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Introduction
PROGRAM MANUAL OVERVIEW

This publication is as a guide for Washington State Student Assistance Prevention-Intervention Services Program Coordinators/Supervisors who plan to, or have, implemented a comprehensive, research-based program to address the problems of youth impacted by substance use/abuse and have experienced barriers to learning. The Introduction Section discusses the framework for the theoretical underpinnings of school-based prevention and intervention models; outlines effective program approaches; describes the Washington State’s Prevention-Intervention Service Program 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, and includes a 10th component—Sustainability, which is critically important in the State of Washington.

BACKGROUND AND SIGNIFICANCE

Substance use continues to be a significant problem among young people, here as elsewhere. Recent survey data indicate the prevalence of substance use among students in Washington State. Among 2004 Healthy Youth Survey (HYS) participants, alcohol was reported as the drug of choice among students statewide, followed by marijuana and cigarettes (Einspruch, 2005). Of those student participants, 73 percent of 12th graders, 60 percent of 10th graders, 42 percent of 8th graders, and 30 percent of 6th grade students had tried alcohol at some time in their lives. Reported lifetime use of marijuana included 41 percent of 12th graders, 30 percent of 10th graders, 14 percent of 8th graders, and 3 percent of 6th grade youth (Einspruch, 2005).

Of greater concern, 43 percent of those high school seniors, 33 percent of 10th graders, and 18 percent of 8th grade respondents reported having used alcohol in the past 30 days. Recent (past 30 day) marijuana use was reported by 20 percent of 12th grade participants, 17 percent of 10th graders, 9 percent of 8th graders, and 2 percent of younger students. Students also reported engagement in other health risk behaviors (e.g., bullying, violence- and suicide-related behaviors). Such findings underscore the need for student assistance services that support students to make positive decisions regarding alcohol, tobacco, and other drug use (Einspruch, 2005).

On the national level, recent studies link drug and alcohol use to negative impacts on a student’s school performance (NCADI, 2005). The 2002 National Survey on Drug Use and Health reported that adolescents who received grades of D or below were more likely than their peers with higher grades to have used cigarettes, alcohol, or other drugs. The percentages of students who reported past 30-day substance abuse in the study were as follows:

- 6 percent of students with an A average
- 13 percent of students with a B average
- 20 percent of students with a C average
- 36 percent of students with a D average

These issues are disconcerting given the evidence that suggests 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; Skiba & Peterson, 1999).
Washington State’s School-based Student Assistance Prevention-Intervention Services Programs (SAPISP) are 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 problem behaviors such as delinquency, violence, and mental health problems (Adelman & Taylor, 2002; Carlson, 201; Moore & Forster, 1993; Klitzner, Fisher, Stewart, & Gilbert, 1992).

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; Moore & Forster, 1993; Klitzner, Fisher, Stewart, & Gilbert, 1992; Steinberg, 1991). 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):

1. The intensity of the intervention must be commensurate with the severity or intensity of the problem behavior.
2. 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 student assistance prevention and intervention services 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 socio-emotional health-related services at schools facilitates access by students and families with this especially true for underserved and difficult-to-reach populations. Noam and 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, social, emotional, and behavioral needs have the potential to be addressed together (Adelman & Taylor, 1997, 2002). Such delivery systems promise to be more useful and efficient as well as more cost effective.

EFFECTIVE PROGRAM CHARACTERISTICS

The optimal model for health-related services to adolescents is a coordinated response to multiple concerns and service needs (Stroul & Friedman, 1994). Current knowledge of school-based prevention and intervention services support the conclusion that there are high needs for such services, and services would be most effective if comprehensive, integrated and multifaceted and coordinated with other school and community resources (Adelman & Taylor, 1997, 2002). 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).
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 and 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).

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.

**CONTINUUM OF SERVICES**

Program approaches must adopt multi-level services because issues related to student learning and the reasons that place students at risk are complex and multifaceted. Services must be coordinated in a manner to ensure students receive timely assistance and, as stated earlier, services are appropriate to students’ level of need and development. 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; 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 three levels of dosage or strengths of prevention and intervention services are provided:
   a) Universal–strategies 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.

b) Selective – more intensive interventions strategies 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, students who are experimenting or misusing alcohol, tobacco and other drugs (ATOD), drop outs or students 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 (Quinn et al., 1998).

c) Indicated–strategies are 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. Research has found that generally between 1–7 percent of students require this level of intensive services (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.

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 illustrates that “school-based interventions that change the social context of schools and the school experiences of children can reduce and prevent the delinquent behavior in children younger than 13” (Burns, Howell, Wiig, Augimeri, Welsh, & Petechuk, 2003, p. 6). 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).
- 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 delinquent behaviors later in life. Additionally, students who perform poorly in school are significantly more likely to become involved in delinquency. At the elementary level, prevention and intervention focus on students with conduct disorders 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 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).

**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 behaviors 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, bully 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 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 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, violence, aggression, and delinquency. In doing so, these programs significantly increase the likelihood of success in school, decrease the likelihood of school drop out, 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 Student Assistance Team (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 Student Assistance Specialists, provide classroom-based curriculum that promote development of social and emotional competencies, and norms against violence, aggression, and harassment, intimidation, and bullying. In addition, Student Assistance Specialists 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; family problems; association with inappropriate peers; parental or other significant adult use; students in transition (new to school, divorce in family); and eating disorders.

**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 work. At a minimum, program strategies should focus on reinforcing and sustaining prevention and intervention lessons learned during the early school years and providing “crisis” intervention services to students at highest risk (Dusenbury & Hansen, 2004; Gottfredson, 2001; Sherman, Gottfredson, MacKenzie, Eck, et al., n.d; Quinn et al., 1998). Prevention and intervention approaches include:

- Programs and policies that reinforce norms about behaviors learned at the lower school levels (Universal).
- One-on-one academic, vocational/career, and other counseling interventions (Selective/Indicated).
- Behavior modification programs and groups that teach “thinking skills” to high-risk 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 drop 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 post-secondary transition; general academic guidance; and assistance and referrals for substance abuse to school and community-based programs. Students identified with substance use issues or those disciplined due to violation of the district’s no 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; family problems; association with inappropriate peers; parental or other significant adult use; students in transition (new to school, divorce in family); and eating disorders.

**BARRIERS TO EFFECTIVE PROGRAMMING**

Not surprisingly, there are identified characteristics common among ineffective student support programs (Gottfredson & Gottfredson, 2000; NIJ, 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”—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 (NIJ, 2004; Quinn et al., 1998).
SUMMARY

The literature on comprehensive student assistance prevention and intervention programs clearly delineates the components necessary for effective program practices to reduce barriers to student learning while providing a safe, drug-free, learning environment. Successful programs are comprehensive, multifaceted, and cohesive, attend to the developmental stages of students, and ideally services are provided across the continuum of school grades (K–12).

WASHINGTON STATE’S MODEL

Washington State's comprehensive Student Assistance Prevention-Intervention Services Program (SAPISP) model is based upon findings that support a multi-level approach to prevention and intervention services to address substance use and other student problem behaviors and reduce student barriers to learning. As previously noted, this method has been demonstrated as a highly effective practice to address school wide 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 State's model, the majority of programs focus on providing services to students at the secondary grade levels (6th–12th); 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 and related problems. In Washington, more than two-thirds of middle and high schools participate in the state’s Student Assistance Prevention-Intervention Services Program, which serves over 20,000 students each year (Deck, 2004).

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 Student Assistance Prevention-Intervention Services Program

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1The following information is adapted in part from: Deck, D. (2002). Washington’s prevention and intervention services program: Highlights from the 2001–2002 statewide evaluation. Office of Superintendent of Public Instruction, Olympia, WA.
operated by the Office of Superintendent of Public Instruction (OSPI), places Student Assistance Specialists in schools to implement comprehensive student assistance programs that address problems associated with substance use 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 drug and alcohol prevention and intervention services to students.
2. Provide high quality prevention and intervention programs to maintain a safe and supportive learning environment for all students.
3. Develop collaborative relationships with treatment agencies to better serve students.

Where are the local programs? Annually, nearly $5 million are distributed 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 are based on a formula that accounts for both the school enrollment and the estimated need for services of each region.

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.

Universal prevention activities typically target intact classrooms or the entire school. Examples include assistance to classroom teachers in the use of age-appropriate prevention curricula, supervision of peer leadership or pledge programs, and promotion of drug-free after-school activities.

Intervention and support services activities involve the identification of students who are: (a) at risk of initiating substance use or antisocial behavior, (b) coping with the substance use of significant others, (c) using tobacco, alcohol, or other drugs, or (d) developing a dependence on drugs. 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. When the severity of use requires services that cannot be provided in the school setting, students are referred to community services such as chemical dependency treatment.

The statewide Student Assistance Prevention-Intervention Services Program (SAPISP) is designed to reduce student risk factors, promote protective factors, and increase asset development (Deck, 2002). Five organizational factors present in successful SAPISP programs include:

- **Formal Student Identification Process**—schools have a designated team or staff person assigned to screen student’s problem behavior risks, develop intervention plans, and provide case management.
- **Staff Training and Identification**—All school staff receive formal in-service training on signs and symptoms of ATOD use as well as the referral process.
- **Staff Involvement in Identification**—All staff—classified and certified—are involved in the identification of students at-risk.
• **Training for Student Assistant Prevention-Intervention Services Program Staff**—extensive and on-going professional development opportunities are provided addressing community and school-based resources, issues related to substance abuse and other problem behaviors, effective intervention techniques such as motivational interviewing and case management strategies.

• **Formal Assessment and Referrals for Identified Students**—referral for AOD 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

**What are the outcomes of the statewide project?** 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 conducted by RMC Research (Deck & D’Ambrosio, 2001) suggest that the program has resulted in positive outcomes in each of these areas as assessed by a self-report instrument administered before and after participation in program services.

**Skills and attitudes.** Students reported that social skills and attitudes that help them resist drug use and other inappropriate behavior were strengthened while participating in the Prevention-Intervention Services Program. Students with an intervention goal of strengthening protective factors reported significantly higher scores on nine scales such as self-esteem, self-control, assertiveness, cooperation, and bonding with school. Students emphasized that bonding with intervention specialists was a key factor in re-establishing a connection with their school (Deck, 2002).

**Antisocial behavior.** Students with an intervention goal of reducing antisocial behavior indicated significant reductions in six different behaviors including truancy and fighting (Deck, 2002).

**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 five forms of substance use after the program such as associated with binge drinking and marijuana use (Deck, 2005).
- Significantly fewer students reported using tobacco, alcohol, and marijuana in the past 30 days after participation in the program. Students reported modest reductions of tobacco use but substantial reductions for other substances. For example, 28 percent fewer students reported marijuana use and 21 percent fewer students reported binge drinking in the past 30 days after participating (Deck, 2005).

**School success.** Both teacher ratings and school records provided evidence that participation in the Student Assistance Prevention-Intervention Services Program can be linked to improved school success:

- 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 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).

Additionally, research on the effectiveness of the SAPISP program revealed the success of the Student Assistance Prevention-Intervention Services Program as follows (Deck, 2002):
• The program is aligned with current reform efforts to improve academic achievement, establish and/or maintain safe and healthy environments, help students build positive social skills, increase coordination between program specialists and school staff and other school-based programs, and provide alternative learning opportunities for 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 ensure safer and healthier environments where students from diverse groups receive appropriate counseling, from early abuse to treatment.
• Student Assistance Specialists 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 behavior problems at home, better problem-solving skills, and improved relationships with friends.


LEGISLATIVE DIRECTIVE

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.

Student Assistance Prevention-Intervention Services Program, according to the legislation, shall be directed at assisting students in kindergarten through twelfth grade to overcome problems of drug and alcohol abuse, and to prevent abuse and addiction to such drug use.

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

Individual and family counseling, including preventive counseling; Assessment and referral for treatment;
   a) Referral to peer support groups.
   b) Aftercare.
   c) Development and supervision of student mentor programs.
   d) Staff training, including training in the identification of high-risk children and effective interaction with those children in the classroom.
   e) 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 (OSPI) 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.

The application procedures for grants under this section shall include provisions for comprehensive planning, establishment of a school and community substance abuse advisory committee, and documentation of the district’s needs assessment. Planning and application for grants under this section may be integrated with the development of other substance abuse awareness programs by school districts. 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 students in grades five through nine. Additionally, the legislation allows for the use of funds to provide services for students who are enrolled in approved private schools.

The legislation further states that school districts receiving grants under RCW 28A.170.090. shall be required to establish a means of accessing formal assessment services for determining treatment needs of students with drug and alcohol problems. Grant applications submitted by districts are required to identify the districts’ plan for meeting this requirement. Furthermore, school districts receiving grants are required to perform biennial evaluations of their drug and alcohol abuse prevention and intervention programs, and to report on the results of these evaluations to the Superintendent of Public Instruction.
ORGANIZATION OF THE MANUAL

The Washington State Student Assistance Prevention-Intervention Services Program manual provides guidance to program coordinators and program staff related to the implementation of a research-based, comprehensive, Student Assistance Prevention-Intervention Services Program (SAPISP). The remainder of the manual is organized into 11 sections including nine (9) aligned with the components of a comprehensive student assistance program in accord with the National Student Assistance Association. The manual contains the following sections:

- **Section I 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 Student Assistance Team:** provides information related to the forming of Student Assistance Teams and providing case management.
- **Section 7 Program Evaluation:** outlines the state’s program evaluation process and provides a general framework for quality improvement of student assistance services and outcomes.
- **Section 8 Educational Support Groups:** specifically addresses Washington State’s standards of the four educational support groups.
- **Section 9 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.
- **Section 10 Integration:** provides information related to how the SAPISP integrates with other school based programs to increase resilience, improve academic performance, and reduce student risk factors.
- **Section 11 Sustainability:** provides information regarding how to sustain program efforts.

To assist the Project Coordinator in implementing SAPISP services, each section, as applicable, includes suggested Program Operations linked to the role of the Coordinator and the Student Assistance Specialists, as well as additional resource information. A Glossary of Terms and a Reference section are at the end of the manual.
What Are Risk Factors And Protective Factors?

Studies over the past two decades have tried to determine the origins and pathways of drug abuse and addiction—how the problem starts and how it progresses. Many factors have been identified that help differentiate those more likely to abuse drugs from those less vulnerable to drug abuse. Factors associated with greater potential for drug abuse are called “risk” factors, while those associated with reduced potential for abuse are called “protective” factors. Please note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. Also, a risk factor for one person may not be for another.

As discussed in the Introduction, risk and protective factors can affect children in a developmental risk trajectory, or path. This path captures how risks become evident at different stages of a child’s life. For example, early risks, such as out-of-control aggressive behavior, may be seen in a very young child. If not addressed through positive parental actions, this behavior can lead to additional risks when the child enters school. Aggressive behavior in school can lead to rejection by peers, punishment by teachers, and academic failure. Again, if not addressed through preventive interventions, these risks can lead to the most immediate behaviors that put a child at risk for drug abuse, such as skipping school and associating with peers who abuse drugs. In focusing on the risk path research-based prevention programs can intervene early in a child’s development to strengthen protective factors and reduce risks long before problem behaviors develop.

The table below provides a framework for characterizing risk and protective factors in five domains, or settings. These domains can then serve as a focus for prevention. As the first two examples suggest, some risk and protective factors are mutually exclusive—the presence of one means the absence of the other. For example, in the Individual domain, early aggressive behavior, a risk factor, indicates the absence of impulse control, a key protective factor. Helping a young child learn to control impulsive behavior is a focus of some prevention programs.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Domain</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Aggressive Behavior</td>
<td>Individual</td>
<td>Impulse Control</td>
</tr>
<tr>
<td>Lack of Parental Supervision</td>
<td>Family</td>
<td>Parental Monitoring</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Peer</td>
<td>Academic Competence</td>
</tr>
<tr>
<td>Drug Availability</td>
<td>School</td>
<td>Antidrug Use Policies</td>
</tr>
<tr>
<td>Poverty</td>
<td>Community</td>
<td>Strong Neighborhood Attachment</td>
</tr>
</tbody>
</table>

Other risk and protective factors are independent of each other, as demonstrated in the table as examples in the peer, school, and community domains. For example, in the school domain, drugs may be available, even though the school has “antidrug policies.” An intervention may be to strengthen enforcement so that school policies create the intended school environment.

Risk factors for drug abuse represent challenges to an individual’s emotional, social, and academic development. These risk factors can produce different effects, depending on the individual’s personality traits, phase of development, and environment. For instance, many serious risks, such as early aggressive behavior and poor academic achievement, may indicate that a young child is on a negative developmental path headed toward problem behavior. Early intervention, however, can help reduce or reverse these risks and change that child’s developmental path.

For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. By adolescence, children’s attitudes and behaviors are well established and not easily changed.

Risk factors can influence drug abuse in several ways. They may be additive: The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors are particularly potent, yet may not influence drug abuse unless certain conditions prevail. Having a family history of substance abuse, for example, puts a child at risk for drug abuse. However, in an environment with no drug-abusing peers and strong anti-drug norms, that child is less likely to become a drug abuser. And the presence of many protective factors can lessen the impact of a few risk factors. For example, strong protection—such as parental support and involvement—can reduce the influence of strong risks, such as having substance-abusing peers. An important goal of prevention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors.

Gender may also determine how an individual responds to risk factors. Research on relationships within the family shows that adolescent girls respond positively to parental support and discipline, while adolescent boys sometimes respond negatively. Research on early risk behaviors in the school setting shows that aggressive behavior in boys and learning difficulties in girls are the primary causes of poor peer relationships. These poor relationships, in turn, can lead to social rejection, a negative school experience, and problem behaviors including drug abuse.

What are the early signs of risk that may predict later drug abuse?
Some signs of risk can be seen as early as infancy. Children’s personality traits or temperament can place them at increased risk for later drug abuse. Withdrawn and aggressive boys, for example, often exhibit problem behaviors in interactions with their families, peers, and others they encounter in social settings. If these behaviors continue, they will likely lead to other risks. These risks can include academic failure, early peer rejection, and later affiliation with deviant peers, often the most immediate risk for drug abuse in adolescence. Studies have shown that children with poor academic performance and inappropriate social behavior at ages 7 to 9 are more likely to be involved with substance abuse by age 14 or 15.

In the Family
Children’s earliest interactions occur within the family and can be positive or negative. For this reason, factors that affect early development in the family are probably the most crucial. Children are more likely to experience risk when there is:
• Lack of mutual attachment and nurturing by parents or caregivers.
• Ineffective parenting.
• A chaotic home environment.
• Lack of a significant relationship with a caring adult.
• A caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior.

These experiences, especially the abuse of drugs and other substances by parents and other caregivers, can impede bonding to the family and threaten feelings of security that children need for healthy development. On the other hand, families can serve a protective function when there is:
• A strong bond between children and their families.
• Parental involvement in a child’s life.
• Supportive parenting that meets financial, emotional, cognitive, and social needs
• Clear limits and consistent enforcement of discipline.
Finally, critical or sensitive periods in development may heighten the importance of risk or protective factors. For example, mutual attachment and bonding between parents and children usually occurs in infancy and early childhood. If it fails to occur during those developmental stages, it is unlikely that a strong positive attachment will develop later in the child’s life.

**Outside the Family**

Other risk factors relate to the quality of children’s relationships in settings outside the family, such as in their schools, with their peers, teachers, and in the community. Difficulties in these settings can be crucial to a child’s emotional, cognitive, and social development. Some of these risk factors are:

- Inappropriate classroom behavior, such as aggression and impulsivity.
- Academic failure.
- Poor social coping skills.
- Association with peers with problem behaviors, including drug abuse.
- Misperceptions of the extent and acceptability of drug-abusing behaviors in school, peer, and community environments.

Association with drug-abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behavior. Research has shown, however, that addressing such behavior in interventions can be challenging. For example, a recent study (Dishion et al., 2002) found that placing high-risk youth in a peer group intervention resulted in negative outcomes. Current research is exploring the role that adults and positive peers can play in helping to avoid such outcomes in future interventions. Other factors—such as drug availability, drug trafficking patterns, and beliefs that drug abuse is generally tolerated—are also risks that can influence young people to start to abuse drugs.

Family has an important role in providing protection for children when they are involved in activities outside the family. When children are outside the family setting, the most salient protective factors are:

- Age-appropriate parental monitoring of social behavior, including establishing curfews, ensuring adult supervision of activities outside the home, knowing the child’s friends, and enforcing household rules.
- Success in academics and involvement in extracurricular activities.
- Strong bonds with pro-social institutions, such as school and religious institutions.
- Acceptance of conventional norms against drug abuse.

**What are the highest risk periods for drug abuse among youth?**

Research has shown that the key risk periods for drug abuse occur during major transitions in children’s lives. These transitions include significant changes in physical development (for example, puberty) or social situations (such as moving or parents divorcing) when children experience heightened vulnerability for problem behaviors.

The first big transition for children is when they leave the security of the family and enter school. Later, when they advance from elementary school to middle or junior high school, they often experience new academic and social situations, such as learning to get along with a wider group of peers and having greater expectations for academic performance. It is at this stage—early adolescence—that children are likely to encounter drug abuse for the first time.

Then, when they enter high school, young people face additional social, psychological, and educational challenges. At the same time, they may be exposed to greater
availability of drugs, drug abusers, and social engagements involving drugs. These challenges can increase the risk that they will abuse alcohol, tobacco, and other drugs.

A particularly challenging situation in late adolescence is moving away from home for the first time without parental supervision, perhaps to attend college or other schooling. Substance abuse, particularly of alcohol, remains a major public health problem for college populations.

When young adults enter the workforce or marry, they again confront new challenges and stressors that may place them at risk for alcohol and other drug abuse in their adult environments. But these challenges can also be protective when they present opportunities for young people to grow and pursue future goals and interests. Research has shown that these new lifestyles can serve as protective factors as the new roles become more important than being involved with drugs.

Risks appear at every transition from early childhood through young adulthood; therefore, prevention planners need to consider their target audiences and implement programs that provide support appropriate for each developmental stage. They also need to consider how the protective factors involved in these transitions can be strengthened.

When and how does drug abuse start and progress?
Studies such as the National Survey on Drug Use and Health, formerly called the National Household Survey on Drug Abuse, reported by the Substance Abuse and Mental Health Services Administration, indicate that some children are already abusing drugs by age 12 or 13, which likely means that some may begin even earlier. Early abuse includes such drugs as tobacco, alcohol, inhalants, marijuana, and psychotherapeutic drugs. If drug abuse persists into later adolescence, abusers typically become more involved with marijuana and then advance to other illegal drugs, while continuing their abuse of tobacco and alcohol.

Studies have also shown that early initiation of drug abuse is associated with greater drug involvement, whether with the same or different drugs. Note, however, that both one-time and long-term surveys indicate that most youth do not progress to abusing other drugs. But among those who do progress, their drug abuse history can vary by neighborhood drug availability, demographic groups, and other characteristics of the abuser population. In general, the pattern of abuse is associated with levels of social disapproval, perceived risk, and the availability of drugs in the community.

Scientists have proposed several hypotheses as to why individuals first become involved with drugs and then escalate to abuse. One explanation is a biological cause, such as having a family history of drug or alcohol abuse, which may genetically predispose a person to drug abuse. Another explanation is that starting to abuse a drug may lead to affiliation with more drug-abusing peers which, in turn, exposes the individual to other drugs. Indeed, many factors may be involved.

Different patterns of drug initiation have been identified based on gender, race or ethnicity, and geographic location. For example, research has found that the circumstances in which young people are offered drugs can depend on gender. Boys generally receive more drug offers and at younger ages. Initial drug abuse can also be influenced by where drugs are offered, such as parks, streets, schools, homes, or parties. Additionally, drugs may be offered by different people including, for example, siblings, friends, or even parents.

While most youth do not progress beyond initial use, a small percentage rapidly escalate their substance abuse. Researchers have found that these youth are the most likely to have experienced a combination of high levels of risk factors with low levels of protective factors. These adolescents were characterized by high stress, low parental support, and low academic competence.

However, there are protective factors that can suppress the escalation to substance abuse.
These factors include self-control, which tends to inhibit problem behavior and often increases naturally as children mature during adolescence. In addition, protective family structure, individual personality, and environmental variables can reduce the impact of serious risks of drug abuse. Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.

### Risk and Protective Factor Framework

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Adolescent Problem Behaviors</th>
<th>Protective Factors</th>
<th>Social Development Model (SDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOMAINS</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNITY</strong></td>
<td></td>
<td></td>
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<tr>
<td>Availability of drugs</td>
<td>√</td>
<td></td>
<td>Opportunities for pro-social involvement in community</td>
</tr>
<tr>
<td>Community laws and norms favorable to drug use</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Transitions and mobility</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Low neighborhood attachment and community disorganization</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Extreme economic deprivation</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>FAMILY</strong></td>
<td></td>
<td></td>
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<tr>
<td>Family history of the problem behavior</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Family management problems</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Family conflict</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Favorable parental attitudes and involvement in problem behaviors</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<tr>
<td><strong>SCHOOL</strong></td>
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<tr>
<td>Academic failure</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Lack of commitment to school</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>INDIVIDUAL/PEER</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Early and persistent antisocial behavior</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Rebelliousness</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Friends who engage in the problem behavior</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Favorable attitudes toward the problem behavior (including low perceived risk of harm)</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Early initiation of the problem behavior</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Constitutional factors</td>
<td>√</td>
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</tbody>
</table>

SDM is a synthesis of three existing theories of criminology (control, social learning, and differential association). It incorporates the results of research on risk and protective factors for problem behavior. It is based on the assumption that children learn behaviors.
**Sources of Prevention Research**

The following graphic supports a public health model using a theoretical framework of risk reduction and protection enhancement. Developments in prevention and intervention science have shown that there are characteristics of individuals, their families, and their environment (i.e., community, neighborhood, school) that affect the likelihood of negative outcomes including substance abuse, delinquency, violence, and school dropout. Other characteristics serve to protect or provide a buffer to moderate the influence of the negative characteristics. These characteristics are identified as risk factors and protective factors (Hawkins, et al., 1994; Hawkins, Catalano, Miller, 1992).

**Sources of Prevention Research**

The following documents are excellent sources for information about promising approaches to and “best practices” in the prevention of the use of alcohol, tobacco, and other drugs. In addition, many sites on the Internet can direct you to databases, prevention organizations, and further research. Several such sites are the following:

- [www.westcapt.org](http://www.westcapt.org) CSAP’s Western Center for the Application of Prevention Technologies.
- [www.samhsa.org](http://www.samhsa.org) National Substance Abuse and Mental Health Association.
- [www.csap.org](http://www.csap.org) Center for Substance Abuse Prevention.
- [www.ncadi.org](http://www.ncadi.org) National Clearinghouse of Alcohol and Drug Information.

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.

**Preventing Drug Use Among Children and Adolescents**, National Institute on Drug Abuse (1997). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #PHD 734.

**Drug Abuse Prevention: What Works**, National Institute on Drug Abuse (1997). To obtain a copy, contact National Technical Information Services, 800/553-6847, and request Publication Number PB#97-209605. This book is part of a five-book packet that costs $83.00 plus $5.00 handling.

**Prevention Strategies: A Research Guide to What Works**, Developmental Research and Programs (1996). To order a copy ($49.95—discounts available on volume purchases), contact Developmental Research and Programs at moreinfo@drp.org or 800/736-2630. A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention, Center for Substance Abuse Prevention (1996). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #PHD 731.

**Making the Grade: A Guide to School Drug Prevention Programs**, Drug Strategies (1996). To order a copy ($12.95 for 1–4 copies and $9.95 for 5 or more copies), contact Drug Strategies at 202/663-6090.

**Selected Findings in Prevention: A Decade of Results from the Center for Substance Abuse Prevention**, Center for Substance Abuse Prevention (1997). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #PHD 747.

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4 Source: CSAP’s Western CAPT Web site: http://captus.samhsa.gov/western/resources/sapst-man/index.cfm
The Practical Theorist: Prevention Research in Parenting and Family Intervention, Community Anti-Drug Coalitions of America (1997). To order a copy ($3.50), contact Community Anti-Drug Coalitions of America, 800/54-CADCA.

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention (1997). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #PHD 744 (for 12-page community guide), #PHD 745 (for prevention practitioners guide), or #PHD 746 (full document).

Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches, Center for Substance Abuse Prevention (1998). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #SMA 3224-FY98. Prevention practitioners guide and parent/community guide available.

Preventing Problems Related to Alcohol Availability: Environmental Approaches, Center for Substance Abuse Prevention (1999). To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), 800/729-6686, and request Publication Order #PHD 822.
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 1970s 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 1960s (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 — No Child Left Behind — schools must strategically assist students in reaching their greatest potential. Student Assistance Programs provide greater opportunities for improvement in student achievement and academic success by addressing the many barriers that face today’s students.

The Student Assistance Prevention-Intervention Services Program model promotes healthy, safe, and drug-free lifestyles through strength-based approaches in working with youth. SAPISP programs do not provide treatment to students, but utilize existing resources within the school and community to address identified concerns, and link students and their families with resources to meet more intensive, specialized, service needs.

SERVICE DELIVERY MODELS

Nationally, three service delivery models, or program designs, have emerged from school-based student assistance programs (Anderson, 1993). These are: (1) internally-based; (2) externally-based; and (3) core (or student assistance) team models. 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 Student Assistance Prevention-Intervention Services Program (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—Student Assistance Specialists (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 work 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 Core or Student Assistance Team 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 alcohol, tobacco, and other drug (ATOD) issues.

According to Anderson (1993), there are specific advantages and disadvantages of each of the three service delivery models, with these outlined in the table below.

Table 1: Advantages and Disadvantages of Service Delivery Models

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Internally-Based Model</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expertise</strong> – professional ATOD counselor brings specialized skills and/or experience.</td>
<td>Little school ownership – single ownership can discourage involvement of others.</td>
<td><strong>Little school ownership</strong> – single ownership can discourage involvement of others.</td>
</tr>
<tr>
<td><strong>Single focus</strong> – School staff and others are aware of to whom referrals are to be made.</td>
<td><strong>Limited staff awareness</strong> – ATOD expertise and awareness is limited to one staff member.</td>
<td><strong>Limited staff awareness</strong> – ATOD expertise and awareness is limited to one staff member.</td>
</tr>
<tr>
<td><strong>Cost</strong> – the costs are primarily based upon a single person’s salary.</td>
<td><strong>Discontinuity</strong> – if the staff member leaves, so goes the program.</td>
<td><strong>Discontinuity</strong> – if the staff member leaves, so goes the program.</td>
</tr>
<tr>
<td><strong>Confidentiality issues</strong> – information cannot be shared with others in the school without consent.</td>
<td><strong>Not a systems approach</strong> – one person is charged with identifying problems and changing the system.</td>
<td><strong>Not a systems approach</strong> – one person is charged with identifying problems and changing the system.</td>
</tr>
<tr>
<td><strong>Exclusionary</strong> – schools are most likely to be excluded from service delivery decisions.</td>
<td><strong>Discontinuity</strong> – Changes in staffing or at the agency affect program services and quality of services.</td>
<td><strong>Discontinuity</strong> – Changes in staffing or at the agency affect program services and quality of services.</td>
</tr>
<tr>
<td><strong>Confidentiality regulations</strong> – Federal regulations related to ATOD issues prohibit disclosure of student related information without student’s consent.</td>
<td><strong>Core or Student Assistance Team Model</strong></td>
<td><strong>Labor intensive</strong> – requires time from a variety of staff members.</td>
</tr>
<tr>
<td><strong>Ownership</strong> – the school has a higher sense of buy in and ownership from school staff.</td>
<td><strong>Conflicts within teams</strong> – potential “turf” issues may arise given differing opinions and approaches within group.</td>
<td><strong>Conflicts within teams</strong> – potential “turf” issues may arise given differing opinions and approaches within group.</td>
</tr>
<tr>
<td><strong>Inclusionary</strong> – the team consists of a cadre of personnel.</td>
<td><strong>Complexity</strong> – each member participates in the program in different ways; managing the process may be difficult.</td>
<td><strong>Complexity</strong> – each member participates in the program in different ways; managing the process may be difficult.</td>
</tr>
<tr>
<td><strong>Broad-based awareness</strong> – training of a variety of personnel increases knowledge and skills.</td>
<td><strong>Cost</strong> – allocation of costs across multiple staff members; intensive training required.</td>
<td><strong>Cost</strong> – allocation of costs across multiple staff members; intensive training required.</td>
</tr>
<tr>
<td><strong>Continuity</strong> – If a member of the team leaves, the program continues.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STAFFING MODELS
In Washington State, existing staffing patterns are aligned with each service delivery model as described above. In the case of internally-based and Student Assistance Team models, staff are employees of the school, district, or ESD, with contracted staff used to provide services in externally-based models. In the case of programs utilizing a combination of service delivery models, both contracted and employed staff provides SAPISP services. As with service delivery models, there are certain positives and negatives to staffing models as noted by Washington State project coordinators (Deck & D’Ambrosio, 2002), with these outlined in Table 2.

Table 2: Positives and Negatives of Staffing Models

<table>
<thead>
<tr>
<th>Staffing Model</th>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
</table>
| ESD Staffing Model               | Coordinators have direct supervision over project staff, resulting in increased standardization.  
Program staff are better integrated into school system.  
Support group curricula tend to be more skills based. | Program staff’s duties are not always focused solely on ATOD counseling |
| School District Staffing Model   | School districts take ownership of project.  
Program staff are considered school staff as opposed to “outsiders” or itinerants. | Coordinators do not have direct supervision over program staff, resulting in less standardization and cooperation |
| Contract Staffing Model          | Contracting agencies ensure that program staff’s duties are focused solely on ATOD counseling.  
Contracting agencies assume responsibility for the clinical supervision of program staff.  
Projects acquire information and networking opportunities through the agencies. | Program staff are not considered school staff and face greater difficulty gaining staff support.  
Communication between agencies and schools is sometimes lacking.  
Coordinators do not have direct supervision over program staff. |
| Mixed Staffing Model             | Projects experience greater flexibility in meeting local needs. | Project coordination and implementation is more complicated.  
Pay scales differ among hiring staff. |

ROLES WITHIN THE WASHINGTON STATE SAPISP MODEL

Role of the State
In 1989, the state Legislature passed the Omnibus Alcohol and Controlled Substances Act (ESSHB 1793) to address the state’s concerns regarding student alcohol, tobacco, and other drug use. The act required the creation of a school-based alcohol and other drug abuse prevention and intervention services program. The Office of Superintendent of Public Instruction (OSPI) is responsible for the administration and oversight of the program. OSPI allocates funds to local grantees (ESDs and districts) for the purpose of implementing school-based prevention and intervention services.

The Office of Superintendent of Public Instruction’s Prevention-Intervention Services Program is a component of the division of Learning and Teaching Support. The program is under the direct supervision of the SAPISP Program Supervisor. The supervisor manages multiple state and federal grant programs and facilitates the planning and implementation of 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 problem behavior through policy development, committee membership, and expert technical assistance consultation to school districts, ESDs, community organizations, and other state agencies.

Role of the Program Coordinator
At the local level, the program coordinator is responsible for implementation and oversight of all aspects of the comprehensive Student Assistance Prevention-Intervention Services Program. 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 and substance abuse issues, risk and protective factors, and resilience concepts.

Depending on the service delivery model, the coordinator may or may not assume a supervisory role. Coordinators generally work at the school district’s central office or at an Educational Services District’s Prevention Center. In either case, they may opt to hire directly or contract for services with qualified agencies (see Table 1 above). In general, when the Student Assistance Specialist is an employee of the district or the ESD, s/he is directly supervised by the coordinator.

Coordinator supervisory responsibilities encompass providing direct program and clinical supervision as well as on-site supervision, monitoring, and reviewing clinical records, student progress, and data collection systems. Program coordinators plan and coordinate staff schedules, site assignments, and orientation and training for SAPISP staff.

In the case of contracted services, Student Assistance Specialists 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 working with community partners, participating in community coalition activities, collaborative needs assessment, and program promotional activities as a means of sustaining and marketing program services.

**Role of the Student Assistance Specialist**
Program staff, hired and placed in schools, deliver Student Assistance Prevention-Intervention Service Program 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. Student Assistance Specialists are often trained chemical dependency professionals, guidance counselors, school social workers, or prevention specialists. Staff provide comprehensive program services including (1) screening/pre-assessment; (2) resource referral and case management; (3) individual and group counseling; and, (4) program awareness. Program services are delivered to reduce barriers to student learning in an effort to provide a safe, drug free, learning environment.

**Role of the School**
Schools are particularly appropriate sites for providing 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 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 the effects of ATOD use and other problem behaviors of 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 Student Assistance Prevention-Intervention Services Program. Through training, all staff members gain awareness and develop knowledge of the levels of the prevention and intervention continuum and the role of the Student Assistance Specialist and the Student Assistance Team (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 prevention messages, serving as mentors or tutors, assisting with prevention activities, 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. Staff members assist students by (Anderson, 1993):

- Referring students to the SAP.
- Completing the behavior checklist.
- Consulting with the Student Assistance Team or Student Assistance Specialist.
- Acquiring basic training in fundamental, violence, alcohol and other drug abuse, prevention and intervention concepts and risk and protective factors.
- Maintaining confidentiality.
- Reporting policy violations immediately.
- Taking care of themselves by not enabling.

**PREVENTION STRATEGIES**

In a 1994 report on prevention research, the Institute of Medicine (IOM, 1994) 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 Student Assistance Prevention and Intervention Services program.

*Universal prevention strategies* address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying 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 substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs. Universal prevention strategies in Washington State’s SAPISP include:

- Information dissemination.
- Classroom or small group education.
- Alternative programming e.g., drug-free dances, and youth leadership activities.
- Problem identification and referral.
- Schoolwide awareness events e.g., Red Ribbon Week, Great American Smoke Out.
- Community-based activities.
- School substance abuse policies.

*Selective prevention strategies* target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—for example, children of adult alcoholics, dropouts, or students who are failing academically. 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), 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 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 and referral.
- Individual counseling.
- Support group services.
- Case management.
- Alcohol, tobacco and other drug screening.
- Core Team training.
- Family consultation.
- Community referrals.

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.

Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet Diagnostic and Statistical Manual-IV (DSM-IV) criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals are exhibiting substance abuse-like behavior, but at a sub-clinical level (IOM, 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem.

Indicated prevention programs address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. 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 of first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated 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:

- Referral for treatment.
- Treatment support.
- Aftercare/Recovery support.
- Recovery planning.
DISTRIBUTION OF TARGETED STUDENTS AND 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. Approximately twenty percent (20 percent) of SAPISP program services are dedicated to providing 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 (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; 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 group of youth are student-centered, highly individualized, and provide an array of support services. Services aim to increase positive interactions.

PROGRAM LOGIC MODEL

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 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, linking school characteristics, activities, and targeted short and long term outcomes.

### School or Community Characteristics
- Early onset of substance use by students.
- Unacceptably high level of substance use or violence among students in the school.
- Lack of clear, pro-social, no use attitudes among students and staff.
- Lack of accurate information about the effects of alcohol and other drugs, the role of the media, and actual prevalence of use.

### Group Prevention Activities
- Age-appropriate prevention curriculum aligned with Essential Academic Learning Requirements.
- School policies promoting a drug-free environment and addressing substance use or violence related discipline.
- Peer leadership or pledge programs and peer-lead school activities with no use message.
- Classroom presentations on effects of drugs.
- Positive after school and summer activities.
- Parent engagement activities.
- Staff training.

### Short-Term Outcomes
- Establishment of pro-social norms and attitudes about substance use and violence.
- Expanded knowledge of drug effects, the role of the media, and prevalence of use.
- Involvement in drug-free activities.

### Long-Term Outcomes
- Delayed onset and reduced prevalence of substance use or violence in whole school.

*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 Student Assistance Prevention-Intervention Services Programs provide early intervention (selective/indicated) services to students identified as at risk of initiating or escalating ATOD use or other problem behaviors. These intervention services usually include ATOD screening/pre-assessment, 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 as using or abusing to community-based treatment agencies of alcohol, and other drug assessment and treatment, if needed.

*Figure 2, on the following page, illustrates the logic model for intervention (selective/indicated) services adopted by Washington State's Student Assistance Prevention/Intervention Services program, 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 anti-social, and other problem behaviors, and increased likelihood that the student will make healthy life style choices.*
REQUIRED COMPONENTS OF AN EFFECTIVE SAP PROGRAM

The National Student Assistance Association established nine required components for effective SAP services (NSAA, 2003). **Washington State’s Student Assistance Prevention-Intervention Services Program model has adopted the nine components and added a tenth component addressing Sustainability.** The Student Assistance Prevention-Intervention Services Program 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.

1. **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.

2. **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.
3. **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.

4. **Internal Referral Process:** To identify and refer students with academic and social concerns to a multi-disciplinary problem-solving, case management team.

5. **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.

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

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

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

9. **Integration with Other School-Based Program:** To integrate student assistance services with other school-based programs designed to increase resilience, improve academic performance, and reduce student risk for alcohol, tobacco, other drugs, and violence.

10. **Sustainability:** To develop long-term plans to sustain program operations.

### 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**  
Approximately, twenty percent (20 percent) of SAP services are to be delivered in the area of universal prevention, which includes classroom ATOD presentations or curriculum delivery (i.e., Project Alert), schoolwide awareness events (see Section 4 Program Awareness), student prevention clubs, and parent education and support.
Selective and Indicated Prevention/Intervention Services

Prioritizing students: There may be times when the SAS will have more students referred than they 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.

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.

<table>
<thead>
<tr>
<th># OF DAYS PER WEEK/BUILDING</th>
<th>TARGET # OF STUDENTS SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day a week/1 building (0.2 FTE)</td>
<td>15–20 students</td>
</tr>
<tr>
<td>2 days a week/1 building (0.4 FTE)</td>
<td>20–40 students</td>
</tr>
<tr>
<td>2.5 days a week/1 building (0.5 FTE)</td>
<td>40–60 students</td>
</tr>
<tr>
<td>5 days a week/2 buildings (1.0 FTE)</td>
<td>60–100 students</td>
</tr>
<tr>
<td>5 days a week/1 building (1.0 FTE)</td>
<td>75–125 students</td>
</tr>
</tbody>
</table>

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. 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.

- **Affected Others** – 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, but may be impacted by a friend’s substance use as well.

- **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 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.

<table>
<thead>
<tr>
<th># OF DAYS PER BUILDING</th>
<th># OF GROUPS IMPLEMENTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day a week</td>
<td>1 group per week minimum of 2 groups per year</td>
</tr>
<tr>
<td>2–3 days a week</td>
<td>3 groups per week minimum of 6 groups per year</td>
</tr>
<tr>
<td>5 days a week</td>
<td>6 groups per week minimum of 12 groups per year</td>
</tr>
</tbody>
</table>

**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.

1. **Meet the Building Principal**
   - Explain groups and alignment with Essential Academic Learning Requirements (EALR), 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.

2. **Presentation to School Staff (with Core Team if possible)**
   - Explain purpose of program.
   - Explain process for making referrals.
   - Office hours and days in their building.
   - Handouts–explain groups, EALRs alignment, and outline of services available.
   - Other ways to communicate with staff including memos and information flyers.

3. **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.”

4) **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.

1–7 percent of students require more targeted, indicated services.
10–15 percent requires selective services that are more intensive.
The majority of students (80 percent) will never present major behavioral problems.

5. 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 individually with students prior to placement.
   - Collect permission slips (if required by program) and complete disclosure, consent, and release of information forms with student.

6. Become Knowledgeable about Community Resources
   - Treatment agencies.
   - Mental Health services.
   - Other community resources.

7. 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.
   - Drug Free Washington Month.
   - Kick Butts Day.
   - Prom Promise.
   - World No Tobacco Day.
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/crases/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).

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

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8 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
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 and 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 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 and 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
SCHOOL BOARD POLICY

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES ACT

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:

a. 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.

b. prevent violence and promote school safety.

c. 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 receiving Drug-Free Schools funding develop and implement policies related to alcohol and other drugs.

PUTTING POLICY INTO ACTION

The purpose of an alcohol, tobacco, and other drug 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 the use of alcohol, other drugs, violence, and high-risk behaviors. Moreover, 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 alcohol and other drug-related 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 ATOD problem. Once implemented, schools should be consistent and fair in their adherence to enforcement of ATOD policies. Finally, records regarding enforcement should be maintained, through the implementation of a reporting system that tracks ATOD 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 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 ATOD 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.

**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.

**Coordinator’s Role in Policy Implementation**

The 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.
Student Assistance Prevention-Intervention Services Program Manual

Substance Use Policy Violation Flowchart

Student Violates Policy

The decision is made by Administrator to offer student/parents SAP intervention services or to bring the case to a district hearing for expulsion.

Student/parents receive services at school through SAP contract.

No other violation for a year and completion of the program the student is exited from the SAP.

Student has a second violation within the year period and/or non-compliance with SAP contract.

Student is brought before the school administrator to hear the substance use violation case.

Returned to school with consequences and SAP intervention.

Expulsion held in abeyance if student/parents agree to buy back and comply with SAP recommendations.

Student expelled from school.

Student/parents petition the school board for reinstatement. Boards agrees to reinstate at school with SAP intervention.
SUBSTANCE ABUSE PROGRAM

The board recognizes that the abuse of alcohol, and the use and abuse of controlled illegal, addictive, or harmful substances including anabolic steroids is a societal problem and may represent an impairment to the normal development, well-being and academic performance of students. To ensure the safety, health and well-being of all students, the board is committed to the development of a program which emphasizes drug and alcohol abuse prevention, intervention, aftercare support and necessary corrective actions. The program will address the legal, social and health consequences of drug and alcohol use, and provide information about effective techniques for resisting peer pressure to use illicit drugs or alcohol. The program will be age-appropriate and developmentally based for all students in all grades.

The board recognizes the effects to the school, home and community resulting from the abuse of alcohol and the use and abuse of controlled illegal, addictive or harmful substances including anabolic steroids. While the primary obligation to seek assistance rests with the student and his/her parent(s)/guardian(s), school staff shall work with the home and community to develop and implement a comprehensive prevention and intervention program. The board of directors shall seek the support, cooperation and coordination of public and private agencies through formation of an advisory committee, including representatives from the instructional staff, students, parents, state and local law enforcement staff and the county coordinator of alcohol and drug treatment or a representative of a treatment provider.

The superintendent is directed to develop and implement procedures to assess the scope of the problem of the use of addictive substances such as alcohol, drugs and nicotine, and to reduce and/or eliminate the problems associated with the use of alcohol, drugs and nicotine.

Parents and interested community members are encouraged to visit the school and/or classroom to observe classroom activities and review instructional materials. At the conclusion of each year, the district will evaluate the effectiveness of the program.

Cross References: Board Policy 5203 - Staff Assistance Program

Legal References: RCW 28A.210.310 - Prohibition on use of tobacco products on school property.

28A.170.075 - Substance Abuse Prevention and Intervention
20 U.S.C. 3171 et seq. - Drug-free Schools and Community Act

Adoption Date: 
School District Name
Revised: 
Classification: Essential
Substance Abuse Program

Actions taken by staff in dealing with student use of alcohol and the use and abuse of controlled illegal, addictive or harmful substances including anabolic steroids will have as their first concern the welfare of the student involved and the other students in the school. Although a helping relationship rather than an investigative and punitive approach will be emphasized, necessary and appropriate disciplinary action will be taken when laws or school regulations are violated. Law enforcement agencies will be called upon for investigative and consultative assistance where illegal drug or alcohol activity has occurred.

Prevention
The prevention program shall focus on classroom instruction, guidance services and the school climate.

Instruction
This dimension of the prevention program shall focus on:

a. The effects of addictive substances such as alcohol, drugs and nicotine upon the body.

b. Skill development related to self esteem, goal-setting, decision-making, conflict management, problem-solving, refusal and communication.

Guidance Services
Staff shall meet with students, individually and in small groups, to supplement addictive substance prevention, instruction and skill development. Staff will also assist parents to maximize the prevention efforts of the school.

School Climate
A facilitative school environment can help students to achieve in a productive manner (academically, socially and emotionally). The school shall strive to be a place where:

a. Students, staff, and parents respect themselves and others.

b. Individuals can be trusted to do what they say they will do.

c. High morale is evident.

d. Each person feels that he/she has a voice in the decisions that affect him/her.

e. All feel that they are continuing to learn and grow.

f. All value diversity and accept it as an opportunity for growth and development.

g. All possess a “sense of belonging”.

h. All feel that they can make a difference to someone else.

To this end, the school will encourage the formation of “natural helper”, Core Team and any education and/or prevention promotions that increase the awareness of the effects of substance abuse. Student support groups shall assist students concerned about their own substance abuse, students living in families suffering from substance abuse, and students concerned about the substance abuse of someone else.
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Intervention

The goal of the intervention program shall be to eliminate use of alcohol and the use and abuse of controlled, illegal, addictive or harmful substances including anabolic steroids abuse by students. Ongoing in-service will be provided for faculty and staff. Important aspects of in-service training will include dimensions of the family illness and dynamics of the addiction process; enabling behaviors; intervention techniques; children in chemically dependent families; student experimentation, abuse and dependency; parental involvement and community resources; prevention issues and strategies; treatment and aftercare support; and implementation of the program into the classroom/building.

Staff roles for the intervention program are as follows:

a. Administrators, counselors, selected staff and nurse meet weekly for the purpose of identifying any student(s) who may be in need of assistance. Such staff shall be sensitive to identifying symptoms of substance abuse.

b. Suspected student(s) shall be referred to the Core Team, consisting of staff members who have exhibited a strong interest in attending to the needs of such students and who have received specialized training in substance abuse dependency.

c. The Core Team will meet regularly to review referrals; confer with students and, if warranted, counselors, administrators and/or parents; collect data; make recommendations for services; and maintain a confidential system of record keeping. Parents will be involved before any action is taken.

d. Students returning to school from a community inpatient or outpatient treatment program will be given aftercare support by the Core Team. Such students will receive support from “natural helpers” so that they may develop a strong sense of bond with other students and the school. Primary aftercare responsibility for students returning from a community treatment program rests with the student, parent and community treatment program personnel. School staff, the student, parent(s) and community treatment personnel will work cooperatively to facilitate the aftercare plan.

Corrective Action

If a student appears at school or at a school-sponsored function demonstrating behavior which indicates that he/she may be under the influence of a addictive substances and/or admits to an administrator that he/she is under the influence of a addictive substances, the school will take the following action:

a. The parents will be notified to arrange for appropriate treatment.

b. If the student’s illegal use of addictive substances is confirmed, the school administration may request the assistance of a law enforcement official in investigating the source of the addictive substance.

c. Appropriate school disciplinary action will be taken.

If school authorities find a student in possession of addictive substances at school, the addictive substances will be confiscated and turned over to law enforcement officials for investigation and disposal. Appropriate school disciplinary action will be taken by a school administrator regardless of law enforcement action.

If a school administrator receives information concerning sales and use of addictive substances outside of school, the information will be reported to law enforcement officials for their investigation.

Date:
THE IMPORTANCE OF STAFF DEVELOPMENT

Key to the success of an effective student assistance prevention-intervention services program 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 reduce risk, increases protective factors, and fosters 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 as well as the community at large (parents, stakeholders). Professional development opportunities are necessary to support effective program services. Staff development offerings are practical, experiential, and designed to increase knowledge and skills, shape attitudes, change behaviors, and challenge participants to expand their knowledge base and increase awareness. Additionally, offerings may include support for faculty wellness, and information about community resources for staff, students, and families.

STAFF DEVELOPMENT FOR SCHOOL FACULTY

The purpose of providing school staff development offerings is to: (1) educate faculty about the identification and referral processes of SAPISP; (2) educate staff about the impacts of substance use on the learning environment and academic achievement; (3) build awareness about the program’s aim to reduce barriers to learning; (4) increase staff awareness and skill level to reduce risks, increase protective factors, and foster resilience in students; and, (5) support staff wellness through education and referral.

Goals of School Staff Development Offerings

In addition to the purposes listed above, there are specific goals related to staff in-service trainings. These goals include increasing the number of students with problem behaviors identified by school staff; linking students to support systems–Student Assistance Prevention-Intervention Services Program; and, providing school staff with a common language that encourages students in need 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 and policy and procedures for referral (i.e., staff, disciplinary, parent, outside, peer and self).
- Staff members’ role in identification and referral.
- Confidentiality.
- ATOD dynamics of use, abuse, and dependency and symptomology of use associated with each substance.
- Summary of drugs of abuse-current trends and signs and symptoms.
- Impact of substance abuse on the family structure and especially upon children in the case of adult children of alcoholics (ACOA).
- Denial and enabling concepts.
- Services provided to families for pre-assessments, treatment referrals, and re-entry support following treatment.
- Understanding school policies and procedures for disciplinary referrals.
- Student Assistance Program model and the relationship to academic achievement and the School Improvement Process.
- Purpose of universal, selective, and indicated services and activities such as schoolwide awareness events, and individual and group counseling.
- Student Assistance/Core Team model and approach.
- Risk and Protective factor theory, Assets model and Resiliency theory.

Component 2
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.
• Ethics and standards of practice.
• Needs assessment data such as Healthy Youth Survey results and how to put them to use.
• Resources—school and community-based.

STAFF DEVELOPMENT FOR STUDENT ASSISTANCE SPECIALISTS

To increase the likelihood of an effective student assistance program as well as to improve the probability of reaching targeted program objectives, Student Assistance Specialists require adequate staff development and technical assistance opportunities integrated across the continuum of program services with continued support beyond start up. Staff development is extensive and on going, and provides program staff with the basic knowledge, skills, and competencies in chemical dependency, mental health, treatment process, and recovery and aftercare (see Program Staff Competency Rubric page 65).

At a minimum, staff development offerings focus on providing staff with a general understanding of: (1) linking educational support group objectives to Washington State’s Essential Academic Learning Requirements (EALRs); (2) aligning program objectives to the School Improvement Process; (3) decision-making regarding student service needs based upon ASAM placement and DSM IV criteria and screening/pre-assessment findings; and (4) the relationship between prevention and intervention services and a supportive learning environment.

In addition, staff development offerings 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 SASs are recommended as follows:
• Awareness of the components of a comprehensive Student Assistance Prevention- Intervention Services Program.
• Nature and progression of adolescent substance use, abuse, and dependency (continuum of use).
• Knowledge of ASAM placement and DSM VI criteria.
• Awareness of the dynamics of denial.
• Understanding the system of enabling.
• Awareness of the effects of others’ chemical dependency on adolescent and adolescent development.
• Understanding and skills related to screening, pre-assessment, identification, and the internal referral process.
• Exploration of the treatment and recovery process.
• 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.
• Family dynamics, rule, and roles and the impact of family chemical dependency.
• Clear understanding of the types and purposes of educational support groups–objectives, targeted students–and issues related to implementation.
• Overview of the School Improvement Process and Washington State’s Essential Academic Learning Requirements.
• Confidentiality and student rights to privacy (42 CFR part 2, FERPA, and HIPPA).
• Record keeping and data entry requirements.
In addition, specialized training is provided for all Student Assistance Specialists expected to conduct educational support groups. Training topics include group dynamics and stages, group activities, active listening, 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, areas of professional growth and development, and staff training needs.

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

At a minimum, staff development offerings focus on providing staff with a general understanding of:

1. **linking educational support group objectives to Washington State’s Essential Academic Learning Requirements (EALRs).**
2. **aligning program objectives to the School Improvement Process.**
3. **decision-making regarding student service needs.**
4. **the relationship between prevention and intervention services and a supportive learning environment.**
# STUDENT ASSISTANCE SPECIALIST
## COMPETENCY RUBRIC ASSESSMENT TOOL

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<thead>
<tr>
<th>Name of Specialist</th>
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<table>
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<tr>
<td><strong>Does not meet expectations</strong></td>
<td><strong>Meets expectations; demonstration of basic understanding of SAPI services</strong></td>
<td><strong>Meets expectation; demonstration of thorough understanding of SAPI services</strong></td>
<td><strong>Exceeds expectation; capable of training others in the basic concepts of SAPI</strong></td>
</tr>
</tbody>
</table>

## STUDENT ASSISTANCE PROGRAM SERVICES MODEL

- Limited understanding of student assistance program services model evidenced by inability to:
  - Describe purposes of program (services identification, intervention referral support, and follow up)
  - Define program target groups (at-risk, CASAP, abuse/dependent, recovery support, and non users)
  - Describe continuum of care (prevention-early intervention-treatment-recovery support, and follow up)
  - Describe the NSAA nine components of an effective student assistants program
  - Describe the role and function of an SAP in the educational process

- Demonstrates a basic understanding of student assistance program services model evidenced by ability to:
  - Describe purposes of program (services identification, intervention referral support, and follow up)
  - Define program target groups (at-risk, CASAP, abuse/dependent, recovery support, and non users)
  - Describe continuum of care (prevention-early intervention-treatment-recovery support, and follow up)
  - Describe the NSAA nine components of an effective student assistants program
  - Describe the role and function of an SAP in the educational process

- Thorough understanding of the purposes of student assistance program services model evidenced by ability to provide examples of services in the following context:
  - Placement of students in program target groups (at-risk, CASAP, abuse/dependent, recovery support, and non users)
  - Case manages students served based on the continuum of care (prevention-early intervention-treatment-recovery support, and follow up)
  - Incorporates NSAA nine components of an effective student assistants program
  - Markets program within the school setting and integrates role and function of an SAP in the educational system

- Capable of training others in basic concepts of student assistance program services model evidenced by ability to:
  - Mentor new staff assigned to shadow the SA Specialist
  - Provide input at staff meetings and in one-to-one with peers on counseling support and case management based on the continuum of care (prevention-early intervention-treatment-recovery support and follow up)
  - Incorporates NASAA nine components of an effective student assistants program based
  - Markets program with community partners as well as maintains a level of interest at the school level and sustains SAP within the school setting
<table>
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<th>KNOWLEDGE OF PREVENTION CONCEPTS AND THEORY</th>
<th>Rating 1: Does not meet expectations</th>
<th>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</th>
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<tbody>
<tr>
<td>Limited understanding of prevention concepts and theory evidenced by inability to:</td>
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<tr>
<td>Define risk, protective and resiliency concepts and the relationship to substance abuse prevention</td>
<td></td>
<td>Thoroughly understands the prevention concepts and theory as it relates to the purposes student assistance program services model evidenced by ability to provide examples of services in the following context:</td>
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<tr>
<td>Coordinate program services based on universal, selective, and indicated</td>
<td>Demonstrates a basic understanding of prevention concepts and theory evidenced by ability to:</td>
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<tr>
<td>Define risk, protective and resiliency concepts and the relationship to substance abuse prevention</td>
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<tr>
<td>Coordinate program services based on universal, selective and indicated</td>
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<tr>
<td>Capable of training others in basic concepts of prevention principals evidenced by ability to:</td>
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<tr>
<td>Train others in how to effectively identify risk and protective factors and appropriate interventions</td>
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<tr>
<td>Train others in the concept of resiliency and how these concepts are used in working with youth at high risk</td>
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<tr>
<td>Serve as a role model to others by having in place program services that encompass universal, selective and indicated services</td>
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<tr>
<td>POLICY AND PROCEDURE</td>
<td>Rating 1: Does not meet expectations</td>
<td>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</td>
<td>Rating 3: Meets expectation; demonstration of thorough understanding of SAPI services</td>
<td>Rating 4: Exceeds expectation; capable of training others in the basic concepts of SAPI</td>
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<tr>
<td>Lacks knowledge about effective policy and procedure</td>
<td>Knowledgeable about effective policy and procedure</td>
<td>Thoroughly understands the purpose of policy and procedures</td>
<td>Articulates to school board, building administration, faculty, parents, and community partner’s effective policy and procedures that address student use, distribution, sale, and manufacturing substances</td>
<td></td>
</tr>
<tr>
<td>Lacks knowledge in required school policy related to ATOD offenses</td>
<td>Knowledgeable in required school policy related to ATOD offenses</td>
<td>School administration articulates value in effective policy and procedure to ATOD offenses</td>
<td>Articulates policy with a clear statement that disciplinary sanctions up to and including expulsion and referral for prosecution for students that violate code of conduct</td>
<td></td>
</tr>
<tr>
<td>“Buy Back” disciplinary process is not in place at the school served by the specialists</td>
<td>“Buy Back” disciplinary process is in place at the school sites served by the specialist</td>
<td>“Buy Back” disciplinary process has been integrated within the school setting and is maintained each year as part of the disciplinary procedures</td>
<td>Specialist assists other schools and Student Assistance Professionals in implementing a “Buy Back” disciplinary process within a school setting</td>
<td></td>
</tr>
<tr>
<td>Staff have not been presented to and few school staff have a clear understanding of ATOD the policy</td>
<td>Staff have been presented to and are aware of ATOD the policy</td>
<td>Staff presentations on SAP program and policy review are integrated within the school setting. The majority of staff have a clear understanding of the ATOD policy</td>
<td>Ability to train school staff in ATOD policy and procedures</td>
<td></td>
</tr>
<tr>
<td>Rating 1: Does not meet expectations</td>
<td>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</td>
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<tr>
<td>STAFF DEVELOPMENT</td>
<td>Basic understanding of:</td>
<td>Thoroughly understands:</td>
<td>Ability to train others to:</td>
<td></td>
</tr>
<tr>
<td>STUDENT</td>
<td>• Identification of common drugs of abuse, street names, and methods of use</td>
<td>• Identification of common drugs of abuse, street names, and methods of use</td>
<td>• Identify common drugs of abuse, street names, and methods of use</td>
<td></td>
</tr>
<tr>
<td>ASSISTANCE</td>
<td>• Common signs and symptoms of substance abuse</td>
<td>• Common signs and symptoms of substance abuse</td>
<td>• Describe common signs and symptoms of substance abuse</td>
<td></td>
</tr>
<tr>
<td>PREVENTION</td>
<td>• The impact of addiction on the family system</td>
<td>• The impact of addiction on the family system</td>
<td>• Discuss the possible impact of addiction on the family system</td>
<td></td>
</tr>
<tr>
<td>INTERVENTION</td>
<td>• The impact of substance abuse on the physical, physiological, psychological, and sociological development on students</td>
<td>• The impact of substance abuses on the physical, physiological, psychological, and sociological development on students</td>
<td>• Discuss the impact of substance abuse on the physical, physiological, psychological, and sociological development on students</td>
<td></td>
</tr>
<tr>
<td>SPECIALSIT KNOWLEDGE</td>
<td>• Identification of behaviors observed in the school setting that may indicate substance abuse</td>
<td>• Identification of behaviors observed in the school setting that may indicate substance abuse</td>
<td>• Identify behaviors observed in the school setting that may indicate substance abuse</td>
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<td></td>
<td>• The school’s role, responsibility, boundaries in addressing substance abuse issues that present barriers to school success</td>
<td>• The school’s role, responsibility, boundaries in addressing substance abuse issues that present barriers to school success</td>
<td>• Describe the school’s role, responsibility, boundaries in addressing substance abuse issues that present barriers to school success</td>
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<tr>
<td></td>
<td>• The influence of enabling on school faculty and community</td>
<td>• The influence of enabling on school faculty and community</td>
<td>• Describe the influence of enabling on school faculty and community</td>
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</tr>
<tr>
<td></td>
<td>• The stage-appropriate interventions from initial usage to relapse</td>
<td>• The stage-appropriate interventions from initial usage to relapse</td>
<td>• List the stage-appropriate interventions from initial usage to relapse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The ATOD continuum of care</td>
<td>• The ATOD continuum of care</td>
<td>• Outline ATOD continuum of care</td>
<td></td>
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<tr>
<td></td>
<td>• The key features of the addictive process including progression from experimentation to dependency</td>
<td>• The key features of the addictive process including progression from experimentation to dependency</td>
<td>• Describe the key features of the addictive process including the progression from experimentation to dependency</td>
<td></td>
</tr>
<tr>
<td>Rating 1: Does not meet expectations</td>
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</table>
| **STAFF DEVELOPMENT FOR SCHOOL FACULTY** | • Limited understanding on how to engage and educate school faculty as part of the student assistance program | • Demonstrates a basic understanding on how to engage and educate school faculty as part of the student assistance program  
• Provides information to school faculty on the impact of substance abuse on student learning, signs and symptoms, and referral process  
• SAS is able to articulate, pursue, and gain support for a pull-out model to best serve youth within the school system | • Staff/faculty presentations are integrated within the school setting to provide information to school faculty on the impact of substance abuse on student learning, signs and symptoms, and referral process  
• SAS is able to articulate, pursue, and gain support for a pull-out model to best serve youth within the school system | • Specialist can assist peers in developing presentations to provide information to school faculty on the impact of substance abuse on student learning, signs and symptoms, and referral process  
• Ability to train staff in the SAPI service model |
| **PROGRAM AWARENESS** | • Limited understanding of the importance of student awareness events  
• SA Specialist has not coordinated/sponsored a large awareness event  
• SAS has not engaged school/community partners in awareness activities  
• Student classroom presentation and awareness events are limited or nonexistence | • Understands the importance of student awareness events and can articulate how they are part of the continuum of comprehensive SAPI services  
• Coordinates awareness events that reach all students within the school setting  
• Events involve school and community partners | • Thoroughly understands the importance of engaging students in awareness events to change attitudes and norms  
• Awareness events are integrated within the school setting and faculty are actively involved | • Specialist can assist peers in developing awareness events – shares ideas at staff meetings, takes on leadership role within the school district and involves more than just the school he/she serves (i.e., elementary schools as well as secondary schools host similar age appropriate events)  
• Specialist is engaged in planning awareness events with community partners as well as school faculty |
<table>
<thead>
<tr>
<th><strong>INTERNAL REFERRAL PROCESS</strong></th>
<th><strong>Rating 1:</strong> Does not meet expectations</th>
<th><strong>Rating 2:</strong> Meets expectations; demonstration of <strong>basic</strong> understanding of SAPI services</th>
<th><strong>Rating 3:</strong> Meets expectation; demonstration of <strong>thorough</strong> understanding of SAPI services</th>
<th><strong>Rating 4:</strong> Exceeds expectation; capable of training others in the basic concepts of SAPI</th>
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</thead>
</table>
| • New to the field and has limited understanding on how to establish a referral process  
• New to the field and has limited knowledge on effective screening processes and procedures | • SAS conceptualizes the referral process from referral through intervention to follow up support  
• Faculty have been educated by the SAS on the referral process, appropriate referrals, and who can make referrals made to SAP (faculty, administration, peers, parents, self)  
• Faculty have been educated on observable student behaviors appropriate for SAP | • SAS can explain and provide examples of the referral process from referral through intervention to follow up support  
• Faculty make regular referrals to the SAP and are well informed by the SAS on the referral process, appropriate referrals, and who can make referrals made to SAP (faculty, administration, peers, parents, self)  
• Faculty education on referral process and signs and symptoms is integrated into the school setting | • Has the ability to train/mentor others on how to establish a referral/screening process  
• Peers are able to contact SAS to case consult on students who are screened and need to be referred  
• Stays up to date on current effective screening practices and applies these practice to his/her role as a SAS |
<table>
<thead>
<tr>
<th>PROBLEM SOLVING AND CORE TEAM</th>
<th>Rating 1: Does not meet expectations</th>
<th>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</th>
<th>Rating 3: Meets expectation; demonstration of thorough understanding of SAPI services</th>
<th>Rating 4: Exceeds expectation; capable of training others in the basic concepts of SAPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specialist lacks the knowledge and skills necessary to implement a problem solving team</td>
<td>• Specialist can define appropriate roles and responsibilities for team members within the team and in relation to others in the school community</td>
<td>• Shows ability to participate effectively in the core team meeting process</td>
<td>• Ability to train others i.e., school team in the problem solving/core team model</td>
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<td></td>
<td>• Describes and outlines a flow chart that highlights to SAP Core Team process from receipt of referral through intervention to follow up and support</td>
<td>• Able to describe the need for ongoing follow-up and the potential need for consecutive and sequential intervention</td>
<td>• Serve as a role model to peers</td>
<td></td>
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<tr>
<td></td>
<td>• Shows ability to facilitate the core team meeting process.</td>
<td>• Ability to demonstrate various intervention methods and differentiate when each is appropriate</td>
<td>• Demonstrates strategies for selecting, integrating, retaining, and rotating team members</td>
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<td></td>
<td>• Describes observable student behaviors appropriate</td>
<td>• Articulates the importance of effective strategies for ongoing team maintenance and self-care for team members</td>
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<td></td>
<td>• Lists methods to gather information regarding student behaviors from various sources</td>
<td>• Identifies strategies to inform the school, students, parents, and community of the SAP team process</td>
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<td></td>
<td>• Identifies school-based and community based resources</td>
<td></td>
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<tr>
<td>STUDENT ASSISTANCE PROGRAM EVALUATION</td>
<td>• Evaluation data is not consistently entered into the web-based reporting system</td>
<td>Demonstrates:</td>
<td>• Generates and utilize online performance reports</td>
<td>• Generates and utilize online performance reports</td>
</tr>
<tr>
<td></td>
<td>• SA Specialist does not understand the connection of program evaluation and program services</td>
<td>• Ability to enter data into web-based reporting system with little assistance</td>
<td>• Incorporates results of SAP evaluation in program planning, service delivery, and improvement with little guidance from supervisor</td>
<td>• Incorporates results of SAP evaluation in program planning, service delivery, and improvement with little guidance from supervisor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data is entered on a consistent basis</td>
<td>• Evaluation data is used for presentations to students, faculty, parents, and community partners</td>
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<td></td>
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<td>• Data is shared with building and/or district administration</td>
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<tr>
<td>Rating 1: Does not meet expectations</td>
<td>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</td>
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<tr>
<td><strong>EDUCATIONAL SUPPORT GROUPS</strong></td>
<td>Specialist needs direction from supervisor to organize groups and properly screen and place in appropriate groups settings</td>
<td>Ability to organize groups according to target populations</td>
<td>Specialist provides guidance and provides group activities content and ideas to peers</td>
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<tr>
<td></td>
<td>Specialist needs direction from supervisor to develop content for support groups</td>
<td>Students are properly screened and placed in appropriate group settings</td>
<td>School expects and sees value in support groups as part of schoolwide efforts to address barriers to learning</td>
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<td></td>
<td>Only one or two of the three core groups (COSAP, Intervention, Recovery Support) have been implemented and are not offered on a consistent basis</td>
<td>Each support group has clear goals and objectives for student learning, outcome measures for student progress, and focused on removing barriers to academic learning</td>
<td>Faculty receive information/education through faculty presentations on benefits of support group in addressing barriers to academic learning</td>
<td></td>
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<tr>
<td></td>
<td>Limited understanding of laws regulating confidentiality and release of records</td>
<td>Understand laws regulating confidentiality and release of records</td>
<td>Group offerings have been expanded beyond the three primary core groups based on identified needs within the school setting</td>
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<tr>
<td></td>
<td></td>
<td>Groups have been integrated into the school setting and are part of the SAP programming</td>
<td>Complies with all components of program implementation related to the laws regulating confidentiality and release of records</td>
<td></td>
</tr>
<tr>
<td>Rating 1: Does not meet expectations</td>
<td>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</td>
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<tr>
<td><strong>COOPERATION AND COLLABORATION</strong></td>
<td>• Specialist works in isolation. SAP program is a one person program with little or no involvement from school staff.</td>
<td>• Specialist has implemented a referral process within the school setting that includes referrals from administration for discipline violation and faculty concerns.</td>
<td>• The SAP referral process is well integrated into the school system. Administration and faculty report they cannot live without the service.</td>
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<td></td>
<td>• School district/building policy regarding referrals for student violations has not been successfully implemented.</td>
<td>• RMC data indicates students access services for youth and their families within the community for ATOD and mental health assessments and treatment.</td>
<td>• Discipline referrals include youth at-risk of dropping out, failing, and/or have attendance problems.</td>
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<td></td>
<td>• RMC data indicates few referrals were made to outside services with student follow through.</td>
<td>• Relationships have not been established with local service agencies and coalitions such as substance abuse and mental health treatment providers, juvenile justice probation officers, CPS, and ATOD community coalition members.</td>
<td>• RMC data shows thoroughness in program case management and follow through by Specialist.</td>
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<tr>
<td></td>
<td>• Relationships have not been established with local service agencies and coalitions such as substance abuse and mental health treatment providers, juvenile justice probation officers, CPS, and ATOD community coalition members.</td>
<td>• Specialist actively meets with local service agencies (i.e., substance abuse and mental health treatment providers, juvenile justice probation officers, CPS, and ATOD community coalition members) to case consult and coordinate services.</td>
<td>• Specialist maintains positive working relationships local service agencies.</td>
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<td></td>
<td>• Specialist actively participates in local school/community coalitions activities.</td>
<td>• Specialist actively participates in local school/community coalitions activities.</td>
<td>• Specialist takes a lead role in coordinating local school/community coalitions activities.</td>
<td></td>
</tr>
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<tr>
<td><strong>CULTURAL COMPETENCY</strong></td>
<td>• Specialist is unaware of local community cultural and how they impact the school climate</td>
<td>• Specialist thoroughly understands the local community cultural and issues and how they impact the school climate</td>
<td>• Specialist is able to provide guidance and consult with peers on the local community cultural and issues and how they impact the school climate</td>
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<tr>
<td></td>
<td>• Specialist is limited in ability to discuss the factors that help to define the culture of each individual student and family, including ability to demonstrate culturally competent interviewing and communication skills with students and families</td>
<td>• Specialist demonstrates the ability to discuss the factors that help to define the culture of each individual student and family, including ability to demonstrate culturally competent interviewing and communication skills with students and families</td>
<td>• Specialist is seen as a resource by peers to case consult on factors that define the culture of each individual student and family, including interviewing and communication skills with students and families</td>
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<td></td>
<td>• Identifies and uses professional practices that encourage SAP professionals to respect the diversity of each student and family</td>
<td>• Identifies and uses professional practices that encourage SAP professionals to respect the diversity of each student and family</td>
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<td></td>
<td>• Assesses his or her own strengths, needs, and boundaries when working with each student and family</td>
<td>• Assesses his or her own strengths, needs, and boundaries when working with each student and family</td>
<td>• Assesses his or her own strengths, needs, and boundaries when working with each student and family</td>
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<td>• Demonstrates culturally competent interviewing and communication skills with students and families</td>
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<td></td>
</tr>
<tr>
<td>PROFESSIONALISM, LAWS AND REGULATIONS</td>
<td>Rating 1: Does not meet expectations</td>
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<tr>
<td>• Limited knowledge of implications of federal and state legislation that impacts SAPs.</td>
<td>• Demonstrates a basic understanding of practical implications of federal and state legislation that impacts SAP</td>
<td>• Thoroughly understands the purpose of federal and state legislation that impacts SAP</td>
<td>• Provides guidance and consults with peers on practical implications of federal and state legislation that impacts SAP</td>
<td></td>
</tr>
<tr>
<td>• Does not know legal rights of parents/caregivers and students in the SAP process.</td>
<td>• Ability to identify legal rights of parents/caregivers and students in the SAP process</td>
<td>• Thoroughly understands the legal rights of parents/caregivers and students in the SAP process.</td>
<td>• Legal rights of parents/caregivers and students in the SAP process.</td>
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<tr>
<td>• Inability to summarize the difference in legal and professional responsibilities of school professionals and agency personnel with particular attention to the application of confidentiality laws.</td>
<td>• Recognizes the importance of regularly reviewing and updating local school policies that involve SAP such as ATOD, mental health, etc.</td>
<td>• Thoroughly understands the purpose and application of confidentiality laws</td>
<td>• The difference in legal and professional responsibilities of school professionals and agency personnel with particular attention to the application of confidentiality laws</td>
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<tr>
<td>• Can summarize the difference in legal and professional responsibilities of school professionals and agency personnel with particular attention to the application of confidentiality laws.</td>
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<tr>
<td>ENAGAGING PARENTS/CAREGIVERS IN THE SAP PROCESS</td>
<td>Rating 1: Does not meet expectations</td>
<td>Rating 2: Meets expectations; demonstration of basic understanding of SAPI services</td>
<td>Rating 3: Meets expectation; demonstration of thorough understanding of SAPI services</td>
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<tr>
<td>• Lacks a clear understanding of how to engage parents/caregivers in the SAP process</td>
<td>• Engages the majority of parents/caregivers in the SAP process</td>
<td>• Thoroughly understands the purpose and importance of engaging the parents/caregivers in the SAP process</td>
<td>• Ability to train others and serve as a role model to peers in engaging parents/caregivers in the SAP process</td>
<td></td>
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<tr>
<td>• Needs guidance and structure from supervisor to identify strategies for establishing and maintaining working relationships with parents/caregivers</td>
<td>• Identifies strategies for establishing and maintaining working relationships with parents/caregivers</td>
<td>• Outlines models of stages of change as they relate to students and parents/caregiver motivation</td>
<td>• Utilizes the stages of change as they relate to students and parents/caregiver motivation to intervene on substance using/abusing/dependent youth and families</td>
<td></td>
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<tr>
<td>• Identifies strategies for establishing and maintaining working relationships with parents/caregivers</td>
<td>• Describes adaptations and considerations needed for culturally effective/competent communication with parents/caregivers</td>
<td>• 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</td>
<td>• Consistently is involved with and working with parents/caregivers in efforts to better the family system</td>
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<tr>
<td>• Describes adaptations and considerations needed for culturally effective/competent communication with parents/caregivers</td>
<td></td>
<td>• Utilizes multiple strategies for establishing and maintaining working relationships with parents/caregivers</td>
<td>• Ability to adapt intervention strategies with family system/culture</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Describes adaptations and considerations needed for culturally effective/competent communication with parents/caregivers</td>
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SUGGESTED ETHICAL GUIDELINES AND STANDARDS OF PRACTICE

Philosophy Statement for Student Assistance Programs
A Student Assistance Program is a school-based comprehensive prevention and intervention program for students in Kindergarten through Grade 12 characterized by a team approach. This professional, systematic process is designed to provide education, prevention, early identification, intervention, referral, and support services for students exhibiting risk behaviors which are interfering with their education. The positive influence of Student Assistance Programs encourages student success in the school environment, fosters risk reduction, and positive asset development, provides a safe environment, and promotes opportunities for knowledge, skill, and attitude development. Key components are developmental curriculum and education, policy, staff and community in-service and education, early identification, development of support processes, use of community resources, and ongoing evaluation of program effectiveness.

Mission Statement for Student Assistance Programs
The Student Assistance Program utilizes a multidisciplinary team and intervention system to remove the educational and behavioral barriers which interfere with student learning, and works to enhance the developmental assets of students. This goal is accomplished by providing strategies and support to the school community and parents to improve their ability to help students succeed in school. The team also marshals other school and community resources as necessary for an effective intervention.

This document includes ethical guidelines and standards of practice for those people involved in a Student Assistance Program in any capacity. These guidelines and standards are intended to clarify the ethical responsibilities to students, families, school staff, Student Assistance Teams, community, school support groups, and the profession of Student Assistance.

These guidelines were developed to identify the standards of conduct necessary to maintain and regulate the high standards of integrity and leadership among persons involved in Student Assistance Programs. They are meant to stimulate reflection, self-examination, and discussion of issues and practices.

A. Responsibilities to Students
Those involved in the Student Assistance Program will:

- Have primary responsibility to the student, who is to be treated with respect and dignity and with concern for confidentiality.
- Be responsible to offer Student Assistance components to all students who indicate a need for such services and include all students with evidence of risk behavior.
- Promote and enhance student’s strengths, skills, and capabilities while addressing their developmental needs.
- Inform the student of the purposes, goals, and procedures under which he/she may receive Student Assistance. Include the possible necessity for consulting with other professionals and legal or other authoritative restraints.
- Maintain current knowledge of laws relating to Student Assistance Program practice and ensures the rights of students are adequately protected.
- Make referrals to appropriate service providers based upon student’s needs and monitor student progress.
- Protect the confidentiality of student records and exchange personal data only according to prescribed laws and school policies.
- Provide and act upon only accurate, objective, and observable data regarding a student’s behaviors.

10 Source: National Student Assistance Association as adapted from the work of the Office of Student Services, Indiana Department of Education. Available at www.nasap.org/ethics.html

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• Inform appropriate authorities when the student’s condition or statements indicate clear and imminent danger to the student or others. This is done after careful deliberation and when possible in conjunction with other professional consultation.
• Provide explanation to parents/guardians and those who provide services to the students of the nature, purpose, and results of screening or assessment interviews.
• Account to each student referred to the Student Assistance Program by continued evaluation of student success and needs and provide additional assistance whenever necessary.

B. Responsibilities to Families
Those involved in the Student Assistance Program will:
• Have primary responsibility to the family of the student, who is to be treated with respect, dignity, and with concern for confidentiality.
• Respect the inherent rights and responsibilities of parents for their children and endeavor to establish a cooperative relationship with parents.
• Inform parents of the role of Student Assistance Programs with emphasis on the positive nature of the program and the role of confidentiality between students, staff, and families.
• Treat information received from families in a confidential and ethical manner.
• Share information about a student only with those persons properly authorized to receive such information.
• Offer ongoing support and collaboration with families for the success of their child.

C. Responsibilities to School Staff
Those involved in the Student Assistance Program will:
• Establish and maintain a cooperative relationship with faculty, staff, and administration to facilitate the provision of optimum Student Assistance Program services.
• Promote awareness and adherence to laws and ethical guidelines regarding confidentiality and the distinction between public and private information.
• Provide staff with accurate, objective, and concise data necessary to assist the student.
• Offer appropriate in-service training and current Student Assistance Program information for all staff.
• Encourage awareness and appropriate use of related professions and organizations to which the student may be referred.
• Provide services within their board-approved job descriptions and with an awareness of the specific areas of responsibilities and limitations.

D. Responsibilities to Student Assistance Team Members
Those involved in the Student Assistance Program will:
• Select multidisciplinary teams based upon the goals and mission of Student Assistance Programs/Teams as defined by appropriate state entities and implemented within the particular needs of each individual school system.
• Support the components included in a Student Assistance Program with an emphasis on prevention, asset/resiliency development, confidentiality, referral, identification, intervention, support, and evaluation.
• Select professionals with leadership, communication skills, and expertise that relate to the wide range of issues of youth and families.
• Act upon referrals to the team by collecting observable data and planning developmentally appropriate levels of interventions.
• Treat information received from school staff, students, parents, and community resource in a confidential and ethical manner.
• Provide staff with accurate, objective, and concise data necessary to assist the student.
• Know and utilize community resources and services for referrals.

E. Responsibility to the School and Community
Those involved in Student Assistance Program will:
• Inform appropriate officials of conditions that may be potentially disruptive or damaging to the school’s mission, personnel, students, or property.
• Work cooperatively with the community agencies, organization, and individuals in the school.
• Delineate and promote the Student Assistance Program role and function in meeting the needs of those served.
• Assist in the development of curricular and environmental conditions and programs appropriate for the school and community to meet student needs.
• Develop a systematic evaluation process for Student Assistance Programs.
• Offer ongoing educational opportunities for families and community members regarding issues of our youth.
• Provide an ongoing cooperative link between school and community services.

F. Responsibilities to School Support Groups
Those involved in Student Assistance Program will:
• Adhere to the Ethical Guidelines for Group Counselors and Professional Standards for Training of Group work approved by the Association for Specialists in Group Work and promote knowledge of these guidelines among peers.
• Emphasize that school-based student support groups are psycho-educational and information groups, not therapy groups.

G. Responsibilities to the Student Assistance Profession
Those involved in Student Assistance Program will:
• Conduct themselves in such a manner as to bring credit to self and the Student Assistance Program practice.
• Actively participate in local, state, and national associations that foster development and improvement of Student Assistance programming.
• Adhere to ethical standards applicable to Student Assistance Program practice and other professional practices, school board policies, and relevant statutes established by federal, state, and local governments.
• Clearly distinguish between statements and actions made as a private individual and as a representative of the school Student Assistance Program.

H. Responsibility to Self
Those involved in the Student Assistance Program will:
• Monitor one’s own physical, mental, and emotional health and professional effectiveness.
• Refrain from any destructive activity leading to inadequate services or harm to self or a student.
• Take personal initiative to maintain professional competence and keep abreast of innovations, trends and legal issues related to the field of Student Assistance Programs.
• Understand and act upon their commitment and responsibilities to the Student Assistance Program.
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
PURPOSE OF PROGRAM AWARENESS

Program awareness is an important component of an effective Student Assistance Program (SAP). It is a means of promoting program services to those inside and outside of the school environment, with the aim of sustaining prevention and intervention efforts. The purpose of program awareness is to educate school staff, parents, students, agencies and the community about the school’s policy on alcohol, tobacco, and other drugs, and to provide information about student assistance services that promote resilience and student success. There are two distinct types of program awareness: social marketing and awareness events.

The goals of social marketing are to involve parents, students, school staff, and community members in developing safe, disciplined, and drug-free schools. In social marketing, parents and the community are educated about policies and made aware of student assistance program services that promote resilience and support student success. The goals of awareness events are to provide frequent schoolwide activities directed at students and school staff; these are opportunities for program staff to disseminate information about the comprehensive SAPISP services with the aim of raising awareness, changing attitudes, and ensuring program visibility.

SOCIAL MARKETING

Within the school setting, social marketing is a tool to accomplish social change—increasing knowledge and awareness of ATOD use—and building consensus for strategies and practices to strengthen students, families, the school, and the community. Social marketing, built upon basic marketing tactics, aims to influence action, to change internal attitudes (education/persuasion), structure (policy), and/or work to make the targeted behavior unnecessary (University of Washington, 1997). There are two basic elements to social marketing: (1) market messages to motivate people to make changes; and (2) create strategic alliances with stakeholders to ensure program sustainability through increased awareness. 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.

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

AWARENESS EVENTS

As noted, awareness events serve to change attitudes and norms by providing information that challenges existing ATOD use attitudes and norms. Awareness events also target groups such as the whole school, community, nation, or specific subgroup. These events are generally large in scope and have a concrete message aimed at creating attitudinal change. If implemented properly, expected outcomes include increased perception of harm, decreased ATOD use, increased safety, or reduction of age onset.

11 For additional information on social marketing skills and training, visit CSAP’s Central CAPT Web site at: http://www.ccapt.org/sm_skills.html)

Component 3
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 SAPISP services that promote resilience and student success.
In the school and community setting, awareness events create attitudinal and normative changes through various strategies such as information dissemination, educating consumers, providing drug-free alternatives, environmental changes (ATOD policies, policy enforcement), and community strategies (needs assessments, training, volunteer services) as well as other strategies to increase understanding of program aims.

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’S ROLE IN SOCIAL MARKETING AND PROGRAM AWARENESS
Student Assistance Specialists are the “front line” marketers of SAPISP program services. Part of program staff’s responsibilities is to promote services and raise awareness through the dissemination of information about program offerings 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.

Social Marketing to School Staff
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. And, with the support of the school administrator, continued program marketing takes place throughout the school year.

Suggested School Staff Marketing Strategies
At an orientation session, program staff provide school staff with the opportunity to give feedback regarding program services, what is working and what needs improving. Social Marketing strategies for faculty include:

- Program Orientation that covers such topics as:
  - Overview of program services and basic structure.
  - Fundamentals of ATOD issues.
  - Guidelines and constraints of federal and state confidentiality laws.
  - Role of program staff.
  - Internal referral process.
  - Review of signs and symptoms.
  - Opportunity for feedback—What’s working, what’s not, and how to make it better.
  - Report on program progress.
- Regular updates at staff meetings.
- Distribution of SAPISP Newsletter.
- Educational/informational offerings.
- Review findings needs assessment data such as Healthy Youth Survey.

SUGGESTED SCHOOLWIDE SOCIAL MARKETING STRATEGIES
In addition to directly promoting SAPISP services through staff in-services, trainings, and distribution of promotional materials, it is important that SAS’s foster a positive, supportive environment in the school. To accomplish this task means employing a variety of marketing strategies such as:
• Visibility. Get 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.” Good classes for this are Health, PE, and Science, or homerooms.
• Knowing where students congregate and be there.
• Talking to students in the lunchroom.
• Attending school prevention club activities.
• Distributing a monthly newsletter, tailored to the individual needs of your school.
• Putting up positive “no use” messages, create and distribute posters.
• Being visible in the teachers’ lounge. Introduce yourself to everyone in the school.
• Attending and participating in open house or other extra curricular or school-supported activities. Distribute program promotional flyers, brochures, and resource materials.
• Having an open door policy to invite students to drop in.
• Being interviewed with the school paper.

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

Other Schoolwide Promotional Ideas
To further program staff’s marketing efforts, a variety of other marketing strategies can be offered, including:
• Developing a SAPISP Newsletter.
• Writing 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.
• Conducting prevention activities via prevention clubs.
• Creating a SAPISP handbook.
• Creating and maintaining a SAPISP Web Page via the school.
• Creating a SAPISP pamphlet or add a SAPISP column to an existing Counseling Center pamphlet.
• Attending ATOD task force meetings.
• Presenting at community information nights or on ATOD information panels.
• Attending PTA or Booster Club meetings.
• Regularly interacting with treatment providers in the community, pediatricians, other doctors, mental health care providers.
• Offering a parent education series.

SOCIAL MARKETING THROUGH CLASSROOM PRESENTATIONS
An effective way to promote programs/services to the student body is to conduct classroom presentation. The most appropriate classes to conduct SAPISP awareness presentations are core or required classes such as Math, English, or Science. In addition to increasing student and teacher awareness of program services, classroom presentations are a prime opportunity for generating referrals. Oftentimes during classroom visits, program staff become aware of a student that is of concern, or a student may refer a peer, or self refer. Classroom presentations cover the basic information about drug use, abuse, and dependency; provide an overview of program services; and give students an opportunity to ask questions. A follow up presentation may include information on the affects of drug abuse on the family, and discuss support groups for Affected/Concerned Others.

Other Student Centered Promotional Ideas
Additional, student centered promotional strategies beyond classroom-based presentations may include:
• Start a Prevention Club.
• Make regular announcement concerning ATOD issues and program services;
• Inform incoming students of program services, start a “New Comers” group.

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It is important to remember that social marketing is a continuous process: it works best to start early and continue throughout the school year!
• Continue to provide classroom presentations to promote program services and increase student awareness/knowledge.

A sample classroom presentation format is available in “Additional Resources” at the end of this section.

SOCIAL MARKETING IN THE COMMUNITY
It is important for program staff to network within the community to promote program services. Social marketing strategies for the community include:

• Conduct informal site visits at local agencies to orient agency staff to the overall program and basic structure.
• Distribution of program information in the community setting
• Networking with community-based program providers.
• Attendance at coalition meetings, health fairs, and other ATOD related prevention activities.
• Collaboration with community partners to host ATOD awareness events.

AWARENESS EVENTS
As noted earlier, there are two types of program awareness—Social Marketing and Awareness Events. Awareness Events serve to change attitudes and norms by providing information that challenges existing ATOD use attitudes and norms. Awareness, or universal strategies, 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 and youth leadership functions.
(4) Environmental strategies include establishing ATOD-free policies, changing environment rules, and public policy efforts.
(5) Community strategies include assessing community needs, training services, technical assistance, and community/volunteer services.

Classroom-Based Awareness Activities
In addition to scheduling and coordinating schoolwide awareness events, the SAS may also be involved in providing activities in individual classrooms. Similar to schoolwide events, the aim of classroom activities is to raise student awareness and challenge existing attitudes and norms regarding ATOD use. Classroom activities led by the SAS, combine both didactic and experiential approaches with outcomes anticipated to: (1) increase student's knowledge/awareness of the effect of substance use; (2) decrease favorable attitudes toward ATOD use; (3) correct misperceptions about the prevalence and acceptability of ATOD use; (4) increase student's knowledge and skills related to resistance; and, (5) decrease unhealthy ATOD related behaviors.

Classroom-based awareness activities are meant to supplement existing Universal prevention programs such as Project Alert and are not a substitute for proven-effective curriculum. These awareness activities are aimed at presenting educational materials to both users and non-users. For students who do not use, the information provided reinforces non-use and is intended to delay the onset of use. For students who are currently using, awareness activities may help to reduce use.
Presentation topics include ATOD awareness, with the goal of increasing student perception of the causes and effects of ATOD abuse. Possible objectives include recognizing the stages of ATOD use, dispelling “everyone uses” myths, and distinguishing between drug use facts and fiction. A separate presentation may address coping skills, with the goal of assisting students to develop skills to handle problems or pressures related to adolescence. Objectives include identifying common adolescent stressors, alternative/healthy ways to cope with stress, understanding and coping with peer pressure, and role-playing refusal skills.

ADDITIONAL RESOURCES

SAMPLE CLASSROOM PRESENTATION FORMAT

Setting Up Social Marketing Classroom Presentations
In smaller schools, this may be a much easier task than in larger schools, which may take weeks to accomplish. Larger schools may require the assistance of an assistant principal, school counselor, or other school staff. These knowledgeable staff members can help the SAS locate computer reports with class information that is necessary in preparing classroom presentation schedules, including:

1. Teacher’s name.
2. Classroom number.
3. Class title.
4. Time or period of the day class takes place.
5. Grade intended for the class (9th Grade English, 11th Grade English, etc.).

The activities director in larger schools can also be helpful with making certain that presentations do not conflict with previously scheduled activities. They can also help to avoid scheduling during student government activities that may be too distracting to the SAPISP’s goal (homecoming, spirit week, prom activities, etc.).

In preparation for classroom presentations, the SAS should have an outline of the information to be presented, a sign up sheet, and a hand out that gives students the opportunity to self-referral. At a minimum, student-centered classroom presentations should include the following elements:

- Introduction.
- Mission and purpose of the program.
- SAPISP hours and days of availability.
- Location of the SAPISP office.
- Basic description of support groups provided.
- Detailed explanation of how to access program services—group and individual.
- Student expectations.
- Overview of confidentiality including exceptions to rules.
- Description of available support groups.
- Review of group rules.

Classroom-based presentations should be considered an opportunity for the SAS to market program services, solicit support, and increase awareness of program aims. In the end, the time spent in the classroom will serve to improve program visibility and possibly referrals to program services.
Technical Assistance Bulletin

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.

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.

12 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.
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 alcoholic 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 judgement 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, antimigraines, tranquilizers, antinauseants, 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 U.S. 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.

The basis of all CSAP principles and guidelines is one major tenet: “Do no harm.”

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 drugs 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 a 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 1970s, 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 spokespeople 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 and 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.

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Section 5:
Internal Referral Process
INTRODUCTION

Essential to the success of the Washington State 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 academic and social problems, suspected ATOD use, 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 Student Assistance Team for appropriate screening/pre-assessment, referral, and support services.

Washington State’s comprehensive SAPISP model’s internal referral process consists of five components: (1) Early identification; (2) Screening/Pre-assessment; (3) Intervention; (4) Referral to other school and community-based services; 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/Pre-Assessment. 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).
- Intervention. 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 8 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).
- Referral. Students are referred to in-school programs or community-based ATOD assessment, treatment (out-patient, in-patient), or other community-based services based upon the student’s identified needs (Deck, 2004).
- Support Services. Support services include advocating for students, removing barriers to accessing treatment or other 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: (1) Implement or review with school administrators no use policies and procedures, disciplinary referral processes, and possible buy back structure—in lieu of suspension; (2) Educate faculty about ATOD signs and symptoms, other behaviors of concern, and school policies and procedures for ATOD violations; (3) Provide staff development and in-service trainings in the referral process, confidentiality and students’ rights to privacy; and (4) Promote program services to students, parents, and the community at large.

EARLY IDENTIFICATION

The early identification of students at risk for substance use or other problem behaviors 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 (1) academic performance – a decline in grades, or participation; (2) attendance–unexplained absences or increased tardiness; (3)
disruptive classroom behaviors—fighting, sleeping in class, acting out; (4) disciplinary problems; (5) legal problems—possession charges, shoplifting, vandalism; (6) problems with out of school activities—sudden loss of involvement and/or interest in extracurricular activities; (7) problems at home; or (8) violation of no use policies or ATOD specific behaviors.

As part of the early identification process, Student Assistance Specialists educate referral sources about the signs and symptoms of problem behaviors and changes in a student’s attitude or behaviors that generate a referral to the SAPISP program (see Section 3: Staff Development). School staff complete a Referral Form (See sample form, page 109), 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.

The following is a checklist of substance abuse indicators that may signify the need to refer a student to program services.

**SUBSTANCE ABUSE INDICATORS**

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means extreme caution must be exercised to avoid misidentifying and inappropriately stigmatizing a [student]. Never overestimate the significance of a few indicators.

The type of indicators usually identified are:

- A prevailing pattern of unusual and excessive behaviors and moods
- Recent dramatic changes in behavior and mood.

School staff and those in the home should be concerned if they note:

- Poor school performance; skipping or ditching school.
- Inability to cope well with daily events.
- Lack of attention to hygiene, grooming, and dress.
- Long periods alone in bedroom/bathroom apparently doing nothing.
- Extreme defensiveness; negative attitudes; dissatisfied about most things; argumentative.
- Frequent conflicts with others; verbally/physically abusive.
- Withdrawal from long-time friends/family/activities.
- Disregard for others; extreme egocentricity.
- Taking up with new friends who may be drug users.
- Unusual tension or depressed states.
- Seems frequently confused and “spacey”.
- Often drowsy.
- General unresponsiveness to what’s going on (seems “turned off”).
- Increasing need for money; disappearance of possessions (perhaps sold to buy drugs); stealing/shoplifting.
- Excessive efforts to mislead (lying, conning, untrustworthy, insincere).
- Stooped appearance and posture.
- Dull or watery eyes; dilated or pinpoint pupils.
- Sniffles; runny nose.
- Overt indicators of substance abuse (e.g., drug equipment, needle marks).

*Indicators of abuse categorized by commonly abused substances are available in Additional Resources at the end of this section of the manual.*

**REFERRAL SOURCES**

Students are referred to program services from a variety of sources and for a variety of

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reasons. Referral sources include school administrators, school staff, self, peers, parents, and community members. The 2001–03 Final Report—Addressing Adolescent Substance Abuse: An Evaluation of Washington's Prevention and Intervention Services Program (Deck, 2004) found that the school staff refer the majority (73 percent) of students to program services, including 26 percent referred by school administrators related to disciplinary actions. Students themselves are also a primary referral source, with 43 percent of students served self-referred (Deck, 2004).

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 are disruptive to the learning environment. In general, the administrator offers the disciplined student a “buy-back” or “in lieu of suspension” alternative in accord 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 s/he follows through with referral and program service recommendations.

Staff Referrals
Teachers, counselors, and other school staff make up the largest proportion of referents to program services. Due to school staff’s 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. To ensure staff are engaged in the referral process and knowledgeable about properly identifying students of concern, specific training is necessary to increase staff awareness of program services, school ATOD policies and procedures, issues associated with ATOD use and other related topics such as symptomology of use, or symptoms of affected others, and confidentiality and student’s right to privacy (Anderson, 1993). (Refer to Section 3 Staff Development for additional information).

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 page116). 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 know 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 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 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
During the 2002–03 WA SAPISP program year, 43 percent of referrals to program services came from students themselves (Deck, 2004). 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).

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: (1) provide an overview of SAPISP program services; (2) ask the parent about any concerns he/she may have had with his/her son/daughter (this may include exploring family history of substance abuse); (3) provide general information about signs and symptoms of ATOD use; and (4) 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 SASs with suggested program operations related to implementing an internal referral process including steps to screening/pre-assessing referred students. Also provided, is information on several adolescent screening tools, suggested protocols related to confidentiality and record keeping as well as a collection of other sample forms.

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 on page104 provides detailed information on what a student needs to understand when agreeing to participate in program services.
This section of the manual is of vital importance in assisting the SAS in understanding his/her role in providing SAPISP services to substance impacted students. 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/PRE-ASSESSMENT PROCESS

Once a student is referred to the SAPISP program, the SAS begins a multi-step screening/pre-assessment process. The four step screening and pre-assessment process 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 or pre-assessment 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 (ATOD 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 first hand 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).

STEP TWO – BUILDING RAPPORT

Program staff conduct 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.

*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 97–108 for additional information on confidentiality).
• 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/pre-assessment if the student is going to continue with services.

STEP THREE – IDENTIFY RISKS AND NEEDS

The third step in the screening/pre-assessment 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; nature of the student’s substance use history and severity of use; and the student’s readiness to change. A sample Intake Form on page 138 guides the SAS in collecting risks and needs data. Additional information regarding selecting screening instruments to compliment the intake form and assessment process is on page 112.

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); therefore, screening for such is an important step during the screening/pre-assessment process. Student Assistance Specialists 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 reduce or prevent student use of substances. Students referred to program services span a range of substance use 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 ATOD 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. Validated and reliable instruments\(^{14}\) are necessary for the effective collection of data in the screening process, with supportive information, as noted previously, gained through student interviews and observations (Grisso & Underwood, 2004; Winters, 1999). According to the National Institute of Alcohol Abuse and Alcoholism (2003), screening is defined as:

\(^{14}\) Reliability refers to “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 (Vogt, 1993, p. 195).

Validity is “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 (Vogt, 1993, p. 240).
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).

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. Definitions of substances are (Deck, 2005, p. 12):

- **Alcohol.** Include beer, wine, and coolers as well as distilled liquor.
- **Tobacco.** Mark any tobacco use, either smoked (cigarettes, cigars) or smokeless (snuff, chewing tobacco).
- **Marijuana/hashish.** Include all forms of marijuana with street names like hash, hash oil, pot, grass, mary jane, sinsemilla, weed, and joint.
- **Hallucinogens.** Natural sources include peyote, mescaline, and psilocybin (magic mushrooms). Synthetic sources include LSD (acid, trip, purple haze, microdot, tab, blotter), PCP (angel dust, hog, love boat, wack) and MDMA (ecstasy).
- **Amphetamines.** Include amphetamines (Benzedrine, Dexedrine) and methamphetamine. Street names include bennies, speed, uppers, ice, crystal, meth, co-pilots, and black beauties. Include prescription diet pills used to get high here.
- **Cocaine/crack.** Include all forms of cocaine. These have street names like coke, snow, toot, crack, freebase, and nose powder.
- **Inhalants.** Include inhaled substances that do not fit other categories such as glue, polish remover, lighter and cleaning fluids, white-out, and products with aerosol propellants, as well as amyl nitrate (snappers, poppers) and butyl nitrate (locker room, rush).
- **Other drugs.** Include all other drugs not listed such as: depressants (sedatives and tranquilizers such as Amytal, Butisol, Nembutal, Phenobarbital, Seconal, Valium, Librium, and Serax), opiates (heroin, opium, morphine, and codeine), and any over-the-counter drugs used to get high.
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):\(^\text{15}\)

- Never used. The student has never used this substance.
- Abstained. The student has used this substance, but not in the past 3 months.
- Misused. The student has used the substance in the past 3 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 3 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/pre-assessment 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, an 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.

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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 reentry support, upon returning from or while involved in treatment.

*A more detailed discussion regarding case management (Section 6) and support group services (Section 8) is provided.*
Figure 5.1 SAPISP Decision Tree for Services

**Identification and Referral**
- School Administrator
- School Staff
- Self/Peer
- Parent
- Community

**SAP Quick Intervention**
- (less than 2 contacts)
- No/Minimal Risks; No Use

**SAP Full Intervention**
- Screen / Pre-assess: Collateral information
- No/Minimal Risks; No Use

**Mineral/Mod Risks; Minimal Use/experimentation**
- RMC Intake & Services Pre-Test Consent

**SAPI Services**
- Individual sessions
- Group sessions: At Risk/Social Skills; Intervention; Concerned Persons/Affected Others
- Case Management
- Referral Services

**Refer to Other School Services:**
- School Counselor
- School Psychologist
- After School Program Tutoring/Mentoring

**Community Resources**
- Mental Health
- Medical Care
- Family Services
- Parent Support/ED
- Social & Health Services
- Educational (Voc/College)
- Work Source
- 12-Step/Faith-based/Other

**SAPI Services**
- Individual sessions
- Group sessions: Intervention; Challenge
- Case Management
- Referral Services

**Refer to Other School Services:**
- School Counselor
- School Psychologist
- After School Program Tutoring/Mentoring

**Other Services**
- School Counselor
- School Psychologist
- After School Program Tutoring
- Community-based services

**Moderate Risks; Moderate Use/Abuse**
- RMC Intake & Services Pre-Test Consent

**SAPI Services**
- Individual sessions
- Group sessions: Intervention; Challenge
- Case Management
- Referral Services

**Refer to Other School Services:**
- School Counselor
- School Psychologist
- After School Program Tutoring/Mentoring

**High Risks; High Use/Dependent**
- RMC Intake & Services Pre-Test Consent

**SAPI Services**
- Individual sessions
- Group sessions: Intervention; Challenge
- Case Management
- Recovery group
- Reentry Support
- Formal ATOD Assessment
- Family Consultation
- Refer to Treatment
- Treatment Support

**Referral to Other School Services:**
- School Counselor
- School Psychologist
- After School Program Tutoring/Mentoring

At completion of SAPI services or the end of school year complete RMC post-test.
SELECTING A SCREENING/PRE-ASSESSMENT INSTRUMENT

All students referred to the Student Assistance Specialist are screened for substance use and other related problem behaviors through the multi-step process outlined above. As noted, the purpose of screening within the Student Assistance Prevention-Intervention Services Program is to focus on the identification of symptoms, problem areas, and needs of referred students. Screening results do not establish a diagnosis, but are useful in guiding staff in making effective referral decisions based upon a standardized process and the use of a valid and reliable data screening/pre-assessment tool.

There are a variety of screening instruments designed for use by professionals within the SAPISP program; the difficulty is determining which is the most appropriate for individual program needs. Grisso and Underwood (2004), provide a summary of the basic criteria desirable among screening instruments for identifying substance abuse-related and psycho-social needs among adolescents (p. 13):

- Require low levels of reading ability and use relatively simple response formats (for paper-and-pencil instruments that must be completed by youth).
- Assess mental distress and disorder and/or substance use needs along dimensions that are meaningful for the specific context and purpose(s) of the evaluation.
- Be amenable to use with youth of diverse ethnic, cultural, and linguistic backgrounds.
- Have some evidence of psychometric reliability and include information regarding the extent of limits of validity within the adolescent population.
- Offer age- and gender-based norms across the span of youth within the population served.
- Assess psychological or behavioral conditions that may indicate a need for immediate or emergency intervention (e.g., suicidal potential, serious depression, anger and aggression, substance abuse).
- Have low per-case costs and low publisher fees.
- Involve brief, simple administration that requires little or no specialized clinical expertise.
- Offer easy scoring that produces uncomplicated results.
- Allow for quick and simple interpretation of scores or application of decision rules in using screening data to determine appropriate response.

Additionally, Winters (1993, p. 8) maintains,

A model screening instrument is short, simple, and appropriate to the youth’s age. The instrument should give the “big picture” of the youth’s situation, not a lot of specific, detailed information. However, the instrument should be of sufficient scope to cover the “red flag” areas of substance use disorders and psychosocial functioning … The tool should not require sophisticated knowledge in testing administration or interpretation; it must have high utility for a broad range of professionals and paraprofessionals.

Examples of Screening Instruments
The following information provides a brief description of four screening instruments currently in use in Student Assistance Programs within the state and nationally. Each instrument has its merits, and subsequently its own downfalls. When choosing a screening instrument keep in mind the basic criteria listed above as well as individual program needs. All four instruments are copyright protected and require licensure and/or out-right purchase. Instruments may also require some level of staff training/certification prior to implementation. Costs should also be considered—Is it a one time licensing fee or a per form charge?
(1) The Global Appraisal of Individual Needs - Quick (GAIN-Q)\(^{16}\)
Interviewer or self-administered screening questionnaire. Developer: Michael Dennis (2002). The GAIN-Q is an efficient behavioral health screening instrument. It can be interviewer- or self-administered in 20 to 30 minutes, and both hardcopy and computer-assisted administrations are possible. Most items are written in a “yes/no” format. Currently, the GAIN-Q is available in 2 forms: a GAIN-Q “Core” instrument and a GAIN-Q “Full” instrument that includes a reasons for quitting scale used to support motivational interviewing with the MET/CBT5 protocol. Available in English and Spanish versions.

**Description:** The GAIN-Q instrument is a general assessment used to identify various life problems among adolescents and adults in the general population. Designed for use by personnel in diverse settings (e.g., Employee Assistance Programs, Student Assistance Programs, health clinics, juvenile justice, criminal justice, etc.), the instrument is used to: (1) identify and be a sufficient assessment for those who may benefit from a brief intervention; (2) identify those in need of a longer, more detailed assessment; and (3) guide staff to make effective referral and placement decisions. Although the GAIN-Q does not provide diagnostic information per se, it does identify areas where the person is likely to have a diagnosis and/or be in need of further exploration.

The GAIN-Q CORE instrument is organized into ten sections:

1. Background
2. General Factors
3. Sources of Stress
4. Physical Health
5. Emotional Health
6. Behavioral Health
7. Substance-Related Issues
8. Service Utilization
9. End
10. Case Disposition

The first four sections provide background and formative indices of factors that are related to behavioral health problems. The next three sections (Emotional Health, Behavioral Health, Substance-Related Issues) contain the core behavioral health indices. These sections assess the breadth and prevalence of problems using the core symptoms from the central scales of the full GAIN instrument. The core symptom scales cover behavior during the past year (“past 12 months” on the instrument) and each concludes with an item (or items) on the number of days (or times) the problems have occurred during the past 90 days. The instrument concludes with sections covering the participant’s desire for help and the context of the assessment (End) as well as a staff-only section to document reasons for referral and recommendations (Case Disposition).

The GAIN-Q FULL instrument is composed of the GAIN-Q CORE along with one or a series of additional scales specific to user needs. Currently, the supplemental measure that is included as part of this longer GAIN-Q assessment is the Reasons for Quitting (RFQ) scale. A second optional section—the Optional Special Study Detail -- is used to document data from study-specific assessments a project may be using in the situation where these assessments are not a part of the supplemental measure(s) described above.

**Population:** Adolescents (over 11); Adults

**Validity/Reliability:** Reliability studies have been done using test-retest measures, split-half, and internal consistency. Validity studies have also been done, using content, measures of criterion (predictive, concurrent, “postdictive”), and construct.

(2) The Global Appraisal of Individual Needs – Short Screener (GAIN-SS)\(^{17}\)

\(^{16}\) Source: Chestnut Health Systems, www.chestnut.org/li/gain
\(^{17}\) Ibid.
The GAIN-SS is a brief, 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 recency 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 four subscales (five-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 (TDScr)–one or more of any of the above identifies over 99 percent of the disorders listed above.

- **Population:** Adolescents (over 11); Adults

**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 percent) for identifying people with a disorder and excellent specificity (89 percent) 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 subscreener, using a cut point of 1+ achieved over 90 percent sensitivity and 70 percent specificity (within the area) for both adults and adolescents. Using 3+ in the subscales provided 70 percent sensitivity and 90 percent 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.

**3) Personal Experience Screening Questionnaire (PESQ)**

Self-administered screening questionnaire. Developer: Ken C. Winters (1991). The PESQ can be scored automatically as it is administered, using the AutoScore Form (as the examinee circles responses directly on the form, the answers are transferred to the scoring sheets on the inside pages of the form, which the examinee cannot access). Norms are provided in the manual for a school sample, a school clinic sample, a drug clinic sample, and a juvenile correctional institution sample.

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18 Source: Alcohol and Drug Institute of the University of Washington, http://adai.washington.edu

Student Assistance Prevention-Intervention Services Program Manual
Office of Superintendent of Public Instruction
Description: This instrument provides a quick, cost-effective way to screen 12- to 18-year-olds for substance abuse. In just 10 minutes, this brief self-report questionnaire identifies teenagers who should be referred for a complete chemical dependency evaluation.

In clinical settings, the PESQ helps service providers make appropriate referrals. It is especially useful in schools, juvenile detention facilities, medical clinics, and other settings where routine screening rather than in-depth assessment is the goal. For researchers, the PESQ is useful in screening subjects, as an initial step in identifying those with chemical dependency problems. The PESQ contains 40 yes-no and multiple-choice Likert items, organized in three subscales (Problem Severity, Psychosocial Items, and Drug Use History), and is available in pencil-and-paper self-administered format (written at a 4th grade reading level). It takes approximately 10 minutes to administer.

Population: Adolescents, Adults

Validity/Reliability: Reliability studies have been done on the PESQ using internal consistency measures. Validity studies have also been done, using measures of content, criterion (predictive, concurrent, “postdictive”), and construct. Detailed psychometric information is available in the APA book.

(4) Substance Abuse Subtle Screening Inventory (SASSI)


Description: The SASSI is a brief self-report, easily administered psychological screening measure that is available in separate versions for adults and adolescents. The Adolescent SASSI-A2 is designed to identify individuals who have a high probability of having a substance use disorder, including both substance abuse and substance dependence, with its decision rules yielding an overall accuracy of 94 percent. The SASSI includes both face valid and subtle items that have no apparent relationship to substance use. The subtle items are included to identify some individuals with alcohol and other drug problems who are unwilling or unable to acknowledge substance misuse or symptoms associated with it.

In clinical settings, interpretations of the SASSI profiles suggest possibilities that the clinician may find useful in understanding clients and providing effective feedback. Examples of clinical inferences that may be drawn on the basis of certain scale scores include indication of defensive responding, clients' level of insight and awareness of the effects of their substance misuse, evidence of emotional pain, and relative risk of involvement with the legal/judicial system. In combination with other available assessment information, the clinical inferences suggested by examining SASSI profiles provide ideas for further evaluation and treatment considerations.

This instrument is especially helpful in inpatient and outpatient settings, including criminal justice, employee assistance, educational, mental health, medical, and vocational. The SASSI for adults consists of 100 items and the same for adolescents. Each test is available in pencil-and-paper self-administered, computer self-administered and optical scanning version, or via web-based administration. It takes approximately 10–15 minutes to administer and can be administered by support staff.

Population: Adolescents, Adults

Validity/Reliability: Reliability studies have been done using test-retest measures. Validity studies have also been done using measures of criterion (predictive, concurrent, “postdictive”).

19 Ibid.
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 ANSWERS

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.
• In a message on an answering machine or voice mail.

• 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, tobacco cessation counseling, and substance abuse prevention counseling.

At times, program staff need 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
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 premises 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 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 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 the 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 INFORMATION

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.
  - 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 once the Confidentiality and Release of Information forms are 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
- 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; and
- Behavior contracts, case management, and family situations.

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21 Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.
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 SAT/CORE teams:
We want SAS to participate in SAT/CARE 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/CARE 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.

Helpful Hints to Build Relations without a Signed Release:
- Assist teachers and building administrators by providing generic descriptions (i.e., a child coming from a difficult home environment may exhibit [example]. A way to address this behavior in the classroom would be to [example].
- 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 Student Assistance Team members.
### SAMPLE

**SAPISP CONFIDENTIALITY FORMS CHECKLIST FOR AGENCY-BASED PROGRAM**

<table>
<thead>
<tr>
<th>✓</th>
<th>Form</th>
<th>Purpose</th>
<th>Key Elements</th>
</tr>
</thead>
</table>
|  | 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. | • 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 anytime 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. | • 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. | • 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. | • 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 anytime except if already relied upon; and consent expires when participant is no longer a student in district.  
• Signed by both participant and P/IS 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. | • 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. |

---

22 Source: Puget Sound ESD, Prevention Center, Kimberly Noel, Director
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:

1. 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.)
2. A court order that includes special findings requires it.
3. The disclosure is made in the course of reporting suspected child abuse or neglect as required by state law.
4. 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.
5. The Program Director, in the course of carrying out his or her duties to administer the Program and supervise staff.
6. The disclosure is made to medical personnel in a medical emergency where disclosure of the diagnosis is necessary to treat the emergency.
7. The disclosure is made to qualified personnel for research, audit, or program evaluation.
8. 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 or disclosure of any information that identifies a participant as a person who has a substance abuse, 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.

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:

1. 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.
2. 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
SAMPLE

STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM
DISCLOSURE STATEMENT AND CONSENT FORM[23]

This disclosure statement explains my theory, training, and experience so that you may make an informed decision about receiving counseling services. Please take the next few minutes to read about our policies and sign the informed consent agreement. Before signing this disclosure, please ask any questions or discuss any concerns that you may have. You will be provided a signed copy of this required disclosure, which shows that you have read and understand the information provided.

1. STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM: We provide assistance, counseling support, and referral to youth impacted by alcohol, tobacco, and other drug use when referred by the attending school. Support groups usually last for 10–12 weeks over a period of 3 months. Groups and one-on-one counseling sessions occur during the school day and one-on-one counseling is ongoing depending on need. Our aim is to help resolve problems, and to provide alcohol/drug screening, referral counseling, and skill building support.

2. APPOINTMENTS: Appointments are scheduled during the school day and groups usually rotate throughout the 12 weeks. Appointments with family members are arranged in advance usually between 7:30 a.m.–4:30 p.m. Keeping appointments is very important, as this is a time-limited service. If there is an emergency and you need to reschedule an appointment, please contact me in advance.

3. COUNSELOR TRAINING AND METHODS: All staff members are either registered counselors, Washington State Certified Chemical Dependency Counselors, Certified School Counselors, Psychologists, School Nurses, School Social Workers, or Licensed Children’s Mental Health Specialists certified to practice in the state of Washington. We are employees of Olympic Educational Service District 114, not any particular school or school district.

4. FEES: There is no cost for students and their families referred by the school.

5. REGISTRATION OR CERTIFICATION OF COUNSELOR: Counselors practicing counseling for a fee must be registered or certified with the Washington State Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

6. PURPOSE OF THE COUNSELOR CREDENTIALING ACT: The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is: (A) To provide protection for public health and safety; and (B) To empower the citizens of the state of Washington by providing a complaint process against those who would commit acts of unprofessional conduct.

7. CLIENT RIGHTS: All consumers served by the Student Assistance Specialist are entitled to the following basic rights:

a. To choose counselors who best suit their needs and purposes.

b. To receive confidentiality and to be informed of program policies regarding confidentiality or records, including when information may be released without consumer consent. (See “Student Assistance Program Confidentiality Notice and Consent Form”).

c. To review their files of written records in accordance with relevant statutes and regulations.

d. To receive a copy of this statement of consumer rights.

e. To have a copy of the acts of unprofessional conduct (RCW 18.130.180 attached) and the complaint hotline number at the Counselor Programs Division of the Department of Health, (360) 236-4902.

---

8. TERMINATION: Please inform your therapist in advance if you will be discontinuing counseling for any reason. The final session is important and should be discussed in advance.

9. ACKNOWLEDGEMENT AND CONSENT: The student program participant and/or the student’s parent or guardian have been provided a signed copy of this disclosure statement and have read and understand the information provided. By signing below, the student program participant and/or the student’s parent or guardian consent to the services described above.

_______________________________________________________
Signature of participant/student              Date

_______________________________________________________
Signature of parent/guardian*              Date

_______________________________________________________
Signature of Student Assistance Specialist Date

Counselor Phone Number

_______________________________________________________
Counselor Address

_______________________________________________________
_______________________________________________________

Counselor Registration/Certification Number: RC

_______________________________________________________

*Required for students under the age of thirteen
SAMPLE 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, education, 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

__________________________________________________________________________

SAMPLE
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 CPR 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.

SAMPLE
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.
SAMPLE

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,

______________________________
(Print Name)
Program Staff Name
SAMPLE

STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM
CONFIDENTIALITY AGREEMENT

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

26 Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.
SAMPLE
Protection of Pupil Rights Amendment (PPRA):
Model Notification of Rights

The Protection of Pupil Rights Amendment (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 U.S. 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 non-emergency, 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 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 U.S. Mail or email, 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 ED.
- Any non-emergency, invasive physical examination or screening as described above.

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5901
Parents who believe their rights have been violated may file a complaint with:

WASHINGTON STATE SAPISP RECORD KEEPING

Each project site determines locally 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, and 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. The Department of Alcohol and Substance Abuse 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 Educational Service District (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 and 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).*
7. Personal Progress Chart.*
8. Student Outcome Plan.*

*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
SCHOOL STAFF REFERRAL FORM
STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM

Date of Referral __________________________ Person Reporting __________________________
Student Name ______________________________ Grade ______ Age ______________
Homeroom Teacher __________________________

Areas of Concern (please check all that apply)

____ No interest in school and poor academic performance
____ Frequent absence/tardiness
____ Sudden or extreme behavior/attitude change or appearance
____ Withdrawn or feelings of isolation and/or being alone
____ Detachment/lack of bonding
____ Feelings of being picked on or persecuted
____ Being a victim of violence
____ Uncontrolled anger
____ Excessive feelings of isolation and being alone
____ Suicide threats/self-mutilation
____ Family substance abuse or violence
____ Threats toward others
____ Atypical behaviors (lack of attention to hygiene, grooming, dress)
____ Unusual risk-taking behaviors
____ Aggressive/hostile behaviors
____ Patterns of impulsive and chronic hitting, intimidation and bullying behaviors
____ History of disciplinary problems
____ Delinquent/criminal activity
____ Unusual interest/preoccupation with weapons
____ Expression of violence in writings or drawings
____ Suspected substance abuse

Please note any additional concerns or pertinent information regarding this student’s behavior:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
SAMPLE
PARENT PERMISSION
STUDENT ASSISTANCE PREVENTION-INTERVENTION SERVICES PROGRAM

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.
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 SASAPI 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 children can participate in these questionnaires, pursuant to the Protection of Pupil Rights Amendment (PPRAA).

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!

Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.
### SAMPLE INTAKE FORM

<table>
<thead>
<tr>
<th>1. Student ID #:</th>
<th>2. School:</th>
<th>3. Enrollment Date:</th>
</tr>
</thead>
</table>

#### I. DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>4. Student Name (Last, First, MI):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. Gender (circle one)</th>
<th>6. DOB: (mm/dd/yyyy)</th>
<th>7. Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Transgender (ID as female)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Transgender (ID as male)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Race: (circle one)</th>
<th>9. Living Arrangement (circle one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. White/Caucasian</td>
<td>a. Both parents</td>
</tr>
<tr>
<td>b. Black/African American</td>
<td>b. Mother only</td>
</tr>
<tr>
<td>c. Asian</td>
<td>c. Father only</td>
</tr>
<tr>
<td>d. American Indian or Alaska Native</td>
<td>d. Mother and step-parent</td>
</tr>
<tr>
<td>e. Native Hawaiian/Pacific Islander</td>
<td>e. Father and step-parent</td>
</tr>
<tr>
<td>f. Hispanic, Latino or Chicano</td>
<td>f. Mother and partner</td>
</tr>
<tr>
<td>g. Multi-racial (specify):</td>
<td>g. Father and partner</td>
</tr>
<tr>
<td>h. Grandparent(s)</td>
<td>h. Other relative (specify)</td>
</tr>
<tr>
<td>i. Foster Care</td>
<td>i. Other (specify)</td>
</tr>
<tr>
<td>j. Homeless</td>
<td>j. Other (specify)</td>
</tr>
</tbody>
</table>

|--------------|----------|----------|--------|

<table>
<thead>
<tr>
<th>14. Home Phone #:</th>
<th>15. Cell Phone #:</th>
<th>16. Work Phone #:</th>
<th>17. Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. Parent/Responsible Adult (Last, First, MI):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>19. Responsible Adult’s Address:</th>
<th>20. Responsible Adult’s Employer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

|----------|----------|--------|

<table>
<thead>
<tr>
<th>24. Responsible Adult’s Employer:</th>
<th>25. Work Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>26. Student’s Employer:</th>
<th>27. Work Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28. Emergency Contact (Last, First) (different from #18):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>29. Emergency Phone #:</th>
</tr>
</thead>
</table>

#### II. SCHOOL/EDUCATION HISTORY

<table>
<thead>
<tr>
<th>30. Last School Attended: (Name, City, State)</th>
<th>31. Last Date Attended: (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>32. Highest Grade Completed:</th>
<th>33. On Task to Graduate</th>
<th>34. Ever held back or flunked</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td>b. No</td>
<td>a. Yes b. No If yes, # of times ______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>35. School Services (circle all that apply)</th>
<th>36. Current Enrollment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Regular Classroom</td>
<td>a. GED Prep</td>
</tr>
<tr>
<td>b. Bilingual Education</td>
<td>b. Enrolled full-time</td>
</tr>
<tr>
<td>c. Title I/LAP</td>
<td>c. Enrolled part-time</td>
</tr>
<tr>
<td>d. Gifted/Honors</td>
<td>d. Suspended</td>
</tr>
<tr>
<td>e. Home/Hospital</td>
<td>e. Expelled</td>
</tr>
<tr>
<td>f. Special Education</td>
<td>f. Dropped out</td>
</tr>
<tr>
<td>g. Alternative School</td>
<td></td>
</tr>
<tr>
<td>h. Family Support/RTL</td>
<td></td>
</tr>
<tr>
<td>i. Tutor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37. Attendance (most recent semester)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Excellent, no unexcused absences</td>
</tr>
<tr>
<td>b. Good attendance; few unexcused absences</td>
</tr>
<tr>
<td>c. Some partial-day unexcused absences</td>
</tr>
<tr>
<td>d. Some full-day unexcused absences</td>
</tr>
<tr>
<td>e. Truancy petition/equivalent or withdrawn</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38. Suspension/Expulsion History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1 time suspended/expelled</td>
</tr>
<tr>
<td>b. 2–3 times</td>
</tr>
<tr>
<td>c. 4–5 times</td>
</tr>
<tr>
<td>d. 6–7 times</td>
</tr>
<tr>
<td>e. 8 or more times</td>
</tr>
<tr>
<td>f. Never suspended/expelled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. Academic Performance (most recent semester)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Honor students (mostly A’s)</td>
</tr>
<tr>
<td>b. Above 3.0 (mostly A’s and B’s)</td>
</tr>
<tr>
<td>c. 2.0 – 3.0 (mostly B’s and C’s, no F’s)</td>
</tr>
<tr>
<td>d. 1.0-2.0 (mostly C’s and D’s, some F’s)</td>
</tr>
<tr>
<td>e. Below 1.0 (some D’s and mostly F’s)</td>
</tr>
</tbody>
</table>
### III. JUVENILE JUSTICE HISTORY

<table>
<thead>
<tr>
<th>40. Juvenile Justice Status: (circle all that apply):</th>
<th>41. Criminal History (circle all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. On probation</td>
<td>a. Against person offenses/arrests (specify)________</td>
</tr>
<tr>
<td>b. On diversion</td>
<td>b. Property offenses/arrests (specify)__________</td>
</tr>
<tr>
<td>b. Other (specify)</td>
<td>c. Drug and alcohol offenses/arrests (specify)____</td>
</tr>
<tr>
<td>Reports to:</td>
<td>d. Other offenses/arrests (specify)______________</td>
</tr>
<tr>
<td></td>
<td>e. None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42. Age of first offense:</th>
<th>43. Times in secure confinement:</th>
</tr>
</thead>
</table>

### IV. PERSONAL HISTORY

<table>
<thead>
<tr>
<th>44. In your lifetime, have you ever been …</th>
<th>45. Mental health diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. physically abused?</td>
<td>a. Yes (specify)______________</td>
</tr>
<tr>
<td>b. sexually abused?</td>
<td>b. No</td>
</tr>
<tr>
<td></td>
<td>c. Unknown</td>
</tr>
<tr>
<td></td>
<td>c. emotionally abused?</td>
</tr>
<tr>
<td></td>
<td>d. involved with CPS/ICW?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>46. Past/Current AOD Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes (specify agency)____________</td>
</tr>
<tr>
<td>b. No</td>
</tr>
<tr>
<td>c. Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>47. Sexually active?</th>
<th>48. Pregnant?</th>
<th>49. Parent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>50. Extracurricular Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Currently involved? If yes, specify ___________________________</td>
</tr>
<tr>
<td>b. Previously involved? If yes, when? ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>51. Student Self Assessment of Problem:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>52. Peer Behaviors (past 30 days):</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. % of friends who used any drugs ______</td>
</tr>
<tr>
<td>b. % who got drunk (5 or more drinks) ______</td>
</tr>
<tr>
<td>c. % of friends who worked fulltime ______</td>
</tr>
<tr>
<td>d. % of friends involved in illegal activity ______</td>
</tr>
</tbody>
</table>

### V. FAMILY BONDING/ATTACHMENT

<table>
<thead>
<tr>
<th>53. Family Relationships:</th>
<th>Rating (1=poor 10 = excellent)</th>
<th>Current/Past Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Name: __________________</td>
<td>Age: ____ Relation: ________</td>
<td>Rating: _____ Yes No</td>
</tr>
<tr>
<td>b. Name: __________________</td>
<td>Age: ____ Relation: ________</td>
<td>Rating: _____ Yes No</td>
</tr>
<tr>
<td>c. Name: __________________</td>
<td>Age: ____ Relation: ________</td>
<td>Rating: _____ Yes No</td>
</tr>
<tr>
<td>d. Name: __________________</td>
<td>Age: ____ Relation: ________</td>
<td>Rating: _____ Yes No</td>
</tr>
</tbody>
</table>

### VIII. ATOD USE HISTORY

<table>
<thead>
<tr>
<th>54. In your lifetime, have you ever used any alcohol, marijuana, hallucinogens, amphetamines, cocaine/crack, inhalants, or other drugs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
</tr>
<tr>
<td>b. No, if no <strong>SKIP to Question 60</strong></td>
</tr>
</tbody>
</table>
**IX. SEVERITY OF USE**

_In the following section, I am going to ask you about your specific drug use. Please be honest about your drug use, if any._

<table>
<thead>
<tr>
<th>55. Drug used</th>
<th>Age of first use?</th>
<th>Last time you used (days)?</th>
<th>In the past 90 days, on how many days did you use?</th>
<th>What was the most you had in one day?</th>
<th>What was the least you had in one day?</th>
<th>How much do you normally use?</th>
<th>How often do you use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Amphetamines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Heroin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Ecstasy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Hallucinogens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. RX drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. OTC drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>56. Has your alcohol/drug use ever caused you problems at home or at school?</th>
<th>57. Have you ever dealt drugs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td>a. Yes</td>
</tr>
<tr>
<td>b. No</td>
<td>b. No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>58. Do you think you may have a problem with alcohol, marijuana, or other drugs?</th>
<th>59. Do you want help with your drug use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td>a. Yes</td>
</tr>
<tr>
<td>b. No</td>
<td>b. No</td>
</tr>
</tbody>
</table>

**FAMILY USE HISTORY**

<table>
<thead>
<tr>
<th>60. Do you every worry about your mom’s or dad’s drinking, use of medication, or use of drugs?</th>
<th>61. Do you wish you mom or dad drank less or used less medication or used fewer drugs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td>a. Yes</td>
</tr>
<tr>
<td>b. No</td>
<td>b. No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>62. Do you wish your mom or dad didn’t drink at all, didn’t use medication, or didn’t use any drugs?</th>
<th>63. What makes you worry or wish?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td></td>
</tr>
<tr>
<td>b. No</td>
<td></td>
</tr>
</tbody>
</table>

**X. OTHER INFORMATION**

<table>
<thead>
<tr>
<th>64. Reason for Referral (circle all that apply)</th>
<th>c. School Problems (academic performance, attendance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Possible ATOD Use</td>
<td></td>
</tr>
<tr>
<td>b. Behavior/Peer Relations</td>
<td></td>
</tr>
<tr>
<td>d. Home/Neighborhood issues</td>
<td></td>
</tr>
<tr>
<td>e. Mental Health issues</td>
<td></td>
</tr>
<tr>
<td><strong>65. Previously Enrolled in SAPISP program?</strong></td>
<td><strong>66. Parent involved in process</strong></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>a. Yes (specify)</td>
<td>a. Yes ___ Called ___ Family Conference</td>
</tr>
<tr>
<td>b. No</td>
<td>b. Yes ___ Info Provided ___ Release Signed to Parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>67. Intervention Group Completed</strong></th>
<th><strong>68. Student Declined Release</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes</td>
<td>a. Yes, reason</td>
</tr>
<tr>
<td>b. No, if not reason</td>
<td>b. No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>69. Referred for full ATOD assessment?</strong></th>
<th><strong>70. Release signed for treatment center and case management.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes, if yes, date.</td>
<td>a. Yes</td>
</tr>
<tr>
<td>b. No</td>
<td>b. No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>71. Choices Given (specify)</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>72. Notes</strong></th>
</tr>
</thead>
</table>
SAMPLE

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 ATOD 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.

29 Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.
SAMPLE
INDIVIDUAL ATTENDANCE LOG

Student Name: ___________________________  ID #: __________________
School: _________________________________ School Year: ___________
Status: Active ____ *Closed Code____

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC CODE(S)</th>
<th>DATE</th>
<th>TOPIC CODE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Topic Codes:**
I = Intake  SS = Social skills  RS = Recovery support  F = Family support
CU = Consequences of use  CO = Concern for other’s use  RU = Reasons for use  DUH = Drug
use history SA = Self-assessment  O = Other

**Closed Codes:**
M = Moved/transferred  Q = Quit program  S = Suspended/Expelled  A = Alt. school
D = Dropped out  JD = Juvenile Detention  C = Completed  G = Graduated
E = End of school year  O = Other/unknown

---

30 Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.

Student Assistance Prevention-Intervention Services Program Manual
Office of Superintendent of Public Instruction
SAMPLE
PERSONAL PROGRESS CHART

NAME ___________________________ DATE __________________

ADDRESS ____________________________________________________________________

PHONE NUMBER ___________________ CELL ________________________

GRADE ______ AGE ______

PARENT _____________________________________________________________________

EVALUATION DATE ______ LOCATION ___________ WITH ________________

COMPLETED __________ RECOMMENDATIONS ____________________________

AA MEETINGS REQUESTED ___________ COMPLETED ____________

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
<th>GOAL</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

STUDENT ASSISTANCE SPECIALIST: ________________________________

COMMENTS: __________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

___ Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director. ___
SAMPLE
Student Outcome Plan

Student Assistance Specialist ____________________________________________ Date ______

District __________________________________ Building ________________________
Review Date _____________________________________________________________

Student ____________________________________________________________
(Use code number) Grade Level __________________________ Review Date ______

Counseling:

☐ Individual Counseling
☐ Group Counseling
☐ At Risk/Social Skills
☐ Affected Others
☐ Intervention (Insight)
☐ Challenge
☐ Recovery Support
☐ Other

<table>
<thead>
<tr>
<th>Description of Intervention Goals:</th>
<th>Academic Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Establish at least two goals)</em></td>
<td><em>(Establish at least one goal)</em></td>
</tr>
<tr>
<td>Goal 1</td>
<td>Goal 1</td>
</tr>
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SUGGESTED GUIDELINES IN RESPONDING TO DISCIPLINARY REFERRALS

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

1. 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).

2. 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 parent’s 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.

3. Following the meeting one or more of the processes may occur:

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<td>Following parent meeting you meet with the student individually and begin the intervention by getting to know the student and completing the intake process.</td>
<td>Following parent meeting you meet with the student in Insight group and begin the intervention process through the Insight group.</td>
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<td>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.</td>
<td>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.</td>
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<td>If the student is appropriate for in-school intervention, complete the program with the student.</td>
<td>Upon completion of the intervention, make additional recommendations to the referring administrator.</td>
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<td>Upon completion of the intervention, make additional recommendations to the referring administrator.</td>
<td>Meet again with the parent(s) and the student to discuss any further recommendations.</td>
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33 Source: OESD 114 Prevention and Treatment Center. Kristin Schutte, Director.
Being Specifically Alert to Substance Abuse Indicators

Signs and symptoms of substance use/abuse.

**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
- decreased motor coordination
- itchiness
- watery eyes/pinpoint pupils
- lethargy
- weight loss
- decreased blood pressure
- possible needle marks
- as drug wears off nausea &
- runny nose

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34 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
### 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
- Altered perceptions of time, space, sights, sounds, colors
- 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
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.

**Sources of Information on Screening and Assessment Tools are available on the Web at:**


Resource Aid Packet on Screening/Assessing Students: Indicators and Tools. Center for Mental Health in Schools at UCLA. Available at http://smhp.psych.ucla.edu/.

Alcohol and Drug Institute of the University of Washington—access to a database of substance use screening and assessment instruments at http://adai.washington.edu includes description of instruments, normed populations, availability, and costs.
Section 6:
Problem Solving and Case Management Team
INTRODUCTION

The Student Assistance Team 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.

The purpose of a Student Assistance Team (a.k.a. Core Team) is to assist the Student Assistance Specialist in reviewing and providing information about referrals generated and prioritizing referrals for services. 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.

ESTABLISHING A STUDENT ASSISTANCE TEAM

Teams consist of individuals with different skills, knowledge, and interest coming together for common purposes—student advocacy—and work interdependently. 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. Here are 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.
HOW DO 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.

Schools that adopt the Student Assistance Team model will have to give consideration to the team’s relationship to any existing teams such as multidisciplinary teams/504. If schools have more than one team that serve similar requirements, then at a minimum there should be regular communication among the various team members.

SUGGESTED PROGRAM OPERATIONS

The following provides program coordinators and Student Assistance Specialists with suggested guidelines to use in forming a Student Assistance Team. 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 Student Assistance Team 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 Student Assistance Specialist case manages the referral, implements, monitors, and evaluates the individual plan, and reports back to the team. Some Student Assistance Teams 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 (Figure 6.1).
SAMPLE SAPISP – STUDENT ASSISTANCE TEAM REFERRAL CHART

(SOURCE: STATE OF VIRGINIA, SAP PROGRAM MANUAL)

Identification of Concerns

Referred to Student Assistance Team by:
- Self
- Peer/Friend
- Policy Violation
- Administration
- Faculty
- Parents
- Courts
- Other Community Agency

Parents Contacted

Grades, Attendance, Discipline, and a Behavior Checklist completed if warranted

Student Assistance Team meets and reviews available information

Parents/Student Contacted – More Information gathered – Develop plan

Data Did Not Indicate Contact with Parents/Students

Parents/Student Refuse Services

Student/Parents Agrees To Services

SCHOOL INTERNAL PREVENTION/INTERVENTION
LEVEL OF SERVICES
- Universal
- Selected
- Indicated
OTHER SERVICES – School Counselor -Tutoring – Nurse - In-School Mentor – Conflict Mediation

COMMUNITY REFERRAL
- AOD Assessment
- Outpatient Assessment for Counseling Services
- Other Community Agencies
- Urine Screens
- Medical Services.

Ongoing Case Management Services
Review student’s progress (minimum of once every two-months) and revised as needed and/or exits
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. Roles and functions include:

**SAS**
- 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.
- Reports findings and updates to the team.

**Core Team 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.

**Core Team Recorder**
- Records group discussion and decisions that are made.
- Places information on a flip chart, erasable board, or overhead.

**Core Team Timekeeper**
- Keeps the group on time and informs members when a transition will occur.
- Keeps members on task.

**Core Team Participants**
- Stay actively involved in discussion.
- Monitor the recorder.

Student Assistance Team 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.

**STUDENT ASSISTANCE TEAM MEMBER TASKS**

Members work interdependently in order to achieve agreed upon program goals, including promoting the philosophy of the Student Assistance Prevention-Intervention Services Program; 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 Student Assistance Team 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.
The school counselor assigned to the team may provide insight and knowledge regarding social, emotional, and other developmental needs of referred students as well as resources and activities available to the student/family in the school and the community. The classroom teacher may be called upon to provide insight into referred students' academic developments, pro-social behaviors, and other school climate issues. Whereas the school nurse, may be able to provide knowledge regarding health-related issues, and effects of medication including possible behavioral changes due to side effects. And, the school nurse may be able to provide physical health assessments when a student's behavioral and cognitive functioning have abruptly changed. The coach or other interested faculty members on the team may provide perspectives into the needs of students beyond those described above, including social interaction, changes in behaviors or attitudes outside of the regular school day, and possible difficulties or constraints in the student’s life that extends beyond the school such as home or community.

Pre-Meeting Tasks
The team leader (most likely the SAS) will need a preliminary file or case for presentation to the team. These would 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).

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. This preliminary information should be recorded on a student profile sheet kept in a confidential SAPISP file separate from student records (see attached sample student profile form).

Team Meeting
Team members should come to meetings prepared to collaborate with all members. 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.

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, or to close the case.

Another option for the Student Assistance Team 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, 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 a list of possible suggestions for classroom management techniques and strategies for working with referred students. 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 anytime 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 Student Assistance Team, 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. This includes keeping on file an attendance list of team members present at each meeting (see p. 163), 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.

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 Student Assistance Prevention-Intervention Services Program files 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. Student Assistance Team 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 student assistance prevention/intervention program model. Case management is designed primarily to:

- Engage the student in the recommended SAPISP process.
- 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.
- Prevent students from dropping out of recommended services.
- Encourage participation in community support groups or peer-led support groups.

The Student Assistance Specialist, along with the Student Assistance Team, 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 (ProjectCare 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?
   i. How urgent is the situation?
   ii. How can the team encourage parent involvement?
   iii. What is the scope of the problem?
4. What in-school resources and/or services could be offered to support the student?
5. What community resources would be available and appropriate for this situation?
6. Is it appropriate to involve the liaison in this case?

If the Student Assistance Team 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?
   i. Who will be the case manager?
   ii. Who will call the parent?
   iii. 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 should provide 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

#### SAMPLE

*Student Assistance Team Meeting Attendance Record*

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April 2006
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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 | | | | | | | | | | | | High

3. How satisfied are you with the results of this meeting?

   
   
   Low | | | | | | | | | | | | 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?

---

36 Source: Project CARE SAP Training Workbook - www.projectcare.org
PRACTICE NOTES: 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.
- 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 selfdetermination in clients by encouraging participation in decisionmaking 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 7:
Program Evaluation
WHY EVALUATE?

In 1998, the U.S. Department of Education adopted the Principles of Effectiveness and published non-regulatory guidelines for implementing them by agencies receiving Safe and Drug Free Schools and Communities Act funding. The principles call for recipients of Title IV funding to:

1. Base programs on a thorough needs assessment of objective data about the drug and violence problems in the schools and communities.
2. Establish performance measures aimed at ensuring school and communities served by the program have a safe, orderly, and drug-free learning environment.
3. Implement programs founded on scientifically-based research that provides evidence of program strategies that prevent or reduce drug use, violence, or disruptive behavior among program participants.
4. Implement programs based on an analysis of data regarding the prevalence of risk and protective factors, buffers, or assets, or other variables identified through scientifically-based research.
5. Include meaningful and ongoing consultation with and input from parents in the development of the program, administration, and activities.
6. Periodically evaluate program to assess progress toward achieving goals and objectives, and use evaluation results to refine, improve, and strengthen the program, and objectives as appropriate.

In addition to abiding by the Principles of Effectiveness, 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 goal and objectives to establish a standardized measure of program performance. These are:

State Goal:
Reduce substance abuse risk factors and increase protective factors among selected and indicated students served in the Prevention/Intervention Services Program (PISP).
State Objectives:
1. By the end of the school year, 10 percent of 12–18 year old youth participating in the SAPISP will show a reduction in tobacco, alcohol, and marijuana use as compared to program entry.
2. 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 toward substance use as compared to program entry.
3. By the end of the school year, 10 percent of 12–18 year old youth participating in the SAPISP will show an increase in bonding to school as compared to program entry.

STATEWIDE EVALUATION EFFORTS
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 Student Assistance Specialists 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 Activities
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 consistent, accurate, reliable, and timely information to Program Coordinators, Student Assistance Specialists, 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).

Student Assistance Specialists 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.

37 Source: RMC Research website – www.rmccorp.com
Prevention and Intervention Services Program
Web-Based Data Entry and Reporting System

User Guide

Updated September 9, 2005
Access to this web database requires a valid username and password. When your project director adds you as a user to the system, or changes your status from inactive to active, your username and password are automatically created.

1. **Getting your password.** In order to retrieve your password, you must have a valid email address. Your program director needs to enter this when adding you to the system. Once this is done you go the main login page, click the link in “Forgot your password? Need to change it? Click here.”, enter your username in the box under “OOPS! I forgot.”, and click Email. Your password will be emailed to you momentarily.

2. **Changing your password.** Click the link in “Forgot your password? Need to change it? Click here.”, enter your username, your current password, and the new password (twice) in the boxes under “Change password”, then click Change.

3. **Logging off.** To securely log off the system you must close your web browser.

4. **Time outs.** As an added level of security, your session in the database will “time out” after twenty minutes of inactivity. After this time, if you attempt to work within the database you will receive a notice that your session has timed out and you need to log in again.

Once you have your username and password, follow these steps:

1. Open your web browser. (Internet Explorer, Netscape Navigator, etc.)

2. In the Address box type http://www.rmccorp.com/pieval/login.asp and click on Go next to the box. At this point you could save the page to your Favorites or Bookmarks.

3. You should now see the Login screen.

![Login Screen](image)

**Figure 1.** Login screen for the PISP web database.
4. If you do not see this page and you have typed the address correctly, then consult your technology person to verify that you are properly connected. Note that you should add this address to your Favorites (click on Favorites and then Add) so you do not need to type it again.

5. Click in the Username box and enter your username.

6. Click in the Password box and enter your password.

7. Click Log In. If an error occurs, you will receive a message stating “Login Incorrect. Please try again.” Click Continue and try again. If the problem persists, contact your project director. Once you successfully log in, you will see the following screen:

![Figure 2. Main menu of database.](image)

8. You are now logged into the database.

9. Now choose one of the following from the main menu:
   a. **Activity Records**: Click here to enter, view, or summarize your Universal Prevention activities.
   b. **Student Records**: Click here to describe students referred to the program and participating in indicated prevention activities; view your case list and enter or edit student activity information; and, if selected to do so, enter and edit student follow-up information.
   c. **Administrative**: You may change your password and email address or transfer a student to another school or specialist.
   d. **Reports**: You may view a variety of reports regarding prevention activities, indicated student interactions, and quality control issues.
   e. **Help**: You may view documents designed to assist you in using the web site and in collecting timely and accurate data.
1. Click *Activity Records* on the menu. Then click *View Prevention Plan*.

2. You should now see the following screen listing universal prevention activities you may report on:

![Figure 3](image)

**Figure 3.** Prevention Plan showing planned activities you may report on.

3. This page provides you with a list of the types of activities you may record in the database. A description provides further detail about what qualifies as this type of activity. The target population and prevention strategy are also given. The fields are:

   a. **Target.** The primary type of participant targeted by this type activity (Student, Family, Staff, Community).

   b. **Strategy.** The primary prevention strategy used by this type of activity (Awareness, Education, Curriculum, Planning).

   c. **Activity name.** A name given for the activity in pull-down menus. These are generic names—you will need to determine what generic names best correspond to certain local activities.

   d. **Activity Description.** A brief narrative that clarifies what does or does not fit with this type of activity. Please review these descriptions when there is any question about what an activity name means.
Adding Universal Prevention Activities

1. Click on Activity Records and Enter/Edit Activities. You will now see a list of activities that you have entered, along with a set of tools for filtering the list as it becomes longer. To filter the list of activities, select any combination of items in the "Filters" area then click Filter Activities List. Now, only activities matching the filters you set will be shown.

![Activity Records Screenshot]

Figure 4. Main Activity Records page.

2. Then click on the Add Activities button. You should now see a prompt to select an activity.
3. First select the activity name from the pull-down menu and click *Continue*.

4. If you chose a recurring activity, you will be asked to indicate whether this entry is the first session in a series or a continuation of a previous activity. (See Figure 6 below.) If this is the first time you have performed this activity with this specific group of students, choose “First Session”, then click GO. If this is a continuation of a previous activity, choose the appropriate activity from the list and click GO.

5. If you chose a non-recurring activity (or once you have selected a choice as in Figure 6), you will then see the “Add New Activity” screen as in Figure 7.
6. Fill in the form.
   a. **Activity Description (optional).** You may enter a brief description of the activity or the group served to help distinguish it from other similar activities you might have provided at this school of the same activity type. For example, if you present Project Alert to three different classes in the same school, enter three Project Alert records and type a brief label in this box (e.g., the grade level or period) to distinguish between the classes.
   
   b. **School.** Select the school where you provided this activity from the pull-down menu. Note that your program assistant will have to update your school assignments if a school you serve does not show up in the list. If the activity was not linked to a particular school, specify "Non-school location".
   
   c. **Activity Date.** Enter the date the activity occurred.
   
   d. **Number of participants.** Enter the number of individuals who actually participated in this activity. Be sure you know who the intended participants are for the activity. For example, if the activity was providing technical assistance to school administrators in interpreting the Healthy Youth Survey results, count the number of school administrators participating in the session, not the number of students who took the survey.
   
   e. **Session Hours.** Report the hours for this session of this activity. Report hours as a decimal (for example, 15 minutes would be 0.25 hours and 90 minutes would be 1.5 hours). Note that you should use the perspective of the participant (How many hours of exposure did he or she have?). If you make a brief presentation as part of an assembly, report only the length of your presentation.
   
   f. **Tobacco related.** For some activities you will be asked if this activity included tobacco-specific content. Indicate yes or no.
7. **Add Activity.** When you have completed the form, click **Add Activity.** You will be returned to the activities list and your new activity will now be shown there.

Some examples may be helpful:

1. You have made six 15-minute presentations introducing SAP services to different classrooms. Report this as six separate activities with **Hours per Session** as 0.25, **Number of Participants** as the number of students in that particular class.

2. You have presented the first 3 sessions of Project Alert to the 8th grade class during 45-minute class periods. Report each session as a separate activity. Report 0.75 for **Hours per Session.** Do not report sessions that have not yet been presented.

3. You disseminated a prevention newsletter to teachers in each of three schools you serve. Report a separate activity in each school and report the number of teachers that received the newsletter in that school as the **Number of Participants.**

4. As part of a school health fair, you discuss prevention issues with 23 parents (individually or in small groups) for an average of 15 minutes each. Although a total of 100 parents attended the fair and the fair lasts three hours, you only report **Number of Participants** as 23 and **Hours per Session** as 0.25 hours.
Editing and Deleting Universal Prevention Activities

1. Click on Activity Records and Enter/Edit Activities on the menu. You should now see the main Activity Records page as below.

![Main Activity Records page](image)

Figure 8. Main Activity Records page.

2. To edit a record in the list, click on the Edit link in the first column for that record. Make your changes in the edit screen and click on Submit Changes.

3. To delete a record in the list, click on the red X in the second column for that record. You will be asked to verify whether you really want to delete this activity. Choosing “Yes” will delete the record and return you to the main Activity Records page. Choosing “No” will simply return you to the main Activity Records page without deleting the record.
Starting a New Student Intake and Services Record

1. Click **Student Records** on the menu, then click **Start New Student Record**. You should now see the following screen:

![Add Student form](image)

**Figure 9.** Add Student form.

2. Complete the form:
   a. **Select School.** Select the school the student attends from the Select School list. This list is pre-arranged to contain only the schools to which you are assigned. If the list is in error, please contact your project director.
   
   b. **Student ID.** Click in the Student ID box and enter a local identifier for this student. This identifier can be anything that helps you recognize this student in a list. You may enter up to fifty characters.
   
   c. **Student Birthdate.** Click in Student Birthdate and enter the appropriate date in the format mm/dd/yy. Entering an incorrectly formatted date or an impossible date (e.g., 02/31/98) will cause an error message prompting you to correct the date.
   
   d. **Gender.** Select the student’s gender from the list.
   
   e. **Ethnic Group.** Select the student’s ethnic group from the list.
   
   f. **Previous Indicated Activities.** Indicate whether or not this student participated in indicated activities last year. If you do not know and are unable to ascertain this, select “Do not know” from the list.
   
   g. **Intervention Type.** Indicate whether this is a “quick” or “full” intervention.
h. *Other Student Code.* This is an optional field. Some projects wish to use their own coding system for identifying students. This field provides a place to enter this optional identifier.

3. Click *Create Record.* If the above criteria have been met, the system will create a new student record and notify you that this was done successfully.
Entering/Editing student data

1. Click **Student Records** then click **Enter/Edit Student Data** on the menu. You should now see the master list for your caseload as in Figure 10. If you serve a number of schools and wish to see students for only one school, choose a school from the **Select School** list and click **Filter by School**. To see records for all of your schools again, choose “ALL” from the **Select School** list and click **Filter by School**. Clicking the label box at the top of a column will sort the list by that column.

![Image of student records](https://example.com/student_records.png)

**Figure 10.** Master List of students participating in indicated prevention (early intervention) activities.

2. To edit a student’s name, birth date, gender, ethnicity, or indication of previous participation, click on **ID** in the Edit/View column for that student. This will take you to a screen where you can edit this information and **Submit Changes**.

   To enter or change Intake and Services data (i.e., the online version of the original “bubble sheets”), click on **I/S** in the Edit/View column for that student. This will take you to a form for recording extensive information regarding the student’s participation and progress in indicated activities throughout the year.
Note that if the **I/S** link is in bold and red, this indicates that the underlying student record has errors in it. It is a good idea to review the master list periodically, look for this indicator, and correct any such records.

Complete all the fields on the Intake and Services form that you can for this student (but you will need to edit this form during the year to update the information). When finished, click *Submit Data*. You should receive a message stating that the data for the chosen student has been updated. If you wish to enter or edit more Intake and Services data, click *Enter/Edit Student Data* on the menu.

3. Some students may have a Link labeled **TEST**. This link will appear for all students receiving a “full” intervention. Clicking the link will take you to a brief form where you can enter Program Evaluation pre and post sheet numbers and their related date of administration.

4. Finally, clicking the red **X** on a student’s line will delete that student and all related records. You will be asked to verify that you really wish to do this.
Entering Student Follow-up Data

If any of your students from last year are chosen for long-term follow-up, they will be listed on the Student Follow-up page. To enter data for those students:

1. Click Student Records then click Edit Follow-up Form. You will now see the Student Follow-up List as shown in Figure 11. This list provides instructions for filling it out, a school filter to reduce the size of the list shown, and the list of all students from your caseload selected for follow-up.

![Figure 11. Student Follow-up list.](image)

2. Select a student to edit by clicking on the related Student Code. You will now see an edit form as in figure 12.
Figure 12. Student follow-up, edit view

3. Complete as much information for that student as possible.
4. Click **Submit Changes**.
5. You will now be redirected to the Student Follow-up list.
1. Click *Administrative*. Some or all of the options below will be available to you.

2. Click on the desired item.
   a. *Edit my own information.* This page allows you to view your interventionist
code, username, and user group as well as edit your contact information
(e.g., address, phone number, email).
   b. *Edit another user’s information.* Here you can view and edit another user’s
contact information. You can also render their access to the Web database
“Active” or “Inactive.”
   c. *Add a new user.* This page provides a way to add new staff members and to
assign them to select schools.
   d. *Add or delete school assignments for specialists.* Here you can choose an
individual specialist and view his or her currently assigned schools, as well as
a list of all schools not currently assigned to this specialist. By selecting
schools in each list, you can simultaneously add and delete multiple school
assignments for this specialist. Note, however, that you can only delete
assignments for a specialist once all of his or her students have been
transferred to another specialist.
   e. *View summary of all staff assignments.* On this page you will see a complete
list of intervention specialists for your site along with the schools to which they
are assigned. This list can be sorted by staff name or by school. Clicking on
any instance of a staff name will bring you to the Add or delete school
assignments for specialists page for that specialist.
   f. *Transfer caseload to another specialist.* This page allows you to transfer an
entire caseload from one specialist to another. Keep in mind, this means ALL
of one specialist’s students will be re-assigned to another specialist of your
choosing. Also, the specialist receiving the students must be assigned any
and all schools which those students attend.
   g. *Transfer student to another school.* Here you may transfer a single student
from one school to another. As part of the process, you also must choose the
specialist to which the student will be assigned.
   h. *Transfer caseload at one school from one specialist to another.* This page
provides you a way to transfer a specialist’s entire caseload at a single school
to another specialist assigned to the same school.

3. Complete the chosen form and click *Submit.*
Viewing Reports

1. Click Reports on the menu. You should now see a screen like Figure 13 below. Here you may select from a variety of reports based on the current year or any previous year.

![Figure 13. Menu of available reports.](image)

2. The available reports are:
   a. *Prevention Activities Summary*. Here you can view summary or detailed information regarding all universal activities thus far. The report includes information about the number of sessions, the number of unique participants, average number of participants per session, and average hours per session.
   c. *Quality Control*. This report gives a synopsis of the specialist’s year-to-date activity, recent activity, and data quality issues.
   d. *Student Progress*. Here, student progress through case management activities, and group sessions is summarized along with information regarding exits from the program.
   e. *Summary of Evaluation Information, Attitudes, and Behavior*. This report shows aggregate values for responses given by students on the Program Evaluation Form.
   f. *Program Evaluation Survey Status by Specialist*. For each specialist, this report provides information about how many Program Evaluation forms have
been entered (pre and post) by the specialist and how many of those sheets have been turned into RMC and successfully linked to the database.

g. **Follow-up Status.** This report lists each specialist, the number of students he or she had selected for follow-up, and how complete the provided data are at the time of viewing.

h. **Quality Control Summary by Specialist.** For each specialist, this report gives a breakdown of his or her program activities. This includes total students served, intakes, updates, and exits in the past 30 days, total number of students exited, number of records with intake or goal information missing, number of universal activities sessions, and number of students with pre and post Program Evaluations logged.

3. **Report Filters.** Most reports include a system at the top of the page for filtering the report’s contents. This allows you to answer more pointed questions about activities and outcomes within your program. For example, you might ask: “What tobacco-related activities have occurred so far at school X?” In the Prevention Activities Summary report you would select Tobacco-Activity?” equals “Yes” and School equals “X”, then click Show Summary to answer this question. While the filters vary from one report to the next, Figure 14 does show a fairly common view.

![Figure 14. An example of report filters.](image)
Troubleshooting

Trouble logging in

1. The first thing you need to check is whether or not you can get onto the internet. Try browsing to a Web site that is external to your current workplace, such as www.yahoo.com or www.google.com. If this is not working, contact your local tech support person for help.

2. If you can browse the Web, but cannot get to RMC's Web site, check the following items:
   a. Many schools and district offices run firewalls to enhance security. Sometimes Information Systems staff will set these firewalls to limit where you can go and what you can do over the Internet. Contact your technical staff and talk with them about this. Make sure they have allowed you full permissions to RMC's domain. (www.rmccorp.com)
   b. Try a different computer.
   c. Try a computer at a different location. (e.g., home, cyber-cafe, library, etc.)

3. If you can browse the Web and can bring up RMC's home page (www.rmccorp.com), but cannot log into the database, check the following items:
   a. Are you using the right username and password? Sometimes users will attempt to access the database using their school or OSPI login information. You need to use the username and password given to you for this database.
   b. Has your program director changed your status to inactive?
   c. Did you recently change your password?
   d. Is the database down? While we try hard to avoid this, it can happen. A quick call to RMC will let you know.

Records not saving or records disappearing

If you are confident you entered specific records that no longer appear in the database, check the following:

1. Did you remember to click Submit for each record? Because this database is on the Internet, it cannot save your records as you go. You must click Submit to save your data.

2. Are the filters on the page hiding the records? Some pages in the database default to specific filters in order to shorten page load times. Check the filters to be sure they include the data you are looking for.
3. If items 1 and 2 above are not the problem, please contact RMC immediately with specific information regarding the lost data. If a system error is to blame, we need to be aware as soon as possible.

Performance Issues

Things to check if you are experiencing poor system performance when using the Prevention and Intervention Web database:

1. If you are using an older computer, turn off any unnecessary programs. This will free up system memory and increase your Web browser's performance. Often, rebooting your computer and starting fresh can significantly improve overall performance.

2. Make sure your computer is healthy. Clearing your Web browser's cache, deleting "off-line" files, and defragmenting your hard drive can help to speed up your web browsing experience. (However, this is a job best left to your local tech guru.)

3. Log in at a different time of day. (Depending on your geographic location and available bandwidth, things can slow down noticeably when many people are using the Internet.)

If you are still experiencing difficulties, send a message to tguy@rmccorp.com with the following information:

1. Describe the problem. What form/page/report were you viewing? What happened? (e.g., slowness, error message, freezes, etc.)

2. What kind of system were you using? (e.g., Windows PC, Mac, Linux, etc.)

3. What browser and version were you using? (e.g., Netscape 4.7, Explorer 6.1, etc.)

4. Were you working behind a firewall? (Ask your tech person.)

5. Where were you working from? (e.g., School name, district office, home, what city?)

6. What time of day was it?
FAQs for Project Coordinators

How do I add a staff member and provide them a username and password?

1. Login to the Web database.
2. Click Administrative.
3. Click Add a new user.
4. Enter the user’s First Name, Last Name, and Email Address; and, select the schools to which the user is assigned. **NOTE: A valid email address is absolutely necessary in order for a staff member to retrieve his or her own password.**
5. Click Add User.
6. You should receive a confirmation message letting you know the addition was made.
7. Give the user his or her username directly and instruct him or her to go to the login page, select the password maintenance link, enter the username, and click email. This will send an email to the user with his or her password.

How do I edit another staff member's info?

1. Log into the database.
2. Click Administrative.
3. Click Edit another user’s information.
4. Select the desired staff member.
5. Click Edit User.
6. Change some or all of the user’s information.
7. Click Submit changes.
8. You should receive a confirmation message letting you know the changes were made.

How do I update or change staff assignments?

1. Login into the Web database
2. Click Administrative
3. Click Add or delete school assignments for specialists
4. Choose a specialist from "Select specialist" and click Select
5. On the left you will see a list of schools to which the user is currently assigned (if any). On the right you will see a list of schools available at your project.
6. Select schools on the left from which you want to un-assign the specialist.
7. Select schools on the right to which you want to assign the specialist.
8. Click Submit Changes.
9. You should receive a confirmation message letting you know the changes made.

How do I transfer an entire caseload from one specialist to another?

1. Login into the Web database.
2. Click Administrative.
3. Click Transfer caseload to another specialist.
4. Select the specialist to transfer the caseload from.
5. Select the specialist to transfer the caseload to.
6. Click Transfer Caseload.

NOTE: The specialist to whom you are transferring the caseload MUST be assigned to ALL of the schools to which the specialist you are transferring from is assigned. If this is not the case, you must adjust the assignments before attempting this transfer.

How do I transfer an entire caseload at one school from one specialist to another?

1. Login into the Web database.
2. Click Administrative.
3. Click Transfer caseload at one school from one specialist to another.
4. Select the school at which the caseload resides.
5. Click Next Step.
6. Select the specialist to transfer the caseload from.
7. Click Next Step.
8. Select the specialist to transfer the caseload to.
9. Review the choices listed. If correct, and if you are sure you wish to make this transfer, click Transfer Caseload. Otherwise, click Cancel Transfer.
FAQs for Intervention Specialists

How do I retrieve a new or forgotten password?

2. Click the link that says: "Forgot your password? Need to change it? Click here."
3. Enter your username in the "Oops, I forgot" box and click email.
4. Your password will be emailed to you.

How do I transfer a single student from one school to another?

1. Login into the Web database.
2. Click Administrative.
3. Click Transfer student to another school.
4. Select the code for the student you want to transfer.
5. Click Select.
6. Select the school to which to transfer the student.
7. Click Select.
8. Select the specialist who will now be responsible for the student.
9. NOTE: If the student will still be assigned to the same specialist in the new school, then just select that specialist from the list.
10. Click Transfer Student.
11. Verify or cancel the transfer when prompted.
12. You should now receive confirmation of the transfer request.

How do I transfer a single student from one specialist to another?

1. Login into the Web database.
2. Click Administrative.
3. Click Transfer student to another school.
4. Select the code for the student you want to transfer.
5. Click Select.
6. Select the school to which to transfer the student.
7. NOTE: If the specialist from whom you are transferring the student and the specialist to whom you are transferring the student both work at the SAME SCHOOL, then just select that school from the list.
8. Click Select.
9. Select the specialist who will now be responsible for the student.
10. Click Transfer Student.
11. Verify or cancel the transfer when prompted.
12. You should now receive confirmation of the transfer request.

How do I change an evaluation date in a student's record?
1. Login into the Web database.
2. Click Student Records.
3. Click Enter/Edit Student Data.
4. In the line belonging to the student of interest, click Test under the “Edit/View” column.
5. Enter the test dates and sheet numbers.
6. Click Submit Changes.
7. Your changes will be made and you will be returned to your master list.

How do I change a student ID, birthdate, gender, or ethnicity?
1. Login into the web database.
2. Click Student Records.
3. Click Enter/Edit Student Data.
4. In the line belonging to the student of interest, click ID under the “Edit/View” column.
5. Enter or change information as needed.
6. Click Submit Changes.
7. Your changes will be made and you will be returned to your master list.
DESIGNING AND DOING OUTCOMES EVALUATION

IDENTIFYING OUTCOMES: What are you trying to do?
Identifying measurable outcomes requires you to know what it is you are trying to accomplish through your program or activity. To do an evaluation, this knowledge must be very specific and it is not likely to be a standard part of what you write or say in response to the question “what are you trying to do?” Getting to the answers you need for an evaluation requires careful consideration of four questions:
1. What are your goals?
2. What are your outcomes in regard to these?
3. How do you plan to accomplish these?
4. How will you know when you do?

If you think this looks like the layout for a grant proposal, you’re right. It is also very similar to the guidelines you’re expected to follow for the “Principles of Effectiveness” for Department of Education funding. And it’s even possible you already have all or part of the answers to these questions for your program. Their purpose here is as a structured format for asking questions that requires you to differentiate among broad goals, outcomes, activities, outputs, resources, and the measurement or documentation of accomplishment. Following the outline in the table below keeps you from confusing these (which is easy), clarifies their interrelationships (which may be complex), and gets you started on evaluation design (which is the point).

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Inputs/Resources – elements that make up a program, e.g., staff, resources, collaborators.</td>
<td>Tasks that you will carry out in order to accomplish the outcome – method for providing program services, e.g., mentoring, tutoring, skill building.</td>
<td>The direct, tangible, product of program operations – how many, how often, how long? e.g., 1:1 two-hour mentoring session, weekly; 6-week 45 minute, classroom-based social skills group, twice weekly.</td>
<td>Short, intermediate, or long-term changes expected as a result of program participation. Specific, Measurable, Achievable, Realistic, and Time-limited, e.g., reduced anti-social problem behaviors; improved classroom behavior.</td>
<td>General statements about what you want to happen as a result of the program, usually beyond the scope of what one program alone can achieve, e.g., reduce juvenile delinquency; improve social status.</td>
</tr>
</tbody>
</table>

DEFINITIONS
Goals: Goals are fairly general statements about what you want to have happen as a result of a program. In some ways, goal statements are the program rationales—the reasons for doing something. They do not necessarily have to be directly measurable in and of themselves, at least not within a limited time frame. Goals do have to be ultimately attainable, however, particularly over time, and this attainment should be able to be known—that is—it should be measurable.

Outcomes: Outcomes are what you expect from the program. They must logically and explicitly contribute to the attainment of specific goals—an appropriate outcome is one that indicates progress toward a given goal. Your outcomes must be directly measurable within the time frame set for your program or project—they must be stated in such a way that

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38 Adapted from: Carlson, K. (2000). Designing and doing outcomes evaluation: Asking the right questions to get better answers. Praxis Research, Port Angeles, WA. kcarlson@olycom
you will be able to demonstrate whether or not the desired movement or progress has
occurred. And they must be attainable given the application of program activities—they
contribute to achieving a goal through activities or tasks designed to accomplish it.

Activities: Activities are the specific tasks that you will carry out for the process of
accomplishing your outcomes. To do this, activities must have some demonstrable
connection with the outcomes you expect them to lead to—program activities have to make
sense in light of desired outcomes. Activities also are measurable, but in a different way
than are outcomes. The measurement of activities concerns documentation of some thing
—events, interventions, attendance, performances, etc—often referred to as outputs. The
accomplishment of activities is not itself the achievement of any specific effect or outcome.

Indicators: You need to know both when you have achieved some desired outcome
(outcome indicators) and what you did to do this (activity indicators). In evaluation terms,
acquiring this knowledge for outcomes is referred to as summative or outcomes evaluation;
for activities, it is formative or process evaluation. To actually do a full outcomes evaluation,
you must have information both about what you accomplished and how you did it. We’re
familiar with evaluations that concentrate on documenting activities but never provide
information about how these contribute to a program goal. Equally unsatisfactory are
evaluation data that report on outcomes but does not tell you what went into achieving
these. In the first case, you cannot know if a program is worth doing; in the second example,
you cannot know how to keep doing it. Don’t neglect inputs (resources) or outputs (activities)
in order to focus on outcomes—the shift in evaluation emphasis towards outcomes requires
different information, but this is in addition to what you may have done, not instead of it.

EVALUATION DESIGN: HOW WILL YOU KNOW WHEN YOU’VE DONE
IT?

Attributing Cause and Effect
Outcomes evaluation concentrates on a program’s end products or effects, and depending
on the methodology used, may or may not be able to attribute cause to the program
studied. So-called “net impact” evaluations assess the types or degree of change caused
by participation in a particular program, a conclusion possible only when program
participants are compared with similar individuals who did not participate. This requires
an experimental or quasi-experimental design, including either random assignment to
test and control conditions or identification of a “matched” control group. Evaluations
based on these designs have considerable power as evidence of program outcome, but
they are not usually done because their conduct is both costly and difficult. There may be
ethical issues associated with withholding intervention or assigning potential participants to
test conditions. More commonly, there are simply practical barriers to using experimental
designs that are insurmountable except in rare cases. The relatively small number of
programs identified as “effective” is more a product of the costs and difficulties of doing such
causal research than it is an indicator of the shortage of good programs. There are almost
certainly other effective prevention strategies, to say nothing about effective intervention
approaches, but we do not have the scientific substantiation to clearly single these out from
other approaches.

Much more typical are outcomes evaluations that assess “gross impact”—program
outcomes among program participants only. This is the type of evaluation you are most
likely to do and the one discussed here. Outcome evaluations can provide reliable
knowledge about program quality and effectiveness for those who were program
participants. This knowledge can address questions about program success and inform
further program development and progress. It cannot substantiate claims that the program
is necessarily superior to some other intervention or no intervention at all because of

Evaluation is a
type of research,
and although
persons not
trained in research
methods often
carry out program
evaluation, a good
evaluation still
requires attention
to some core
characteristics of
research practice.
Three of the most
critical elements of
research are:

(1) theory,
(2) objectivity.
(3) design.
the lack of an appropriate comparison group. You cannot use information from such outcomes evaluations to identify best program development and progress. It cannot substantiate claims that the program is necessarily superior to some other intervention or no intervention at all because of the lack of an appropriate comparison group. You cannot use information from such outcomes evaluations to identify best program approaches, only to identify ones that may have some desired effect. Other programs (or no program at all) may have similar or even more favorable outcomes.

**EVALUATION IS RESEARCH**
Research involves a careful inquiry aimed at the discovery and interpretation of facts or new understandings of the practical application of theory. Evaluation is a type of research, and although persons not trained in research methods often carry out program evaluation, a good evaluation still requires attention to some core characteristics of research practice. Three of the most critical elements of research are: (1) theory; (2) objectivity; and (3) design.

**Theoretical foundation:** A theory is a statement or group of statements about how some part of the world works. Social and other programs are always based on some theoretical assumptions about how people are likely to act and respond, even if these are not explicit. These theoretical assumptions are underlying the identification of goals and outcomes, and are the basis for the presumed relationship between these and between program activities and outcomes. By identifying the theory (or theories) guiding your program, you are able to add explanatory power to program outcomes. There are many possible theories, some old, some more recent, some combinations. New theories are built on previous ones, seeking to continually improve understanding of why things occur. The most powerful theories are those that can effectively explain and predict outcomes—but no theory is perfect.

Risk and protective factors are core aspects of a prominent current theory in substance abuse prevention—social development theory. It is on the basis of the theory connecting these factors to adolescent problem behaviors that program activities intended to have outcomes such as stronger social bonds or reductions in the early initiation of substance use are proposed. An evaluation with a strong theoretical basis can overcome some of the limitations associated with lack of a comparison group. It comes closer to the explanatory power afforded by impact evaluation through its focus on outcomes known to contribute to change in problem behaviors, and through its use of interventions that have been proven effective elsewhere.

**Objectivity:** An objective evaluation is one whose conduct and findings are not influenced by personal preferences for the program or the desire to “look good.” Because of this, program funders often require the presence of an outside evaluator, someone who is not associated with the program. This independence (and some professional research qualifications) are presumed to make an external evaluator an objective judge of program outcomes. This practice does not necessarily preclude program staff from designing and carrying out an effective evaluation, but it does identify a need for sensitivity to the problems of subjectivity. Research demands difficult decisions and these may be compromised when one is very committed to a particular end.

There are solutions to the problems of subjectivity other than the hiring of an outsider. In scholarly research, one such alternative is represented by the “null hypothesis”—efforts aimed at proving the opposite of what the research would like to demonstrate. In evaluation, the same idea is reflected in an approach that allows for the collection of undesirable or unfavorable information as well as the positive. The evaluation has to be evenly balanced, asking questions that permit findings of no or negative outcomes as well as those that demonstrate achievement of objectives. An evaluation that doesn’t
offer room for program failure is a poor indicator of program effectiveness, regardless of
the strengths of its indicators of program success. You have to take the chance that your
evaluation will show your program did not work.

**Design:** The attention to design in evaluation research means that you have thought
through how and why you are collecting certain data and what these will contribute to your
understanding of program effects, and on the basis of these thoughts, have developed a
systematic strategy that you will be following in the conduct of the evaluation. Evaluation
is not a random effort, where you put together whatever comes to hand and hope it gives
you what you need. Good evaluation is structured, based on and informed by theory, and
carried out in accord with a specific, articulated plan. This doesn’t mean you need to prepare
a detailed schedule and accompanying justification for everything you will do. You should;
however, have a clear sense of when in the program process certain evaluation tasks should
be done, and know the rationale for this timing.

**STEPS IN EVALUATION DESIGN**

Evaluation design begins with the beginning. This is called the “baseline,” the point from
which program actions take place and ideally have effect. Generally, you need to know
where you start from in order to know the implications of where you end—**outcomes alone
say nothing about program impact**. Many evaluations incorporate some type of pre-post
measurements as a way of identifying features or characteristics of program participants
before program intervention and again after this is completed. Remember that any change
cannot usually be attributed directly to the actions of the program in most evaluations. Still,
one can at least discuss the occurrence of any positive shifts during the time of program
involvement and note improvements. The timing of the post measurement can make a
big difference in what your evaluation can claim. Immediate post-program measures,
such as those done at the end of a one day training, cannot assess whether or not any
knowledge acquired is actually applied, whether behavior changes as a result, or whether
that knowledge is even retained over time. Delaying the post-measurement gives time for
program effects to be manifested and mature; it also allows time for initial effects to erode.

One can also collect evaluation information through a single post-test. While this method
does not address program impact or change, it can meet the need for information about
accomplishment of outcomes. Use of a post-program-only measure follows the procedure
typically utilized in education. For example, students are expected to demonstrate that they
have acquired some set of skills or knowledge. The grade they earn is not premised on
how much (or how little) they have gained since beginning the course. Rather, satisfactory
progress or completion is based on a pre-determined standard of what it is they should learn
or be able to do as a result of the class. The amount of gain this requires could range from a
lot to very little, but all that matters is whether or not they meet the standard. A comparable
outcome is appropriate for programs offering training or emphasizing learning. Post-test
methods are particularly desirable when a program does not select participants on the
basis of need, problem, or deficit—a situation that may result in an unknown proportion of
participants already meeting an outcomes objective prior to program entry.

The overall process of evaluation design includes continuing work on the logic model structure
of resources, activities, outputs, outcomes, and goals. Your design builds another
structure attached to this one that specifies the indicators that will be used and when, how,
and for whom data on them will be collected. You cannot build the evaluation design without
the initial structure—that is, you cannot design an evaluation until you know what it is you
are trying to do and how you are planning to accomplish this. There are no generic designs.
There are, however, generic approaches that lead you through common design consider-
ations. Some of these steps have already been done:
1. Clarify goals, outcomes, and activities and their relationships;
2. Identify indicators that can measure inputs and outcomes and describe program activities;
3. Who is your audience for evaluation? What are the expectations for the program, and how critical is the evaluation to program continuation?
4. What are the resources available for evaluation—how much time can staff devote to evaluation activities, how much can you spend (5 percent to 20 percent of the program budget is often required by funders), and what will that buy; and how long can the evaluation extend after program exit?
5. What is the availability and value of existing or already being collected program data? It is both cost and time efficient to maximize the use of existing data for evaluation.
6. What is it you must know in order to demonstrate program effectiveness?
7. Identify key performance standards—what is the level of change or strength of indicator that is acceptable as success—Abstinence (how long)? Reduced use (how much)? Improved attitude (how much improvement)?
8. Lay out your evaluation design—complete the logic model diagrammed in the following table.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators &amp; Targets</th>
<th>Data Collection Method &amp; Tools</th>
<th>Data Collection Schedule</th>
<th>Sample Size/Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short, intermediate, or long-term changes expected as a result of program participation.</td>
<td><em>Indicator:</em> Identifies what is being measured to track the program’s success on an outcome. An indicator is observable and measurable. <em>Target:</em> The desired level of achievement of a program on its outcome indicators.</td>
<td>Identify how indicators will be measured, e.g., school records, observation, surveys, interviews.</td>
<td>Describe when and how often data will be collected, e.g., program end, school end, mid-point, pre/post program services.</td>
<td>State whether data will be collected from the entire population or a sub-sample. For example, all students involved in program services, parents of identified at-risk children.</td>
</tr>
</tbody>
</table>

**COLLECTING DATA:**

**How will you know what you know?**

While you are determining what you need to know in order to measure program outcomes, you should also be thinking about how you are going to know this. It is important that these two considerations occur together because often what you would like to know about some change or program effect cannot be determined through the means you have available. Many of the most important outcomes of prevention and intervention efforts are outside the scope of what we can usually know. Your capacity to know is always limited. These limits are imposed by time—some possible program outcomes won’t occur for years while others might happen only during a very brief but unpredictable time span; money—it is costly to do follow-up studies or use multiple or sophisticated measures; and the difficulties inherent in characterizing complex behavior-problem behaviors are interrelated and imbedded in overlapping individual, familial, social, and cultural histories and dynamics.

This means that there is no single best way to collect data and no clear end to the need for further information. You simply must select something that works for your information needs. Doing this is not quite as difficult as it might sound. You need to review a limited set of general options, draw a number of diverse data collection methods from these, and select or develop instruments that will provide you with the desired information.
DATA COLLECTION CONSIDERATIONS

Qualitative and Quantitative Data: There are really only two kinds of data—qualitative and quantitative. These distinctions are sometimes presented as subjective and objective, but this is an inaccurate description. Neither type of data are necessarily more accurate or "objective" than the other, and both have strengths and weaknesses as evaluation methods. The following table compares the two. Your selection of one or the other or both depends on what you need to know.

<table>
<thead>
<tr>
<th>QUALITATIVE</th>
<th>QUANTITATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe it</td>
<td>Count it</td>
</tr>
<tr>
<td>What range or diversity</td>
<td>What proportion</td>
</tr>
<tr>
<td>Convincing with examples, experiences</td>
<td>Convincing with numbers, statistics</td>
</tr>
<tr>
<td>Gather with personal conversation</td>
<td>Gather from surveys, existing statistics</td>
</tr>
<tr>
<td>Don’t know the answer</td>
<td>Know the answers already</td>
</tr>
</tbody>
</table>

You can assign categorical values to identifiable aspects of qualitative data and make them quantitative, but in doing so, you will lose some detail and depth. The conversion into discrete categories requires you to choose some interpretations of meaning and value as being more "real" or accurate than others. You need consistency in order to count things. In real life, there’s a great deal of inconsistency. Knowledge of risks associated with drug use, for example, often coexists with personal use. Thus, while the advantages of qualitative data are their richness and depth of descriptive and other detail, the disadvantage is the difficulties this richness poses for comparison and summary.

Conversely, quantitative data always have a qualitative base. That is, the categories that are used to differentiate items or elements—typically numbers—are symbols of some set of values or experiences. There is invariably an underlying judgment (read “subjective”) about what matters and to what extent. This judgment allows us to call some things “alike” and other things “different,” but the distinctions on which these choices are made are not fixed or inevitable. By doing this, we can aggregate information from different people, times, and places; we can look at things without taking into account their unique characteristics but rather in terms of similarities. These comparative and analytical capacities are the advantages of quantitative data, and they are considerable; their weaknesses are a loss of detail and the risk of under-representing complexity.

Data Collection Strategies: Data collection strategies can be clustered into three categories: (1) surveys— including structured, semi-structured, and unstructured, focus group and individual interviews and questionnaires. (2) assessments— including tests, observations, and standardized assessment tools. (3) records— including data routinely generated by the program, archival records and media materials, or public data bases such as the census, and other existing data from the program agency and other agencies. The best use of the comparative strengths and weaknesses of different forms of data collection and different approaches is a combination of measurement approaches that provides both qualitative and quantitative data. This can be done in a single instrument, such as a survey, and through different data collection methods. Your aim should be triangulation—that mix of approaches and methods that gives you different ways of looking at and assessing your program and its outcomes.

One of the core aspects of effective prevention is to cover multiple problems with diverse program approaches. This complexity of programming is needed for complex issues where there are likely to be considerable individual differences in need and program response. The same sort of approach needs to characterize evaluation design. Triangulation refers to the use of different research methods to zero in on the answers.
to a problem. It lets you draw on the strengths associated with particular methods while also compensating for their weaknesses through use of other methods. The variation in methods also permits an approach that covers different elements of the problem, important when you’re dealing with human behavior. Incorporate several ways of measuring important indicators, using not only different data sources but also different methods of data collection. This not only gives you the capacity to identify an outcome in several ways. It also gives you back-up in the event that one method is unworkable or fails to show the desired effects—something that is unfortunately, quite common.

**Sampling:** With all data collection approaches, you need to pay attention to sampling and who it is that is providing you with your evaluation information. Your conclusions about the meaning of your findings will vary depending on whether your sample is all program participants or some specific group of participants such as those from a particular program element or those who completed the program activities. The first is called a total population sample; the second is a selected sample. You also might collect information from a random sample—meaning that all participants or all participants of some type had an equal likelihood of being included. There is also what is known as an opportunity sample—information collected on the basis of participant availability.

All approaches can give you worthwhile data, but it is very important for the interpretation of this data that your sampling method is spelled-out. Information from a total population or a random sample is considered to be equivalent, and it may be easier to do one than the other. Either allows you to talk about program effects on all program participants. Information from a selected sample may pose questions of bias that skew your results, and like that from an opportunity sample, can only be applied to those who actually were part of the sample, not program participants in general. Still, with appropriate qualifications as to their source and limits, either sample may provide reasonable data collection choices for your program.

Sometimes the only possible source of outcomes data is that select group who remain in the program until its conclusion. If you use this type of survivor sample, be sure you explicitly state how its inevitably biased selection might influence your evaluation findings. Program attrition is unlikely to be random: those completing services may be very different from that total population of program entrants, and these differences may be more important to their program outcomes than the intervention itself. Knowing this means, you can often identify these differences, and recognizing sources of bias takes you long way toward controlling their effects on your conclusions.

**INTERPRETATION: So what?**

Evaluations are often unsuccessful not because of problems in data collection but because of failure to interpret results. The mass of information that is accumulated even in a modest evaluation design can be daunting. Computers are an enormous help to make the mass more manageable, but even the best software cannot tell you what your data means. No surprises here—you have to ask questions to understand what you have.

The initial interpretation questions for outcomes evaluation concern the characteristics of your program participants, what types of information were collected from them and how, and what other kinds of things might have influenced program outcomes or evaluation results. These are detailed below. The first five are relatively straightforward descriptions. The last is a control question, seeking to identify other features that may have influenced program outcomes. These questions establish the parameters of your evaluation results—the answers will allow you to compare findings with other studies, and let others compare results with you. The questions are:
1. Who?—who are the people who participated in or were affected by your program? Describe them in terms of their demographics (age, race, sex) and other characteristics; characterize program participants and how they differ from the general population or some other group; give a description of how you selected your samples; identify the differences between those who left the program and completers, etc.

2. What?—what are the features of the program interventions and how were they carried out; what was the attendance, completion, recovery rate; etc.

3. When?—at what points did you collect evaluation data? Before participation, during, at exit, as part of follow-up, etc.?

4. Where?—what were the sites for data collection? The program office, at participants’ homes, a public setting, other, etc.?

5. How?—what were your methods (survey, assessment, etc.) and under what conditions did you apply them (anonymous, face-to-face, written, verbal, telephone, etc.)?

6. What Else?—what was the context of program activities that might have affected activity outcomes or evaluation results. This context includes the general and specific environment (community and program site), as well as the participants’ social and economic environments, such as stress, unemployment, community tolerance, etc.

**CLOSING THE CIRCLE**

Answering these questions takes you half way to a complete evaluation, and if you have been able to maintain your evaluation design, the second half is even more straightforward. The key question for identifying outcomes is simply “How do your findings relate to your outcomes?” That is, did you accomplish what you proposed to achieve? If not, why not? (the answers should be in your evaluation data). If you did reach your outcomes, you also need to identify why this occurred. The need for interpretation applies equally to success as to failure. The primary explanations for program outcomes, whether positive or negative, are found in your theory, your process data (that reveal what the program activities were and how they were conducted), the program context, the characteristics of program participants, and those indicators you selected to reveal program outcomes. You can also look to explanations in evaluation findings for similar programs or programs serving similar populations, and finally, to the published research literature. A strong evaluation design should give you confidence in your data and the capacity to draw conclusions about its implications.

The utility of outcomes evaluation results lies in the future and whether or not it would be effective to continue a given program in its current form or in some modified form that has been suggested by evaluation findings.
Section 8: Educational Support Groups
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 Student Assistance Prevention-Intervention Services Program, educational support groups are beneficial for several reasons (Anderson, 1993):

1. Time efficient: Due to limited staff resources, one-on-one counseling may be burdensome to staff given their caseloads. Support groups ease the burden of individual sessions and broaden the range of services offered.
2. Emphasize information: The group setting offers a safe, positive environment in which students gain information, skills, and knowledge about the effects of drugs.
3. Opportunity for social interaction: Students benefit from learning how to problem solve in groups and increase pro-social behaviors (communication).
4. Healthy relationships: Relationships formed in group settings serve as a guideline for interacting in other healthy relationships outside the group.
5. Respect: Group rules or guidelines teach students how to give and receive respect from their peers.

IMPLEMENTING SUPPORT GROUPS IN THE SCHOOL SETTING

The decision to implement support groups within the school setting represents a high level of commitment on the part of the school system, with this decision based upon identified needs to justify implementation. During the early years of student assistance programming, support groups were an optional service component, with schools limiting their role to referring identified students to appropriate community-based programs. Today, however, student support groups are an integral part of a comprehensive SAPISP program. Anderson (1993) notes that there are three major arguments to support implementing groups, [support groups] are efficient, they provide a developmentally appropriate context for changing behavior in children and youth, and they are effective in addressing ATOD-specific issues” (Anderson, 1993. p. 174).

Support Groups Are Efficient
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.

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

Component 8: Educational Student Support Groups. To provide information, support, and problem solving skills to students who are experiencing academic and social problems.


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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.

Once a school district has a fairly clear idea of how many of its students are affected by their own or others’ drug-related problems, it is faced with the problem of how to reach all of those students in need, or at least of how to reach them to a significant degree. Consequently, another argument in support of implementing groups has to do with numbers. Hypothetically speaking, a group leader or counselor can accomplish with eight students in one hour what would take eight hours if each was seen individually. Moreover, leading three support groups each week enables a counselor to work with 24 students. In some average-size high schools, it is not uncommon to find 10 or 12 support groups operating during the week, attended by 70 or 80 students over a period of nine weeks. Because the support groups are sometimes facilitated by classroom teachers (and often by outside volunteers), many more students can be helped than would normally be possible for the average counselor working alone.

Just as research on class size shows, however, the number of students seen is not as important as the quality of the time spent. The small, problem-focused group permits counselors and others who lead groups to bring about changes that would be difficult or next to impossible to accomplish in a comparable number of one-to-one meetings with students. The small group permits an intensity of interaction that is often the most conducive to helping kids deal with difficult problems.

Finally, aside from being helpful to students, support groups can help the school system to perform the basic program functions more effectively. Data collection, for example, is an important assessment task. By listening to and observing students in use-focused groups a counselor can acquire a more thorough and intuitive notion of the nature and severity of a student’s relationship with chemicals than would be possible in one-to-one interviews alone. Similarly, this type of support group can provide invaluable data for a formal intervention as well as leading a student to respond to it more readily.

**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.

40 Ibid.
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 Groups Are Effective at Changing Alcohol/Drug-Specific Behavior**

Perhaps the greatest benefit of support groups is their particular efficacy in addressing the needs of children and youth who are specifically affected by alcohol/drug-related problems. Yalom (1975. pp. 3–69) has identified a number of “curative factors” of psychotherapy groups, for example, which also uniquely describe the ways in which the brief problem-focused support groups in school are effective in dealing with alcohol/drug-specific needs of students.

Inclusion. Regardless of whether their concern is with their own alcohol/drug 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.

**Support Group Composition**

It is important to be sensitive to group make up or composition, especially to the potential risks of conducting group activities with students who are at high risk for ATOD use and other problem behaviors. It is critical that placement is based upon identified student risks and needs and that groups are appropriately mixed (Einspruch and 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 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 non-dependent 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 a 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 ATOD-related groups may include information about the continuum of substance use experience, personal communication skills, the consequences of substance use, alternatives to substance use, the economics of substance use, 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 adolescents. 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).**
WASHINGTON STATE’S SAPISP SUPPORT GROUPS OFFERINGS

Washington State’s Student Assistance Prevention-Intervention Services Program model has four standard student support groups: (1) At Risk/Social Skills; (2) Intervention; (3) Affected Others; 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 LOGISTICS

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 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 SASs 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 alleviative students’ anxiety or uncertainness 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.

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42 Adapted in part from: Kids Like Us Everywhere KCDASAS Prevention Program, Seattle, WA
extra curricular 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. SASs 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 SASs 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. Student Assistance Specialists 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 97).

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 Student Assistance Prevention-Intervention Services Program 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 the 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. 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 non-verbal cues that could 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 155). 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 Affected Others may meet twice weekly to assist students who are coping with stressful family situations. 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 8–10 weeks of group sessions.

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, Affected Others, and Recovery Support. However, to protect confidentiality, actual groups should have a neutral name, for example, 1st period group, Orange group, or Group 1. 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).
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, feel, 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 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 CHANGE\textsuperscript{43}

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’ Student Assistance Prevention-Intervention Services Program model. The five stages of change are precontemplation, contemplation, preparation, action, and maintenance (figure 8.1).

- **Precontemplation** 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 Model\textsuperscript{44}**

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
</table>
| Precontemplation| 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: “Sit 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 |

\textsuperscript{44} Retrieved from http://www.cellinteractive.com/ucla/physician_ed/stages_change.html
STANDARD SUPPORT GROUPS

The following pages provide detailed information about the four statewide SAPISP educational support groups including group goals and objectives, targeted student population, topical areas of discussion, and alignment with Washington State’s Essential Academic Learning Requirements (EALRs). After the support groups standards is a set of sample forms for the SAS to use in the implementation of groups.

1. Group sign up sheet—students complete the form following a classroom presentation to indicate interest in group participation.
2. Group session summary/lesson plan (PSESD 121)—the form is used to provide information to administration, counselors, teachers, parents, and community partners about the linkage of support groups to the school improvement process/EARLs.
3. Group Attendance log—a record of student’s weekly attendance and topics covered during group.

Recommended Books to Compliment Support Group Activities:


NOTE: The information in this section was compiled in conjunction with the assistance and hard work of Martin Fleming, author and Intervention Specialist; Randy Town, Coordinator of Alcohol and Drug Programs, ESD 105; and Sandy Mathewson, Coordinator, Drug and Alcohol Programs, ESD 112; and Kristin Schutte, Director, Prevention and Treatment Center, OESD 114.
AT RISK/SOCIAL SKILLS GROUP
(Primary Group #1)

At Risk/Social Skills Group: 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. Examples include students who lack commitment to school, exhibit low impulse control, are alienated from peers, or 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 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:
   • making friends.
   • managing conflict.
   • listening and communicating effectively.

2. Information related to risks of mood-altering chemicals
   Since the fundamental goal for this category of support groups is to prevent students from using alcohol or other drugs, it is important that they hear a clear “no-use” message. This message needs to be backed by age-appropriate information concerning health risks related to use by covering topics such as:
   • health implications associated with using mood-altering chemicals.
   • legality issues.
   • the dynamics of physical and psychological addiction.

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. 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.

STANDARD SUPPORT GROUPS

The following pages provide detailed information about the four statewide SAPISP educational support groups including group goals and objectives, targeted student population, topical areas of discussion, and alignment with Washington State’s Essential Academic Learning Requirements (EALRs).
**AT RISK/SOCIAL SKILLS GROUP**
**ESSENTIAL ACADEMIC LEARNING REQUIREMENTS ALIGNMENT**

**Introduction**
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. Examples include: (a) students who lack commitment to school, (b) exhibit low impulse control, (c) are alienated from peers, and (d) suffer from low self-esteem.

<table>
<thead>
<tr>
<th>Our objectives for prevention groups include having students:</th>
<th>Alignment with the Washington State Essential Academic Learning Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Learn <strong>communication skills</strong> including:</td>
<td><strong>Communication 3.0</strong> – The student uses communication strategies and skills to work effectively with others.</td>
</tr>
<tr>
<td>- Self-awareness and identification of emotions.</td>
<td><strong>Communication 3.2</strong> – Work cooperatively as a member of a group.</td>
</tr>
<tr>
<td>- Listening and paraphrasing.</td>
<td><strong>Communication 4.2</strong> – Seek and use feedback to improve communication; offer suggestions and comments to others.</td>
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<tr>
<td>- Managing conflict.</td>
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<tr>
<td>- Working together as a member of a group to solve problems.</td>
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<tr>
<td>2. Learn the <strong>disease concept of alcoholism/chemical dependency</strong> including:</td>
<td><strong>Health and Fitness 2.1</strong> – Recognize patterns of growth and development...how heredity and environmental factors may influence growth and development.</td>
</tr>
<tr>
<td>- Heredity and its role in development of the disease.</td>
<td><strong>Health and Fitness 3.1</strong> – Understand how environmental factors affect one’s health.</td>
</tr>
<tr>
<td>- Gain accurate information on disease-related behaviors including black-outs, codependency, and enabling.</td>
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</tr>
<tr>
<td>3. Learn <strong>feeling identification</strong> including:</td>
<td><strong>Health and Fitness 2.3 and 3.4</strong> – Understand how emotions influence decision making.</td>
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<tr>
<td>- Developing a feeling vocabulary.</td>
<td></td>
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<tr>
<td>- Expressing emotions appropriately.</td>
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<tr>
<td>4. Developing a <strong>School Success Plan</strong> including:</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely...anticipate risky situations and demonstrate skills to live safely...identify situations and decisions related to drug use.</td>
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<tr>
<td>- Steps for academic success.</td>
<td></td>
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<tr>
<td>- Developing good study habits.</td>
<td></td>
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<tr>
<td>- Establishing and building trust with others.</td>
<td></td>
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<tr>
<td>- Anticipating and making plans to avoid “risky” situations with regard to drug use.</td>
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<tr>
<td>- Developing drug-free recreation/activities.</td>
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</tbody>
</table>
INTERVENTION GROUP  
(Primary Group #2)

Intervention Group: 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. These types of groups are often used as a “buy back” alternative to suspension/expulsion.

The goal of intervention groups is to assist students to gain insight into how tobacco, alcohol, marijuana, or other drugs and other negative behaviors impact their lives. Participants gain information about the progression of chemical dependency and can consider the consequences of their use and make decisions about changing behaviors. SAS also learn more about the student(s) level of involvement/use of ATOD and; therefore, make more informed decisions regarding students’ drug use levels and thus can refer students to needed services such as ATOD assessment or other community-based services.

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. Typical names for this support group include Insight, Choices, and Chemical Health group. A second phase intervention group is known as a Challenge group. This group is for students who need further intervention services and support to address their substance abusing behavior. The fundamental goals are similar to the insight education group. 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 and affects on the physical body.
   - long-term implications for drug abuse.

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.

3. Interpersonal skills
   It has been said that drugs are a people substitute. This being the case, group members needs 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.
   - communication and listening skills.
   - understanding of personal defenses.
4. 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 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 acquiring mentors.
  • promoting constructive and positive activities.
  • action plans for meeting personal goals.

5. Motivate group members to stop using drugs
This goal is sometimes so basic it gets overlooked. A strong “no-use” and “quit now” message 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 contracts.
  • rewards for “clean” time.
  • urinalysis.
  • strong “no-use” messages.
  • consequences for a chemical use incident.
**INTERRUPTION GROUP ESSENTIAL ACADEMIC LEARNING REQUIREMENTS**

**ALIGNMENT**

**Introduction**
This group is for students who are involved with chemicals, ranging from those just beginning to experiment with mind-altering substances to students whose extensive chemical use warrants in-patient treatment.

We strongly believe the primary goal of this group is to stop using drugs. Therefore, strong “no-use” and “quit now” messages are woven throughout group curriculum. In addition to the following education strategies, group policies and rules are created to help satisfy these goals. Examples of these include: (a) abstinence contracts, (b) rewards for “clean” time, (c) strong “no-use” message, (d) consequences for a chemical use incident.

<table>
<thead>
<tr>
<th>Our objectives for groups include having students:</th>
<th><strong>Alignment with the Washington State Essential Academic Learning Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Learn the <strong>disease concept of alcoholism/chemical dependency</strong> including: Heredity and its role in development of the disease.</td>
<td><strong>Health and Fitness 2.1</strong> – Recognize patterns of growth and development…how heredity and environmental factors may influence growth and development.</td>
</tr>
<tr>
<td>2. Learn refusal skills including:</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely…anticipate risky situations and demonstrate skills to live safely…identify situations and decisions related to drug use.</td>
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<tr>
<td>• How to anticipate “risky situations.”</td>
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<tr>
<td>• How to avoid dangerous behaviors and still keep friends.</td>
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<tr>
<td>3. Learn the <strong>stages of addiction</strong> from no use/experimentation to full addiction and recovery including:</td>
<td><strong>Health and Fitness 2.1</strong> – Recognize patterns of growth and development…how heredity and environmental factors may influence growth and development.</td>
</tr>
<tr>
<td>• Physical and psychological addiction process.</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely…anticipate risky situations and demonstrate skills to live safely…identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>4. Participate in a self-assessment process including:</td>
<td><strong>Communication 3.0</strong> – The student uses communication strategies and skills to work effectively with others.</td>
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<tr>
<td>• Self-assessment tied to a continuum of use, abuse, and dependence.</td>
<td><strong>Communication 3.2</strong> – Work cooperatively as a member of a group.</td>
</tr>
<tr>
<td>• Personal understanding of drug-using behavior and its consequences.</td>
<td><strong>Communication 4.2</strong> – Seek and use feedback to improve communication; offer suggestions and comments to others.</td>
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<tr>
<td>• Relationship between academic performance and drug use.</td>
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AFFECTED OTHERS GROUP  
(Primary Group #3)  

Concerned Persons/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. But can also be impacted by a friend’s use as well (note this may need to be a separate group). 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 alcoholics, concerned persons or a variety of other titles, such as family issues, life skills, and communications. It is suggested that the group name “children of alcoholics” 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
Young people experiencing family members with drinking or other drug problems 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 concepts of alcoholism.
   - blackouts.
   - codependence.
   - enabling.

2. 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 refuse to ride home with an intoxicated parent. This goal area is not limited to just this, however, and can include topics such as relationship building and conflict resolution. Examples include:
   - physical safety when with a chemically-impaired adult.
   - communication.
   - relationship-building.
   - seeking a mentor.
   - self-assertion.

3. Identify and express emotions
Young people with chemically dependent parent have many experiences that give 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 goal area includes:
   - expressing emotions.
   - 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:

- Alateen and other community groups.
- mentors.
- supportive school staff.
- community-based counselors/therapists.
AFFECTED OTHERS GROUP
ESSENTIAL ACADEMIC LEARNING REQUIREMENTS ALIGNMENT

This support group is fundamentally aimed at assisting students with a chemically dependent parent, sibling, relative or loved one who has a problem with alcohol or other drugs.

Young people experiencing family members with drinking or other drug problems 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 the SAS provides facts about the addictive process and its impact on the family and assists in breaking the cycle of addiction.

<table>
<thead>
<tr>
<th>Our goals for recovery group include having students:</th>
<th>Alignment with the Washington State Essential Academic Learning Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Accepting responsibility for own behavior</strong> including:</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely, anticipate risky situations, and demonstrate safety skills; identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>• “Survival Skills.”</td>
<td><strong>Health and Fitness 2.1</strong> – Recognize patterns of growth and development, how heredity and environmental factors may influence growth and development. <strong>Health and Fitness 3.1</strong> – Understand how environmental factors affect one’s health.</td>
</tr>
<tr>
<td>• Relationship building with others.</td>
<td><strong>Communication 3.2</strong> – Work cooperatively as a member of a group. <strong>Communication 3.3</strong> – Seek agreement and solutions through discussion.</td>
</tr>
<tr>
<td>• Physical safety when with a chemically impaired adult.</td>
<td><strong>Health and Fitness 2.3 and 3.4</strong> – Understand how emotions influence decision making.</td>
</tr>
<tr>
<td><strong>2. Learn the disease concept of alcoholism/chemical dependency</strong> including:</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely, anticipate risky situations and demonstrate skills to live safely. Identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>• Heredity and its role in development of the disease.</td>
<td><strong>Health and Fitness 3.2</strong> – Gather and analyze health information, make informed choices about health services and products.</td>
</tr>
<tr>
<td>• Gain accurate information on disease-related behaviors including black-outs, co-dependency, and enabling.</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely, anticipate risky situations, and demonstrate safety skills; identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td><strong>3. Learn communication skills</strong> including:</td>
<td><strong>Communication 3.2</strong> – Work cooperatively as a member of a group. <strong>Communication 3.3</strong> – Seek agreement and solutions through discussion.</td>
</tr>
<tr>
<td>• Working together as a group.</td>
<td><strong>Health and Fitness 2.1</strong> – Recognize patterns of growth and development, how heredity and environmental factors may influence growth and development. <strong>Health and Fitness 3.1</strong> – Understand how environmental factors affect one’s health.</td>
</tr>
<tr>
<td>• Learning they are not the only one with this struggle.</td>
<td><strong>Health and Fitness 2.3 and 3.4</strong> – Understand how emotions influence decision making.</td>
</tr>
<tr>
<td>• Experiencing acceptance and a “sense of belonging” with the group.</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely, anticipate risky situations and demonstrate skills to live safely. Identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td><strong>4. Learn feelings identification</strong> including:</td>
<td><strong>Health and Fitness 2.3</strong> – Acquire skills to live safely, anticipate risky situations, and demonstrate safety skills; identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>• Developing a feeling vocabulary.</td>
<td><strong>Health and Fitness 3.2</strong> – Gather and analyze health information, make informed choices about health services and products.</td>
</tr>
<tr>
<td>• Expressing emotions.</td>
<td><strong>Health and Fitness 2.3 and 3.4</strong> – Understand how emotions influence decision making.</td>
</tr>
</tbody>
</table>
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 no ATOD 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.
   • creating a drug-free check in.
   • typing group membership with abstinence.

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.
   • asking for help.
   • acquiring mentors.
4. 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.
RECOVERY SUPPORT GROUP
Essential Academic Learning Requirements Alignment

Introduction
This is a program for students who have stopped using chemicals either on their own or by completing some type of treatment program and who need assistance in maintaining their goals of abstinence. We believe these students need assistance at school because school is often a place with many opportunities to make negative decisions regarding drug use or interaction with other students who might dissuade them from their abstinence goals. It is important to note that the school-based support group is not intended to take the place of a community-based aftercare program.

<table>
<thead>
<tr>
<th>Our goals for recovery group include having students:</th>
<th>Alignment with the Washington State Essential Academic Learning Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintaining sobriety through relapse prevention activities including:</td>
<td>Health and Fitness 2.3 - Acquire skills to live safely, anticipate risky situations and demonstrate skills to live safely, identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>• Teaching refusal skills.</td>
<td></td>
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<tr>
<td>• Identifying peers who have values and norms reflecting non-use.</td>
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<tr>
<td>• Identifying relapse triggers.</td>
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<tr>
<td>2. Identify community resources which encourage growth recovery including:</td>
<td>Health and Fitness 3.2 - Gather and analyze health information, make informed choices about health services and products.</td>
</tr>
<tr>
<td>• Community-based support programs.</td>
<td></td>
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<tr>
<td>• Aftercare programs.</td>
<td></td>
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<tr>
<td>• Supportive school staff.</td>
<td></td>
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<tr>
<td>• Acquiring mentors/sponsors.</td>
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<tr>
<td>3. Develop a recovery plan including:</td>
<td>Health and Fitness 2.3 - Acquire skills to live safely, anticipate risky situations and demonstrate skills to live safely, identify situations and decisions related to drug use.</td>
</tr>
<tr>
<td>• Steps for attendance &amp; academic success.</td>
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<td>• Developing good study habits.</td>
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<td>• Establishing and building trust with others.</td>
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<tr>
<td>• Anticipating and making plans to avoid “risky” situations with regard to drug use.</td>
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<tr>
<td>• Developing drug-free recreation and social activities.</td>
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<tr>
<td>4. Learn coping and communication skills including:</td>
<td>Health and Fitness 2.3 and 3.4 – Understand how emotions influence decision making.</td>
</tr>
<tr>
<td>• Feeling identification, expressing emotions appropriately.</td>
<td>Communication 3.2 - work cooperatively as a member of a group.</td>
</tr>
<tr>
<td>• Dealing with life issues without chemicals.</td>
<td>Communication 3.3 – Seek agreement and solutions through discussion.</td>
</tr>
<tr>
<td>• Working together as a member of a group to solve problems.</td>
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<tr>
<td>• Developing listening skills.</td>
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<tr>
<td>• Encouraging others.</td>
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<tr>
<td>5. Learn the disease concept of chemical dependency and its progression including:</td>
<td>Health and Fitness 2.1 - Recognize patterns of growth and development, how heredity and environmental factors may influence growth and development.</td>
</tr>
<tr>
<td>• The genetic, biological, environmental, and emotional aspects of their role in the development of addiction.</td>
<td>Health and Fitness 3.1 - Understand how environmental factors affect one’s health.</td>
</tr>
<tr>
<td>• Gaining accurate information on disease-related behaviors including black-outs, co-dependency, enabling, and denial.</td>
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<tr>
<td>• Tolerance, withdrawal.</td>
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</tbody>
</table>
SAMPLE

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.*
SAMPLE
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.
✓ 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 EALRs 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

Source: Puget Sound ESD 121 and Educational Service District 105 Prevention Centers
**GROUP ATTENDANCE LOG**

<table>
<thead>
<tr>
<th>Group Topic and Attendance</th>
<th>Topic</th>
<th>Topic</th>
<th>Topic</th>
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<tbody>
<tr>
<td>Student Name</td>
<td>Date</td>
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Source: Olympic Educational Service District 114
Section 9: Cooperation and Collaboration with Other Agencies and Resources
INTRODUCTION

In order to effectively address barriers to learning and promote 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 resources can do a better job by working closely with schools. On a broader scale, communities need schools to play a key role in strengthening families and neighborhoods.

When addressing the problems of adolescent substance abuse and related behaviors, it becomes clear that these issues affect the school, family, and community. Therefore, it is important to that Student the Assistance Prevention-Intervention Services Program not work in a vacuum if the intent is to effectively address student 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, Alateen, Narcotics Anonymous, Cocaine Anonymous, 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.

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 and to consistently reinforce messages across all levels of service thus limiting confusion and inconsistencies.
Benefits of Collaborations 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:
- 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 Student Assistance Prevention-Intervention Services Program has a strong history of school-community partnerships in the development of a systemic, comprehensive, multifaceted approach to 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 the Office of Superintendent of Public Instruction and Department of Alcohol and Substance Abuse 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 is working with the State’s Community Public Health and Safety Networks to prevent important social problems. The networks are 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 are 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 (Family Policy Council, www.fpc.wa.gov/).

- 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 Department of Health 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 work 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 EFFORTS

State Prevention Summit: The State Prevention Summit is sponsored annually by the state Department of Social and Health Services—Division of Alcohol and Substance Abuse; the State Department of Health—Tobacco Prevention Program; the Office of the Superintendent of Public Instruction; the Comprehensive Health Education Foundation; and the state Department of Community, Trade and Economic Development. The purpose of the Prevention Summit is to provide an opportunity for students, adults, and legislative leaders to engage in a process of preventing alcohol and other drug misuse and to understand the impacts of substance use on families and communities.

Healthy Youth Survey: The Healthy Youth Survey (HYS) is a collaborative effort of the Office of Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service’s Division of Alcohol and Substance Abuse, and Community, Trade and Economic Development.

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. The state-level data is used to compare Washington to other states that conduct similar surveys and to the nation (www.doh.wa.gov/).
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/intervention services, jointly supported training/education events, and assisting with coordinating regional youth substance abuse treatment efforts.

The Family Policy Council: Each county in Washington State had community and school partners participate in a year-long study in 1994–95 to identify community risk factors, and potential resources available or needed to address risk factors. The results of community surveys and community hearings brought forward a series of priorities of risk factors identified and prioritized by each county. These priorities applied to the comprehensive integrated Safe and Drug-Free Schools Title IV programming/Principal of Effectiveness plans as well as Student Assistance Prevention and Intervention Program Service comprehensive plans from 1995 to present. Continued coordination with the network has helped align and update community prevention plans yearly and increased 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.

Advisory Councils: Both Educational Service Districts and local schools districts have established advisory Councils. The advisory council consists 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 serving as the advisory council. The role of the advisory council is to assist the local school districts in developing and implementing promising and effective research-based alcohol and other drug and violence prevention programs and student activities conducted by local school districts; and advise them on coordination of program efforts with relevant agencies, reviewing program evaluation material and information; and making recommendations for improving the local drug and violence prevention program.

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.

SUGGESTED PROGRAM OPERATIONS

The following information provides project coordinators with suggested program operations related to the SAS’s role in working and networking with community agencies, and additional resources.

On an ongoing basis the SAS’s needs to:
• 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.

**SAS’s ROLE IN WORKING WITH COMMUNITY AGENCIES AND RESOURCES**

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, and 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 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.

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*Adapted from Center for Mental Health in Schools, School-community partnerships: A guide. Available at http://smhp.psych.ucla.edu*
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?47

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 post secondary 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; and building a sense of community.*

47 Ibid.

*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.”
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.

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 that 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

<table>
<thead>
<tr>
<th>I. Initiation</th>
<th>V. Scope of Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. school-led</td>
<td>a. narrow-band— a small proportion of youth and families can access what they need</td>
</tr>
<tr>
<td>b. community-driven</td>
<td>b. broad-band— all in need can access what they need</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Nature of Collaboration</th>
<th>VI. Ownership and Governance of Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Formal</td>
<td>a. owned and governed by the school</td>
</tr>
<tr>
<td>▪ memorandum of understanding</td>
<td>b. owned and governed by the community</td>
</tr>
<tr>
<td>▪ contract</td>
<td>c. shared ownership and governance</td>
</tr>
<tr>
<td>▪ organizational/operational mechanism</td>
<td>d. public-private venture— shared ownership and governance</td>
</tr>
<tr>
<td>b. Informal</td>
<td></td>
</tr>
<tr>
<td>▪ verbal agreements</td>
<td></td>
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<tr>
<td>▪ ad hoc arrangements</td>
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</table>

<table>
<thead>
<tr>
<th>III. Focus</th>
<th>VII. Location of Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Improvement of program and service provision</td>
<td>a. community-based, school-linked</td>
</tr>
<tr>
<td>▪ for enhancing case management</td>
<td>b. school-based</td>
</tr>
<tr>
<td>▪ for enhancing use of resources</td>
<td></td>
</tr>
<tr>
<td>b. Major systemic reform</td>
<td></td>
</tr>
<tr>
<td>▪ to enhance coordination for organizational restructuring for transforming system structure and function</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. Scope of Collaboration</th>
<th>VIII. Degree of Cohesiveness among Multiple Interventions Serving the Same Student/Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of program and services involved (from just a few— up to a comprehensive, multifaceted continuum)</td>
<td>a. unconnected</td>
</tr>
<tr>
<td>b. Horizontal Collaboration</td>
<td>b. communicating</td>
</tr>
<tr>
<td>▪ within a school/agency</td>
<td>c. cooperating</td>
</tr>
<tr>
<td>▪ among schools/agencies</td>
<td>d. coordinated</td>
</tr>
<tr>
<td>c. Vertical Collaboration</td>
<td>e. integrated</td>
</tr>
<tr>
<td>▪ within a catchment area (e.g., school and community agency, family of school, two or more agencies)</td>
<td></td>
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<tr>
<td>▪ among different levels of jurisdictions (e.g., community, city, county, state, federal)</td>
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</table>

### 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.49

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49 Ibid
<table>
<thead>
<tr>
<th>As guidelines, Kinney et al (1994) stress:</th>
<th>Interventions that are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• a focus on improving systems, as well as helping individuals</td>
<td>• family-centered, holistic, and developmentally appropriate</td>
</tr>
<tr>
<td>• a full continuum of interventions</td>
<td>• consumer-oriented, user friendly, and that ask consumers to contribute</td>
</tr>
<tr>
<td>• activity clustered into coherent areas</td>
<td>• tailored to fit sites and individuals</td>
</tr>
<tr>
<td>• comprehensiveness</td>
<td>Interventions that:</td>
</tr>
<tr>
<td>• integrated/cohesive programs</td>
<td>• are self-renewing</td>
</tr>
<tr>
<td>• systematic planning, implementation, and evaluation</td>
<td>• embody social justice/equity</td>
</tr>
<tr>
<td>• operational flexibility and responsiveness</td>
<td>• account for diversity</td>
</tr>
<tr>
<td>• cross disciplinary involvements</td>
<td>• show respect and appreciation for all parties</td>
</tr>
<tr>
<td>• de-emphasis of categorical programs</td>
<td>• ensure partnerships in decision making/shared governance</td>
</tr>
<tr>
<td>• school-community collaborations</td>
<td>• build on strengths</td>
</tr>
<tr>
<td>• high standards-expectations-status</td>
<td>• have clarity of desired outcomes</td>
</tr>
<tr>
<td>• blending of theory and practice</td>
<td>• incorporate accountability</td>
</tr>
</tbody>
</table>
Section 10:
Integration with Other School-Based Programs
INTRODUCTION
According to the National Student Assistance Association (2003), to be effective student assistance programs must take a "comprehensive multi-disciplinary approach to prevention, intervention, and support services" which includes the integration of SAPISP with other school-based programs. Through the school improvement process and review of needs assessment data such as the Health Youth Survey, each school and community must assess and determine the services that best meet the needs of their diverse population. Depending upon identified student and school needs, the following student assistance services may be integrated into with other school-based programs: Classroom Prevention Curriculum; Parent Education; Character Education; Identification of Learning Styles; Career Exploration; Conflict Resolution; Peer Mediation; Mentoring; Service-Learning; Community Mobilization; Asset Development; Violence Prevention; and a Crisis Response Team.

PURPOSE OF INTEGRATION
All schools have services and practices that contribute to establishing the learning environment that support academic success. The impact of these services and practices can fall short without a coordinated effort involving all key stakeholders invested in developing cohesive and comprehensive strategies based on best practices. The key to success is to strategically and energetically embrace comprehensive plans that involve professionals both inside and outside of the school system. It is not enough that teachers are highly competent and ready to teach; they must also be equipped with a comprehensive support system to address student barriers to learning. It is a common challenge that existing resources, skills, and practices are given less consideration than instructional practices that result in fragmented and inconsistent approaches. Confronting this issue requires organized access to effective resources to address individualized learning challenges, as well as coordinated approaches to delivering cohesive prevention, intervention, and aftercare practices through school-community partnerships, programs, and events.

Key Sources for Integration
A critical factor in the development and maintenance of a supportive learning environment is a coordinated student assistance program with a focus on collaboration and networking among key stakeholders in the school community. Strong administrative support is critical in establishing the value of a coordinated and cohesive student assistance program. It is with that message that other members of the school community embrace the aim of creating a supportive learning environment. Linking to school improvement goals that articulate the school plans to address issues related to school climate/culture and/or safety further emphasizes this approach. It is in this context that the efforts of direct service providers and program coordinators are able to provide leadership and expertise in establishing the infrastructure for a supportive learning environment.

A key contact must be identified to effectively coordinate and/or collaborate between multiple program services such as the Student Assistance Prevention-Intervention Services Program, Safe and Drug-Free Schools, health education teachers, special education, mental health, and other program professionals and service providers. Optimally, this will be the Student Assistance Specialist. If the school administrator has not established a key contact for the SAS, it is appropriate for program staff to facilitate the identification of the key contact, or request that s/he assume the role. The role of this contact is to regularly meet with the building administrator and assist with the informal development of strategies to address identified student needs, including strategies/methods to inform and support teachers through consultation, training, and recommendation of materials/curriculum.

Component 10: Integration with Other School-Based Programs
To integrate student assistance services with other school-based programs designed to increase resilience; improve academic performance and reduce student risk for violence, alcohol, tobacco, and other drugs.

Historically, Student Assistance Specialists are seen as experts working outside the school’s mission, system, and operations. This view is further reinforced when program staff are part-time or are contractual and perceived by school staff as itinerants or “outsiders.” As such, this perception tends to encourage work independent of the school team thus contributing to fragmented services. The SAPISP program functions at its best when linked to the school team and school mission. The first step in achieving program-school connectedness is to meet with school counselors, or other key school staff such as the SAT Coordinator or School Resource Officer to identify potential compliments and overlaps in job descriptions, duties, and expectations. When SASs and counselors work together on the same team, they can develop a communication system that enables each job to function at a higher quality. Suggestions for establishing and developing a strong team include collaborating on specific tasks such as writing an article for the school, conducting parent outreach, and providing staff trainings on signs and symptoms of ATOD use, and developing an effective cross-referral system.

Because each school comes with its own mix of resources and priorities, the next step for effective collaboration is to establish a working relationship within existing networks and/or to develop an advisory committee that represents the voices of all stakeholders within the school community, including special education. This may be a stand alone advisory committee, or may be combined with the overall mission of school safety and support services, or combined with staffing student needs and monitoring an overall intervention system (such as a Multi-Disciplinary Team or CORE Team), or may represent multiple schools within the district. The advisory committee is best suited to identify and remove barriers to school-based prevention and intervention efforts and to facilitate and support a comprehensive prevention and intervention strategy.

Typical components that require coordinated integration or complimentary processes include school policies, staff trained in the philosophy of creating supportive learning environments, skilled in approaching students of concern, access to community services, and integration of school curricula and school programming.

Focuses for community networking may include mental health and youth service agencies, substance abuse treatment centers, recreation/community centers, faith-based youth groups, parent driven organizations, neighborhood businesses, service clubs, libraries, CPS, homeless shelters, and other relevant community services. Additional, areas to align within the school include peer leadership, health education and social skills curricula, media literacy, athletics, special education, discipline practices, school safety, bus driver training, staff course work on sexual harassment and child abuse intervention, tutor programs, and mentor programs.

**Special Education**

Students involved in special education programs are of special consideration due to their relative standing as at high risk for substance abuse, and due to the distinctive treatment they receive through school policies and practices. Ensuring effective services for students in the Special Education program therefore require the attention of a P/I Specialist. There are three roles that a Student Assistance Specialist will need to interact:

- Every school has a Special Education Coordinator assigned to serve as the primary contact for the students at that site. It is recommended the P/I Specialist introduce themselves to this person at the beginning of the year and establish a mutually supportive consultant relationship and communication system for
sharing information regarding the needs of students and families they share as clients.

- Each school district has a Special Education Director who is able to provide guidance on policy, operating principles, and program structure.
- Each school has a Multi-Disciplinary Team (MDT team) that identifies and addresses the needs of Special Education qualified students. These teams may serve a broader purpose, including identifying youth who are at risk for substance abuse. All MDTs need basic substance abuse information and skills to differentiate between a student in need of either or both special education and substance abuse intervention referral and support services.

**DESIGNING A STRATEGY FOR INTEGRATION**

Market the SAPISP program. There are sample brochures, flyers, and posters accessible through your local youth treatment agency or the ESD contact. Work with your building principal to ensure a broad marketing strategy for students, parents, community partners, and all school employees.

Survey the landscape and network with all aspects of the school community.

- Interview administrative and counseling staff to determine what programs are underway. Learn about the full range: clubs, sports, arts, leadership; teacher curricula integration for social skills, health promotion, and/or peace and civility lessons.
- Attend staff meetings, core teams, PTSA, School Improvement Committees, School Safety Committee, and any existing community collaborations—all with the purpose of gaining understanding and increasing awareness about such activities.

Make a game plan. Some may prefer to design a logic model in an effort to determine where program goals compliment, overlap, or possibly contradict. Bring this to the school based supervisor, administrator, and/or advisory. Use the district's Principles of Effectiveness tool to help identify areas of congruence and incongruence.

Share in ongoing functioning and maintenance. At its best, the SAPISP program does not belong to the Student Assistance Specialist. It becomes integrated into the goals of a larger entity and is used to determine how best to strengthen the school’s comprehensive school climate strategy program and meet the school community’s needs through varied prevention and intervention efforts.

**STUDENT ASSISTANCE SPECIALIST’S ROLE IN INTEGRATION**

Work with the key contact to determine your approach. Common supportive approaches are listed below:

1. Make it a habit to disseminate information on a regular basis. Provide quick updates at staff meetings, placing handouts in all staff boxes that remind them of signs and symptoms, helpful tips for approaching students they are concerned about, and how to access help. Other useful handouts include sample lesson plans for particular subject areas, and an occasional resource for staff to give to students and/or their families. These should go directly to those staff coordinating complimentary programs (i.e., tutoring, peer helpers, etc.)
2. Get a schedule of school and parent newsletter dissemination and contribute articles every quarter.
3. Place posters in halls and key areas, literature in the lunchroom, and administration office.
4. Offer posters, curricula, and other materials to Special Education teachers operating contained and/or specialized classrooms.

5. Look for opportunities to reinforce positive attitudinal messages that are visual, auditory, and kinesthetic.

6. Arrange for trainings relevant to the need and interest of staff. One strategy is to provide presentations to staff on topics specific to ATOD prevention. In addition, it is recommended the PI get a schedule of all existing staff trainings and presentations, and work with the trainers to integrate ATOD information into their presentations. This helps underline the point that the PI program is designed to support healthy development and academic success.

7. Arrange trainings relevant in particular to the needs and interests of paraprofessionals, who tend to work with a more vulnerable population of students.

8. Identify all parent involvement avenues in the school and contribute materials/resources to strengthen ATOD prevention messages with these groups. If a need exists, create your own parent involvement strategies and get staff to help you in their promotion.
Sustainability is a process. A dictionary definition indicates that to sustain is to keep in existence; to maintain; or to nurture; to keep from failing; to endure. Another way to view sustainability is in terms of institutionalizing system changes. As Robert Kramer states: Institutionalization is the active process of establishing your initiative—not merely continuing your program, but developing relationships, practices, and procedures that become a lasting part of the community.

Few will argue with the notion that something of value should be sustained if it is feasible to do so. Thus, the keys to sustainability are clarifying value and demonstrating feasibility.

Properly conceived and implemented substance abuse prevention and intervention programs are essential to improving schools and communities. Optimally, sustainability should be a focus from the day a project is implemented. Sustainability should not be thought about in terms of hopefully finding more grant money. Rather, they understood the necessity of taking steps each year to move policy in ways that would sustain valued functions that had been established through the project’s work. Moreover, they understood the importance of embedding such functions in a broader context to enhance their status in the eyes of decision makers.

A common tendency is for those involved in a project to think about (a) their work as simply a specially funded project, and (b) their jobs as providing project-based discrete services. It also is common for policy makers and those interacting with project staff to assume the work being done will end when the grant runs out. It is not surprising, then, that everyone sees the new activity mainly in narrow and time-limited terms. This mind set contributes to fragmented approaches and marginalized status and, thus, works against developing comprehensive, multifaceted, and integrated programs for enhancing long-term positive results for school and community. It also works against capitalizing on the opportunity to be a catalyst for the type of systemic changes that sustain and expand innovations.

Moreover, as the funding cycle nears its end, a number of very human concerns make it difficult for staff to focus on systemic change as the key to sustaining valued functions. These concerns include fear of program elimination and job loss and belief that extramural funding is the only hope. These concerns push project staff to pursue a limited strategy for sustainability—seeking additional, dedicated funding to continue as a categorical project, rather than focusing on systemic changes that can incorporate valuable innovations.

**SUSTAINABILITY OF WHAT? MAKING A STRONG ARGUMENT**

One of the most pressing concerns to the staff of a specially funded project is sustaining their jobs when the project ends. The desire for maintaining one’s job is more than understandable. The problem is that this is the weakest argument for sustainability that can be offered to decision makers, especially when budgets are tight. Policy makers are constantly confronted with requests to maintain and add more personnel. Their decisions are supposed to be based on evidence of need and institutional priorities. For this reason, requests that simply advocate for sustaining all facets of a complex and expensive project also are weak. Decision makers want to know which facets are really necessary to achieve outcomes and which are nice but unessential accessories.

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51 Adapted from: 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.
Two Alternative Ways of Thinking about Sustaining Programs

1) Give us more money so we can carry on the work.
2) We need to make systemic changes because if we don’t we will lose some valued functions.

With respect to alternative 1, the focus often is on writing for grants, providing services that tap into third party payers (e.g., Medicaid), fundraising campaigns, or convincing school and/or agency decision makers to allocate money to cover personnel. More often than not, these efforts do not provide the needed resources. Thus, as the end grows near, there is a growing realization and a sinking feeling that much of the activity and most of the staff cannot be maintained.

With respect to alternative 2, it is recognized from the onset that sustainability of valued functions requires making and institutionalizing systemic changes. This involves (a) creating readiness for such changes, and (b) playing an active role in guiding implementation of the changes.

While these alternatives are not mutually exclusive, it is wise to begin with the second. That is, it is best to think in terms of the probability that more money will not be available when current funding runs out. This means moving away from a project mentality and then connecting the activity to critical system needs and using resources to leverage systemic changes. In schools these days, connecting with system needs means fully integrating the work into the accountability demands of the No Child Left Behind Act. Leveraging includes using allocated funds as a catalyst and also cultivating champions (including key district and school leaders).

Strong arguments for sustaining school-based innovations are framed within a “big picture” context of school and community efforts to strengthen students, families, schools, and/or neighborhoods. Compelling arguments (a) focus on specific functions that are essential to achieving highly valued outcomes and that will be lost when a project ends, (b) connect those functions with the overall vision and mission of the institutions asked to sustain them, and (c) clarify cost-effective strategies for maintaining the functions.

For example, in developing innovations to better meet the needs of students experiencing learning, behavior, and emotional problems, it is important to stress how often the educational mission is thwarted because of many factors that interfere with youngsters' learning and performance. In addition, emphasize that, if schools are to ensure that all students succeed, designs for school improvement must reflect the full implications of educating all students. Clearly, all includes more than students who are motivationally ready and able to profit from “high standards” demands and expectations. Thus, the focus on all must also include the many who aren’t benefiting from instructional reforms because of a host of barriers interfering with their development and learning, including external risk factors arising from neighborhood, family, school, and peer determinants and internal conditions such as those related to biological and psychological dysfunction.

Policy makers also need to be reminded that ensuring all students have an equal opportunity to succeed at school is the reason schools invest in education support programs and services and that given how substantial the investment is, greater attention must be paid to rethinking learning supports. From this perspective, an umbrella of a comprehensive, multifaceted enabling or learning support component to coalesce the

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52 Additional resources and sustainability tools are available in Parts II-V of this document, available online at http://smhp.psych.ucla.edu
full range of functions that can address such barriers can be presented. The emphasis on addressing barriers to student learning allows one to present and underscore why new approaches are needed; in particular, we stress the need to fill basic gaps in the ability of schools to engage and re-engage students in effective classroom learning. Finally, discuss the cost-effectiveness by focusing on reducing fragmentation and enhancing resource use via systemic changes related to restructuring how existing student supports are conceived and implemented (Adelman, 1996; Adelman & Taylor, 1997b; Adelman, Taylor, & Schneider, 1999; Center for Mental Health in Schools, 1999).

Examples of weak and strong arguments:

- **Weak argument** One of the most pressing concerns to the staff of a specially funded project is sustaining their jobs when the project ends. The desire for maintaining one's job is more than understandable. The problem is that this is the weakest case that can be made for sustaining a program.

- **Weak argument** Any argument that advocates for sustaining all facets of a complex and expensive program. Decision makers want to know which facets are really necessary to achieve outcomes and which are nice but unessential accessories.

- **Strong argument** focus on specific functions that are essential to achieving highly valued outcomes and that will be lost when a project ends.

- **Strong argument** connect the functions to be sustained with the overall vision and mission of the institutions that are being asked to sustain them and clarify cost-effective strategies for doing so.

- **Strong argument** are framed within a "big picture" context of school and community efforts to (a) address barriers to development and learning, and (b) promote healthy development.
WHAT’S INVOLVED IN SUSTAINING VALUED FUNCTIONS?

Sustainability involves a host of complementary activities. The figure on this page can be used as a framework for understanding major matters for consideration in planning, implementing, sustaining, and going-to-scale.

**Figure 11.1: Summary of Some Specific Concerns Related to Sustainability Planning and Implementation**

1. **Nature and scope of focus**
   - What specific functions are to be sustained (e.g., specific interventions or program packages)?
   - Will one or more sites/organizations be involved?
   - Is the intent to make systemwide changes?

2. **Key facets related to undertaking any area of focus**
   - Ongoing social marketing.
   - Articulation of a clear, shared vision for the work.
   - Ensuring there is a major policy commitment from all participating partners.
   - Negotiating partnership agreements.
   - Designating leadership.
   - Enhancing/developing an infrastructure based on a clear articulation of essential functions (e.g., mechanisms for governance and priority setting, steering, operations, resource mapping and coordination; strong facilitation related to all mechanisms).
   - Redeploying resources and establishing new ones.
   - Building capacity (especially personnel development and strategies for addressing personnel and other stakeholder mobility).
   - Establishing standards, evaluation processes, and accountability procedures.

3. **Phases related to making systemic changes**
   - Creating readiness (motivation and capability–enhancing the climate/culture for change).
   - Initial implementation (phasing-in the new with well-designed guidance and support).
   - Institutionalization (maintaining and sustaining the new).
   - Ongoing evolution and creative renewal.

To highlight the host of interacting concerns and activities involve in sustaining valued programs:

1. With respect to sustainability, the nature and scope of focus raises such questions as: What specific functions will be implemented and sustained? Will one or more sites/organizations be involved? Is the intent to make systemwide changes?

2. With respect to key facets, whatever the nature and scope of the work, efforts for sustainability begin with articulation of a clear, shared vision for the initiative, ensuring there is a major policy commitment from all participating partners, negotiating partnership agreements, and designating leadership. This is followed by processes for enhancing/developing an infrastructure based on a clear articulation of essential functions, including mechanisms for governance and priority setting, steering, operations, resource mapping, and coordination. Pursuing the work requires
strong facilitation related to all mechanisms, redeploying resources and establishing new ones, building capacity (especially personnel development and strategies for addressing personnel and other stakeholder mobility), and establishing standards, evaluation processes, and accountability procedures. And, throughout, there must be an ongoing focus on social marketing.

3. When sustainability is approached as systemic change, the process must address each of the major phases of systemic change. These include (a) creating readiness with respect to the climate/culture for change by enhancing both the motivation and capability of a critical mass of stakeholder, (b) initially implementing changes by phasing them in with well-designed guidance and support, (c) maintaining and sustaining changes through practices that ensure institutionalization, and (d) ensuring appropriate evolution by enabling stakeholders to become a community of learners and facilitating periodic creative renewal activity.

GUIDELINES, STAGES, AND STEPS

As indicated in Figure 11.1, the phases of the change process are a major dimension of the framework. Although these phases are rather self-evident, the intervention steps related to sustaining valued functions are less so. As a guide for those working on sustainability and system change, we have drawn on what we have learned from the literature and our own work to delineate 16 key steps related to the first two phases of the change process (i.e., creating readiness and initial implementation). These are organized into four “stages.” The stages are conceived in terms of the need to intervene in ways that:
1. Develop a strong argument for sustaining functions.
2. Mobilize interest, consensus, and support among key stakeholders.
3. Clarify feasibility.
4. Proceed with specific systemic changes to sustain innovations.

These stages and steps are offered in the following section as guides for specific action planning.

First, a few guidelines for pursuing sustainability as systemic change:

- To counter marginalization, translate interventions into functions that are essential to the institution’s mission and accountability measures and frame them in terms of a comprehensive approach.
- To avoid fragmentation and counterproductive competition among staff, design and implement new and expanded school-based activities in ways that integrate them fully with existing school programs, services, and personnel.
- Use acquisition of extra mural funding to leverage commitments for the type of systemic changes that will be essential to sustaining and scaling-up valued functions. (In doing so, establish clear priorities, and revisit memoranda of understanding–MOUs–to leverage stronger commitments.)
- Focus first on the redeployment of current resources so that recommendations for systemic change are based on existing resources as much as is feasible. (This requires mapping and analyzing the available resource base.) Requests for additional resources are made only after it is evident that major gaps cannot be filled using existing resources more efficiently.
- Design and establish an infrastructure that not only can carry out program functions, but also connects with decision making bodies and is capable of facilitating systemic change. For example, someone must be responsible for facilitating the creation of motivational readiness for any specific systemic change.
- Use effectiveness data and information on cost-effectiveness in advocating for sustaining specific activities and approaches.
Identify a critical mass of “champions” to advocate and expedite and establish them as an active steering body.
Throughout, pursue social marketing and formative and benchmark evaluation.

PREPARING FOR SUSTAINABILITY

The following section highlights the 16 steps, organized into four “stages” to prepare a sustainability plan. (Part II of the tool kit can be accessed online at available online at http://smhp.psych.ucla.edu . The tool kit offers concrete examples and some specific tools and aids related to each step.)

Stage A: Preparing the Argument for Sustaining Valued Functions
The process of preparing a strong argument for sustainability begins by ensuring that advocates for sustaining a project’s functions understand the larger context in which such functions play a role (see Part II). Of particular importance is awareness of prevailing and pending policies, institutional priorities, and their current status and how existing resources might be redeployed to sustain valued functions that otherwise will be lost. With this in mind, there are five steps to pursue in readying the argument:

1. Developing an understanding of the local “big picture” context for all relevant interventions. This involves, for example, amassing information that clarifies the school and community vision, mission statements, current policies, and major agenda priorities.
2. Developing an understanding of the current status of efforts to accomplish goals related to the school and community vision, for example, clarifying the degree to which current priorities are well-founded and the rate of progress toward addressing major problems and promoting healthy development.
3. Delineating the functions, tasks, and accomplishments the project initiative has contributed with respect to the larger agenda and where the functions fit in terms of current policy and program priorities.
4. Clarifying what functions will be lost if the school(s) and community do not determine ways to sustain them. The emphasis here is on articulating the implications of the loss in terms of negative impact on achieving the larger agenda.
5. Articulating cost-effective strategies for sustaining functions, for example, focusing on how functions can be integrated with existing activity and supported with existing resources, how some existing resources can be redeployed to sustain the functions, and how current efforts can be used to leverage new funds.

Stage B: Mobilizing Interest, Consensus, and Support Among Key Stakeholders
In presenting the argument for sustainability, it is important to have a critical mass of influential and well-informed stakeholders who will be potent advocates for the initiative. The steps involved in developing this cadre of supporters include:

6. Identifying champions and other individuals who are committed to sustaining the functions and clarifying the mechanism(s) for bringing supporters together to steer and work for sustainability.
7. Planning and implementing a “social marketing” strategy to mobilize a critical mass of stakeholder support.
8. Planning and implementing strategies to obtain the support of key policy makers, such as administrators and school boards.
Stage C: Clarifying Feasibility
The preceding steps all contribute to creating initial readiness for making decisions to sustain valued functions. Next steps encompass formulating plans that clarify specific ways the functions can become part of the larger school and community agenda. This raises considerations related to infrastructure and daily operations and the full range of systemic change concerns. These are addressed by:

9. Clarifying how the functions can be institutionalized through existing, modified, or new infrastructure and operational mechanisms, for example, mechanisms for leadership, administration, capacity building, resource deployment, and integration of efforts.
10. Clarifying how necessary changes can be accomplished, for example, mechanisms for steering change, external and internal change agents, and underwriting for the change process.
11. Formulating a longer-range strategic plan for maintaining momentum, progress, quality improvement, and creative renewal.

By this point in the process, the following matters should have been clarified:
- a. What valued functions could be lost.
- b. Why they should be saved.
- c. Who can help champion a campaign for saving them.
In addition, strong motivational readiness for the necessary systemic changes should have been established. Done effectively, the process will have engendered strong motivational readiness for the necessary systemic changes.

Stage D: Proceeding with Specific Systemic Changes
At this juncture, it is time to initiate the implementation process for the necessary systemic changes. Because substantive change requires stakeholder readiness, it is essential to determine if the preceding steps accomplished the task. If not, it becomes necessary to revisit some of the earlier steps. Then, it is a matter of carrying out the plans made during Stage C with full appreciation of the complex dynamics that arise whenever complex systems undergo change. Specific steps encompass:

12. Assessing, and if necessary enhancing, readiness to proceed with systemic changes needed to sustain valued functions.
13. Establishing an infrastructure and action plan for carrying out the changes.
14. Anticipating barriers and how to handle them.
15. Negotiating initial agreements, such as a memorandum of understanding.
16. Maintaining high levels of commitment to accomplishing necessary systemic changes, for example, ensuring each task/objective is attainable, ensuring effective task facilitation and follow-through, negotiating long-term agreements and policy, celebrating each success, and facilitating renewal.

Clearly, the many steps and tasks described above call for a high degree of commitment and relentlessness of effort. Major systemic changes are not easily accomplished. Awareness of the myriad political and bureaucratic difficulties involved in making major institutional changes, especially with limited financial resources, leads to the caution that the type of approach described above is not a straight-forward sequential process. Rather, the work proceeds and changes emerge in overlapping and spiraling ways.
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.

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 referred 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.

COA
Children of Alcoholics. More commonly referred to as "affected others" children who are affected by the alcohol and/or other drug abuse.

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.

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. States receive 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
U.S. Department of Health and Human Services.

DoEd
Department of Education.

DUI
Driving Under the Influence.

DWI
Driving While Intoxicated.

EALRs
Essential Academic Learning Requirements.

Early Intervention
A process for recognizing warning signs that individuals are at risk for mental health 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.

**Evaluation**
Evaluation is a process that helps prevention practitioners discover the strengths and weaknesses of their activities so that they can make 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 Effect.

**FERPA**
Family Educational Rights and Privacy Act. Assures the following rights to parents and students who are 18 years and older, or enrolled in post secondary 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 substance abuse and mental health prevention and treatment interventions.

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

NCLB
No Child Left Behind. Sometimes referred to as “nickelby.”

OJJDP
Office of Juvenile Justice and Delinquency Prevention.

OSPI
Office of Superintendent of Public Instruction

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 non pharmacological).

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 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.

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

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 nonusing peers, autonomy and sense of purpose, and clear expectations about not using substances are protective factors.

Safe and Drug-Free Schools (SDFS)
SDFS is the federal government’s primary 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 designed to prevent violence in and around schools, and to strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs, involve parents, and coordinate with related federal, state, and community efforts and resources. The Safe and Drug-Free Schools Program consists of two major programs: State grants for Drug and Violence Prevention Programs and National programs. State grants is a formula grant program that provides 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 carries out a variety of discretionary initiatives that respond to...
emerging needs. Among these are 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 is also launching 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 oversees a valid and reliable process for identifying exemplary school-based programs that promote safe, disciplined, and drug-free schools. Once programs are designated as exemplary or promising, the Department will disseminate information about the programs and will encourage their use in new sites. The expert panel initiative is a way of enhancing prevention programming by making schools aware of alternative programs that have 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, train others, and promote 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.

**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 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.

**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. LEAs (Local Education Agency) 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).

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://prevention.samhsa.gov/
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