusenbury and Hansen, 2004). One of the most effective approaches for weekly contact is the provision of school-based educational support groups. Student Assistance Specialist (SAS) trained in the dynamics of group process facilitate support groups. These support groups are educational, curriculum-based, student-centered, and solution-focused discussion groups. Educational support groups are not unstructured rap sessions nor therapeutic in nature. In the SAPISP, educational support groups are beneficial for several reasons:⁸²

- **Time and cost efficiency.** Since several children participate in support groups at once and focus on common concerns, the group format may be more time efficient than one-on-one counseling. Further, not all schools can afford school counselors, social workers, and/or psychologists. In any case, these professionals are burdened with ever-increasing caseloads. Support groups facilitated by trained professionals can ease the counseling burden and broaden the range of services, especially in small, rural communities.
- **Breaking the isolation** of participants when they meet, talk to, and work with other students and a caring adult to solve similar problems.
- **Appropriate emphasis on information.** COAs and children from other disrupted family environments have a lot to learn about how their family problems affect them. Support groups provide a safe, positive environment in which information can be learned.
- **Safety and protection.** Group members offer each other ideas and experiences on how to stay safe at home and on the streets.
- **Healthy relationships.** The relationships developed in support groups can serve as guidelines for developing healthy relationships outside of group.
- **Respect.** Participants learn and model how to give and receive respect from their facilitators and peers. This may be a new and affirming experience for them.
- **A positive peer and community environment.** Although support groups generally take place during one period, one day a week, participants may gather outside of group for recreation or volunteer activities.
- **Validation of their own experiences.** Group feedback helps participants do a “reality check” and gain perspective on how others’ behavior affects them. By seeing how their peers are affected by family situations, participants are better able to understand their own.

⁸² Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.29–30). Substance Abuse and Mental Health Services Administration. Rockville, MD.

- **Absolution of blame.** Support groups provide an opportunity for students to hear often, and from many different sources, that they are not the cause of their parent's addiction or other family problems.
- **Inclusion**⁸³ Regardless of whether their concern is with their own alcohol/drug issues experience or with another's, most children and adolescents have been forced to deal with these problems in isolation. Most feel that they are the only ones who feel the way *they* do, that no one else has similar problems, and that others would judge them harshly if they knew. The strength of the "no talk rides" and society's general unwillingness to be open about family alcoholism *leads* most affected children to think they are the only ones facing such problems. Few young people who are abusing alcohol or other drugs discuss their pain with each other. The student in treatment also often feels isolated and "different," convinced that no one else could possibly share his problems. One of the things which the brief, problem-focused group accomplishes better than anything else is allowing students to discover that they are not alone. Students discover that they are not alone in feeling guilty for causing their parent's drinking, in feeling confused and scared about their own drug experiences, or about their struggle to stay straight. The feeling of isolation diminishes immediately upon entering the group room for *the* first time and disappears entirely as the group develops.

Implementing Support Groups in the School Setting

Support groups are seen as an effective and practical way to provide support to young people who are struggling with their own SEBH issues including substance abuse, lack competent, caring adults in their lives due to chemical dependency, marital strife, abuse, neglect, abandonment and various other problems. School-based educational support groups provide healthy relationships with the adult group leader and the children/youth in the groups. "People of all ages but especially young people need support when attempting to understand and change their behavior. Most get support from their immediate or extended family. However, millions of children lack Competent, caring adults in their lives due to alcoholism, parental marital conflicts, abuse, abandonment, and other problems" (Center for Substance Abuse Prevention, 2007, p. 27).

Support Groups Are Efficient⁸⁴

A primary reason for implementing ATOD-related support groups has to do with the fact that drug abuse and related problems *are* extremely resistant to change. Whether they are recovering from chemical dependency, are struggling with their own drug abuse, or are dealing with the stress of living with a chemically dependent family member, the promotion of healthier and more constructive behaviors in students requires considerable education, illustration, and support. Changing resistant behavior requires an environment that is safer and more Supportive of change than that provided by a student's routine associations with other students, family members, and even staff members.

⁸³ Reprinted by permission from "When Chemicals Come to School." p. 174–175. Copyright 1993 by Gary L. Anderson. S68 W20707 Stonecrest Rd., Muskego, WI 53150

⁸⁴ Ibid

One of reasons why constructive change is difficult is that the behavior required is both new and risky. Thus, from a more *pragmatic* standpoint, whether the issue is confronting a family member with a drinking problem, expressing a feeling, or resisting peer pressure, the group provides an opportunity for students to *experiment with and practice new behavior in group before trying* it out in the "real world." Enlisting the ideas and suggestions of group members also *provides* the student with many realistic alternative behaviors that he would typically have been unable to come up with by himself.

According to the Center for Substance Abuse Prevention (2007) "Support groups are neither "rap" nor therapeutic groups, but are age-appropriate, curriculum-based, solution-focused student discussion groups. The goal of such groups is to provide education and support behavior change." "Research shows that daily or weekly contact with a caring, concerned adult greatly increases protective factors and reduces risk factors in youth." (p.28)

Support Groups Are Developmentally Appropriate

Most drug-related behavior occurs within and is supported by a fairly strong and cohesive peer group that does not readily sanction individual independence, even if the adolescent is developmentally equipped to resist peer group pressures. For the children of alcoholics, the family represents a "group" setting which is even more intense and less accepting of changes that can involve the open recognition of an ATOD problem, violation of the "no talk rules," or the reduction of enabling behavior by the affected child or adolescent. The support group, made up of other children or adolescents facing similar problems and tasks, thus provides a developmentally appropriate context within which to discover, examine, and experiment with change and still do so in an environment that is both emotionally "safe" and made up of one's peers.

Similarly, students struggling with their own chemical abuse are not responding to "*peer pressure*" to use drugs so much as *they* are responding to an intense need to belong and to avoid behavior that would precipitate rejection by their *peers*. Groups focusing on drug abuse provide a controlled and directed peer setting within which individual students can examine "peer pressure" and ways of rejecting drugs that are based on affirming positive aspects of themselves and that do not involve rejecting other *adolescents* as people. Groups provide opportunities to explore such issues and practice behaviors to a degree that one-to-one counseling relationships do not provide as readily.

Finally, groups are *even* more developmentally appropriate for the recovering student who is faced with internal pressures to return to chemical abuse, and an external family, school, and peer environment that at best often does not understand the magnitude of the task of staying straight. At worst, the environment actively promotes the return to chemicals. For these students more than others, the support group provides an environment of peers who are struggling with the same issues.

Support Group Composition

It is important to be sensitive to group make up or composition. Grouping students will like issues and risk factors are important (i.e. not combining those harmfully involved with substances with those who are experimenting or those at potential risks ATOD use and other SEBH issues. It is critical that placement is based upon identified student risks and needs and that groups are appropriately mixed (Einspruch & Deck, 1999). Anderson (1993) notes that close attention must be paid when making group placement decisions. He states: " Among those students affected by their own chemical abuse, a distinction must also be made between those who are diagnosed as chemically dependent [and serious emotional disturbances and who have been or are involved in a treatment program and those students who are not chemically dependent or who have not yet been diagnosed as such. This division is necessary on both theoretical and practical grounds. First, drug abuse differs conceptually as well as clinically from drug addiction or dependency. Secondly, the "recovery" issues for students in each group will consequently differ significantly. Abstinence, for example, is the prevailing treatment goal for dependent youth, whereas it is not a lifetime necessity for nondependent youth."

The distinction between "recovering" and other drug-involved youth also makes sense for the school from a procedural point of view. There will be many students who may in fact be chemically dependent but who have not yet been so diagnosed through referral to assessment agencies... [A] use-focused group is often the device by which the school can gather enough meaningful information about a student's drug involvement to justify as well as bring about a successful referral. Moreover, it would be highly inappropriate to mix students who have elected a use-focused group in lieu of suspension with students who have returned to the school from a treatment program (p. 180).

SAP Support Group Limitations

Anderson (1993) notes that establishing the intended target group (i.e., recovering students, affected others, etc.) as well as identifying goals and objectives for achievement in the support group setting is an essential step in the planning process. Generally, the intent of educational support groups should be "to improve rather than cure" (p. 210), and it is important to distinguish "support groups" from "therapy." SAPISP support groups have two general goals: 1) "to promote, enhance, or maintain students' abilities to cope healthfully and constructively with ATOD-related problems in themselves and/or others, and 2) to enable students to make use of those resources available in the environment, where the 'environment' is the group, the school the family, or the community" (p. 210).

Two critical strategies to address personal change within a group setting is to allow students to define their own ATOD use as a problem and then to provide them with the knowledge, skills, competencies, and support needed to modify their substance use with reduction of use and abstinence as the main goal (Einspruch & Deck, 1999). Suggested topics for social, emotional behavioral health, including substance abuse groups may include information about the continuum of substance use experience, personal communication skills, the consequences of substance use or other social, emotional, behavioral problems, alternatives/solutions to problem behaviors, peer pressure, and decision making.

Einspruch and Deck (1999) conducted research on the effectiveness of SAPISP support groups intended to provide early intervention to substance using adolescences. Based upon their findings, they make the following recommendations as a means of increasing the likelihood of obtaining positive outcomes for students participating in peer support groups (p. E-3):

1. Groups should be based on specific activities designed to enhance skills rather than simply be a time for students to interact with each other in an unstructured environment that promotes the sharing of deviant norms.
2. The adult group facilitator needs to directly address substance use behaviors and should deliver a clear message that substance abuse is unacceptable, while still nurturing the trust and respect of the participating students.
3. Careful consideration should be given to the membership composition of early intervention peer support programs (e.g., whether new and more experienced substance users should be in the same group or whether new users and highly deviant users should be placed in the same group).

See additional resources for more information on the role of the Support Group Facilitator and Leaders guidelines from Center for Substance Abuse Prevention (2007), *Help is Down the Hall a Handbook on Student Assistance* (chapter 4).

Washington State’s SAPISP Support Groups Offerings

Washington State’s SAPISP model has four standard student support groups: 1) At Risk/Social Skills; 2) Intervention; 3) Children from Substance Abusing Parents (COSAP); and, 4) Recovery Support. Additional groups may include tobacco education/cessation, ATOD education, anger management, friendship group, gang/violence intervention, or bully/victims.

The following pages provide information on logistics, effective practices in group set up, information on the stages of group development, goals, and objectives for the four standard educational support groups and suggested resource list of curriculum/materials for group activities. Group facilitation skills, practice and theory as well as other support group contents other than the four standard groups are not covered in the Washington State SAPISP manual.

Group Logistics⁸⁵

The information below describes the logistical details to address before beginning a group in order to meet the needs of each particular school setting. These seemingly “minor” details can have enormous positive or negative impact on the character and success of a group.

Space: The meeting place should provide auditory and visual privacy with enough room for students to move around comfortably. A blackboard, bulletin board, or other writing/drawing surfaces are available. Desks and chairs are not necessary; if there is a rug and pillows, students can sit comfortably on the floor. Student behavior problems will be minimized if the space does

⁸⁵ Adapted in part from: Kids Like Us Everywhere KCDASAS Prevention Program, Seattle, WA

not include enticing materials or equipment that is off-limits to the students (e.g. audio-video equipment, sports equipment, etc.). *It is important to have this space reserved for the group on a regular and ongoing basis.*

Group space should protect personal privacy. It is important to hold group sessions in areas in which information cannot be overheard – students should feel comfortable sharing intimate feelings. It is equally important that SAS's not confuse privacy with confidentiality. According to Anderson (1993), "Group confidentiality protects what is said and done in group, *not* the fact that a student is in a support group" (p.212). Holding groups in secretive or out-of-the-way places may only serve to reinforce students' secrecy and shame associated with substance related problems. As long as issues of privacy are adequately addressed, locating support groups in common areas sends a message of acceptability to participating students.

Accessibility: Group membership and meeting space should be accessible to any student in the targeted student population. When forming groups, consider the special needs of students to prevent discrimination.

Time Scheduling: School personnel and the SAS establish the specific timing of groups well in advance of the initial group session. Groups need to meet regularly to alleviate students' anxiety or uncertainty about the meeting time and place. Predictability is assured with a regular meeting time; however, this may be difficult for the teacher and student if a student consistently misses a particular subject; a suggested solution is to plan a rotating group schedule (1st period one week, 2nd period the next, etc.). Group leaders need to know about special events, which may interfere with group times to make alternative plans in advance. Anderson (1993) recommends that group sessions be held during the regular school day to alleviate issues associated with transportation, extracurricular activities, or parental consent. In addition, doing so sends a message to both students and staff that SAPISP services are a significant component of the school system.

Getting Students To and From Group: Procedures need to be defined as to how: 1) students are to be excused from class; 2) students get to the group location; 3) attendance is recorded; 4) students return to class; and, 5) teachers and students deal with problem times (e.g., when testing is going on in the classroom or where the class has field trips planned).

Rules: Leaders should follow existing building rules and disciplinary procedures. SAS's should be aware of specific expectations and disciplinary procedures of each of the teachers from whom the students come and coordinate group expectations as much as possible with the classroom and building rules. *Remember*, the school staff member acting as co-leader has existing authority and should be comfortable exercising this authority when necessary.

Confidentiality. Prior to the start of groups, students are informed of the SAS's responsibilities regarding confidentiality including being a designated reporter of child abuse/neglect and sexual abuse under state statutes and staff's requirement to comply with state laws and to follow school procedures for reporting such cases. SAS are expected to safeguard student

confidentiality and disclosure of information within the group setting. Exceptions to this general policy need to be reviewed with the student and the group. (For additional information, see Confidentiality, page 123).

Parental Information and Consent. For students under the age of 13, parent permission is required prior to group Participation. In this case, a letter is sent to the parent/guardian, seeking written permission for their child to participate in a support group. For students over the age of 13, consent may be passive or active and is determined by school policies and the program supervisor. *Note of Caution: Some schools and SAPISP require active and/or passive parent consent regardless of the student's age.*

Group Preparation and Set-up

The overall goal of SAPISP is to improve not "cure" the identified problem behaviors or needs of referred students. Student support groups are one element of a comprehensive approach to helping students, with these viewed as one of many components linking students to other sources of support – school and community-based.

Pre-Group Screening: It is recommended that all students are screened as outlined in **Section 5 Internal Referral Process** and provided with an orientation interview prior to group placement. The orientation interview has a variety of purposes it allows staff to:

- Make appropriate placement decisions.
- Explain the group process and review with the student the group goals, purpose, rules, expectations and requirements.
- Determine if the student can make a commitment to participate in group.
- Assist the student in identifying his/her own goals/needs for group.
- Determine appropriate group material.

Consideration must also be given to compatibility of group members, including ethnic minorities and diverse populations. Finally, it is important that group members and the facilitator have a reasonable chance of successfully working together.

In addition, during the pre-screening/orientation interview that SAS will want to explore the following with the student (Anderson, 1993, p. 213):

1. What brings the student to the group? Is the group the student's idea or someone else's?
2. Is the student motivated to make changes in the direction of improvement?
3. Will this student be "alone" in the group? Is the student compatible with others already selected or already in the group?
4. Does the student understand the purpose for and expectations of the group?
5. Is this the student's first group experience?
6. Does the student possess the personal strengths and social and verbal skills necessary to be in this group at this time?

Goal Orientation: Defining the targeted objectives for students is another critical planning step in the group process. The specific goals, objectives, and outcomes of support groups depend upon the focus and topic addressed. The goals of most student support groups are:⁸⁶

- To provide accurate information in a safe, confidential setting where students can ask questions and get clarification.
- To clarify and define how others' behavior affects the child.
- To provide children with a framework to understand what they experience at home
- To validate their emotions and emotional experiences.
- To address problems by utilizing appropriate problem-solving skills, clarifying options, identifying support resources, and connecting to support systems outside group.
- To provide and support healthy relationships.
- To assess and respond to child protection issues.
- To separate the person from the problem behavior.
- To refer to additional services, such as a formal assessment, family counseling, tutoring, and so forth.

Outcomes of Participation in student support groups may include, but are not limited to:

- Improved attendance.
- Improved academic achievement.
- Decreased denial, confusion, and isolation.
- Improved social skills and sense of belonging.
- Increased self-esteem.
- Increased coping skills.
- Ability to discriminate between safe and unsafe people.
- Hope.

Anderson (1993) notes that for any group, outcomes should generally address three areas: 1) improvement in personal and interpersonal functioning; 2) improvement in academic performance (grades, attendance, classroom conduct); and 3) improvements in specific ATOD-related indicators (perception of risk, reduction/abstinence, coping skills, etc.). When establishing group goals, program staff should consider the overall aim of the support group – “to improve rather than cure” – and establish goals that can be realistically achieved given the limited timeframe, number of participants, or other extenuating factors.

Group Rules: Establish rules with student input at the first session (It is recommended that students agree in writing to group goals and rules). Existing school rules must be followed. At a minimum, rules should include maintaining confidentiality, dealing with absences, class release/return, not coming to group under the influence (no ATOD use for students participating in Recovery Group), and discussion with the facilitator and/or the group prior to a student ending group Participation. Most importantly, student statements or nonverbal cues that could

⁸⁶ Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.29). Substance Abuse and Mental Health Services Administration. Rockville, MD

be seen as supporting ATOD use, or enabling, need to be confronted immediately and consistently.

Structure: Effective SAPISP groups are those in which the student makes a formal commitment to attend all sessions and requires a certain level of engagement and Participation. As previously stated, effective groups are not loosely defined "rap," or "drop-in, drop-out" sessions. Even in groups considered to be more "maintenance" oriented such as Recovery, students should make a commitment to attend an agreed upon number of consecutive sessions. Facilitators need to establish a set group structure and follow content as outlined for the established SAPISP groups (see page 228). Students should be supervised at all times prior to, during, and after the group session.

Time Limited: All groups need to have an established number of sessions (average 8–10) provided over a time limited period. Group/personal goals are evaluated as being achieved/effective by the individual student, the group as a whole, and the facilitator prior to any consideration of additional sessions. Students who want, or are in need of, continuing services can negotiate new goals for the second group offering. For example, a youth who completes Intervention group and is identified as having a difficult time abstaining and is resistance to treatment but open to support maybe referred to an ongoing support group. The new group establishes a set of goals different from the original group such as staying sober, coping with peer pressure, seeking community support, etc.

Frequency/Intensity: Typically, student support groups meet weekly; however, depending on the group focus, targeted audience, and identified student outcomes group scheduling may be flexible. For instance, some groups such as COSAP may meet twice weekly to assist students who are coping with stressful family situations or Recovery, daily for ongoing support. Another example is adapting meeting times to coincide with the school's schedule such as meeting twice a week for 25 minutes in order to adapt to shorter class periods. Optimally, groups should be on an established predictable schedule over the course of several weeks and staggered so that the student does not miss the same class period over the 10–12 weeks of group sessions. After 12 sessions it is recommended students who want to continue services that "new" group goals are discussed and established before continuing with a support group. Follow-up one-on-one on occasion is recommended to check in on the students periodically.

Size: Ideally, group range in size from six to eight members, although larger or smaller groups are possible – a group is two or more participants. Larger groups may require one or more facilitators with goals and expectations adjusted to accommodate group size. Larger groups are less likely to have personal interaction and tend to be more didactic and discussion focused whereas smaller groups allow for a higher level of personal engagement by participants and can focus more on process.

Closed versus Open Groups: Most often groups are closed rather than open enrollment, which means that students start and end the group together. The advantage of closed groups is the continuity and relationship building that takes place among group members. Closed groups

allow students to spend dedicated time together without interruption to the group process which is often caused by entry of new group members or others leaving in open group settings. One major disadvantage of closed groups is that students referred to a group must wait until a new group begins. (Anderson, 1993)

Educational in Nature: Student support groups are educational, focus on providing participants with life skills/coping skills, with structured goals and objectives achieved through curriculum-based content, and are time limited. Students needing open ended, unstructured treatment or therapy groups should be referred to the appropriate agencies for those services.

Labeling Groups and Anonymity: For purposes of the manual, student support groups have been named according to their focus; i.e., at-risk, Intervention, Children from Substance Abusing Parents/Affected Others, and Recovery Support. However, to protect confidentiality, actual groups should have a neutral name, for example, Orange, Yellow or Green group, or Group 1, 2 or 3. Forms, such as parent permission slips, progress reports on discipline students, and hall passes should also use neutral group names. (Sample forms are located at the end of this section).

Credit Options: Explore options to enable students to receive credit for group Participation. Sometimes student support group Participation can be integrated within a regular health or communication class without jeopardizing confidentiality concerns.

Educational Support Groups vs. Therapy Groups

Educational support groups are different from therapy groups in a variety of ways. School-based substance prevention-intervention educational groups are content specific, curriculum-based, and focus on life/coping skills. Conversely, therapeutic groups aim to solve personal problems, and are resolution focused. In support groups, the SAS provides a Supportive group environment and validates, educates and empowers the students served. Whereas a therapist may be Supportive, s/he also diagnoses, establishes a treatment plan and confronts, and probes the client. School-based educational groups are time limited, whereas therapy groups/sessions are determined by patient’s progress or insurance coverage (Lemerand, 1993).

Claudia Black⁸⁷ has articulated the comparison of educational support groups to therapy groups in the following chart:

Educational Groups	Therapy Groups
Focus on life skills/coping skills	Solve personal problems
Education	Resolution
Support/Safety Net	May be Supportive but also include confrontation and probing

⁸⁷ Excerpt from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook

Educational Groups	Therapy Groups
Educational goals and objectives are achieved through curriculum-based content/activities	Individualized treatment plan, use of therapeutic activities; however, process is always more important than content
Building protective factors	Probing; addressing impact of risk factors; may focus later on building protective factors
Conducted by trained facilitators. Caring. Knowledgeable about child development and specific issues. Have "health" to give.	Conducted by trained therapist
LOVEE driven: (Listen, Observe, Validate, Educate, Empower)	Psychological theory and diagnosis driven
Time limited (6–12 weeks)	Length of treatment driven by treatment process and patient's progress, or insurance coverage

Critical Educational Support Group Components

To be effective educational support groups need to address certain skills found to be critical to preventing substance use, including empathy, social/problem solving, anger management or impulse control, communication, stress management and coping, media resistance, Assertiveness, and character development. Support groups are most effective when they (CSAP, 2002):

- Reach students during non-school as well as school hours.
- Use age and culturally appropriate, interactive teaching materials.
- Combine social and thinking skills instruction with resistance skills training.
- Include an adequate "dosage" of at least 8 to 12 sessions per year.
- Include peer education components that are led by students.

GROUP FORMATION

There are many theories on developmental systems. Weber (n.d.), explores developmental issues in a way that allows for continual change within the group process and argues that all groups go through several stages of development to reach competence – Forming, Storming, Norming, Performing. Weber's view, consistent with student assistance programs, maintains that *activities elicit behavior*. Weber notes that since the group is continually experiencing activities, the potential for new behaviors is always present. The group may leap forward to an advanced stage, or it may go back to an earlier stage. He states:

Groups may proceed through the [four] stages quickly or slowly; they may fixate at a given stage; or they may move quickly through some and slowly through others. If they do indeed complete all [four] stages, however, and have sufficient time left in their life together, they will again re-cycle through the stages. This additional development will lead to deeper insight, accomplishment, and closer relationships. (p.1).

Groups will generally grow to a stage that can be somewhat relied upon, though it will revert depending on how it responds to significant challenges. Those challenges can be called "pinch points" or "crunch points," the pinch growing to a crunch if the group fails to deal with the challenges. Weber's group process theory builds upon the stages developed by Tuckman (1965), Schutz (1971) and Bion (1961), those stages are: *Forming, Storming, Norming, Performing, and Transforming*.

Forming: When groups form – or are in their infancy or childhood stage – members are scrambling for leadership and trying to establish a leader. There is confusion, anxiety, and willingness to please, along with solid glimpses into what the group will be like. This is an important time for the group to achieve something for they may be more willing to please each other and the leader at this stage than they will be during the *Storming* stage. Those solid immediate first achievements will be important building blocks to later group processes.

Storming: Others call this the control stage or "adolescence." Weber (n.d) describes it as "possibly the most difficult stage to tolerate in either persons or groups." (p.3). Alliances between members have formed sufficiently to generate negative behavior and power struggles begin to take place. Real testing of the leader begins as members overtly challenge or covertly undermine those in leadership positions. It is truly an all-out get-to-know-you time. Group members are asking through their behavior: *Is this group safe? Am I going to like what I am doing? Can these leaders handle us?* Members are essentially reacting to the situation, with very little initiative or independence exhibited. It is important to continue to deal with the uses of achievement and negotiation, giving group members the solid experiences that will help them move on to the next stage.

Norming and Performing: During its adulthood, the group operates as a unit, taking pride in what it is doing, and using its own strengths. The group is also moving away from its dependency on the leaders, taking initiative, and experiencing pride in group accomplishments. They are more able to confront each other in terms of goals and behavior and group norms are established. Group members begin to develop affection for each other and self-disclosure increases as the group moves toward intimacy. The group is ready to address its goals and to work together collaboratively. Through these stages the group has established its own identity and the group feels balanced, harmonious and healthy.

Transforming (also known as "termination"): Transforming is what a group must do when it has accomplished its goal or has run out of time. This is the change/transition phase. According to Weber (n.d.), there are two choices, 1) to Redefine, start again with a new agenda, purpose, and time period, or 2) to Disengage/Terminate. "The group must decide on its future, or it will proceed down a frustrating, unfulfilling path"(p.4). In this stage, members will feel a range of emotions (anger, fear, despair, acceptance), and there may be issues of loss and grief associated with the group terminating. However, Weber (p.4) notes, "Not uncommonly, groups will attempt to define ways of retaining contact after separation in an effort to escape the pain of disengagement. But failure to disengage, to recognize that the life of the group, as its members have experience it, has come to an end, will only lead to a hollow, unfinished feelings

in the future as a person must face the inevitability of leaving this life, members must realize that groups too must die. But if nourished, the spirit or experience can live on."

These developmental stages can help program staff to decide on intensity and specific tasks of groups activities. Tasks that require a high degree of initiative and responsibility should be reserved for the *Norming/Performing* stage. Tasks that must be watched closely through narrow parameters should be slotted into *Forming* and *Storming*. It is important to remember that groups will recycle through the process, in other words, "two steps forward, one step back." A group will move to a level, but may encounter difficulties, which force them to a previous level. If the difficulties are addressed, the group will grow in a normal "zig-zag" kind of fashion. If difficulties are not addressed, the group is at risk of falling apart.

Stages of Change⁸⁸

Prochaska and DiClemente's (1982) *Stages of Change* theory has been conceptualized for a variety of problem behaviors and is utilized as a foundational approach in Washington States' SAPISP model. The five stages of change are *pre contemplation*, *contemplation*, *preparation*, *action*, and *maintenance* (figure 8.1).

- *Pre contemplation* is the stage at which there is no intent to change behavior in the foreseeable future. Many individuals in this stage are unaware or under aware of their problems.
- *Contemplation* is the stage in which individuals are aware that a problem exists and are seriously thinking about overcoming it but have not made a commitment to take action.
- *Preparation* is the stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.
- *Action* is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. *Action* involves the most overt behavioral changes and requires considerable commitment of time and energy.
- *Maintenance* is the stage in which individuals work to prevent relapse and consolidate the gains attained during *Action*. For addictive behaviors this stage extends from six months to an indeterminate period past the initial action.

Figure 8.1: Stages of Change Model⁸⁹

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence"	Validate lack of readiness Clarify: decision is theirs

⁸⁸ Retrieved from <http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm>.

⁸⁹ Retrieved from http://www.cellinteractive.com/ucla/phycian_ed/stages_change.html

Stage of Change	Characteristics	Techniques
	Not considering change within the next month	Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help student identify social support Verify that student has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

Standard Support Groups⁹⁰

The following pages provide detailed information about the four statewide SAPISP educational support groups including group goals and objectives, targeted student population and topical areas of discussion. After the support groups standards is a set of sample forms for the SAS to use in the implementation of groups.

1. Group signup sheet – students complete the form following a classroom presentation to indicate interest in group Participation.
2. Group Attendance log – a record of student’s weekly attendance and topics covered during group.

⁹⁰ NOTE: The information in this section was compiled in conjunction with the assistance and hard work of Martin Fleming, author and Intervention Specialist; Kim Beeson, Prevention Center Director, PSESD, Sandy Mathewson, Prevention Center Director, ESD 112, Randy Town, Coordinator of Alcohol and Drug Programs, ESD 105; and Kristin Schutte, Director, Services Center, OESD 114.

At-Risk/Social Skills Group

Washington State Primary Group #1

At Risk/Social Skills Group: Prevention-oriented support groups typically focus on students who have been identified as being at risk for substance use due to risk factors or lack of protective factors and other social, emotional behavioral problems, but have not yet started. Examples include students who lack commitment to school, exhibit low impulse control, angry/rage issues, are alienated from peers or experience peer conflicts, suffer from low self-esteem. Experience shows that it is important to reach these students before they begin to use mood-altering chemicals rather than after. With this goal in mind, prevention-oriented groups can take many forms: social skills group, self-esteem group, making friends group, etc. While it is difficult to create an inclusive list of group goals for prevention groups, here are some of the more fundamental goals common to these groups:

1. Social/Communication skills

Often times what places students at risk is their lack of meaningful connection with peers. This deficit typically stems from a lack of social skills resulting in being avoided or even shunned by other students. In order to correct this, we must teach these at-risk students skills that include:

- Refusal and managing peer pressure.
- Coping, problem solving and managing conflict.
- Making friends/friendship skills.
- Self-awareness and identification of emotions.
- Listening and paraphrasing.
- Knowing when and how to ask for help.

2. Information related to risks of ATOD use

Since these students are at-risk for substance use due to SEBH issues and risk or lack of needs to be backed by age-appropriate information concerning health risks related to use by covering topics such as:

- Health implications associated with using ATOD.
- Risk factors/vulnerability.
- Legality issues.
- The progression and dynamics of physical and psychological addiction. As applicable
- Heredity and its role in development of the disease.
- Gaining accurate information on disease-related behaviors including black-outs, co-dependency, and enabling.

3. Affective skills

Since alcohol and other drugs are often turned to because of emotional discomfort, another valuable goal for this group relates to providing students skills they can use to identify and manage their emotions. This skill set includes:

- Identifying emotions.
- Creating a vocabulary for a variety of feelings.

- Learning effective methods for coping with anger.

4. Developing a Success Plan

- Steps for academic success.
- Developing good study habits.
- Establishing and building trust with others.
- Anticipating and making plans to avoid “risky” situations with regard to drug use.
- Developing healthy recreation/activities.

5. Meaningful connections and experiences

Where young people are concerned, perhaps one of the most effective strategies for preventing alcohol and other drug use is to connect them with meaningful and healthy alternatives. Troubled students search for someone they can talk to; bored students are looking for something to do with their free time. A prevention-oriented group can greatly help in this area by:

- Identifying and acquiring mentors.
- Promoting constructive and positive activities.
- Action plans for meeting personal goals.

Intervention Group

Washington State Primary Group #2

Intervention Group: An essential mission of Student Assistance Programs is to prevent the escalation of potentially serious problems. The Early Intervention Groups are a type of student assistance support group for teens in trouble because of their tobacco, alcohol, marijuana, or other drug use, or aggressive/violent [and other SEBH problem] behavior. The SAT often works with school administrators to offer this group experience as a positive alternative to out-of-school suspension. While some students self-refer to this group, students are typically identified and referred to early intervention groups due to a school policy violation. Occasionally, however, a knowledgeable parent or friend will express a concern and ask the student assistance counselor to help (CSAP, 2007, p. 39).

The goal of early intervention groups is to help these young people gain insight into what is going on in their lives at the time and to understand the impact alcohol, tobacco, and other drugs and other negative behaviors have on their mental and physical well-being. Teens consider the consequences of their actions and make a decision about changes they need or want to make. Through the time spent with these students, facilitators can make informal assessments of the level of alcohol and drug use among participants and may refer students to special services outside of school, including addiction assessment, counseling, and other support groups, such as the family issues group. With the information and support participants gain in group, they can equip themselves to make decisions about what changes they need to make in their lives and how to access help in school or in the community (CSAP, 2007, p. 39).

Students in this category, range from those just beginning to experiment with mind-altering substances to students whose extensive chemical use warrant an in-patient intervention setting. The support group may attempt to span this entire continuum or narrow its focus to those who are experimenting and at high risk. **It is important to try and group those with more severity of use together and separate from those with less serious issues. If this is not an option, the SAS should guide the discussions and have little or no self-disclosure of ATOD use or other SEBH issues from the students. Also, if students are only referred for tobacco offense and have no other drug use history the groups should be conducted separately.**

Typical names for this support group include Insight or Choices group. A second phase intervention group is known as a Challenge group. This group is for students who need further intervention "care-formation" motivation and support to address their substance abusing behavior. The fundamental goal is similar to the insight/challenge; however, may include motivation to go to a community treatment or mental health agency.

The following five fundamental goals should be addressed in this group:

1. Information

While most group members will consider themselves well-versed in drug pharmacology, much of it is misinformation – e.g., marijuana is only an "herb", not a real drug. One of the major goals for this group should be to set the record straight about mind-altering chemicals and how they affect a user's life. Examples of this goal include:

- Physical and psychological addiction process.
- Drug classifications.
- Drugs ad effects on the physical body.
- Long-term implications for drug abuse.
- Implications of use on the brain.

2. Self-Assessment

After being given information about drugs and the dynamics of addiction, the curriculum should create opportunities for self-reflection. These students need to take a hard look at their drug-related behavior and the impact that it is imparting on their lives. Examples of this goal include:

- Self-assessment tied to a continuum of use, abuse and dependence.
- Personal understanding of drug-using behavior and its consequences.
- Relationship between academic performance and drug use.

As applicable

- Self-assessment/reflection on anger/aggressive or depression (or other SEBH problems) and impact on self and others.

3. Interpersonal skills

It has been said that drugs are a people substitute. This being the case, group members need to develop skills in the arena of understanding and expressing feelings. By developing quality

relationship with others, they will begin to get their needs – needs that were previously approached through drug use – met in much more positive manner.

- Self-awareness and identification of emotions.
- Understanding of personal defenses.
- Coping strategies and calming down techniques.
- Communication (refusal, Assertiveness, and collaborative) and listening skills.

4. Motivate group members to stop using drugs change negative behaviors

This goal is sometimes so basic it gets overlooked. A strong “no-use” and “quit now” message and as applicable other SEBH positive behavior reinforcement should be woven throughout the group curriculum. In addition to educational strategies, group policies and rules can be created to help satisfy this goal. Examples include:

- Abstinence, positive behavioral management contracts/commitments.
- Rewards for “clean” time and/or positive behaviors, choices and actions.
- Consequences for ATOD use incident or other unhealthy behaviors.

As applicable

- Urinalysis.

5. Develop meaningful connections and experiences

Many group members turn to alcohol and other drugs because they are bored and have only limited avenues for constructive activities. Others with SEBH issues including substance abuse don’t have any meaningful connections with adults who can serve as role models and mentors. This goal area focuses on helping students learn how to successfully meet this need. Goal examples include:

- Identifying and linking students to constructive and positive activities.
- Action plans for meeting personal goals.
- Identifying and acquiring mentors.
- Linkages to other community resources such as Work source, Job Corp, Red Cross, or Volunteer programs.

6. Developing a Success Plan

- Steps for academic success.
- Developing good study habits.
- Establishing and building trust with others.
- Anticipating and making plans to avoid “risky” situations with regard to drug use.
- Developing healthy recreation/activities.

Children from Substance Abusing Parents or Affected Others Group Washington State Primary Group #3

COSAP/Affected Others Group: These groups specifically target students who are impacted by someone else’s substance abuse/use. Students are usually from a chemically dependent/

substance abusing home environment – parents, relative or siblings (COSAP's). But can also be impacted by a friend's use as well – affected others. It is recommended the groups are kept separate because the issues of family are very different than concerns for a friend. A COSAP group may include students impacted by parental or sibling mental health issues. Groups offer students a safe, Supportive environment in which participants learn to cope and to understand that they are not alone through interaction with others like them.

Typical names for this type of group include children of substance abusing parents, concerned persons, affected others or family issues. It is suggested that the group name "children of from substance abusing parents" be avoided due to the stigmatization that occurs as well as the implied diagnosis of the parent. The title "Concerned Persons" or Affected Others has become something of a national standard for this support group. The following four fundamental goals should be addressed:

- 1. Information about family chemical dependency and if applicable mental health** Young people experiencing family members with drinking or other drug problems or other mental health issues need appropriate information to make sense of often bizarre experiences. Instead of relying on misinformation given to excuse drinking behavior, or, in the absence of information, trying to make sense of it themselves, we can provide the facts. Regardless of what else the group accomplishes, this is the first step - arm them with knowledge. Examples of this goal include knowledge of:
 - Disease concept – including the 4 C's did not cause, cure, control but can cope
 - Blackouts
 - Rules and roles within the family
 - Codependence and enabling

Group lessons/activities need to teach these students:⁹¹

- **An Understand that they are not alone.** Others share their experiences and understand their feelings.
- **Validate their perceptions and interpretations of their experiences.** Families in crisis send mixed messages to children, and they need help sorting out the confusion. In an educational support group, they learn that they are reacting to adults who may downplay or ignore the severity of their own problems, deny that certain events ever took place, and behave inconsistently.
- **Gain perspective on how their parents' alcohol or drug use, or other behavior, affects them.** For instance, children from alcoholic families often fall into predictable, unhealthy patterns of behavior. Some become overly responsible to compensate for the irresponsibility of a parent, while others act out to get attention from an otherwise inattentive parent.
- **Shed blame.** Children learn that they are not at fault for the alcoholism, drug addiction, divorce, marital problems, neglect, and physical or sexual abuse in their families.

⁹¹ Taken from: Center for Substance Abuse Prevention (2007). Help is Down the Hall, A Student Assistance Handbook (p.41). Substance Abuse and Mental Health Services Administration. Rockville, MD.

- **Separate the parent from the problem behavior.** For instance, alcoholics or drug addicted parents may be very caring, concerned people when they are not drinking or using; or a depressed, neglectful father may be capable of nurturing when his depression passes. Participants learn that a parent's drunkenness or other behaviors do not mean that their parent does not love them. Most importantly, they learn that they are valuable and that they are not responsible for fixing what is wrong at home.
- **Find hope.** Participants learn that alcoholism is a disease from which their parents can recover. Children from families experiencing a divorce will learn that the initial turmoil will eventually reach a more stable and tolerable resolution.
- **Understand the risks related to drugs and alcohol use.** Participants, especially children of alcoholics, learn that they are at high risk for becoming dependent on alcohol or other drugs and unhealthy relationships.

2. Coping and Social Skills

Another important goal area focuses on helping young people develop the skills to interact constructively with the world around them. Preliminary goals include a skill set often coined "survival skills," such as how to refine to ride home with an intoxicated parent. Examples include:

- Learning how to take care of themselves – doing positive things, playing and engaging in activities vs. worrying or taking responsibility for others
- Physical safety when with a chemically impaired/mentally ill adult/sibling
- Communication (self-assertion refusal, conflict resolution) skills
- Problem solving skills
- Relationship-building (i.e. what is friendship, trust and safety)
- Identifying other positive peer and adults supports

In addition, assisting the students to **cope with their daily lives.** "Because of the stress in the family, even minor tasks such as getting to school on time may be very difficult for some participants. They learn that they will not be pitied or allowed to perform below their potential. Rather, they learn ways to get support to accomplish routine or simple tasks, and move forward, helping them to build a sense of self-efficacy" (CSAP, 2007 p. 41)

3. Identify and express emotions

Young people with chemically dependent parents (and mental illness) have many experiences that give a rise to painful feelings, fortunately, a support group can become a safe place to identify, express and work through a variety of painful and confusing emotions. This goals area includes:

- Expressing emotions especially anger. "Many participants may be very angry with their parents. This anger tends to be expressed in destructive and inappropriate ways. Participants use the safety of the group environment to express their anger appropriately (CSAP, 2007, p. 41)
- Developing a feelings vocabulary
- Learning that they are not the only ones with this struggle
- Experiencing unconditional acceptance

4. Strengthen resources

Students' support group experience has specific time limits, but their lives and struggles will continue. With this in mind, another important goal of this support group is to focus on connecting them with other resources that are both practical and ongoing. This includes resources such as:

- Supportive school staff and peers
- community-based counselors/therapists
- Ala-teen and other community or church groups
- Mentors

5. School Success Planning:

- Steps for academic success if struggling
- Skills – being an adolescent (play, peer/friendships, and involvement in community)
- Establishing and building trust with others
- Anticipating and making plans to avoid “risky” situations with regard to drug use

Recovery Support Group Primary Group # 4

Aftercare/Recovery Support Group: Research indicates that students returning to the school environment following treatment services are much more likely to remain abstinent if provided with school-based recovery support groups. Support groups are important during this critical juncture between relapse and recovery when recovering adolescents are in most need of support to sustain their abstinence. Such groups provide students with strategies to cope with peer pressures, to avoid slippery/risky places, and get support for staying clean and sober. Reinforcing ATOD no use and positive behavioral patterns provides a continuation of lessons learned during outpatient treatment/intensive outpatient treatment or intervention groups.

Recovery support groups range from a brief 15-minute check in or monitoring, daily or weekly, to longer weekly sessions (45-50 minutes). Usual intended outcomes for these groups include addressing student needs and potential for relapse. Assist the student in creating Supportive networks – both within and outside of the school environment – to maintain long-term lifestyle changes addressing ATOD use.

Students who have stopped using chemicals either on their own or by completing some type of intervention program will need assistance. And they need assistance at school because school is often a place with many opportunities to obtain drugs or interact with other students who might dissuade them from their abstinence goals. It is important to note that this school-based support group is not intended to take the place of a community-based aftercare program. With this in mind, it is suggested that the support group not be named “Aftercare” group, but rather a Recovery group, or similar title. The four fundamental goals areas for Recovery support group are:

1. Alcohol and other drug abstinence

First and foremost is sobriety for these newly recovering students. The support group can assist these students in maintaining their sobriety by:

- Promoting abstinence
- Create a drug-free check in
- Group membership/friendship with abstinence
- Identifying triggers/relapse cues

2. Life Skills

Many newly recovering young people do not have skills that others take for granted, while other students were developing specific life skills, group members developmental growth was interrupted as these youth focused on their drug use. Life skills goals can include:

- Following through on tasks
- Self-assertion
- Study habits
- Job interviewing

3. Develop a support system with other students who don't use drugs

The hallmark of being a teenager is inclusion with peers. It is crucial that we help these group members find new and healthy peers. We can address this goal area by covering the following topics in the curriculum:

- Identifying quality peers
- Building new relationships (non-using friends)
- Asking for help
- Acquiring mentors

4. Coping and communication skills.

Often student who are addicted to alcohol or other drugs used to feel comfortable/cope in social settings or to cope with emotions/feelings. This being the case, group members need to develop skills in the arena of understanding and expressing feelings. By developing quality relationship with others, they will begin to get their needs – needs that were previously approached through drug use – met in much more positive manner

- Feeling identification, expressing emotions appropriately
- Dealing with life issues without chemicals
- Working together as a member of a group to solve problems
- Developing listening skills
- Encouraging others

5. Recovery/Success plan

- Steps for attendance and academic success
- Developing good study habits
- Establishing and building trust with others
- Anticipating and making plans to avoid "risky" situations with regard to drug use
- Developing drug-free recreation and social activities

6. Strengthen links with community resources

A group member's recovery program cannot be limited to what the school provides. Rather, these students need to develop connections within the community that will help ensure their continued sobriety during the summer months, as well as after graduation. Goal examples include:

- Involvement in 12-step programs, such as Alcoholic Anonymous
- Aftercare programs
- Community-based counselors and therapists
- Employment opportunities
- Recreational programs

Forms

Group Sign-up Sheet

Name: _____ Grade: _____

I am interested in participating in the following groups (please check all that apply):

- At-Risk/Social Skills:** Support for students who have been identified as being at “high- risk” for substance use but have not yet started
- Intervention:** Support for students who are experimenting or using alcohol and/or other drugs and want to learn about the harmful effects of substance use
- Challenge:** Support for students maintaining abstinence or to motivate a student to attend Intervention if needed.
- Concerned/Affected Others:** Support for students who are concerned about someone else’s use of alcohol and/or other drugs
- Recovery Group:** Support for students who have quit using alcohol and other drugs
- I am not interested in participating in a group at this time*

Group Session Summary/Lesson Plan

SAPISP Services are Linked to Enhancing Academic Success

The work of the Student Assistance Specialist is closely linked to creating a readiness for students to learn and achieve academic success. Through educational support groups, SAPISP activities not only reduce barriers to learning, but also compliment the academic grade level expectations (GLE) addressed by classroom teachers.

At a minimum, all educational support group sessions address the following objectives:

- ✓ Provide ATOD education designed to increase perception of harm.
- ✓ Decrease ATOD use, and
- ✓ Increase student achievement.

Complete the following information for each educational support group session.

Name of Group: _____ Date: _____

Session Topic: _____

Brief Description: _____

For this lesson, check the content areas that you addressed (check all that apply):

- Reading
- Writing
- Communication
- Math
- Science
- Social studies
- Art

For this lesson, check the following topics you assigned or discussed (check all that apply):

- Attendance
- Homework
- Grades
- Time management
- Classroom management/teacher conflicts
- Other school related topics

Section 9

Cooperation and Collaboration

Introduction

In order to effectively address barriers to learning and promote social, emotional and healthy development schools need to be an integral and positive part of the community. If schools are to reach their educational mission, they must have the support of a variety of community resources such as family members, neighborhood leaders, business groups, religious institutions, public and private agencies, community- based organizations, and local government. Likewise, these community partners can do a better job by working closely with schools. On a broader scale, communities and coalitions need schools to play a key role in strengthening families and neighborhoods.

When addressing the problems of adolescent SEBH including substance abuse, it becomes clear that these issues affect the school, family, and community. Therefore, it is important that the SAPISP not work in a vacuum if the intent is to effectively address student SEBH issues. In order to reach positive outcomes, it is essential that families and community agencies are involved, and actively engaged in program services. Eliciting such engagement; however, requires forethought and planning on several different levels.

Who Should be Involved?

When developing collaborative partnerships, who should be involved? It is important that the collaborative process is as inclusive as possible. Initially it may be helpful to take an inventory of community agencies working with the district and schools as well as those that have contact with students and families served by the program. The following is a broad list of key collaborative partners:

- Local police and sheriff's departments.
- Youth-serving agencies (e.g., counseling centers, mental health clinics, etc.);
- Self-help groups, such as Alcoholics Anonymous, Al-Anon, Ala-teen, Narcotics Anonymous, and Families Anonymous.
- Juvenile court judges; municipal magistrates; juvenile intake workers and other participants in the juvenile justice system.
- Probation and parole officers.
- Members of the local or county department of welfare or social services, especially those dealing with child protection services, family violence, sexual abuse, etc.
- Faith-based community members.
- Volunteer organizations (e.g. Big Brothers, Big Sisters, community youth groups).
- Members of the medical community.
- County Prevention Coordinators.
- Parents and Students.

Collaboration and cooperation with community agencies and resources is vital to providing a successful continuum of care for students. Working together to streamline care for students involved with multiple agencies decreases the likelihood of service overlap and interrupting the school day. Additionally, collaboration between school-based and community-based services allows for providers to address students with a common language, promote awareness activities and incorporate environmental strategies to reinforce a no-use or non-favorable attitude messages across all levels of service.

Benefits of Collaborations, Coalitions and Partnerships:

- Identify strengths in current programs and cooperate to meet community needs
- Expand available programs through grant writing/fund raising
- Reduce interagency conflicts and tension by squarely addressing issues of competition and turn
- Improve communication
- Mobilize action to effect needed changes

Components of Successful Collaborations, Coalitions and Partnerships:

- Stakeholders with vested interest
- Trust among and between partners
- Shared vision and common goals
- Open communication
- Clear mission, goals, action plan
- Teamwork strategies and motivated partners
- Sufficient means to implement and sustain efforts

Strategies to Minimize Barriers:

- Keep commitment and activities simple
- Make communication a priority
- Spend time getting to know one another
- Develop clear roles for members and leaders
- Engage new members
- Encourage all to be upfront about needs
- Avoid turf issues and hidden agendas
- Have fun

Cooperation and Collaboration Across the State

Washington State's SAPISP has a strong history of school-community partnerships in the development of a systemic, comprehensive, multifaceted approach to SEBH including substance abuse prevention. This successful collaboration is a result of several legislative initiatives enacted to strengthen the state's commitment to addressing adolescent substance use.

- In 1989, the state legislature passed the Omnibus Alcohol and Controlled Substances Act (ESSHB 1793) to directly address concerns regarding youth substance use in Washington State through the establishment of school-based prevention and intervention services

programs. Local Educational Service Districts, districts, and schools statewide work with OSPI and DBHR to deliver comprehensive SAPISP services in the local schools.

- *The Community Mobilization Against Substance Abuse and Violence* was established in 1989 by the Washington State legislature to address issues of substance abuse and violence through the organized and collaborative efforts of entire communities. *Community Mobilization* requires communities to organize and collaboratively implement and deliver substance abuse and violence prevention programs based upon identified community needs.
- In 1992, the Washington state legislature enacted the Family Policy Initiative, which created the Family Policy Council to design and carry out principle-centered, systemic reforms to improve outcomes for children, youth, and families (RCW 70.190). One of the Council's main activities was working with the State's Community Public Health and Safety Networks to prevent important social problems. The networks were community-based, volunteer boards developed to give local communities more autonomy, to provide resources to improve the lives of children and families in their communities, and to provide recommendations for policy changes to improve state and local child and family serving systems. The primary focus of the Networks was in seven "problem behavior" areas identified by the state: 1) Child abuse and neglect, 2) Youth violence, 3) Youth substance abuse, 4) Teen pregnancy, 5) Domestic violence, 6) School dropout, and 7) Teen suicide
- The Governor's Council on Substance Abuse was established by executive order in 1994. The Council was created to respond to the significant human, social, and economic costs substance abuse inflicts on individuals, families, and communities in Washington State. Council membership includes private industry, local and tribal government, treatment providers, community groups, educators, and law enforcement. State government is represented on the Council by the directors of the seven state agencies providing substance abuse programs and one legislator for each Caucus of the House and Senate. Council staffing is provided by the Department of Community, Trade, and Economic Development (CTED). Responsibilities include: Working with state and local agencies and communities to develop common substance abuse reduction goals; advising the Governor on substance abuse issues by providing recommendations for policy, and identifying program and research strategies (www.cted.wa.gov/).
- In 2000, the Washington State DOH received funding from a settlement lawsuit against tobacco companies and greatly expanded its 10-year-old tobacco prevention and control program. Recognizing the importance of a coordinated, long-term effort to reduce tobacco use, the department's Tobacco Prevention and Control Program works with local health agencies, tribes, schools, and community-based organizations to deliver a comprehensive, integrated approach to preventing tobacco use among residents. The department and its partners worked together to: Prevent youth from beginning to use tobacco; help youth and adult quit using tobacco; reduce exposure to secondhand smoke; and reduce tobacco use in high-risk groups (www.doh.wa.gov/).

Examples of Statewide Collaboration Efforts⁹²

State Prevention Summit: In collaboration with other state agencies and prevention organizations, DBHR supports an annual State Prevention Summit. The Summit is for community-based volunteer prevention task forces, youth, and prevention professionals who are interested in learning new prevention strategies for their communities. For more information visit www.preventionsummit.org.

Healthy Youth Survey: DBHR administers a statewide Healthy Youth Survey in local school districts in collaboration with the Office of the Superintendent of Public Instruction (OSPI), the DSHS Division of Research and Data Analysis, the Department of Health, and the Department of Commerce. Survey data is collected every two years and used for local and state prevention program planning. For the latest survey results, visit www.askhys.net. For more information about the survey, visit www.hys.wa.gov.

The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth. The survey is administered every other year in the fall to participating students in schools statewide. The information from the Healthy Youth Survey is used to identify trends in the patterns of behavior over time.

State Parenting Initiative Network (SPIN): is dedicated to promoting effective parenting to prevent substance abuse and violence among children and youth in our state. The network – open to parents/caregivers and professionals from the public and private sectors – brings together individuals who envision a society in which diverse families, caregivers and communities help children and youth grow-up healthy, drug-free and safe.

SPIN's goals include providing opportunities for caregivers and professionals to learn more about effective and culturally appropriate parenting strategies that will build protection into every family. SPIN is focused on increasing the visibility and ease of access to parenting resources and training opportunities, while enhancing communication efforts for all parents and professionals.

In 2010 SPIN conducted a [statewide survey on parenting needs and resources](#). To learn more about SPIN and becoming a member, contact [DSHS-DBHR](#).

Health Promotion: DBHR develops and distributes research-based educational materials that raise awareness of the harmful consequences of substance abuse and promote healthy attitudes and behaviors. We provide [information and education](#) to the public and our stakeholders about substance abuse trends in Washington, how to prevent and reduce substance abuse, and how to access prevention and treatment resources.

⁹² Retrieved (6/2012) from <http://www.dshs.wa.gov/dbhr/dastateprevention.shtml>

DBHR administers Partnership for a Drug-Free Washington – a state alliance program of the Partnership for a Drug-Free America, to deliver effective drug prevention advertising messages to media outlets in Washington. Online social marketing resources: National Youth Anti-Drug Media Campaign, Social Media Campaign Resources - CDC, SAMHSA Social Media Resources, SAMHSA Communications and Education. For more information, contact Deb Schnellman at DSHS-DBHR.

Examples of Local Level Collaboration Efforts

Community Mobilization: Local ESDs and districts participate bi-annually in collaborative needs assessment process. Other activities of collaborative efforts included Participation in community substance abuse awareness prevention efforts, jointly funding local projects related to prevention and intervention services, jointly supported training/education events, and assisting with coordinating regional youth substance abuse treatment efforts.

Local Treatment Efforts: The SAPISP program maintains regular contact with local substance abuse treatment providers in their residing counties. Examples of this include, direct SAS case management in relation to treatment referrals; and, administrative networking with local providers.

Prevention Redesign Coalition: Each county in Washington State has established a partnership between the community prevention coordinator, Educational Services District SAPISP Coordinator to participate in reviewing data to identify school and community risk factors with the highest needed “community” service area to address risk factors. Once the targeted school/community site is identified, a coalition is formed. The coalition consist of representatives from school districts/schools, local law enforcement, mental health agencies, county alcohol and drug prevention and treatment coordinators, parents and other community organizations. The role of the coalition is to develop and implement a strategic prevention plan to increased school community awareness of the relationship between youth alcohol and other drug abuse and the various risk factors and problem areas that contribute to such behaviors, including other SEBH issues. Substance Abuse and Mental Health Services Administration describes the following as components of an effective coalition:⁹³

1. Clear Organizational Structure

- To be effective, coalitions require:
 - A strong and stable organizational structure that clarifies roles and procedures, and adequately addresses task and maintenance function.
 - A formalized set of structures and practices, such as written roles and procedures (e.g., bylaws).
 - Management strategies, such as effective communication, conflict resolution, perception of fairness, and shared decision-making.

⁹³ Excerpt retrieved (5/2012) from <http://captus.samhsa.gov/access-resources/components-effective-coalition>

- Organizational effectiveness is related to positive work climate, higher member satisfaction, better communication among committee members, stronger linkages with community organizations, and less conflict.
- Effective leadership, opportunities for leadership development, and staff support are frequently identified as the *most* essential elements of an effective coalition.
- Effective leaders are open, task-oriented, and Supportive of the group.

2. Membership Capacity to do the Work

- Key coalition members must have a clear understanding of the coalition development process and a basic knowledge of prevention planning and concepts.
- The community must have an appropriate level of readiness to ensure ownership and commitment to act on substance abuse issues.
- Adequate time and staff support are necessary for effective coalition development, planning, and activities.
- Coalitions require a common vision, high quality communication, strong relationships both internally and externally, targeted outcomes, and human and financial resources to be effective.

3. Sustainability

To be sustained over time, coalitions must:

- Develop and employ a process for leader succession and recruitment of new members.
- Provide recognition and renewal to coalition members to increase energy and reduce burnout.
- Continuously integrate the coalition's goals and strategies into the missions of their own organizations.
- Develop diversified funding streams to ensure balance and commitment to coalition activities and actions.

Suggested Program Operations

The following information provides SAPISP project coordinators with suggested program operations related to the SAS's role in working and networking with community agencies, and DBHR expectations for PRI community coalitions.

Student Assistance Specialist role within the community is to:

- Participate on the coalition and works with coalition on collaborative awareness events as part of universal schoolwide prevention activities (level of Participation is determined by ESD Program Coordinator).
- Make contacts with community agencies and begin building relationships with key personnel.
- Understand how to access substance abuse and mental health assessments from area service providers;
- Develop a list of resources and specific contact persons to provide to parents as needed.

- Develop a protocol for when and how to refer students/families to outside agencies based on building/district external referral policy including confidentiality, and release of information.
- Know when and how to involve Child Protective Services.
- Staff external referrals at the Core/Care/Resource Management Team meetings.
- Engage the parents of students with whom you are working following the confidentiality laws spelled out in 42CFR Part 2 and the HIPPA laws.
- Use outside agencies to help conduct prevention activities in the classroom at a Schoolwide level.

The Community Prevention Coalition/Coordinator⁹⁴

- Serves as staff for the coalition to help plan, implement and report on task categories.
- Serves as a liaison between PRI coalition and DBHR.
- Participates in PRI learning community meetings, monthly DBHR check-in meetings and required training.
- Helps recruit and retain membership on the coalition and support from local key stakeholders/leaders;
- Provides staff support to the community coalition.
- coordinate regular meetings to ensure implementation on the strategic plans.
- Coordinates the regular review of coalition budget by the coalition.
- Assists coalition members in navigating Strategic Prevention Framework and guide coalition to develop a comprehensive action plan based on needs assessment and strategic planning.
- Works with individual coalition member organizations to help them align and integrate their work with the goals and strategies of the coalition and SPF-focused work.
- Reports to the community coalition on progress toward the goals and objectives of the strategic plan and work plans.
- Provides or coordinate services, activities and coalition trainings with the guidance of the coalition members.
- Works with the coalition and projects to develop and monitor outcomes.
- Works with the coalition to coordinate community outreach efforts (presentations, newsletter, volunteer recruitment; etc.
- Functions as the liaison among the coalition members and with the community at large.

The Coalitions Members Role:

- Organize an annual Key Leader Orientation.
- Create/ update and submit the coalition's Strategic Plan which includes:
 - Establish a process and conduct a needs and resource assessment.
 - Make decisions based on state-provided and local data.
 - Select a community organizing framework.
 - Select goals, population and strategies.
 - Identify timelines, anticipated barriers to services, and a logic model.

⁹⁴ Excerpt retrieved (4/2102) from www.theathenaforum.org. More information on The DBHR PRI Key Objectives and Task Category Guides for Cohort 1 and 2 is available online at www.theathenaforum.org

- Recruit and retain membership.
- Confirm partnerships to get the work done.
- Lead and oversee the implementation of direct, environmental strategies, and Washington State media campaigns.
- Report coalition outputs and outcomes to DBHR.
- Implement and support evaluation designed by DBHR. This includes:
 - Support the Healthy Youth Survey (HYS).
 - Participate in the resource assessment survey.
 - Participate in the annual coalition assessment survey.

Additional Resources

Infusing Cultural Competence into the Strategic Prevention Framework (SPF)⁹⁵

This document presents strategies for infusing cultural competence into each step of SAMHSA's Strategic Prevention Framework.

Step 1: Assessment of Needs and Capacity

- Work with the community.
- Use a culturally competent evaluator.
- Ensure a mechanism for collecting cultural competence-related information/data.
- Gain community approval for data collection methods and analysis.
- Ensure data is culturally responsive and appropriate.
- Create process for identifying culturally relevant risk and protective factors and other underlying conditions.
- Formulate culturally based assumptions of change.
 - Identify change from a community perspective.
 - Gain community approval of product.

Step 2: Capacity Mobilizing and Building

- Examine community resources and readiness.
- Provide a safe and Supportive environment for all participants.
- Examine breadth and depth of cultural competence.
- Check cultural representation (e.g., language, gender, age).
- Develop policies (i.e., recruitment and retention, training, communication and community input) to improve cultural competence.
- Ensure that tools and technology are culturally competent.
- Identify and mobilize mutually acceptable goals and objectives.

Step 3: Developing Strategic Plan

- Make sure community is represented in the process.

⁹⁵ Excerpt retrieved (6/2012) from <http://captus.samhsa.gov/access-resources/infusing-cultural-competence-spf>

- When selecting programs and strategies, consider their fit with:
 - Community culture.
 - Existing prevention efforts.
 - Past history.

Step 4: Implementation

- Involve community in the implementation of strategic plan.
- Create a feedback loop for communicating efforts and successes.

Step 5: Evaluation

- Make sure the community is represented in the evaluation process.
- Ensure that data collection tools reflect community culture.
- Use a culturally competent evaluator.

School-Community Partnerships⁹⁶

Increasingly, it is becoming evident that schools and communities should work closely with each other to meet their mutual goals. With respect to addressing barriers to development and learning and promoting healthy development, schools are finding they can do their job better when they are an integral and positive part of the community. Indeed, for many schools to succeed with their educational mission, they must have the support of community resources such as family members, neighborhood leaders, business groups, religious institutions, public and private agencies, libraries, parks and recreation, community-based organizations, civic groups, local government. Reciprocally, many community agencies can do their job better by working closely with schools. On a broader scale, many communities need schools to play a key role in strengthening families and neighborhoods.

For schools and other public and private agencies to be seen as integral parts of the community, steps must be taken to create and maintain various forms of collaboration. Greater volunteerism on the part of parents and others from the community can break down barriers and help increase home and community involvement in schools. Agencies can make services more accessible by linking with schools and enhance effectiveness by integrating with school programs. Clearly, appropriate and effective collaboration and teaming are key facets of addressing barriers to development, learning, and family self-sufficiency.

While informal school-community linkages are relatively simple to acquire, establishing major long-term connections is complicated. They require vision, cohesive policy, and basic systemic reforms. The complications are readily seen in efforts to evolve a comprehensive, multifaceted, and integrated continuum of school-community interventions. Such a comprehensive continuum involves more than connecting with the community to enhance resources to support instruction, provide mentoring, and improve facilities. It involves more than establishing school-linked, integrated health/human services and recreation and enrichment activities. It requires

⁹⁶ Adapted from Center for Mental Health in Schools, School-community partnerships: A guide. Available at <http://smhp.psych.ucla.edu>

comprehensive strategies that are multifaceted. Such a continuum of interventions can only be achieved through school-community connections that are formalized and institutionalized, with major responsibilities shared. (For an example, see Appendix A.)

Strong school-community connections are especially critical in impoverished communities where schools often are the largest piece of public real estate and also may be the single largest employer. As such, they are indispensable to efforts designed to strengthen families and neighborhoods. Comprehensive school-community partnerships allow all stakeholders to broaden resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond.

Comprehensive school-community partnerships represent a promising direction for efforts to generate essential interventions to address barriers to learning, enhance healthy development, and strengthen families and neighborhoods. Building such partnerships calls for an enlightened vision, creative leadership, and new and multifaceted roles for professionals who work in schools and communities, as well as for all who are willing to assume leadership.

What Are School-Community Partnerships?

Definitions

One recent resource defines a school-community partnership as: *An intentional effort to create and sustain relationships among a K-12 school or school district and a variety of both formal and informal organizations and institutions in the community* (Melaville & Blank, 1998).

For purposes of this discussion, the *school* side of the partnership can be expanded to include pre-K and postsecondary institutions.

Defining the *community* facet is a bit more difficult. People often feel they belong to a variety of overlapping communities, some of which reflect geographic boundaries and others that reflect group associations. For purposes of this guide, the concept of community can be expanded to encompass the entire range of *resources* (e.g., all stakeholders, agencies and organizations, facilities, and other resources, youth, families, businesses, school sites, community based organizations, civic groups, religious groups, health and human service agencies, parks, libraries, and other possibilities for recreation and enrichment).

The term partnership also may be confusing in practice. Legally, it implies a formal, contractual relationship to pursue a common purpose, with each partner's decision-making roles and financial considerations clearly spelled out. For purposes of this discussion, the term "partnerships" is used loosely to encompass various forms of temporary or permanent structured connections among schools and community resources. Distinctions will be made among those that connect for purposes of communication and cooperation, those that focus on coordinating activity, those concerned with integrating overlapping activity, and those attempting to weave their responsibilities and resources together by forming a unified entity.

Distinctions will also be made about the degree of formality and the breadth of the relationships.

As should be evident, these definitions are purposefully broad to encourage "break-the-mold" thinking about possible school-community connections. Partnerships may be established to enhance programs by increasing availability and access and filling gaps. The partnership may involve use of school or neighborhood facilities and equipment; sharing other resources; collaborative fund raising and grant applications; shared underwriting of some activity; volunteer assistance; pro bono services, mentoring, and training from professionals and others with special expertise; information sharing and dissemination; networking; recognition and public relations; mutual support; shared responsibility for planning, implementation, and evaluation of programs and services; building and maintaining infrastructure; expanding opportunities for assistance; community service, internships, jobs, recreation, enrichment; enhancing safety; shared celebrations; building a sense of community.⁹⁷

Optimally, school-community partnerships formally blend together resources of at least one school and sometimes a group of schools or an entire school district with resources in a given neighborhood or the larger community. The intent is to sustain such partnerships over time. The range of entities in a community are not limited to agencies and organization; they encompass people, businesses, community based organizations, postsecondary institutions, religious and civic groups, programs at parks and libraries, and any other facilities that can be used for recreation, learning, enrichment, and support.

While it is relatively simple to make informal school-community linkages, establishing major long-term partnerships is complicated. They require vision, cohesive policy, and basic systemic reforms. The complications are readily seen in efforts to develop a comprehensive, multifaceted, and integrated continuum of school-community interventions. Such a continuum involves much more than linking a few services, recreation, and enrichment activities to schools.

Major processes are required to develop and evolve formal and institutionalized sharing of a wide spectrum of responsibilities and resources. School-community partnerships can weave together a critical mass of resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond. Strong school-community connections are critical in impoverished communities where schools often are the largest piece of public real estate and also may be the single largest employer.

⁹⁷ School-community partnerships are often referred to as collaborations. There are an increasing number of meetings among various groups of collaborators. Sid Gardner has cautioned that, rather than working out true partnerships, there is a danger that people will just sit around engaging in "collabo-babble." Years ago, former Surgeon General Jocelyn Elders cited the cheek-in-tongue definition of collaboration as "an unnatural act between non-consenting adults." She went on to say: "We all say we want to collaborate, but what we really mean is that we want to continue doing things as we have always done them while others change to fit what we are doing."

Comprehensive partnerships represent a promising direction for efforts to generate essential interventions to address barriers to learning, enhance healthy development, and strengthen families and neighborhoods. Building such partnerships requires an enlightened vision, creative leadership, and new and multifaceted roles for professionals who work in schools and communities, as well as for all who are willing to assume leadership.

Dimensions and Characteristics

Because school-community partnerships differ from each other, it is important to be able to distinguish among them. An appreciation of key dimensions helps in the respect. Although there are many characteristics that differentiate school-community collaborations, those outlined in the table below will suffice to identify key similarities and differences.

Key Issues Relevant to School-Community Collaborative Arrangements

1. Initiation:
 - School-led
 - Community-driven
2. Nature of Collaboration:
 - Formal
 - Memorandum of understanding
 - Contract
 - Organizational/operational mechanism
 - Informal
 - Verbal agreements
 - Ad hoc arrangements
3. Focus:
 - Improvement of program and service provision
 - For enhancing case management
 - For enhancing use of resources
 - Major systemic reform
 - To enhance coordination for organizational restructuring for transforming system structure and function.
4. Scope of collaboration:
 - Number of program and services involved (from just a few – up to a comprehensive, multifaceted continuum).
 - Horizontal Collaboration.
 - Within a school/agency.
 - Among schools/agencies.
 - Vertical Collaboration
 - Within a catchment area (e.g., school and community agency, family of school, two or more agencies).
 - Among different levels of jurisdictions (e.g., community, city, county, state, federal).
5. Scope of Potential Impact:
 - Narrow-band – a small proportion of youth and families can access what they need.
 - Broad-band – all in need can access what they need.

6. Ownership and Governance of Programs and Services:
 - Owned and governed by the school.
 - Owned and governed by the community.
 - Shared ownership and governance.
 - Public-private venture – shared ownership and governance.
7. Location of Programs and Services:
 - Community-based, school-linked.
 - School-based.
8. Degree of Cohesiveness among Multiple Interventions Serving the Same Student/Family:
 - Unconnected.
 - Communicating.
 - Cooperating.
 - Coordinated.
 - Integrated.

Principles

Those who create school-community partnerships subscribe to certain principles. In synthesizing "key principles for effective frontline practice," Kinney, Strand, Hagerup, and Bruner (1994) caution that care must be taken not to let important principles simply become *the rhetoric of reform, buzzwords that are subject to critique as too fuzzy to have real meaning or impact ... a mantra ... that risks being drowned in its own generality.*

Below are some basic tenets and guidelines that are useful referents in thinking about school-community partnerships and the many interventions they encompass. With the above caution in mind, it is helpful to review the ensuing lists. They are offered simply to provide a sense of the philosophy guiding efforts to address barriers to development and learning, promote healthy development, and strengthen families and neighborhoods.

As guidelines, Kinney, et al. (1994) stress:

- A focus on improving systems, as well as helping individuals.
- A full continuum of interventions.
- Activity clustered into coherent areas.
- Comprehensiveness.
- Integrated/cohesive programs.
- Systematic planning, implementation, and evaluation.
- Operational flexibility and responsiveness.
- Cross disciplinary involvements.
- De-emphasis of categorical programs.
- School-community collaborations.
- High standards-expectations-status.
- Blending of theory and practice.

Interventions that are:

- Family-centered, holistic, and developmentally appropriate.

- Consumer-oriented, user friendly, and that ask consumers to contribute.
- Tailored to fit sites and individuals.
- Interventions that:
 - Are self-renewing.
 - Embody social justice/equity.
 - Account for diversity.
 - Show respect and appreciation for all parties.
 - Ensure partnerships in decision making/shared governance.
 - Build on strengths.
 - Have clarity of desired outcomes.
 - Incorporate accountability.

Section 10

Program Evaluation

Why Evaluate

Evaluation allows the program to measure success, to know whether or not the program is making strides toward accomplishing targeted outcomes. Evaluation provides a systematic approach to collecting and using program information to answer numerous questions to guide program planning efforts. Evaluation is a way of providing more information about the program than was previously available, a tool for making informed decisions, and to assist in problem solving. Evaluation is not about proving a program's worth; rather, evaluation is about *improving* a program's worth.

Moreover, if a program is well designed and implemented with fidelity, evaluation findings provide program staff with statistical information to make statements that show that prevention and intervention activities are making strides toward overcoming the targeted problem behaviors, thus acquires support for continued program efforts.

Washington's SAPISP Program

In 2004, in an effort to explicitly link statewide program goals, objectives and outcomes, the state in collaboration with the Prevention Center Directors developed a set of uniform goals and objectives to establish a standardized measure of program performance. These are:

SAPI Statewide Program Goals:⁹⁸

1. Provide early social, emotional, and behavioral support including drug and alcohol prevention and intervention services to students.
2. Provide high quality prevention and intervention programs to foster a safe and Supportive a social, emotional, behavioral health including substance abuse environment for all students.
3. Develop collaborative relationships with community partners/networks mental health and treatment agencies to serve students and families comprehensively.

SAPI State Outcomes and Indicators:

Universal to delay onset and increase in understanding of perceived risk toward substance use. This is measured by the Healthy Youth Survey and is not necessarily a direct correlation of the SAS work. However, the SAS work can be a contributing variable to the universal outcome.

⁹⁸ Updated 6/15/2012 – Office of Superintendent Public Instruction, Department of Student Support, Educational Service District's Prevention Directors K-20. Changes will be reflected in the 2012-13 Washington State Student Assistance Prevention and Intervention Program Evaluation.

Selective and Indicated:

Outcome #1: To Delay onset or reduce levels of substance abuse

- *Indicator 1a.* Delay onset. This measure has not yet been determined. Data was collected 2011- 2012 school year to establish a baseline.
- *Indicator 1b.* By the end of the school year, 50 percent of 12–18-year-old youth participating in the SAPISP will show a reduction in substance use for those that have a intervention goal of substance reduction use as compared to program entry.

Outcome #2: To improve academic performance and retention in school

- *Indicator 2a.* By the end of the school year, 25 percent of 12–18-year-old youth participating in the SAPISP will show in grades he/she is passing as compared to program entry.
- *Indicator 2b.* By the end of the school year, 10 percent of 12–18-year-old youth participating in the SAPISP will show improvement in attendance as compared to program entry.

Outcome# 3 Healthy life choices

- *Indicator 3a.* By the end of the school year, 10 percent of 12–18-year-old youth participating in the SAPISP will show an increase in understanding of perceived risk towards substance use as compared to program entry.

Outcome # 4 Proposed – Promote positive social emotional and behavior health. This is under review and will be discussed in 2012–13 school year to determine appropriate indicators for this outcome.

Statewide Evaluation Efforts⁹⁹

Since its inception, the Office of Superintendent of Public Instruction has sponsored ongoing statewide evaluation of the SAPISP. RMC Research, contracted external evaluators, began working with the state on the evaluation of SAPISP services in 1994. RMC Research under the auspices of Dennis Deck, Ph.D., has conducted multi-site annual summaries of student level services and outcomes data as well as biennial evaluation reports of progress toward targeted outcomes. Thirteen large school districts and consortia collect outcomes data annually on approximately 20,000 students that receive services provided by SAS statewide.

Suggested Program Operations

The following provides program coordinators with information related to project evaluation and includes the SAS's role in data collection activities.

Data Collection Activities¹⁰⁰

In support of the State's effort to measure progress toward established objectives, RMC Research developed an automated web-based reporting system in collaboration with local grantees to monitor service provision and student outcomes throughout the school year. The purpose of data collection is to support the SAPISP program, with the intent to provide

⁹⁹ Source: RMC Research website – www.rmccorp.com

¹⁰⁰ Ibid

consistent, accurate, reliable, and timely information to Program Coordinators, SAS, school and district administrators, state agencies, and legislators. These groups may thereby make informed decisions regarding local, regional, and statewide prevention-intervention services (Deck, 2005, p. 3).

SAS enter information about universal prevention activities offered to all students and describe services provided to students referred to selective or indicated prevention activities. Students referred to selective and indicated intervention services complete a program evaluation survey prior to starting program services and again after Participation in the program. The pre/post evaluation survey measures changes in attitudes and behaviors among students who participate in selective or indicated prevention activities. Completed forms are sent to RMC Research, scanned, and imported into the database.

Other evaluation activities include conducting case studies, longitudinal follow-up of grades and attendance, site visits, and literature reviews to provide a qualitative perspective of the implementation and impact of the program. Annual evaluation reports assess program strengths and weaknesses to inform local planning efforts and to report on student outcomes to the state legislature and state officials.

The following is information related to the data collection process as well as the specific procedures for entering data into the system, available online at www.rmccorp.com/pisp Under Washington State Student Assistance Prevention and Intervention Services Program Data Collection Manual and Web Application User Guide for Program Directors and Intervention Specialists 2011–12. Prepared for Student Assistance Prevention and Intervention Services Program, Department of Student Support, Office of Superintendent of Public Instruction. Prepared by Ryan D’Ambrosio and Trey Guy RMC Research Corporation
<http://www.rmccorp.com/project/pieval.htm>

Department of Behavioral Health and Recovery, Prevention Redesign Evaluation Measurements

The long and short-term outcomes under DBHR’s redesign include Also has an indicator measurement for each PRI cohort site for the Student Assistance Prevention and Intervention Program. The measurement is a 50 percent reduction in substance use for those students served in the program with an intervention goal of substance abuse reduction. DBHR tracks this indicator measurement on a quarterly basis.

DBHR PRI indicators include measuring reduction in consumption by any underage drinking reduction in the 10th grade and any underage problem or heavy drinking in the 10th grade. For more information on the DBHR redesign logic model and evaluation please go to http://www.theathenaforum.org/pri_logic_model_various_formats

Appendix A

References

- Adelman, H. S. and Taylor, L. (2011). Expanding school improvement policy to better address barriers to learning and integrate public health concerns. *Policy in Education*, 9(3), p. 431–446.
- Adelman, H. S. and Taylor, L. (2010). Creating successful school systems requires addressing barriers to learning and teaching. *The F.M. Duffy Reports*, 15(3), 1–11. Available at <http://smph.psych.ucla.edu/publications/duffyreport.pdf>
- Adelman, H.S. & Taylor, L. (2006). School and community collaboration to promote a safe learning environment. Los Angeles, CA: UCLA School Mental Health Project. Available at <http://smhp.psych.ucla.edu/publications/school&communitycollaboration.pdf>.
- Adelman, H.S. & Taylor, L. (2006). The current status of mental health in schools: A policy and practice brief. Los Angeles, CA: UCLA School Mental Health Project.
- Adelman, H., and Taylor, N. (2002). Issues in the field: Barriers (risk factors), protective buffers, and promoting full development. In *Addressing Barriers to Learning*, 7(3), 10–11. Center for Mental Health in Schools.
- Adelman, H., and Taylor, N. (2002, October). A concept paper: New directions for student support. Retrieved from <http://smhp.psych.ucla.edu/>
- Adelman, H., and Taylor, N. (2002, February). New directions for school and community initiatives to address barriers to learning: Two examples of concept papers to inform and guide policy makers. Retrieved from <http://smhp.psych.ucla.edu/>
- Adelman, H., and Taylor L. (1997). Addressing barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry*, 67, 408–421.
- Anderson, B, et al. (2007). *Help is Down the Hall, A Handbook on Student Assistance*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Anderson, G. L. (1993). *When chemicals come to school (Revised)*. Community Recovery Press. Greenfield WI.
- Arrasmith, D., and Gallon, S. (2001). Performance assessment rubrics for the addiction counseling competencies (2nd edition). Northwest Frontier Addiction Technology Transfer Center Oregon Office of Alcohol and Drug Abuse Programs. Portland, OR.
- Barrett, S., Eber, L, National PBIS Center Partners; and Weist, M. University of South Carolina (and Senior Advisor to the University of Maryland, Center for School Mental Health *Development of an Interconnected Systems Framework for School Mental Health* (a work in progress) Revised:

February, 2012. Retrieved (5/2012) from:
www.pbis.org/common/pbisresources/publications/ISF_rev.

Bond, L. A., and Carmola Huff, A. M. (2004). Taking stock and putting stock in primary prevention: Characteristics of effective programs. *The Journal of Primary Prevention*, 24(3), 199–221.

Bordas J. (2007) *Salsa, Soul and Spirit. Leadership for a Multicultural Age, New approaches to Leadership from Latino, Black and American Indian Communities*. San Francisco, CA: Berrett-Kohler Publishers Inc.

Bosworth, K. (2000). *Protective schools: Linking drug abuse prevention with student success*. Tucson, AZ: University of Arizona, College of Education.

Burk, I. (1998). *Guide for school-based drug policy and advisory councils*. Balance Group Publishers, LLC. Kalamazoo, MI.

Burns, B., Howell, J., Wiig, J., Augimeri, L, Welsh, B., and Petechuk, D. (2003). Treatment, services, and intervention programs for child delinquents. *Child Delinquency Bulletin Series*. U.S. Department of Justice. Available at ojjdp.ncjrs.org.

Carlson. K. A. (2001). School based outpatient treatment for adolescent substance abuse: A review of program models in Washington State. Office of Superintendent of Public Instruction. Olympia, WA.

Carlson, K.A. (2000). Designing and doing outcomes evaluation: Asking the right questions to get better answers. Unpublished paper. Praxis Research. Port Angeles, WA.

Carlson, K. A. (1996). Proof positive: A student assistance program evaluation. *Student Assistance Journal*, 8(4), 15–18.

Carlson, K. A. (1994). Student assistance programs: Do they make a difference? *Journal of Child and Adolescent Substance Abuse*, 4(1), 1–16.

Catalano, R.F., Hawkins, J.D., Wells, E.A., Miller, J., & Brewer, D. (1991). Evaluation of the effectiveness of adolescent drug abuse treatment: Assessment of risks for relapse and promising approaches for relapse prevention. *The International Journal of the Addictions*, 25, 1085–1140.

Center for Substance Abuse Prevention: Northeast Center for the Application of Prevention Technologies. (2002). Early intervention: A strategy for prevention practitioners. Retrieved from:
http://www.northeastcapt.org/products/strategies/whats_science/prevention_rev2.pdf

Center for Mental Health in Schools at UCLA. (2003). School-based client consultation, referral, and management of care. Los Angeles, CA: Author. Available at <http://smhp.psych.ucla.edu>.

Center for Mental Health in Schools at UCLA. (2001). A resource aid packet on screening/assessing students: Indicators and tools. Los Angeles, CA: Author. Available at <http://smhp.psych.ucla.edu>.

Center for Mental Health in Schools. (2004 rev) Sustaining school and community efforts to enhance outcomes for children and youth: A guidebook and tool kit. Los Angeles, CA: Author at UCLA. Available at <http://smhp.psych.ucla.edu>.

Children of Alcoholics: A Guide to Community Action (2004). U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; <http://www.samhsa.gov/>

Children of Alcoholics: A Kit for Educators (2001); National Association of Children of Alcoholics (NACoA); <http://www.nacoa.org/>

Commonwealth SAP Interagency Committee. (2004). Training standards and core competencies. Commonwealth of Pennsylvania, Department of Education. Harrisburg, PA.

Data/summary provided by Defense Center of Excellence (2008) *Strategic Planning and Communication Directorate*.

Deck, D. (2005). Washington state prevention and intervention services program: Data collection manual 2005–06 for Intervention Specialists and Program Coordinators. Office of Superintendent of Public Instruction. Olympia, WA. Available at <http://rmccorp.com/pieval/>

Deck, D. (2004). Washington's prevention and intervention services program: Highlights from the 2003–04 statewide evaluation. Office of Superintendent of Public Instruction. Olympia, WA.

Deck, D. (2004). 2001–03 Final report. Addressing adolescent substance abuse: An evaluation of Washington States' prevention and intervention services program. Office of Superintendent of Public Instruction. Olympia, WA.

Deck, D. and D'Ambrosio, R. (2002). 1999-2001 Final report. Addressing adolescent substance abuse: An evaluation of Washington States' prevention and intervention services program. Office of Superintendent of Public Instruction. Olympia, WA.

Defense Manpower Data Center (May 2011), DRS#5800.

Department of Defense (2010). Report on the impact of deployment of members of the armed forces on their dependent children. Retrieved (4/2012) from: <http://www.militaryhomefront.dod.mil/12038/Project%20Documents/MilitaryHOMEFRON>

[T/Service%20Providers/DoD%20Conferences/MFPP/MHF_page/Report_Impact_of_Deployment_Dependent_Children.pdf](#)

Dougherty, D., Eden, J., Kemp, K., Metcalf, K, et al. (1992). Adolescent health: A report to the U.S. Congress. *Journal of School Health*, 62, 167–174.

Duchnowski, A. J., Kutash, K., and Friedman, R. M. (2002). Community-based interventions in a systems of care and outcomes framework. In Burns, B., J., and Hoagwood, K. (Eds.), *Community Treatment for Youth*, (pp. 16-37). New York, NY: Oxford University Press, Inc.

Dusenbury, L., and Hansen, W. B. (2004). Pursuing the course from research to practice. *Prevention Science*, 5(1), 55–59.

Einspruch, E. (2005). Washington State Healthy Youth Survey 2004: Analytic report. Office of Superintendent of Public Instruction. Olympia, WA.

Einspruch, E., and Deck, D. (1999). Outcomes of peer support groups. Office of Superintendent of Public Instruction. Olympia, WA.

Facts for Families. American Academy of Child and Adolescent Psychiatry (no 17, December 2011)

Fleming, C. B., Haggerty, K. P., Brown, E. C., Catalano, R. F., Harachi, T. W., Mazza, J. J., & Gruman, D. H. (2005). Do social and behavioral characteristics targeted by preventive interventions predict standardized test scores and grades? *Journal of School Health*, 75, 342–349.

Gottfredson, D. (2001). *Schools and delinquency*. New York, NY: Cambridge University Press.

Gottfredson, G., D., Gottfredson, D., C., and Czeh, E., R. (2000). *National study of delinquency prevention in schools*. Ellicott City, M. D.: Gottfredson and Associates.

Grisso, T., and Underwood, L.A. (2004). Screening and assessing mental health and substance use disorders among youth in the juvenile justice system: A resource guide for practitioners (OJJDP publication No. NCJ 204956). Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Available at www.ncjrs.pdf/ncj/204956.pdf

Healthy Youth Survey 2010 Analytic Report. Washington State Department of Health, Office of the Superintendent of Public Instruction, Department of Social and Health Services, Department of Commerce, Family Policy Council and Liquor Control Board, June 2011

Hawkins, D. J., Catalano, R. R., and Miller, J. Y., (1992). Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention. *Psychological Bulletin* 112(1), 64–105.

Hawkins, D. J., Farrington, D. P., and Catalano, R. F. (1998). Reducing violence through the schools. In Elliott, D.S., Hamburg, B., and Williams, K. R. (Eds.) *Violence in American Schools – A New Perspective* (pp 1-28). New York, NY: Cambridge University Press.

Johnson, M. (2007). *Tough topics series learning and teaching support Issue 1: SupportIng Military Children During Deployment*. Office of Superintendent of Public Instruction. Olympia, WA. Retrieved (4/2012) from <http://www.k12.wa.us/OperationMilitaryKids/>.

Juvonen, J., Wang, Y., and Espinoza, G. (2001). Bullying Experiences and Compromised Academic Performance Across Middle School Grades. *Journal of Early Adolescence* 31(1) pp. 152-173. Retrieved 5/3/2012 at http://ucla.academia.edu/GuadalupeEspinoza/Papers/400292/Bullying_Experiences_and_Compromised_Academic_Performance_Across_Middle_School_Grades

Klitzner, M., Fisher, D., Stewart, K., and Gilbert, S. (1992). *Early intervention for adolescents*. Bethesda, MD: Pacific Institute for Research and Evaluation.

Knight, J. R. (1997). Adolescent substance use: Screening, assessment, and intervention. *Contemporary Pediatrics* 14(4): 45–72.

Lemerand, P. (1993). *Safe: student assistance and family education: a dynamic model for elementary schools*. Johnson Institute. Minneapolis, MN.

Lenhardt, A.M. (1994) A collaborative substance abuse model for counselors in training knowledge and practicum. *Counselor Education & Supervision*, 34(2), 102–113. Retrieved January 23, 205, from MasterFILE Premier database.

Lester, P., et al. (2010). The long war and parental combat deployment: Effects on military children and spouses. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(4), 310–320.

Lillis, R. (2011) Relationship Between Bullying and Academic Achievement and Direct and Indirect Impact of Olweus Bullying Prevention Program: A Brief Review of Literature. Evalumetrics Research Report. Available at http://www.evalumetrics.org/files/Olweus_Bullying_Review.pdf.

Moe, J. (2001). *Teachers Can Make A Tremendous Difference. Children of Alcoholics: A Kit for Educators; National Association of Children of Alcoholics (NACoA)*. Retrieved (6/2012) from: <http://www.nacoa.org/>.

Nakamoto, J. & Schwartz, D. (2009). Is peer victimization associated with academic achievement? A meta-analytic review. *Social Development*, 19, 221–242.

National Associations of Alcoholism and Drug Abuse Counselors retrieved (4/2012) from <http://www.naadac.org/about/press-releases/620-student-assistance-professionals-join-naadac>

National Center for Mental Health Promotion and Youth Violence Prevention. (n.d.). Positive Behavioral Intervention and Supports Brief. Retrieved May 5, 2012 from <http://www.pbis.org/>

National Center of Response to Intervention. Multilevel prevention system retrieved (5/2012) from http://www.RTI4success.org/categorycontents/multi-level_prevention_system

Nishioka, V., Coe, M., Burke, A., Hanita, M., and Sprague, J. (2011) *Student-reported overt and relational aggression and victimization in grades 3–8*. (Issues & Answers Report, REL 2011–No. 114). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Northwest. Retrieved from <http://ies.ed.gov/ncee/edlabs>.

Markwood, A. (1997). Best practices in ATOD prevention: Handbook. Illinois Department of Human Services.

Mental Health Fact Sheet Retrieved (4/2012) from: <http://www.promoteacceptance.smsa.gov/publications/thefacts.aspx>.

Military Child Education Coalition (2012). *AACTE Guiding Principles for Preparing Educators to Meet the Needs of Military-Connected Students*.

Moore, D. D. and Forster, J. R. (1993). Student assistance programs: New approaches for reducing adolescent substance abuse. *Journal of Counseling & Development*, 71, 326–329.

NIAAA Handbook, *Assessing Alcohol Problems: A Guide for Clinicians and Researchers, 2nd ed.* Edited by: John P. Allen, Veronica B. Wilson. (NIH Publication No. 03-3745). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 2003. Available online at: <http://www.niaaa.nih.gov/publications/Assesing%20Alcohol/index.htm>

National Institute on Drug Abuse. (1997). *Drug abuse prevention: What works*. (Publication No. 97-4110, 1997). National Institute of Health. Bethesda, MD.

National Institute of Justice. (2004). *Research Brief: Toward safe and orderly schools – The national study of delinquency prevention in schools*. U.S. Department of Justice Office of Justice Programs: Washington, D.C. Retrieved from www.ojp.usdoj.gov/nij

Newsam, B. (1992). *Complete student assistance program handbook*. The Center for Applied Research in Education. West Nyack, NY.

New Mexico Public Education. *The SAT and the Three-Tier Model of Student Intervention: A Guidance and Resource Manual for New Mexico's Response to Intervention (RTI) Framework*, prepared by the New Mexico Public Education Department, Quality Assurance Bureau, Fall 2009. Retrieved (5/2012) from: www.ped.state.nm.us (p.6)

Noam, G. G., Pucci, K., and Foster, E. (1999). Development, resilience, and school success in youth: The prevention practitioner and the Harvard RALLY program. In, D. Cicchetti and S. Toth (Eds.) *Developmental psychopathology: Developmental approaches to prevention and intervention*, pp. 57-109. Rochester, NY: University Press.

Noel, K., and MacKillop, J. (2004, Winter). Arm in arm: Cohesive prevention practices that support the learning environment. *WSADCS Journal: Curriculum in Context* 21(2), 7.

O'Connell, M., Boat, T., and Warner, K. (2009). Preventing mental, emotional, and behavioral disorders among young people. National Academy of Sciences. Available at http://www.nap.edu/catalog.php?record_id=12480

Oregon Adolescent Health Section analysis of 2006 Oregon Healthy Teens Survey data. Prepared November 13, 2006. Retrieved (5/2012) from: ww2.nasbhc.org/.../download.aspx?

Prevention redesign initiative retrieved (4/2012) from: <http://www.dshs.wa.gov/dbhr/dapreventionservices.shtml#dbhr>

Prochaska, J. O., and C. C. DiClemente. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 19(3), 276–288.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for all students: What works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

U.S. National Center for Educational Statistics, (2009). Retrieved (5/2011) from: <http://nces.ed.gov/fastfacts/display.asp?id=98>

Robert Wood Johnson Foundation. (2000). *Prevention 2000: Moving effective prevention programs into practice*. St. Michaels, MD.: Author.

Robertson, E., David, S., and Rao, S. (2003). Preventing drug use among children and adolescents. Chapter 1: Risk and protective factors pp. 6–11. U S Department of Health and Human Services, National Institute of Health. Bethesda, MD.

Schinke, S., Brounstein, P., and Gardner, S. (2002). SAMHSA Model Programs. Science-Based Prevention Programs and Principles 2002: Effective Substance Abuse and Mental Health Programs for Every Community. Available at www.samhsa.gov/publications/publications.htm

Sherman, L. W., Gottfredson, D., MacKenzie, D., Eck, J., Reuter, P., & Bushway, S. (n.d.). Preventing crime: What works, what doesn't, what's promising. A report to the United States Congress. Available at <http://www.ncjrs.org/works/>

Skiba, R. J. & Peterson, R. L. (1999). The dark side of zero tolerance: Can punishment lead to safe schools? *Phi Delta Kappan*, 80(5), 372–382.

Steinberg, L. & Levine, A. (1990). *You and your adolescent: A parent's guide for ages 10–20*. New York: Harper & Row.

Steinberg, L. (1991). Adolescent transitions and alcohol and other drug use prevention. In, E. Goplerud (Ed.), *Preventing adolescent drug use: From theory to practice*. OSAP Prevention Monograph. Rockville, MD: US Department of Health and Human Services.

Stroul, B. A. & Friedman, R. M. (1994). *A system of care for children and youth with severe emotional disturbances*. (Revised edition). Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Substance Abuse Mental Health Administration (2012) *A Behavioral Health Lens for Prevention ... Overlapping Problems, Collaborative, Solutions*. Retrieved (5/2012) from: captus.samhsa.gov/.../prevention-and-behavioral-health/behavioral-health-lens- prevention/2 - 41k - 2012-06.

Substance Abuse and Mental Health Services Administration. (2012). *Top health issues for LGBT populations & resource kit*. HHS Publication No. (SMA) 12-4684. Rockville, MD:

Substance Abuse Mental Health Services Administration (2011), *Leading the Change; A Plan for SAMHSA's Roles and Actions 2011-2014 Executive Summary and Introduction*. HHS Publication No. (SMA) 11-4629 Summary. Rockville, MD.

Tharp-Taylor, S., Haviland, A., and D'Amico, E. (2009) Victimization from Mental and Physical Bullying and Substance Use in Early Adolescence. *Addiction Behavior*, 34(6–7): 561–567. Retrieved (5/2010) from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2707251/pdf/nihms120665.pdf>

The National Association for Addiction Professionals Code of Ethics. Retrieved (4/2012) from: www.naadac.org/resource/codeofethics.

Wagner, E. and Macgown, M. (2006). School-based group treatment for adolescent substance abuse. In, Liddle, H. and Rowe, C. (Eds.), *Adolescent Substance Abuse*, (p. 333–356). Cambridge, NY: Cambridge University Press.

Weber, R.C. (n.d.). *The group: A cycle from birth to death*. Retrieved from www.asamra.ary.mil/eo/eo_docs/The%20Group.htm

Winters, K. C. (1999). Screening and assessing adolescents for substance use disorder: Treatment improvement protocol (TIP) Series 31 (DHHS publication No. (SMA) 99-3282). Washington, DC: US Department of Health and Human Services. Retrieved from <http://ncadi.samhsa.gov/govpubs/BKD306/>


United States Department of Education. (n.d). Putting the pieces together: Comprehensive school linked strategies for children and families. Retrieved from <http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/ppt/putting.htm>

University of Washington (1997). The basics of social marketing: How to use marketing to change behavior. University of Washington. Seattle, WA. Available at www.turningpoint.org

Vogt, P.W. (1993). *Dictionary of statistics and methodology: A nontechnical guide for the social sciences*. Sage Publications: Newbury Park, CA.

Zimmerman, R. (1993). *The CARE team model: How to get everyone involved in your student assistance program for secondary schools*. Johnson Institute. Minneapolis, MN.

Appendix B



Prevention
Redesign
Initiative

Healthy Children,
Families,
and Communities.

Washington State Department of Social and Health Services ■ Division of Behavioral Health and Recovery



Substance abuse prevention programs help kids succeed in school.

FACT:

There were **5,765** deaths in Washington State in 2009 caused by, or related to, **alcohol** or **drug** abuse.

SOURCE: 2011 Risk and Protection Profile for Substance Abuse Prevention for Washington State; www.dshs.wa.gov/rda/research/risk.htm

We all want to live in a healthy community.

When people misuse alcohol and other drugs, it also harms their families and communities. In our communities we see the impacts in higher rates of:

- Child abuse and neglect
- Crime
- Families who need public assistance
- DUI related injuries and deaths
- Unemployment

Alcohol and other drug use often harms children the most.

Children and teens are at high risk for developing short and long-term physical and emotional problems because their brains are still developing. These children are more likely to:

- commit crimes
- develop addiction
- drop out of school
- engage in unplanned and risky sex
- be seriously injured or killed

Children are also harmed by substance abuse in their families. The 2007 National Survey on Drug Use and Health found that 12 percent of children in the U.S. (8.3 million) live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. Substance abuse and addiction are the primary causes of at least 70 percent of all child welfare spending (National Center on Addiction and Substance Abuse).

2007 National Survey on Drug Use and Health

<http://oas.samhsa.gov/2k9/5Aparents/5Aparents.cfm>

National Center on Addiction and Substance Abuse

<http://www.casacolumbia.org/articdefiles/379-No%20Safe%20Haven.pdf>>No Safe Haven

Big Brothers Big Sisters mentoring is a proven program to help youth make healthy choices.



What is the Prevention Redesign Initiative (PRI)?

The Washington State Division of Behavioral Health and Recovery (DBHR) began implementing PRI in 2011 by redirecting state funding to better target and leverage limited prevention resources. PRI is being implemented through active partnerships with counties, Educational Service Districts (ESDs), local school districts, and the Office of the Superintendent of Public Instruction.

A coordinated funding approach will help provide long-term support for positive community change. Communities considered for PRI face complex challenges, such as higher than average rates of academic failure, economic deprivation and substance abuse. The selected communities also have a strong desire to improve the health of their youth, families and community.

Funding for PRI comes from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). PRI supports SAMHSA's initiative to create communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse and suicide.

Does Prevention Work?

Investing in prevention reduces substance abuse and the harm it causes to individuals, families and communities. DBHR funds evidence-based programs that reduce risk factors for substance abuse (such as early first use of drugs) and increases protective factors (such as bonding to community, family and healthy peers).

Since the 1980's, DBHR has invested in school and community based prevention and intervention programs for youth. Our biggest drug problem, underage drinking, is declining. From 2008 to 2010, there were 11,000 fewer youth in Washington who drank alcohol. Since 1990, the number of 8th graders who drink has been reduced by half (2010 WA Healthy Youth Survey).

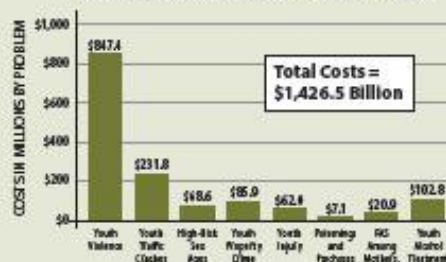
While these results are very promising, there is more work to be done. The 2010 Healthy Youth Survey found that among 10th graders:

- 28% had a drink in the past 30 days
- 16 % had 5 or more drinks in a row in the past two weeks
- 20% had used marijuana
- 13% had used cigarettes



Prevention programs help to increase family bonding, which reduces the risk that a child will misuse alcohol or other drugs.

Underage drinking cost the residents of Washington more than \$1.4 billion in 2007.



SOURCE: Pacific Institute for Research and Evaluation. Underage Drinking in Washington - The Facts. Bellevue, WA November 2009.





**FACT:
EVIDENCE-BASED
PREVENTION PRACTICES
SAVE MONEY**

For every dollar spent on Life Skills Training during 2010, \$360 per student was saved by preventing juvenile crime. During the 2009-2011 biennium, 7,495 youth in 13 Washington counties participated in Life Skills Training funded by DBHR. This is an estimated savings of \$2.7 million.

SOURCE: Washington State
Institute for Public Policy;
www.wslipp.wa.gov/wpfiles/11-07-1201.pdf

How will PRI help my community?

PRI communities will receive funding for training and technical assistance to do capacity building, assessment, planning, implementation and evaluation. This support is intended to help communities build on their past successes and to better measure impacts.

PRI is focusing on reducing underage drinking in the 8th and 10th grades. By reducing underage drinking, we also expect to reduce youth delinquency and mental health problems, and improve school performance.

When communities can show positive outcomes, it will build support for expanding prevention investments to more high need communities.

How are communities chosen for PRI funding?

County governments and educational service districts (ESDs) will identify at least 50 communities in Washington over the next three years to receive PRI services.

The first group of 19 PRI communities began prevention services in July 2011. The second and third group of communities will begin services in July of 2012 and 2013.

To be chosen for PRI, a community must be able to:

- Establish a coalition with people who represent at least eight community sectors.
- Employ at least one full-time prevention/intervention specialist in the selected school(s).
- Have at least one half-time community coordinator
- Show readiness to benefit from prevention programs
- Have trained volunteers and paid staff
- Implement evidence-based strategies: environmental, direct service, capacity building and public awareness
- Leverage resources to match intended outcomes in a performance-based contract
- Participate in integrating substance abuse prevention, mental health promotion, and primary care.
- Evaluate program and community-level change.



Who do I contact for more information?

Email Steve.Smothers@dshs.wa.gov or call (360) 725-3767.

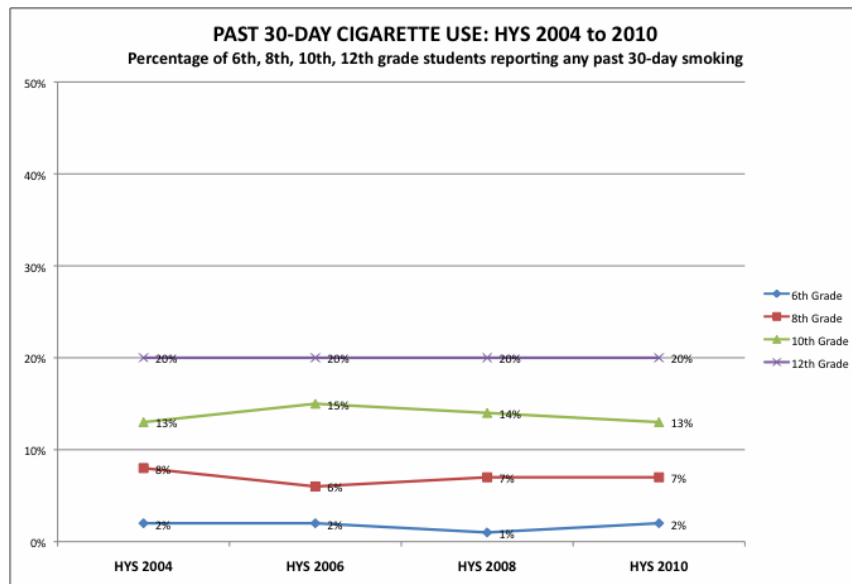


Appendix C

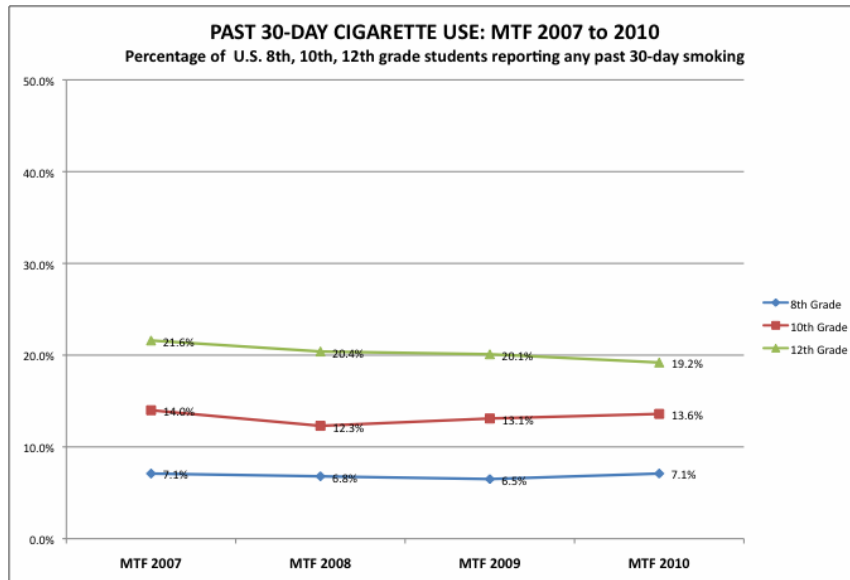
Youth Substance Use Trends

The following information provides a snapshot of national and statewide trends in adolescent substance use from 2004 to 2010, as applicable. Substance use trends in Washington State mirror national trends. The breakdown of substance use trends by ethnicity illustrate there is variance among populations. These national and state trends may be seen at the local level, however SAPs often see changes in substances of abuse before they appear on national and state trend lines because of the delay in reporting and publishing findings. For example, verbal reports of an increase in prescription drug use was first reported by SAPs across the state, and more recently, the movement of those individuals from prescription drugs to heroin use.

Past 30-Day Cigarette Use

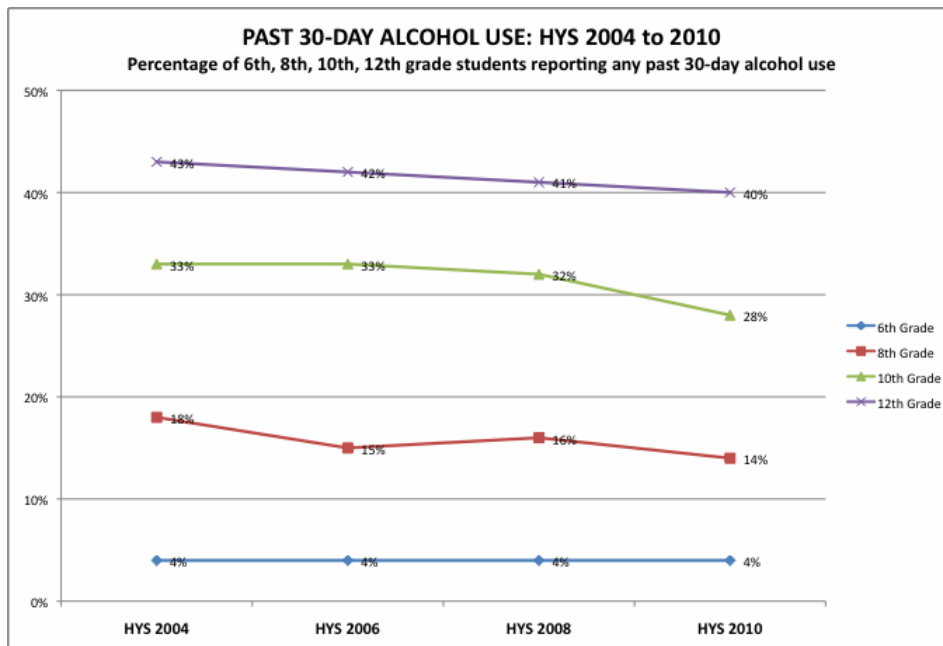


From 2004 to 2010 in Washington State, smoking rates have remained mostly unchanged across grade groups. As is typical, as students age use rates increase with an average of 2 percent of 6th graders reporting current cigarette use in 2010 as compared to 20 percent of 12th grade participants.

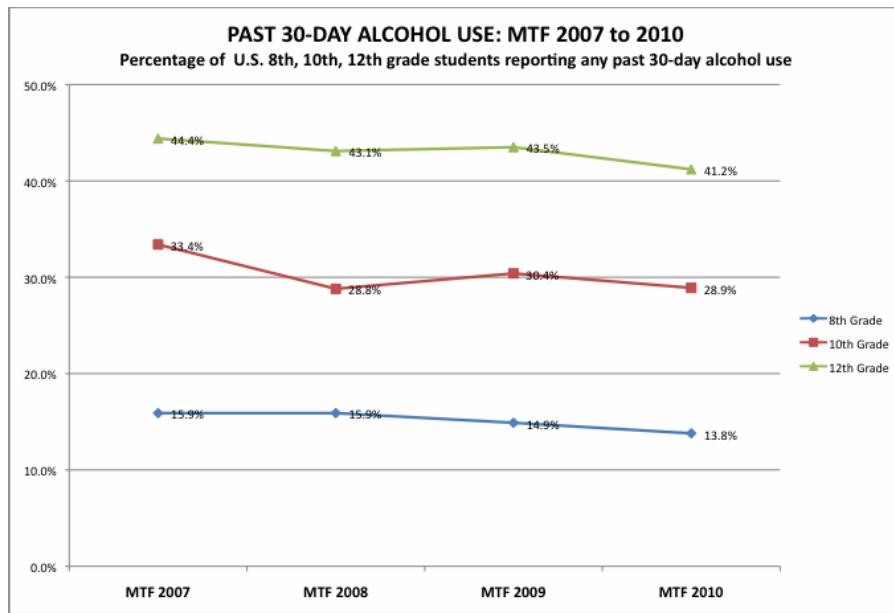


Nationally, current use of cigarettes also indicates that rates of cigarette smoking appear to have stalled across the three grade levels – this is in contrast to several years of declining use both nationally and locally.

Past 30-Day Alcohol Use

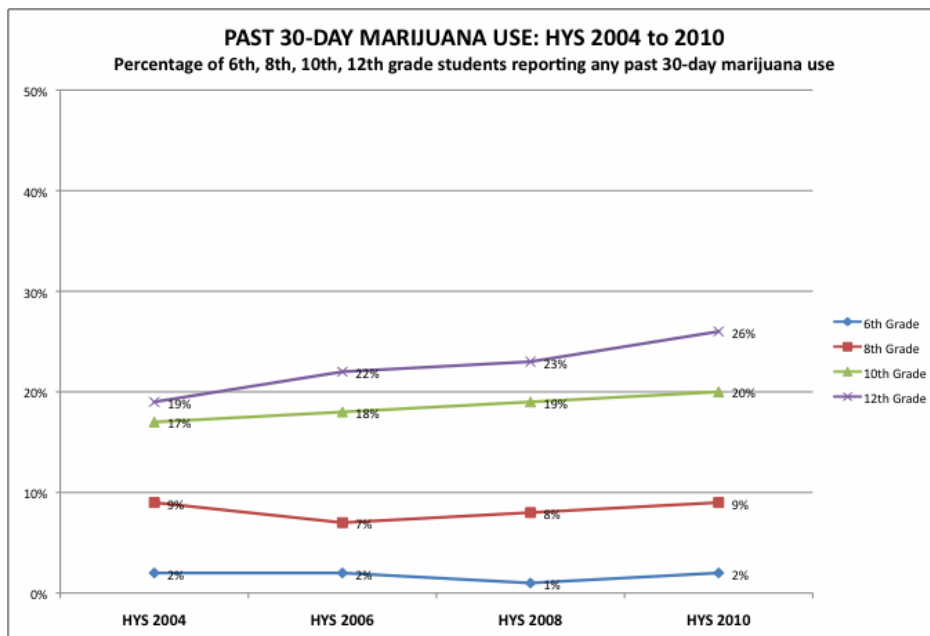


Alcohol use shows a steady decline across three of the four grade groups among Washington State youth. In fact, for high school seniors past 30-day use fell from 43 percent in 2004 to 40 percent in 2010. This positive trend of reduced use is even more notable among 10th grade participants, with use rates declining from 33 percent in 2004 to 28 percent in 2010 – a statistically significant reduction. Alcohol use among the state’s youngest participants has remained steady across the survey periods.



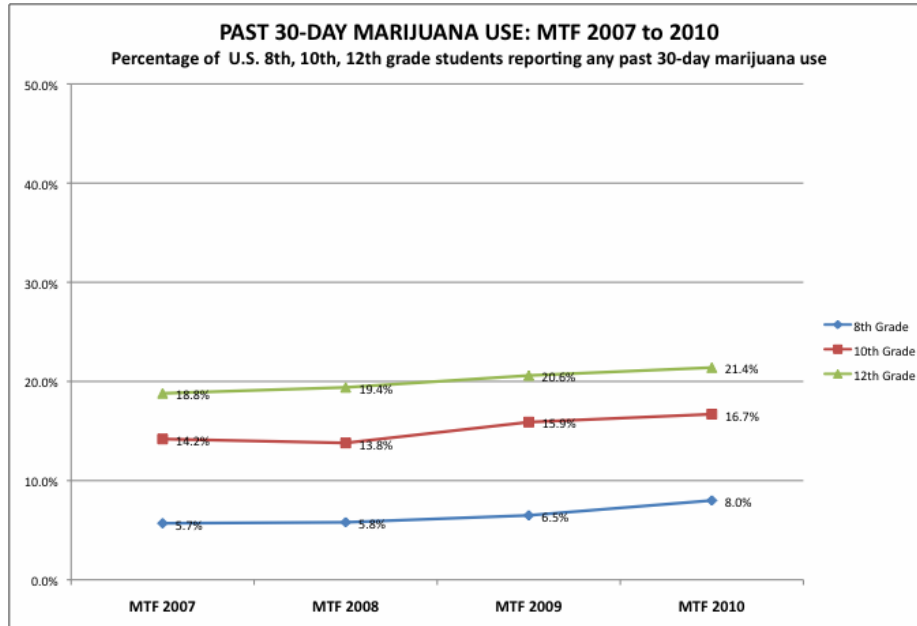
Similarly, declines in current alcohol use rates are demonstrated among youth nationwide, with past-month use falling from 44.4 percent in 2007 to 41.2 percent in 2010 among high school seniors – a statistically significant reduction. Additionally, use fell for 10th grade youth, with 31.4 percent report recent use in 2007 as compared to 28.9 percent in 2010.

Past 30-Day Marijuana Use



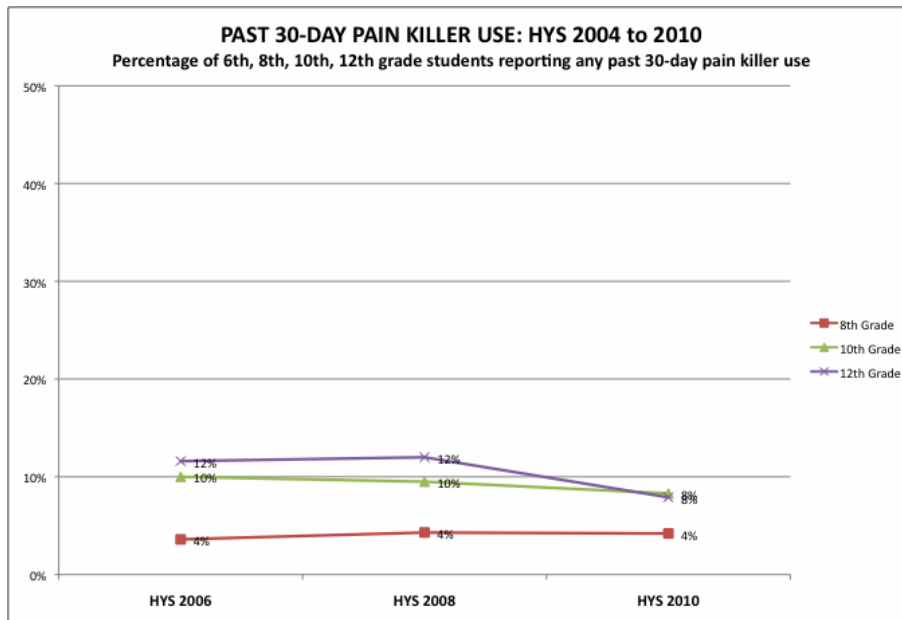
Marijuana use has exceeded rates of cigarette smoking and unlike declines in alcohol use, rates of recent marijuana use have steadily increased across the four survey periods among 10th and 12th graders. The largest increase in use is noted for 12th grade participants, with 19 percent

reporting current use in 2004 as compared to 26 percent in 2010. Rates of marijuana use for middle school-aged participants have remained mostly stable.



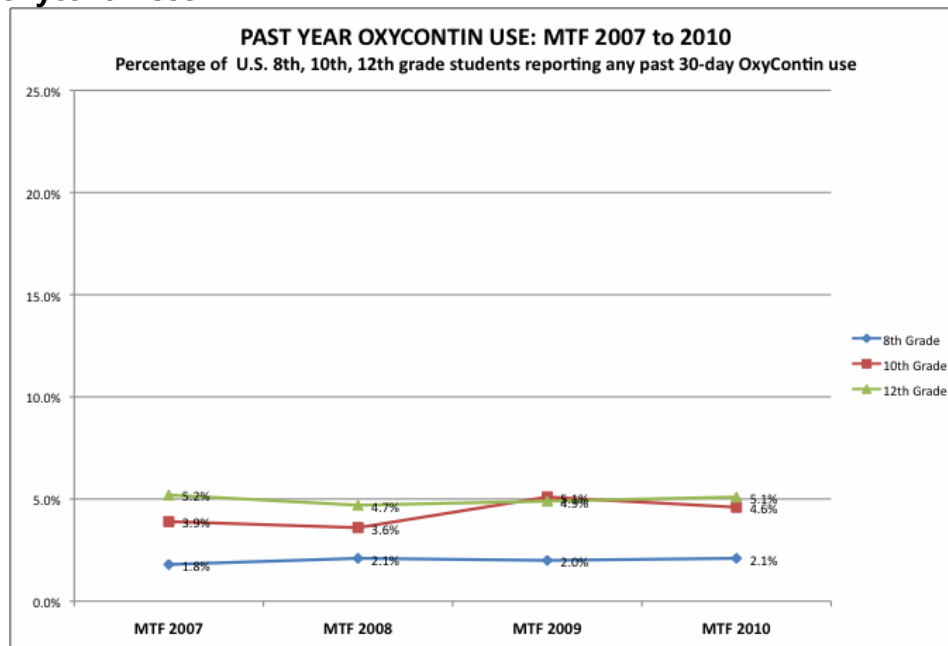
Across the nation, here too, we see a trend of increased use, with this true across all grade levels. From 2007 to 2010, 8th grade rates increased from 5.7 percent to 8.0 percent, while among the nation's 12th graders rates climbed from 18.8 percent to 21.4 percent. Nationally and locally, increased marijuana use parallels the softening of attitudes toward the risks of using.

Past 30-Day Pain Killer Use



A main concern in the past few years has been the increased use of prescription painkillers. In 2008, one in ten or more Washington State high school-aged youth used prescription pain relievers to “get high” in the past 30 days. However, the proportion that reported such use decreased at both grade levels to 8 percent in 2010 suggesting that efforts to raise parental and provider awareness of this type of drug abuse are working.

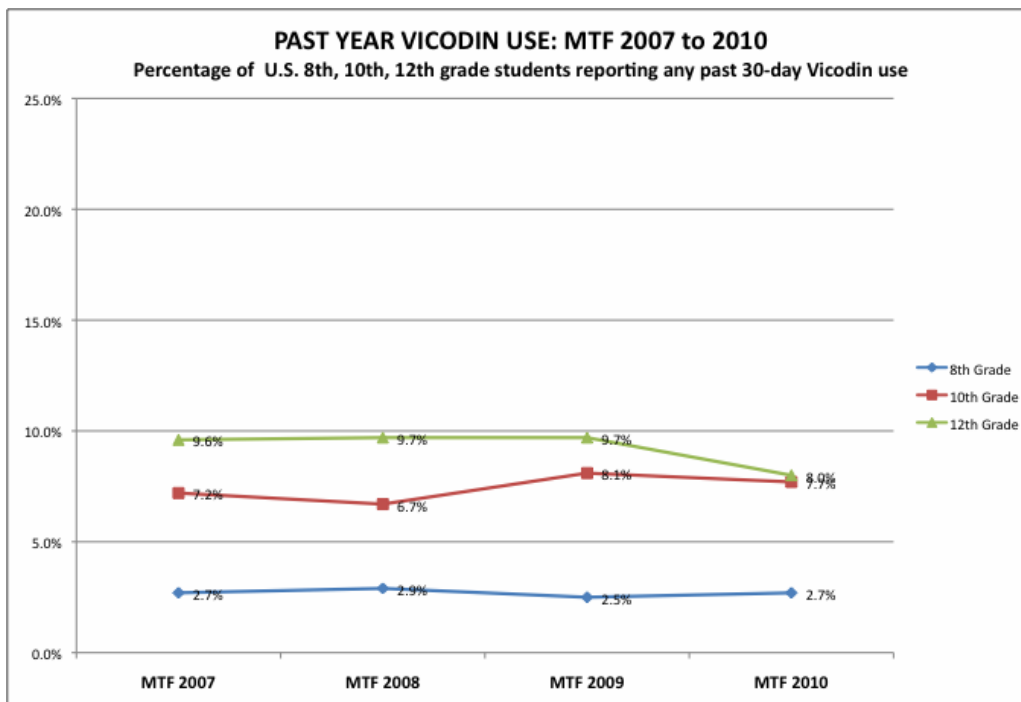
Past Year Oxycontin Use



Nationally, the percentage of youth that reported any past year Oxycontin use has remained relatively stable among 12th graders, with 5.2 percent reporting use in 2007 and 5.3 percent

using in 2010. In contrast, use rates increased among 10th grade participants with 3.6 percent using in 2008 as compared to 4.6 percent in 2010.

Past Year Vicodin Use



Use of the prescription drug Vicodin also shows declining use rates among high school-aged youth in the U.S., with fewer 10th and 12th graders reporting any past month youth in 2010 as compared to 2009. Among 8th grade participants, use levels remained mostly stable.

Substance Abuse Trends by Race/Ethnicity¹⁰¹

The following tables provide trend data on the rates of substance use by racial/ethnic categories of 6th, 8th, 10th, and 12th grade 2006, 2008, and 2010 Healthy Youth Survey respondents.

Table 1: Past 30-Day Alcohol Use: 6th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	3.4%	6.9%	4.6%	6.8%	3.4%	4.6%
HYS 2008	2.2%	4.5%	5.2%	6.2%	2.7%	3.7%
HYS 2010	2.6%	4.2%	4.7%	6.6%	2.8%	3.9%

¹⁰¹ Source: www.AskHYS.net QXQ analysis

Table 2: Past 30-Day Tobacco Use (Smoking): 6th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	2.5%	3.0%	1.8%	2.4%	1.5%	1.9%
HYS 2008	1.1%	2.8%	2.5%	1.7%	1.2%	1.5%
HYS 2010	1.1%	3.6%	1.2%	2.9%	1.3%	1.7%

Table 3: Past 30-Day Marijuana Use: 6th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	1.4%	3.7%	2.3%	2.1%	1.1%	1.5%
HYS 2008	0.7%	2.2%	2.8%	2.4%	0.9%	1.0%
HYS 2010	0.8%	2.2%	3.1%	3.4%	1.1%	1.4%

Table 4: Past 30-Day Alcohol Use: 8th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	10.8%	18.6%	17.7%	22.5%	14.5%	16.2%
HYS 2008	12.9%	19.9%	16.3%	22.3%	15.0%	17.7%
HYS 2010	9.5%	17.7%	15.4%	21.2%	13.1%	15.3%

Table 5: Past 30-Day Tobacco Use (Smoking): 8th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	4.0%	9.0%	9.7%	8.6%	5.6%	7.8%
HYS 2008	5.7%	14.7%	9.5%	7.5%	6.6%	8.9%
HYS 2010	3.8%	11.6%	7.6%	6.9%	6.5%	7.4%

Table 6: Past 30-Day Marijuana Use: 8th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	3.4%	9.7%	14.8%	10.1%	6.1%	8.1%
HYS 2008	6.2%	16.2%	14.6%	10.9%	7.1%	9.2%
HYS 2010	5.5%	16.1%	11.9%	14.0%	8.2%	10.1%

Table 7: Past 30-Day Painkiller Use: 8th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	2.0%	4.3%	5.8%	3.5%	3.3%	4.8%
HYS 2008	3.3%	8.7%	5.6%	3.4%	4.0%	5.3%
HYS 2010	2.9%	4.9%	5.3%	6.2%	3.4%	5.9%

Table 8: Past 30-Day Alcohol Use: 10th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	23.9%	36.8%	34.1%	37.7%	32.6%	35.1%
HYS 2008	23.0%	42.4%	31.2%	36.4%	31.3%	32.0%
HYS 2010	18.5%	33.6%	33.9%	32.2%	26.6%	30.6%

Table 9: Past 30-Day Tobacco Use (Smoking): 10th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	9.3%	23.1%	15.6%	12.7%	14.8%	18.8%
HYS 2008	14.7%	26.8%	21.1%	14.2%	20.8%	23.4%
HYS 2010	6.1%	20.7%	17.6%	12.5%	12.3%	16.4%

Table 10: Past 30-Day Marijuana Use: 10th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	11.1%	28.4%	24.4%	22.3%	17.4%	20.6%
HYS 2008	11.8%	25.1%	29.1%	18.9%	18.3%	22.3%
HYS 2010	10.4%	26.4%	30.4%	23.0%	19.1%	23.5%

Table 11: Past 30-Day Painkiller Use: 10th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	6.1%	14.1%	10.7%	9.7%	10.3%	10.9%
HYS 2008	5.8%	11.1%	17.9%	6.5%	9.3%	12.2%
HYS 2010	3.8%	12.1%	13.5%	10.4%	7.4%	11.0%

Table 12: Past 30-Day Alcohol Use: 12th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	32.1%	43.0%	36.7%	40.4%	44.0%	41.2%
HYS 2008	31.3%	42.3%	36.5%	40.4%	41.9%	42.6%
HYS 2010	30.6%	40.4%	43.5%	39.3%	41.6%	38.8%

Table 13: Past 30-Day Tobacco Use (Smoking): 12th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	13.2%	30.1%	19.9%	14.3%	21.0%	21.5%
HYS 2008	8.6%	27.2%	15.5%	12.5%	14.5%	15.6%
HYS 2010	13.4%	27.3%	21.4%	14.4%	21.2%	19.7%

Table 14: Past 30-Day Marijuana Use: 12th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	15.3%	29.5%	27.1%	17.8%	22.0%	23.6%
HYS 2008	17.6%	30.6%	29.5%	18.6%	23.3%	28.9%
HYS 2010	18.7%	32.3%	39.4%	22.5%	27.4%	26.0%

Table 15: Past 30-Day Painkiller Use: 12th Grade

	Asian/Pacific Islander	American Indian/ Alaska Native	Black or African American	Hispanic or Latino/a	White or Caucasian	Multiple or Other
HYS 2006	6.1%	16.3%	12.7%	6.2%	13.0%	11.2%
HYS 2008	10.3%	21.3%	12.1%	7.9%	12.1%	13.8%
HYS 2010	6.0%	13.5%	12.6%	7.7%	8.1%	6.6%

Things to remember when intervening with prescription drug use:

1. Prescription drugs are abused more than cocaine, heroin, ecstasy and methamphetamine combine.
2. Although not as prevalent as some substances, prescription drug use is often seen as less harmful than other substances.
3. The dangers of abusing prescription drugs is severe, including: increase blood pressure or heart rate, damage to the brain, physical dependence, respiratory depression, seizures, and risks associated with mixing multiple drugs or combining with alcohol.
4. Teens see prescription drug use as safer than using other drug use and see parents as less likely to disapprove.
5. Prescription medicines can be found in homes and many parents are aware of the dangers of misuse.

Teen Prescription Drugs of Choice for Abuse

	How they work	Abused by teens to ...	Drug names
Strong Pain Relievers	Used to relieve moderate-to-severe pain, these medications block pain signals to the brain	Get high, increase feelings of well-being by affecting the brain regions that mediate pleasure	Vicodin, OxyContin, Percocet, Lorcet, Lortab, Actiq, Darvon, codeine, morphine, methadone
Stimulants	Primarily used to treat ADHD type symptoms, these speed up brain activity causing increased alertness, attention, and energy that comes with elevated blood pressure, increased heart rate and breathing	Feel alert, focused and full of energy—perhaps around final exams or to manage coursework, lose weight	Adderall, Dexedrine Ritalin, Concerta
Sedatives or Tranquilizers	Used to slow down or “depress” the functions of the brain and central nervous system	Feel calm, reduce stress, sleep	Valium, Xanax, Ativan, Klonopin, Restoril, Ambien, Lunesta, Mebaral, Nembutal, Soma

Ideas for Action:

- Give a workshop to teens and parents
- Enlist the school prevention or SADD club to take on as an initiative.
- Share information with your local community coalition and encourage activities such as a prescription take back program, distribution of lock boxes, and/or a town hall meeting to inform the community of the problem.

Further resources:

- U.S. Trend Data: www.usdrugtrends.com.
- University of Washington Alcohol and Drug Abuse Institute: www.adai.washington.edu.
Narcotics Anonymous: www.narconon.org.

Source:

Washington State Department of Health, Healthy Youth Survey Reports available at <http://www.doh.wa.gov/healthyyouth/default.htm>

U.S. Department of Health & Human Services. National Institute on Drug Abuse. *NIDA Info Facts* (March 2011). "High School and Youth Trends." Available at <http://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends>

Twombly EC, Holtz KD. (2008) "Teens and the Misuse of Prescription Drugs: Evidence-Based Recommendations to Curb a Growing Societal Problem." *Journal of Primary Prevention*, 29(6), 503–516.