STUDENT ASSISTANCE

A GUIDE FOR SCHOOL ADMINISTRATORS

SAMHSA
Substance Abuse and Mental Health
Services Administration

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Division of Systems Development, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857. SAMHSA Publication No. PEP19-03-01-001. Printed in 2019.

CONTENTS

The purpose of this guide is to provide school leaders and administrators with key information regarding student assistance services. In this guide, we review aspects of providing student assistance, including connections to existing school, substance use, and mental health initiatives; key components of effective programming; considerations for implementation; and planning for success. Information provided in this guide will assist school leaders in beginning and/or improving student assistance services and provide guidance on more comprehensive resources for this critically important work.

BACKGROUND

As the most universal, natural setting for children and adolescents, schools are uniquely positioned to provide programs and services that promote student health and optimal wellness while removing barriers to active learning. In reality, almost every student will face some level of difficulty or be at risk for alcohol and substance use, violence, or mental health problems at least one time during his or her school career. Students' reports of these behaviors raise concerns not only for their health and well-being but also for their academic progress and outcomes later in life.

Consider these statistics:

- Alcohol is the substance of choice among our nation's young people; while they drink less frequently than adults, youth consume more alcohol when they drink.[1]

- In 2018, more adolescents ages 12 to 17 used alcohol for the first time in the past year (2.4 million) compared to marijuana (1.3 million).[2]

- Approximately 4 percent of youth ages 12 to 17 experienced substance use disorders in the past year.[3]

- In 2018, 14.4 percent of youth ages 12 to 17 had a Major Depressive Episode (MDE) during the past year, and 10 percent had a past-year MDE with severe impairment.[4]
- Five youths under the age of 20 complete suicide every day.[5]

Youth are also exposed to violence at school, at home, and in the community at alarming rates:

- In 2016, an estimated 676,000 children were abused and neglected.[6]
- One in 4 children comes from a home affected by substance use disorders.[7]
- An estimated 1.4 million violence-related crimes occurred in U.S. schools during the 2015–2016 school year.[8]

School shootings, which have been documented in the United States since 1966,[9] occur across the country every year, with devastating implications for youth and their families. Since 1996, two-thirds of the shooters were between the ages of 13 and 18, approximately 1 in 6 were 14 years old, and 9 in 10 were male.[10]

Along with other violence-related events, these tragedies highlight the increasing risk violence poses to today's youth and the vital role of schools and community systems in monitoring, assisting, and supporting youth. These statistics underscore the need for student assistance services to provide prevention, early intervention, treatment, and recovery support to protect students from harm, support positive decision-making, and remove barriers to learning. If such problems are not adequately addressed, youth are more likely to experience poor outcomes and economic costs surge.[11]

- Youth who use alcohol or other substances and/or engage in violent and delinquent behaviors score 30 to 50 points lower than youth with low to moderate levels of these behaviors on reading and math achievement tests.[12,13]
- Of these students, 50 percent drop out of high school and face high rates of incarceration, criminality, unemployment, suicidality,[14,15,16] and poverty.[17,18,19]

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports many initiatives to prevent substance use and mental health issues among youth, including:

National Prevention Week—an annual national health observance in which schools and communities can participate to raise awareness of substance use disorders and mental health issues.

"Now is the Time" Project AWARE—a grant program that supports the training of school personnel and other adults who interact with youth in both school settings and communities to detect and respond to mental illness in children and youth, including how to encourage adolescents and their families experiencing these problems to seek treatment.

"Talk. They Hear You."—a free mobile app that helps parents practice broaching the topic of alcohol with their kids, learn questions to ask, and get ideas to keep the conversation going.

Preventing Suicide: **A Toolkit for High Schools**—a publication to assist high schools and school districts in designing and implementing strategies to prevent suicide and promote behavioral health.

KnowBullying—a free mobile app that provides information about the warning signs of a child being bullied or engaging in bullying, as well as prevention tips, conversation starters for meaningful discussion between parents and kids, and information for educators about how to prevent bullying in classroom settings.

- The economic cost of substance use disorders is approximately $1 trillion annually. These costs are largely associated with substance use issues, mental health and physical care, criminal activity and the criminal justice system, academic underachievement, family problems, employment issues, HIV, and teen pregnancy.[20,21]

Given these distressing statistics, dire consequences, and the significant economic burden, there is a critical need to employ effective service delivery models of substance use and mental illness prevention, intervention, and recovery support. Fortunately, there is an extensive research base and renewed federal support for school-based health and mental health programs and services to assist youth (see text box on page 2).

School-based student assistance provides a prominent[22] and effective means to address substance use and mental health concerns through prevention and intervention supports. Student assistance services bring mental health promotion, prevention, treatment, and continuing care practices to K–12 school settings. This often includes, but is not limited to, services that address normal developmental issues for students as well as issues related to substance use, psychological distress, suicide, and mental illness.[23]

Mounting evidence suggests that these problems overlap significantly, as do factors that contribute to physical health problems or concerns addressed through primary care services. For example, in 2018, an estimated 3.2 million people had a substance use disorder, as well as a serious mental illness.[24] The presence of mental illness issues is often associated with physical health issues. As such, it is important to be mindful of these linkages and establish systems and services designed to comprehensively address students' well-being, including learning, achievement, health, behavioral wellness, and self-management.

School-based health centers (SBHCs) provide an overarching structure under which to organize comprehensive promotion, prevention, treatment, and recovery services for students' health. SBHCs offer two types of core student health services: (1) comprehensive physical health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, as well as referrals to and follow-up for specialty care, oral, and vision health services, and (2) screening and assessment of substance use issues and mental illness, as well as crisis intervention, counseling, treatment, and referral to a continuum of services. Policymakers have given priority to the development and enhancement of funding for SBHCs through the health-related sections of the Health Care and Education Reconciliation portions of health care reform efforts.[25] Schools can support implementation of SBHCs through policy and by integrating critical components of student assistance practices within the center's health services. As statistics indicate, there is a significant need for effective school-based substance use and mental health services for today's youth. Student assistance is an effective and proven means of providing these services in school settings through SBHCs.

Given that most children and youth are involved in some type of education program, schools are the ideal setting in which to prevent, identify, treat, and support substance use and mental illness concerns.

In fact, evidence suggests that youth who are referred to school-based programs are seven times more likely to receive services than youth referred to other community agencies.[26] Furthermore, most youth referrals for substance use and mental illness treatment come from schools (followed by juvenile authorities and family), and youth frequently enter treatment due to school-related difficulties.[27,28,29]

Continuum of Student Support Services

Best practices in education and the prevention of substance use disorders and mental illness include the provision of a full continuum of programs and practices. This continuum covers promotion and prevention, intervention, treatment, and recovery support. The field of public health has a long history of providing a full continuum of services to prevent and treat a range of diseases effectively. The public health approach has been increasingly applied in several variations to the fields of education and prevention of substance use disorders and mental illness.[30] For example, as illustrated in Figure 1, the National Academies of Sciences, Engineering, and Medicine (NASEM)[31] model of mental, emotional, and behavioral interventions includes promotion, prevention, treatment, and maintenance efforts.

- *Promotion:* Strategies used to develop skills-based positive attributes, such as self-regulation, self-efficacy, goal setting, and positive relationships that promote mental, emotional, and behavioral development.

- *Prevention:* Strategies offered prior to the onset of a disorder that are intended to prevent or reduce the risk for its development.

- *Treatment:* Care given to an individual who is demonstrating mental, emotional, and behavioral health challenges or has been diagnosed with a mental, emotional, and behavioral health disorder.

- *Maintenance:* Care given to prevent relapse, recurrence, or further deterioration of mental, emotional, and behavioral health status

Figure 1. Spectrum of Mental, Emotional, and Behavioral Interventions
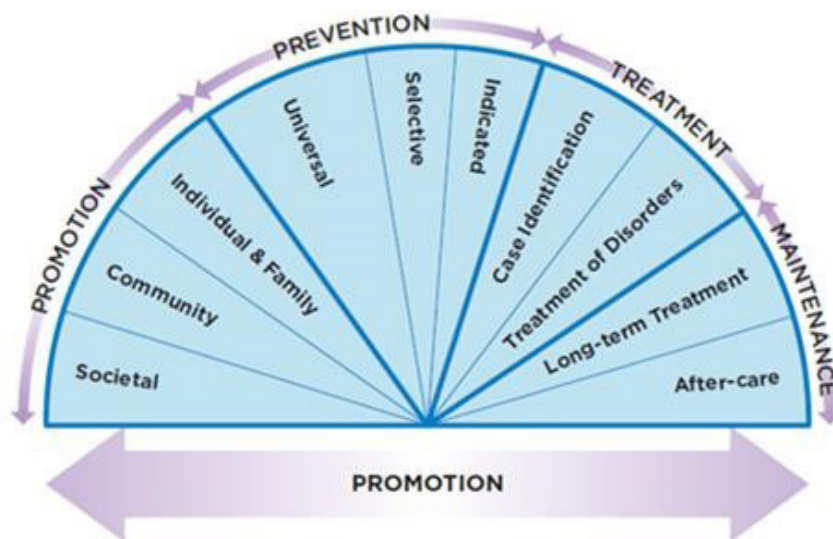
Source: National Academies of Sciences, Engineering, and Medicine. (2019). *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda.* Washington, DC: National Academies Press. Retrieved from https://doi.org/10.17226/25201

Student Assistance

Several models currently widely implemented in schools are based on the public health and NASEM models. Current literature across both fields frequently refers to these models as "Multi-Tiered Systems of Support" (MTSS),[32] which include multiple tiers of increasingly intensive and individualized prevention and intervention activities across all domains of youth development. Models such as Response to Intervention[33] and School-Wide Positive Behavior Supports[34] are examples of MTSS focused on academic and behavioral outcomes. SBHCs are also designed to provide a continuum of health and mental health services within MTSS. Across models, MTSS aim to prevent youth problems as much as possible, provide effective intervention as early as possible to improve student outcomes, and deliver coordinated and integrated treatment and support services to reduce symptomatology and improve outcomes. In student assistance programs (SAPs), a combination of prevention specialists and licensed clinical professionals work in collaboration with school administrators, teachers, nurses, counselors, support personnel, and linked community providers to enable access to a similar range of promotion, prevention, treatment, and continuing care activities for students in grades K–12. SAPs provide a critical framework for preventing substance use and mental illness and assisting students in need by coordinating activities across school- and community-based initiatives.

STUDENT ASSISTANCE PROGRAMS

What Is a Student Assistance Program?

Student assistance programming continues to grow in the United States due to its positive impact on helping students improve their overall emotional, behavioral, and academic functioning. For example, research has found that students who participate in substance use prevention and intervention services have shown significant gains in their grade point average (GPA) after receiving student assistance services for substance use and mental health services.[35]

Student assistance programming is a comprehensive, school-based framework designed to provide a variety of services, including (1) education, (2) prevention, (3) early identification, (4) evidence-based intervention, (5) referral processes, and (6) guided support services for students in kindergarten through grade 12 who are exhibiting a range of risk factors that interfere with their educational success (Figure 2). Students best suited for involvement in student assistance services are those who are experiencing issues with substance use or misuse and/or mental illness.

SAPs integrate trained personnel into schools to support and enhance the work of school faculty, as well as provide direct intervention services to students. Modeled after components of employee assistance programs, SAPs were initially implemented as on-site supports for students affected by issues related to alcohol or substance use disorders.[36]

As previously mentioned, students experiencing academic, substance use, and mental health problems are the target population for student assistance services. Potential barriers to learning include school adjustment difficulties, attendance issues, anxiety, depression, thoughts of self-harm and self-injury, stress, abuse or neglect, substance use disorders, family difficulties, negative peer relationships, and exposure to community violence and crime.[37] When implemented effectively and consistently, student assistance services can directly address these issues and in turn help improve academic performance.[38]

How Do SAPs Function in Schools?

Vulnerable students are identified by teachers, administrators, and interdisciplinary team members who refer students to designated referral sources with a brief description of concerns to allow for case consultation on the best outreach approach. Students then receive a notification from a designated member of the SAP team who meets with the student and assesses current concerns or risks.

Through an interdisciplinary team, which includes school staff (e.g., school psychologists, school counselors, social workers, certified nurses, and teachers) and community partners (e.g., clinical psychologists, social workers, addiction and mental health specialists, and resource officers), SAPs offer a safe and supportive way for students to receive assistance to address problems they are struggling with and build the skills necessary to succeed in school. Student assistance services are matched to students' developmental levels and the targeted reduction of known conditions of risk while also building assets and protective factors for enhancing positive youth development.[39] While working with students and their families, student assistance services help identify specific barriers to student learning and academic success through the development and implementation of individualized skill-building programs that reduce and remove these barriers.

Figure 2. Components and Services of a Successful Student Assistance Program
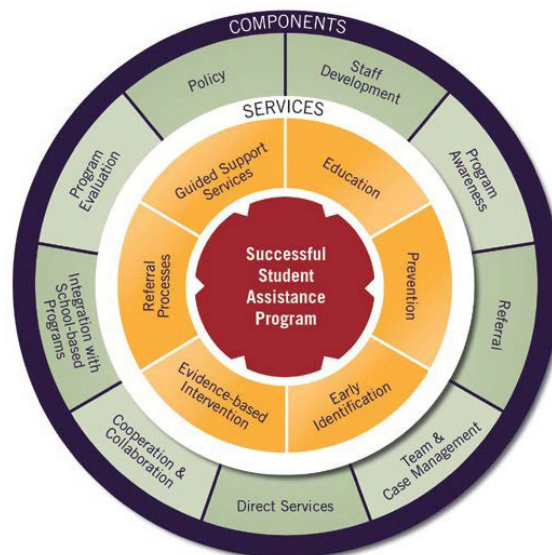
Research indicates that students' social, emotional, and behavioral functioning directly impacts their academic outcomes.[40,41] Student assistance services promote positive social, emotional, and behavioral functioning through a variety of strategies, including (1) improving family-school connections, (2) offering skill-building to students in core competency areas such as problem-solving and positive coping, (3) building on behavioral self-management or self-control, (4) improving relationship skills, and (5) understanding responsible decision-making. Furthermore, these programs help students in areas related to academic achievement, such as assisting with organizational skills, completing missing assignments, and obtaining direct tutoring opportunities.

SAPs complement and strengthen related curricula and existing supports in schools such as SBHCs, health education, substance use and misuse prevention, School-wide Positive Behavior Support, Response to Intervention, and school behavioral and mental health programs. Within this context, SAPs play a key role in linking students in need of more targeted and intensive supports to a team of trained school and community personnel and research-based interventions. Student assistance services also strengthen these existing programs and initiatives by providing more targeted individual supports and services within the first year of implementation rather than waiting three to five years to establish one tier or level at a time. A self-referral component is also included, which enables students and/or families to request help whether or not the student is identified through the school's screening and data collection procedures. In this way, SAPs promote a positive school climate and assist students in feeling connected to school, a critically important protective factor associated with academic achievement.

Links to Academic and Behavioral Success

When implemented to reflect best practices and research, SAPs achieve outcomes that are valued by families and schools, including:[42,43,44]

1. Improved student behavior;
2. Increased school attendance;
3. Increased assignment completion;
4. Higher grades and academic achievement;
5. Higher rates of high school graduation; and
6. Increased self-control, self-efficacy, and social competence.

Most important, student assistance services convey a message to students that positive help and assistance from caring adults is available to them and that problems they experience can be mitigated or overcome. Multiple studies have shown that student assistance and substance misuse and mental health services provide significant benefits to students:

- Two-thirds of students receiving student assistance services improved or maintained regular school attendance, 60 percent had no subsequent suspensions, and 68 percent were promoted or graduated from high school.[45]
- Students' GPAs remained steady from pre- to post-student assistance services, and teacher-rated classroom performance was reported as somewhat to much improved for 85 percent of students enrolled in programs.[46]

To achieve these desired outcomes, student assistance services must be well-implemented and integrated within the school and community settings to support overall student growth and development.

Quality implementation includes the adoption of nine components rigorously evaluated in empirical studies[47,48,49] and recommended by the National Student Assistance Association.[50] The following section articulates these recommended components.

ORIENTATION FOR PRINCIPALS AND ADMINISTRATORS

For student assistance services to be as effective as possible, researchers have identified several program components that are critical to providing necessary services and reducing barriers to learning.

Ensuring that these components are in place as you develop or enhance student assistance programming in your school or district will greatly increase the likelihood of the success of the program and students receiving services. The nine components are as follows:

1. School board policy
2. Staff development
3. Program awareness
4. Internal referral process
5. Problem-solving team and case management
6. Direct services to students
7. Cooperation and collaboration
8. Integration with other school-based programs
9. Program evaluation and improvement

These components are described in the following sections.

1. School Board Policy

Federal guidelines (Elementary and Secondary Education Act of 1965—ESEA, as reauthorized in Every Student Succeeds Act, December 2015) regarding safe schools require that all schools design programs that prevent the use and possession of drugs, prevent violence in schools and promote safety, and develop and implement discipline policies conducive to supportive learning environments. Research shows that school policies that are comprehensive and consistently enforced may reduce the prevalence of student alcohol, tobacco, and substance use disorders.[51] To address these federal guidelines, student assistance programming encourages constructive policy development and analyses by providing operational definitions of a school's role in creating a safe and secure learning environment. This can include addressing student and staff violation of policies, as well as providing direct intervention and assistance. Additionally, these policies should clarify the process of self-referral; the limits of confidentiality for students, parents, and staff; procedures for reporting crimes; and the responsibility of any eyewitnesses. Policies also should include the integration of student assistance services and their coordinated efforts with existing school practices (e.g., school support groups, academic clubs, and extracurricular activities) and youth-serving agencies in the community (e.g., those focusing on juvenile justice, child welfare, and developmental disabilities). The role of SAPs within disciplinary policies should not be punitive in nature, but rather aimed at the development of intervention planning that, when done well, can serve as an alternative to school suspension and other forms of restrictive consequences to students.[52]

2. Staff Development

Professional development, ongoing training and coaching, and technical assistance provided to school employees and SAP staff members contribute significantly to the successful implementation of student assistance services. Informed by a growing literature base on effective implementation, ongoing training opportunities should be stimulating and interactive, and there should be coaching and technical assistance to support high-quality implementation of programs and services.[53]

Themes to emphasize in training and ongoing support for effective implementation include:[54]

- Reducing risk and enhancing protective factors;
- Improving school climate and student connectedness;
- Identifying students who are contending with risk conditions and presenting early and more advanced signs of difficulties;
- Delivering prevention and intervention services within schools; and
- Working with community partners to coordinate services for students presenting more intensive needs.

In addition, effective implementation of student assistance services includes having staff in designated roles as student assistance professionals. These staff members help implement SAP teams, processes, and programs; facilitate awareness of student needs; develop and expand community partnerships; and assure coordination and quality of services. Typically, student assistance professionals are school employees such as teachers with behavioral expertise, school psychologists, and school counselors, or they may be contracted licensed health professionals with specialties in substance use disorder prevention and treatment and mental illness within the community or through a community-based agency.

3. Program Awareness

For student assistance services to be effective, program awareness should be promoted within schools and the surrounding community. The purpose of increasing program visibility is to build knowledge for parents, students, and other agencies in the community on school policies while also providing information on increasing and promoting resiliency and student success.

There are several strategies that can be used to increase awareness, such as disseminating program flyers throughout the school and local community, holding community awareness and training events, and using local media outlets. For example, as part of True North,[55,56] an SAP in Washington state, classroom presentations are conducted to highlight school policies on drugs and alcohol, the effect of drugs and alcohol on health, substance use disorders in the family, and other issues. Resources and tools for communicating about student assistance services with family and community stakeholders are provided on the website of another SAP, the Students Taking A Right Stand (STARS) Nashville Student Assistance Program[57] (www.starsnashville.org). Schools can use resources from this website as examples as they build and disseminate their own program materials.

4. Internal Referral Process

The purpose of the internal referral process is to provide school staff with a mechanism for identifying and referring students contending with risk or presenting with social, emotional, behavioral, or substance use difficulties. For effective early identification of students in need, school personnel must be aware of any unexplained changes in a student's behavior patterns or academic performance, particularly those that indicate a critical decline in positive functioning. Behavioral markers of such declines in functioning include:[58]

- A decline in grades or class participation;
- Decreased attendance rates and increased tardiness;
- Disruptive behaviors at school or in the classroom (e.g., fighting, sleeping, acting out);
- Disciplinary and legal problems;
- Loss of interest in extracurricular activities they once enjoyed;
- Difficulties at home; and
- Violation of school policies regarding substance use.

In their role, student assistance professionals are well-situated to provide school personnel with key information about signs and symptoms of student change that warrant referral to the SAP. School personnel should be trained on signs and symptoms of student problems and methods to refer them for help, including completing referral forms and working with SAP staff to connect students to services. A diagnosis is not the core objective of assessment; rather, the goal is to obtain information that is useful for making an effective referral decision. Taken together with school functioning data, the results from these assessments allow for data-based decision-making to match students with appropriate services.

5. Problem-Solving Team and Case Management

When implementing student assistance services, the school should form a student assistance team (SAT). This team is multi-disciplinary, composed of, but not limited to, interested and willing administrators, teachers, school counselors, nurses, social workers, and addiction and mental health counselors who will be responsible for making decisions on how to best serve students with substance use or mental health needs at their school. The SAT meets regularly to review SAP referrals and determine what program or services an individual student may need, as well as to monitor students who are already receiving services. This process as implemented in Virginia is illustrated in Figure 3.[59] Some factors that contribute to forming a successful SAT include:[60]

1. Administrative support
2. Regular SAT meetings
3. SAT coordinator provided with release time
4. Early parent involvement
5. Adoption of team meeting agreements
   - Team skills (e.g., active listening)
   - Written agenda
   - Consensus decision-making
   - Mutual agreements
6. Clear referral process
   - Staff, students, and parents aware of the process
   - Focus on observable behavior
7. Credibility of the SAP process among staff, students, and parents
8. Sharing information appropriately
9. High level involvement of staff beyond SAT members
10. Written policy to address students at risk and consistent implementation of the policy with all students
11. Ongoing training of all staff
12. Ongoing planning, implementation, evaluation, and refining of the SAT

Figure 3. Sample Referral, Assessment, and Intervention Process for SAT Providing Student Assistance Services


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

    Parents Contacted  ←→  Grades, Attendance, Discipline, and a
                           Behavior Checklist completed if warranted

    Student Assistance Team meets  →  Data Did Not Indicate Contact
    and reviews available information    with Parents/Students

    Parents/Student Contacted – More  →  Parents/Student Refuse Services
    information gathered – Develop plan

    Student/Parents Agree to Services

  SCHOOL INTERNAL PREVENTION/INTERVENTION      COMMUNITY REFERRAL
  LEVEL OF SERVICES                            • AOD Assessment
  • Universal                                  • Outpatient Assessment for Counseling
  • Selected                                     Services
  • Indicated                                  • Other Community Agencies
  OTHER SERVICES – School Counselor – Tutoring –  • Urine Screens
  Nurse – In-School Mentor – Conflict Mediation   • Medical Services

                  Ongoing Case Management Services
          Review student's progress (minimum of once every
          two months) and revised as needed and/or exits
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Source: Virginia Department of Education. (2013). *Student assistance programming: Creating positive conditions for learning.* Richmond, VA: Can't Stop Writing, LLC.

6. Direct Services to Students

Once screening and assessment have been completed, decision-making about services and case management for the student should occur next. As stated before, a range of programs, including prevention and intervention services across the multi-tiered spectrum, should be available and delivered to students based on screening and initial assessment. Tailoring specific programs and supports to students based on individual needs is a sign of high-quality student assistance. In this process, SAPs match students to the most appropriate and effective programs available within the school (e.g., counseling, after-school programming, tutoring) or through community partnerships (e.g., substance use treatment, more intensive mental health services, and mentoring). Case management is also provided to engage students and keep them involved in services. An example of

the decision-making process for matching students to services is provided in Figure 4, along with examples of intervention and case management services.[61] Once students are connected to appropriate programs in the school and/or community by the case manager based on their presenting needs, SATs and case managers track student progress using data on their functioning (e.g., school attendance, behavior, grades, self-reports of emotional and behavioral functioning) and make adjustments in programs and services accordingly.

Figure 4. Services and Decision-Making Process to Match Students to Appropriate Services
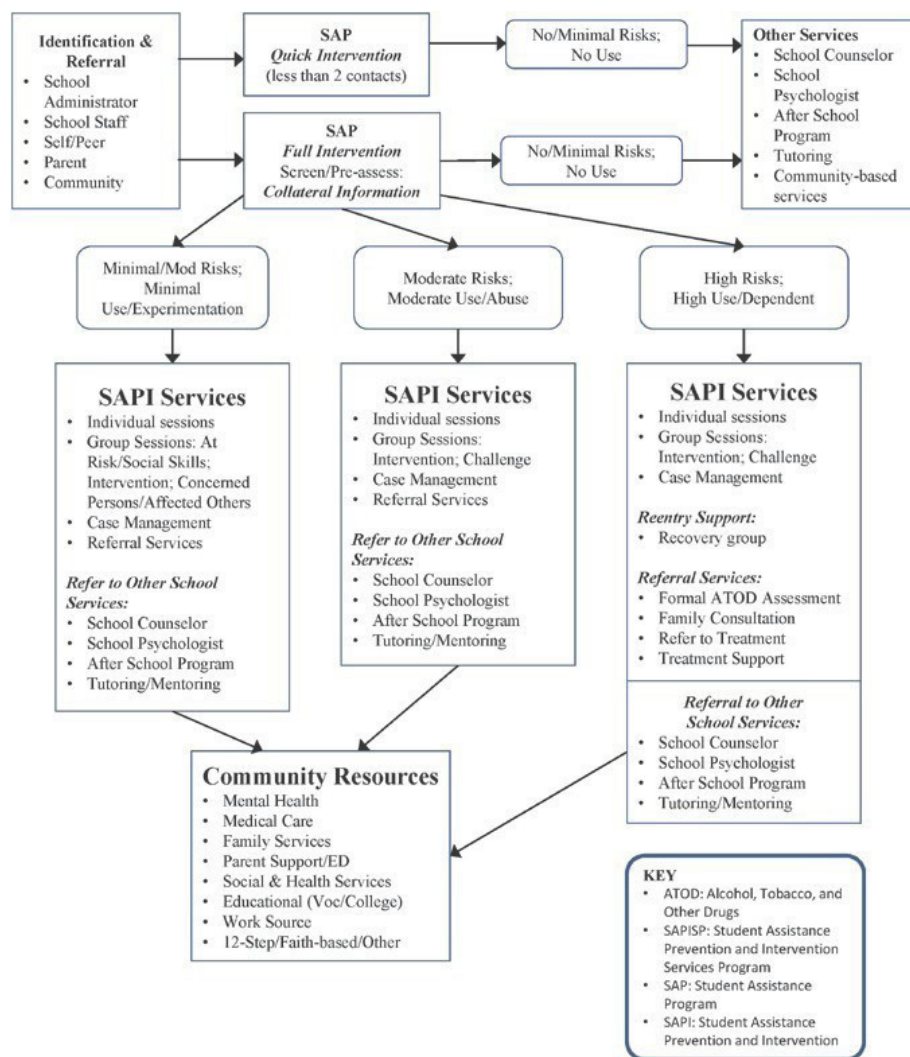
Source: Adapted from Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

7. Cooperation and Collaboration

When addressing complex substance use and/or mental health needs, it is essential that schools collaborate with youth- and family-serving community agencies. It is recommended

that SAPs take the following steps to foster cooperation and collaboration with outside agencies as well as families:

1. Contact community agencies and build a relationship with key personnel charting types of services, eligibility requirements, hours of services, fees, and any other information helpful to share with the student and/or their family members.

2. Learn how to access student assessments from local service providers.

3. Develop a list of resources and contact personnel that can be provided to parents with key names, phone numbers, and email addresses.

4. Develop a protocol for when and how to refer families to community agencies—for example, guidelines for an embedded SAP coordinator to refer students and their families to community providers, the local office of juvenile justice, and other entities in the community, as needed.

5. Know when to involve Child Protective Services and what the ramifications are at any level of contact.

6. Foster cooperation with families of students receiving SAP services and seek support resources for the family members.

7. Utilize prevention activities for the school that community agencies may offer.

8. Integration with Other School-Based Programs

The key to flourishing SAPs is their integration and complementary interface with existing school initiatives supporting academic success.[62] For example, multi-tiered systems of support such as Response to Intervention (RTI) and School-Wide Positive Behavior Supports (SWPBS) are designed to deliver effective academic and behavioral support strategies to students across the tiered continuum of services. While many schools can achieve implementation of prevention activities (Tier 1), most schools often struggle with service provision and system components associated with early intervention, treatment, and support services (Tiers 2 and 3). Furthermore, RTI and SWPBS often fail to address other major barriers to learning, such as substance use disorders and internalized behavior problems.

Meaningfully integrating SAP services within Tiers 2 and 3 of MTSS could help address these gaps and promote better identification, prevention, and intervention for at-risk students or those showing early or more intense signs of being in trouble. As the example in the previous paragraph illustrates, identifying the cross-cutting connections between and among programs and initiatives is central to achieving effective integration.

Logistical considerations regarding the functionality of integration are also critical to integrated service provision. The development of differentiated school teams and protocols for their systematic communication are critical for meeting student needs without duplication of services. The population size of student and school personnel should be considered when choosing a teaming approach. Separate teaming for each initiative may be ideal for larger schools, whereas a combination of initiatives represented on a single team may be more feasible for smaller schools. Designation of liaisons from each team can facilitate cross-team communication efficiently and allow for discussions regarding student referral to the most appropriate service or service combinations.[63]

9. Program Evaluation and Improvement

Every school has a unique set of strengths, needs, and priorities for student intervention. SAPs should operate from a strong understanding of local school needs and resources and those available through community partnerships. Student assistance teams should seek to build depth and quality systematically in the three tiers of student services and supports.

Student assistance professionals can play a critical role here by coordinating meetings, evaluating services, assessing community partnerships and ways to expand and strengthen them, and implementing continuous quality improvement strategies. The development of an advisory committee for the SAP—including leaders from the school and district, local youth-serving agencies, and family advocacy organizations—can help ensure the effective functioning of the program and its connection to relevant programs and initiatives.[64] For example, the advisory committee can work with the SAP to conduct an ongoing evaluation of program processes (e.g., programs and services delivered at each tier; number of students participating in each program; feasibility; staff and student satisfaction with each program) and outcomes (e.g., improvements in student attendance and behavior), as well as outreach to the community and other parents.

For student assistance services to be effective, they must be well-implemented. Quality implementation includes these key components identified through rigorous evaluation[65,66,67] and recommended by the National Student Assistance Association,[68] as well as consideration of additional implementation factors and strategic planning. Additional areas of consideration for implementation of student assistance services are described in the following section.

INTEGRATION WITH OTHER SCHOOL INITIATIVES

Ideally, SAPs function collaboratively with other school initiatives, such as multi-tiered systems of support, school climate improvement, violence prevention, and safety planning to achieve the best academic, behavioral, social-emotional, and life skill outcomes for all students. In previous sections, key considerations for integrating student assistance services and multi-tiered systems of supports were discussed. This section will address the integration of student assistance services with school climate and violence prevention efforts.

School Climate

Schools are a critical context for students to learn about themselves and develop relationships with faculty and peers. As mentioned, students who feel more connected to their school environment are more likely to be academically motivated and successful and less likely to engage in behaviors that result in difficulties. Likewise, positive school climates can increase student connectedness. Research indicates four key themes that promote positive school climate:[69]

1. The relationships among teachers and students;
2. The relationships among students;
3. The promotion of student autonomy in decision-making processes; and
4. The enforcement of clear, consistent, and fair rules and regulations.

Optimally functioning student assistance services can play an important role in promoting positive school climate and student connectedness to the school. For example, as part of an interdisciplinary team, schools can collect climate surveys from students, parents, and staff; make improvements based on findings; and initiate anti-bullying programming such as the Olweus Bullying Prevention Program.[70]

School Violence Prevention and Safety Planning

Keeping children safe in their communities and schools is of notable importance in today's society. While mass school shootings such as those that have occurred at Columbine High School, Virginia Tech, and Sandy Hook Elementary School remain exceptional tragedies, contextualizing these events as shootings at schools allows for maintaining accurate perceptions of school building safety.[71] Children often are safer in schools than in any other place.[72] In the wake of these tragedies, the natural response is to heighten school security—but with caution, so that schools are appropriately and effectively prepared for emergencies without being unwelcoming to students and their families. The *Final Report of the Federal Commission on School Safety* confirms that there are several key ingredients to promoting school safety and school building safety, including understanding that the motivation to commit an act of violence may result from the presence of significant substance use and mental health concerns and intense unresolved interpersonal conflict.[73] These factors can explain why the violence occurs and, in terms of prevention, point toward the increasing need for integration of substance use and mental health resources and supports, such as SAPs, within the school and community for those in need of assistance.[74]

Creating a nurturing school environment can help prevent violence and promote school safety. For this reason, policymakers and prevention experts advocate for a balanced approach to creating effective school and building safety programming. This balanced approach should include three interconnected components of communication, connectedness, and support, so that all students feel positively connected to schools and emotionally safe while in school.[75] All adults and students should feel comfortable attending to and reporting potential signals of violence to personnel who can provide assistance.

Addiction and mental health specialists connected to student assistance programming are uniquely positioned to conduct school violence assessments and help create a school culture of tolerance and respect. In collaboration with school personnel, addiction and mental health specialists can determine when and where violence occurs, then develop and raise awareness for anti-bullying objectives and policies at staff meetings, assemblies, class and parent meetings, and other social marketing outlets (e.g., school websites, social media, and newsletters).[76]

Ongoing support from the school board can further leverage safe environments through the maintenance of ongoing training for school personnel regarding the identification of at-risk students and, ultimately, their referral to a tiered continuum of school-based violence prevention and intervention services. Finally, parent engagement in decision-making regarding the identification and response to troubled students and student engagement in the planning and implementation of school violence prevention can further enhance the effectiveness of student assistance programming.[77]

SCHOOL COMMITMENT

The advent of a school-based service model that includes prevention, intervention, treatment services, and support can require considerable expansion of services. The expansion of services and introduction of new services, such as school-based substance use and mental and physical health services, may be met with resistance. These services may be perceived

as inappropriate and in conflict with the school's role in achieving increased test scores and academic outcomes. However, research indicates that these services are essential to increasing test scores, enabling positive academic outcomes, and creating a safe school environment.[78] Given that the heightened focus on academic outcomes can act as a service barrier, commitment from school administrators is key.

To achieve high-quality service delivery, it is essential to reserve space within the school and determine when services will be administered to students during the school day and what resources and personnel are necessary for facilitating effective service delivery. Balancing the resources necessary for high-quality service delivery in the context of school- and district-wide mandates can be challenging, which underscores the need for district and school commitment. For example, block scheduling may be incompatible with specific treatment modalities.

Overcoming these types of logistical barriers to intervention requires commitment from district- and school-level administrators, prevention specialists, and licensed health professionals to determine the best response, including offering the treatment after school or selecting and implementing a treatment package that fits within the school schedule.

SELECTION OF SERVICE DELIVERY MODEL

There are three major models—or program designs—for delivery of school-based student assistance services: (1) internally based, (2) externally based, and (3) core team models.[79] Internally based programs refer to service models composed of addiction and mental health specialists employed by the school district to deliver prevention and intervention services on a full- or part-time basis. In contrast, an externally based program is in place when schools develop contractual relationships with addiction and mental health specialists from the community to implement school-based prevention, intervention, and treatment and support services within the school or through referrals to the community agency. Contracts for services, or Qualified Service Organizational Agreements, can help facilitate the communication and training needs of the school district.

Finally, within the core team model, an on-site school team composed of administrators, teachers, school counselors, school psychologists, social workers, coaches, student assistance professionals, and other trained personnel is charged with identifying and providing services to students. Prior to selection, school leaders should consider the advantages and disadvantages of all three service delivery models relative to their own unique local practices, needs, and resources when determining the degree to which prevention and intervention services will be provided by district personnel and/or community agencies.[80,81]

For example, externally based models rely heavily on the presence of an acceptable treatment agency in the community and a level of interest and commitment from community-based providers to provide these school-based services. In comparison to core team models, advantages of this model and internally based models include access to experienced professionals for student referrals and staff training, whereas with core team models, the district is responsible for hiring and maintaining staff with required certifications.

Alternatively, core team models can offer service continuity given team member loss, school ownership and commitment to student prevention, intervention, treatment targets, and focused attention on school personnel and their functionality in the school system to meet student needs.[82]

Externally based services provide distance from the school, especially for students and parents who are not trusting of or well connected with school personnel. This type of service model also creates distance from the internal politics of the school, gives the student assistance professional other clinical supports and training, and does not add more liability to the school. One possible disadvantage is the need for a strong commitment from school personnel to work with the community-based organization, as well as the student assistance professional, causing them to be an integral part of the team. Other disadvantages of externally based programs may result from discontinuity and changes in staffing and the quality of services, potential exclusion of school personnel in service delivery decisions, and regulations of confidentiality that prohibit disclosure of student information to schools without parent consent or student assent.[83]

An advantage of the internally based model is that the student assistance professional often is viewed as part of the team. Other advantages of this model include the level of expertise provided by the addiction or mental health specialist, cost effectiveness, and minimal confusion of school staff regarding how to submit referrals.[84] A primary disadvantage of the internally based model is that the student assistance professional may be scheduled to do other activities that reduce their involvement in true student assistance activities when funding cuts or demands of the school increase. Other disadvantages similar to externally based programs may include discontinuity of services if staff members leave, limited school ownership and input, and potential issues involving confidentiality with information that cannot be shared with other staff in the school without consent.[85]

Within the core team model, the primary advantages involve the school's buy-in and ownership of program services, inclusion of school-based team members, broad-based training and awareness, continuity and availability of service providers, and the ability to take a systems approach.[86] Overall, the core team model promotes an increased level of school involvement with the planning and implementation of student assistance programming. Potential disadvantages of the core team approach may include the amount of training for school staff, allocation of time, and financial support needed for programs and services to be effective and beneficial for students. If a school does not have the necessary trained personnel and support to carry out the services on their own, the core team model may not be as suitable as the internally based and externally based models.

The advantages and disadvantages of the three models are summarized in Table 1.

Student Assistance

Table 1. Comparison of SAP Service Delivery Models

Model	Advantages	Disadvantages
Externally based	• Provides distance from the school and any internal politics • Gives student assistance professional clinical supports and training • Does not add more liability to school	• Requires strong commitment from school personnel • Discontinuity and changes in staffing and service quality • Potential exclusion of school personnel in service delivery decisions • Confidentiality regulations
Internally based	• Student assistance professional viewed as part of the team • Expertise provided by addiction/mental health specialist • Cost-effective • Minimizes confusion related to referrals	• Competing demands on student assistance professional • Discontinuity of services if staff leave • Limited school ownership and input • Restricted information sharing due to confidentiality
Core team	• School's buy-in and ownership of program services • Inclusion of school-based team members • Broad-based training and awareness • Continuity and availability of service providers • Ability to use a systems approach	• Amount of training needed for school staff • Time allocation • Financial support needed for programs and services to be effective

When deciding the most appropriate service delivery model for SAPs, school leaders must consider several key factors, including the level of student need for services, training and expertise of current staff, desired level of school ownership of program services, the availability of community-based resources, and the amount of funding allotted to establish and maintain substance use and mental health services.

CONFIDENTIALITY

Requirements and expectations for protecting a student's right to privacy relate to many policies and procedures of student assistance services. For example, FERPA (Family Education Rights and Privacy Act) applies to school and school personnel. HIPAA (Health Insurance Portability and Accountability Act) directly affects health care providers. HIPAA only applies to covered entities and not to schools, unless they become a covered entity (i.e., licensed health care providers). Though schools generally are open in terms of student privacy compared to community-based settings, the provision of prevention, intervention, treatment, and support services in schools should not change the expectations that students' right to privacy will be protected and records will be stored in secure locations.

Student assistance professionals who are unfamiliar with working in schools may have difficulty navigating confidentiality mandates in a more "open" environment.[87] Receipt of additional support and coaching from experienced personnel on how to effectively work in schools can address these difficulties.

Treatment services may require different and more extensive paperwork than those required by prevention and intervention services.[88] This documentation is necessary and in compliance with ethical standards for collection and storage of personal records. Student assistance professionals with strong experience in community-based addiction and mental health settings may be more familiar with data that need to be collected and the confidentiality requirements associated with these data than those who typically provide only prevention and intervention services. Expectations of confidentiality and security of records should be outlined in school policy documents and communicated with all school and licensed health professionals involved in order to resolve any tension between ethical standards and the practices of any professional group.

QUALITY IMPLEMENTATION

Over the past two decades, there has been an increase in knowledge about the best approaches for delivery of effective prevention[89] and treatment[90] of substance use and mental health disorders for adolescents.

Adolescent problem behaviors—and particularly substance misuse, substance use disorders, and mental health disorders—generally occur as a complex set of issues involving many factors.

The optimal model for addressing substance use and mental health concerns for adolescents is one in which there is a coordinated response to multiple concerns to address the needs of the adolescent. In its community-based form, prevention is an encompassing policy concern for public health. As applied to the prevention of substance use disorders,

prevention is defined broadly as policies, programs, and practices designed to reduce the incidence and prevalence of alcohol and other drugs and address environmental factors leading to substance misuse and/or substance use disorders.[91]

The traditional adolescent substance use disorder and mental illness treatment system often represents a break in such an ideal service continuum, separating the adolescent from the school and other ancillary school support services and requiring the student to go elsewhere for services.[92] Providing substance use disorder and mental illness treatment as part of student assistance services onsite eliminates this physical and systems break and is a stronger method than traditional service delivery models.[93]

The benefits in providing both prevention and treatment as part of student assistance services are most likely achieved when programs and services are integrated and well-implemented. However, there are several key characteristics to consider prior to the implementation of services. An extensive review of diverse evaluations, including meta-analyses and best practice approaches of prevention- and treatment-related programs, identified several 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 student assistance prevention and treatment practices in schools.

Characteristics fundamental to prevention program success include the following:

1. Theory and evidence- or 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 addressing 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. Adopts strengths perspective to address competence and protective factors while diminishing risk and adversity.
6. Sensitive in both content and structure/implementation (i.e., is 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.

Characteristics fundamental to successful substance use and mental health disorder treatment include:

1. Assessment and treatment matching. Programs should use standardized screening instruments and comprehensive assessment throughout the course of treatment to provide further guidance based on an adolescent's progress.

2. Comprehensive, integrated treatment approach. Provision of an integrated treatment approach maximizes the changes that the adolescent will be able to make in reducing both substance use and other problem behaviors.

3. Family involvement. Engaging parents and caregivers in the treatment process increases the probability that the adolescent will remain in treatment and that treatment gains will be maintained after treatment has ended.

4. Developmentally appropriate approaches. Treatment approaches for adolescents must take into consideration the biological, behavioral, and cognitive changes that characterize this stage and also incorporate the different context that corresponds to the age of the adolescent.

5. Engage and retain the adolescent in treatment. For the adolescent to become fully engaged in treatment, the therapist must elicit a commitment from the adolescent.

6. Qualified staff. Licensing and certification varies by state. All treatment staff should have certification or licensing appropriate to state laws governing health care professionals. Additionally, all treatment staff should have training and experience in diverse areas related to co-occurring problems of adolescence and adolescent stages of development, as well as experience working with families.

7. Gender and cultural competence. A thorough understanding of gender and cultural issues is essential to the development of a strong therapeutic alliance and resolution to problem behaviors.

8. Assertive continuing care. Examples of continuing care services include relapse prevention planning, a follow-up plan, referral to community resources, and recovery check-ups.

9. Treatment outcomes. Routine measure of client progress, such as clean urine tests, improved school performance, and enhanced family communication, should be carried out during and up to one year after completion of treatment.

Despite the advantages of implementing school-based substance use treatment or mental health services, the idea may encounter some resistance. Treatment delivery represents an expansion of substance use disorder prevention and mental health services, and some school board members and administrators may disagree with offering such services on school campuses.

Adding treatment to the existing prevention and intervention services may be perceived as inappropriate and outside of the school's role. A strong commitment from school administrators and staff is required to ensure satisfactory conditions for service delivery. Space may be a factor in decisions about when and where to offer substance use and mental health treatment services. Class schedules also can interfere with treatment delivery, and current preoccupations with state testing and academic outcomes may contribute to the resistance to school-based substance use and mental health treatment.

While integrating prevention, treatment, and recovery supports into student assistance services may seem daunting, the evidence for doing so is compelling. Substance use disorders are an adolescent onset disorder that for some will be chronic and last for decades, costing an estimated $442 billion each year in health care costs, lost productivity, and criminal justice.[94]

The failure to identify and intervene early in substance use disorders is costly to adolescents, their families, schools, and society in general. Recent evidence suggests school-based programs addressing substance use and mental illness are feasible and cost effective, improve adolescent functioning considerably, and allow school staff to address known barriers to educational attainment for the adolescent.[95] Treatments such as Motivational Enhancement Therapy/Cognitive Behavioral Therapy[96] (MET/CBT 5), Adolescent Community Reinforcement Approach,[97] and recovery supports[98] have all been tested in schools and have provided sound evidence-based practices that effectively treat substance use and mental health disorders.

To establish student assistance services to address substance use and mental health concerns in your school successfully, a strategic planning process should first take place. The process should take into consideration the specific needs, resources, capacity, and valued outcomes of your school and community. In doing so, effective planning should be based on an understanding of school- and community-wide risk and protective factors influencing local youth, as well as developmental stages. A planning process informed by a clear understanding of these factors and principles within the Strategic Prevention Framework is most likely to achieve intended outcomes by linking the school, community, student, and parent with the best services.

STRATEGIC PREVENTION FRAMEWORK

SAMHSA's Strategic Prevention Framework[99] (SPF) is a five-step planning process (see Figure 5) to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. Its steps include:

1. **Assess needs:** Identify school, district, and community-wide needs related to substance use and mental health issues and available resources and readiness to support promotion, prevention, treatment, and support efforts in the school setting.

2. **Build capacity:** Building capacity is critical to the success of student assistance services and can be strengthened by looking closely at assessment data, finding gaps that lie therein, and developing action plans to address those gaps. Components of capacity-building include improving readiness to address substance use and mental health challenges, building partnerships, improving resources, and preparing the workforce.

3. **Plan:** Good planning will increase the likelihood of effective services, ongoing evaluation, and sustainability. Planning activities include prioritizing students' needs and risk and protective factors associated with the issues the school plans to address; selecting evidence-based practices to target the risk and protective factors selected; and building a logic model to link problems, related risk and protective factors, evidence-based strategies, and anticipated outcomes.

4. **Implement:** Implementation is where the rubber hits the road—where you do what you said you were planning to do in the previous steps. Multiple factors influence implementation and should be considered in the planning and implementation stages, including staff selection, training, consultation or coaching, evaluation, administrative support, implementation history, and key stakeholder support.

5. **Evaluate:** A variety of evaluation-related activities are included to help organizations describe what they plan to do, monitor what they are doing, improve effectiveness, and make decisions. Some activities include identifying evaluation expertise; designing evaluation plans; and collecting, analyzing, and reporting data. In the SPF, the entire five-step planning process should be evaluated to determine how each step connects to the steps around it.

The effectiveness of identifying and implementing the correct or efficient evidence-based substance use and mental health practice(s) is built on a risk and protective factors approach to prevention and a series of guiding developmental principles. Without attention to risk and protective factors and principles of development in the assessment, capacity, and planning stages, the wrong service (though evidence-based) could be matched to the wrong child. Therefore, understanding these guiding models and principles is important.

Figure 5. SAMHSA's Strategic Prevention Framework

Source: SAMHSA. (2018). *Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners.* Retrieved from https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

UNDERSTANDING RISK AND PROTECTIVE FACTORS

"Risk and protective factors" refers to individual differences within a student's environment (e.g., family structure, peers, schools, communities) that may influence risky behaviors such as substance use, delinquency, early pregnancy, dropping out of school, and violence. Risk factors associated with a greater potential for these problems include, but are not limited to, poverty, prevalence rates of substance use and misuse in a community, familial substance use, family conflict, traumatic experiences, a deviant peer group, and history of academic failure. In contrast, protective factors that may reduce the likelihood of these risk behaviors include, but are not limited to, strong family relationships and connections to other positive adults, involvement in extracurricular activities, spirituality, involvement in helping others, having pro-social peers, positive connections to school, and interest in and history of academic success.[100]

In general, students may show more difficulties when they encounter more risk factors in their lives and, alternatively, are more likely to be successful in school when more protective factors are present. Students also respond differently to conditions of risk; however, protective factors can help offset the effects of risk factors. Four key features of risk and protective factors are important to remember when designing and evaluating student assistance services (see Figure 6).

1. **Risk and protective factors can be found in multiple contexts.** Individuals are influenced by biological and psychological characteristics, as well as family, peer group, community, and environmental factors that can make them more vulnerable or resilient, as shown in Table 2. Targeting just one context can limit the degree of associated success of the intervention.

2. **Effects of risk and protective factors can be correlated and cumulative** (Figure 6)**.** Risk factors tend to be positively correlated with one another, negatively correlated with protective factors, and cumulative. Young people with multiple risk factors have a greater chance of experiencing difficulties than those with multiple protective factors.

3. **Some risk and protective factors have specific effects, but others are associated with multiple substance use and mental health issues** (Figure 6). For example, negative life events such as divorce or sustained neighborhood violence are associated with multiple difficulties, including substance use and misuse, anxiety, and depression.

Table 2. Risk and Protective Factors According to Different Contexts

Context	Risk Factors	Protective Factors
Family	• Parental divorce • Family conflict • Abuse and/or neglect • Harsh, lax, or inconsistent discipline	• Parental involvement and monitoring • Warm, supportive relationships with parents and other caring adults
Peer group	• Weak ties to friends • Involvement in criminal behavior, violence, and/or drugs • Gang membership	• Strong bond with friends who engage in pro-social, conventional behaviors
Community	• Neighborhood crime, drugs • Neighborhood disorganization	• Availability of faith-based resources and afterschool programs
Environment	• Norms and laws favorable to substance use disorders	• Local ordinances that prevent underage smoking and drinking

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

Figure 6. Shared Risk and Protective Factors
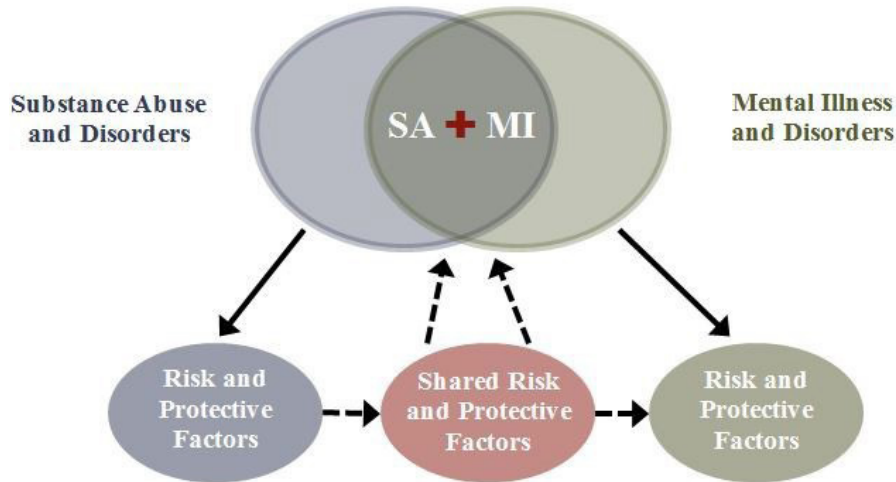
Source: Institute of Medicine (U.S.), O'Connell, M. E., Boat, T. F., Warner K. E., & National Research Council (U.S.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* Washington, D.C.: National Academies Press.

4. **Risk and protective factors influence each other and substance use and mental health problems over time.**[101,102] Risk and protective factors can strengthen or limit the presence of other factors and challenges over a lifetime. For example, effective parenting can serve as a protective factor against multiple risk factors and across multiple contexts (i.e., poverty, parental divorce, and parental mental health problems), whereas risk factors such as delinquent peers and family dysfunction substantially increase the likelihood of mental health challenges and substance use.

Understanding how risk and protective factors influence one another underscores the importance of (1) intervening early, and (2) developing interventions that target multiple factors, rather than addressing individual factors in isolation. The more we understand, the better prepared we will be to develop an appropriate continuum of services, supports, and interventions.

Student assistance services that focus on substance use and mental health concerns provide a means for addressing a broad range of risk and protective factors across multiple contexts and developmental stages, with several intended outcomes aimed at making broad school- and community-wide improvements.[103]

Specifically, when implemented correctly, SAPs promote the following protective factors:[104]

- Students' grade point average—schools with high need and availability of SAPs show strong and stable increases in student achievement over time;
- Students' positive attitude toward school, likelihood of staying in school, and school attendance;
- Staff involvement in student issues and concerns; and
- Parent and community support for students, schools, and parents.

As part of a broad array of integrated prevention and early intervention services, SAPs help reduce risk factors for substance use and mental health challenges and can decrease:[105,106]

- Disruptive behaviors that may interfere with learning;
- Dropout rates, school truancy, and poor attendance;
- Alcohol and drug use;
- Discipline referrals, with as few as 4 percent of students reporting alcohol and drug violations after participating in SAPs;
- Drinking and driving; and
- Other behavior problems.

Additionally, Figure 7 shows the Social Development Strategy, which illustrates the benefits of students' bonding and attachment to school. Easy to understand, the strategy may be beneficial to board members and others who are tasked with a multitude of responsibilities, not only SAP-related issues.

Figure 7. Social Development Strategy
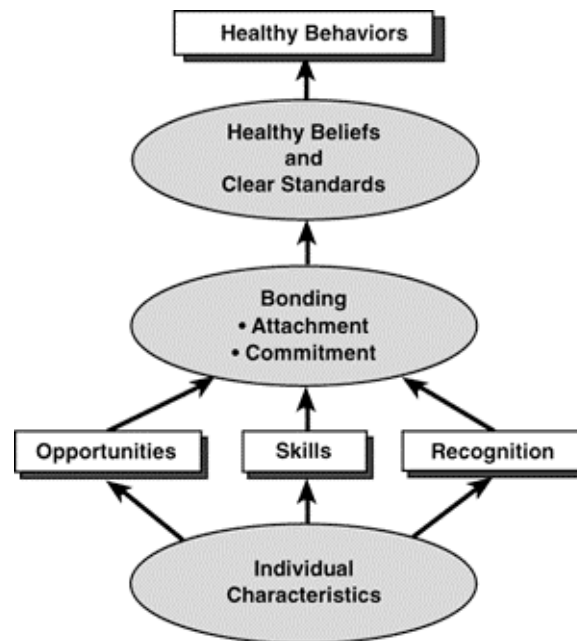
Source: Catalano, R. F., & Hawkins, J. D. (1996). *The social development model: A theory of antisocial behavior.* New York: Cambridge University Press.

ADOLESCENT DEVELOPMENT

Student assistance services and curricula are most successful when designed to match the developmental needs and competencies of the students they serve.[107] Each period of student growth is associated with a set of developmental competencies: cognitive, emotional, and behavioral abilities children need to adapt to new challenges and experiences.

Furthermore, each developmental stage is also associated with varying risk and protective factors that influence children's success in gaining the competencies they need. The influence of services and interventions is greater when they are designed to target the competencies and risk and protective factors associated with the students' developmental period. In this section, specific examples of competencies and risk and protective factors are provided across the K–12 developmental spectrum.

Research suggests that school-based interventions that serve to change the context of the school and create a socially and emotionally supportive environment for elementary school-age students can enhance academic outcomes, promote positive socio-emotional outcomes, and prevent delinquent behavior.[108,109] This is important to consider when planning student assistance services at the elementary school level, especially because consistent presentation of disruptive behavior can double or triple the likelihood of engaging in risky behaviors later in life. Additionally, poor academic performance during these years can predict and significantly impact school absences and dropout.[110] Early intervention before the onset of more severe conduct problems, such as theft, acting out, or destruction, can increase school success and positive mental health outcomes.[111]

Thus, student assistance programming at the elementary school level should focus on promoting social and emotional competencies and reducing problematic behaviors through classroom and school-wide behavior management programs and policies, curricula for teaching pro-social behaviors (e.g., problem-solving, conflict resolution, violence and bullying prevention), parent education programs, and multi-component support groups that address risk and protective factors across home, school, and community settings.[112]

The transition from elementary school to middle school is difficult for many students.[113] Elementary schools are vastly different from middle and high schools, where students frequently change classes, spend less time with their teachers, are expected to be more independent, experience greater academic demands, and have less opportunity for physical activity. These changes in the school environment coincide with social challenges such as increased negative peer pressure; opportunities for bullying; and risk for anxiety, depression, and self-esteem concerns.[114]

Taking this into consideration, it is not surprising that on average, middle schools experience the highest rates of student behavior difficulties and the greatest level of need for student assistance programming. The middle school years (grades 6–8) are pivotal ones for prevention and intervention efforts, and continuity of these efforts into high school is strongly indicated.[115] Students are particularly vulnerable to risky behaviors (e.g., substance use and misuse, sexual activity, conduct problems) during mid- to late adolescence (i.e., middle and high school), with intervention efforts conducted during high school often representing a final opportunity for the education system to reduce negative outcomes for students with substance use and mental health disorders. For example, upon leaving high school, more than half of all students with emotional and behavioral challenges will be arrested.[116] To reduce the likelihood of behavior that results in this unfavorable outcome, timing is critical and intervention should occur prior to students' exit from high school.

Engaging middle and high school students exhibiting at-risk behaviors in appropriate student assistance services can delay and decrease the incidence of alcohol and drug use, violence,

aggression, delinquency, dropout, and future criminality while simultaneously increasing the odds for success in school and adulthood.[117,118]

There are notable challenges to engaging adolescent populations in intervention and treatment, particularly in the case of youth with substance use issues.[119,120] These students often do not think they have difficulties, lack motivation for change, have parents with substance use issues, and may present with co-morbid problems that predate substance use (i.e., mental illness, legal issues, or trauma-related concerns).[121] Given these factors, student assistance programming for substance use disorders must be sensitive to motivational barriers to change, as well as other developmental concerns.[122]
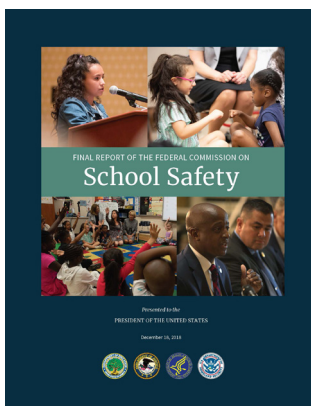
In the beginning stages of intervention, negative coercion and pressure to participate in any program, including SAPs, are not usually conducive to the change process. Student assistance services that incorporate and include the implementation of brief interventions such as Motivational Interviewing/Motivational Enhancement Therapy (MI/MET) strategies[123] are effective in adolescent populations and have been associated with improved youth substance use outcomes.[124] Moreover, adapting student assistance services to the developmental considerations of adolescents includes programming that addresses multiple systems (family, school, welfare, and criminal justice), provides examples that are relevant to situations commonly experienced by youth relative to substance use and substance use relapse (e.g., peer pressure), and offers intervention materials with concrete, rather than abstract, concepts for conveying the passage to recovery.[125,126]

RESOURCES
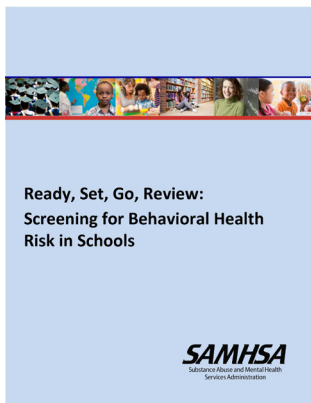
Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools
https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf

Final Report of the Federal Commission on School Safety
https://www2.ed.gov/documents/school-safety/school-safety-report.pdf

As mentioned throughout this guide, schools provide a critical context for the overall development of children and adolescents. Schools are well-positioned to implement programs and practices that promote positive student academic, physical health, mental health, and social-emotional development while removing barriers to teaching and learning. Despite this opportunity to promote positive development and prevent difficulties, statistics show most students do not receive the mental health and substance use services they need.[127] In fact, of the 3.87 million (13.5 percent) youth ages 12–18 currently enrolled in school with substance use disorders (SUDs), only 4 percent (1 in 25) received treatment in an SUD or MHD program. SAPs represent key practices that help schools provide a continuum of supports and ensure the success of all students.

While many practices have emerged that promote positive development through multi-tiered practices that emphasize prevention, early and targeted intervention, and more intensive supports, SAPs complement these practices and can be easily integrated into their multi-tiered frameworks.

For example, SWPBS and RTI provide a space for a continuum of prevention and intervention to be developed through procedures such as universal screening and data-based decision-making. SAPs provide the content to fill gaps in programming through implementation of effective prevention, early intervention, and evidence-based comprehensive intervention services to meet the needs of all students and those identified through the SWPBS and RTI procedures. By linking and partnering with school mental health and substance use services and school-based health centers, SAPs include school-employed and community addiction and mental health professionals in providing more comprehensive and generalizable intervention practices that lead to better student, family, school, and community outcomes.

Adoption and implementation of SAPs lead to many outcomes that are valued by students, families, educators, and communities. When they reflect best practices and research findings, SAPs lead to improvements in student behavior, school attendance, assignment completion, grades, and rates of academic achievement.[128,129,130]

Principals and educators seeking to achieve success for all students and promote comprehensive, positive youth development should strongly consider implementation of SAPs to meet the needs of all students and provide caring and well-intentioned staff with systematic approaches that lead to positive and sustainable outcomes. Going forward, schools striving to support students' success should consider the model of SAPs and their integration with existing school initiatives. Likewise, schools should make a plan for implementing a SAP model with consideration of readiness, school policies, staff training and development needs, program awareness, and strategies for evaluation and ongoing improvement.

Resources provided in this guide support the initiation of these efforts by principals and educators interested in reducing barriers to teaching and learning, as well as others who are passionate about creating schools that promote the success of all students across all domains of youth development.

REFERENCES

[1] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Children's Defense Fund. (2014). *The State of America's Children 2014 Report.* Retrieved from https://www.childrensdefense.org/wp-content/uploads/2018/06/2014-soac.pdf

[6] U.S. Department of Health and Human Services, Administration for Children and Families. (2018). Child maltreatment 2016. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf

[7] Adger, H., Blondell, R., Cooney, J., Finch, J., Graham, A., Macdonald, D. I., … Werner, M. (n.d.). Helping children and adolescents in families affected by substance use. Retrieved from http://www.nacoa.net/pdfs/guide%20for%20health.pdf

[8] U.S. Department of Education, National Center for Education Statistics. (2018). Indicators of school crime and safety: 2017 (NCES 2018-036). Retrieved from https://nces.ed.gov/pubs2018/2018036.pdf

[9] Skadden, Arps, Slate, Meagher, & Flom LLP and Affiliates. (n.d.). Appendix L: Fatal school shootings in the United States: 1966–2007. Retrieved from http://faculty.uml.edu/jbyrne/44.327/appendix_L_school_shootings_in_us.pdf

[10] Pearson Education, Inc. (2014). Timeline of worldwide school and mass shootings. Retrieved from http://www.infoplease.com/ipa/A0777958.html

[11] Califano, J. (2008). *High society: How substance abuse ravages America and what to do about it.* New York: Public Affairs.

[12] Mandell, D., Hill, S., Carter, L., & Brandon, R. (2002). *The impact of substance use and violence/delinquency on academic achievement for groups of middle and high school students in Washington.* Seattle, WA: University of Washington.

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

[14] Califano, J. (2008). *High society: How substance abuse ravages America and what to do about it.* New York: Public Affairs.

[15] U.S. Department of Education. (2001). *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: Author.

[16] Chapman, C., Laird, J., Ifill, N., & KewalRamani, A. (2011). *Trends in high school dropout and completion rates in the United States: 1972–2009* (NCES 2012-006). U.S. Department of Education. Washington, DC: National Center for Education Statistics. Retrieved from https://nces.ed.gov/pubs2012/2012006.pdf

[17] Bullis, M., & Cheney, D. (1999). Vocational and transition interventions for adolescents and young adults with emotional or behavior disorders. *Focus on Exceptional Children, 31,* 1–24.

[18] Hair, E., Ling, T., & Cochran, S. W. (2003). *Youth development programs and educationally disadvantaged older youths: A synthesis.* Washington, DC: Child Trends.

[19] Somers, C. L., Owens, D., & Piliawsky, M. (2008). Individual and social factors related to urban African American adolescents' school performance. *The High School Journal, 91,* 1–11.

[20] Califano, J. (2008). *High society: How substance abuse ravages America and what to do about it.* New York: Public Affairs.

[21] Blackorby, J., & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In *Wave 1 Wave 2 Overview (SEELS)* (pp. 8.1–8.23). Menlo Park, CA: SRI International.

[22] Carlson, K. A. (2001). *School-based outpatient treatment for adolescent substance abuse: A review of program models in Washington state.* Olympia, WA: Office of Superintendent of Public Instruction.

[23] Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). Strategic Plan FY2019 – FY2023. Retrieved from https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf

[24] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

[25] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

[26] Catron, T., Harris, V., & Weiss, B. (1998). Posttreatment results after 2 years of services in the Vanderbilt School-based Counseling project. In M. H. Epstein, K. Kutash, A. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 633–656). Austin, TX: Pro-Ed.

[27] Beschner, G. (1985). The problem of adolescent drug abuse: An introduction to intervention strategies. In A. Freidman and G. Beschner (Eds.), *Treatment services for adolescent substance abusers.* Rockville, MD: National Institute on Drug Abuse.

[28] Andris, L. M., Kamara, S. G., Louden, J. H., & Mumwaw, A. L. (1992). *Adolescent clients of Washington State's Division of Alcohol and Substance Abuse Services: A descriptive study.* Olympia, WA: Department of Social and Health Services.

[29] RMC Research Corporation. (2001). *School-based outpatient treatment for adolescent substance abuse: A review of program models in Washington state.* Portland, OR: RMC Research Corporation.

[30] Walker, H. M., Horner, R. H., Sugai, G., Bullis, M., Sprague, J. R., Bricker, D., & Kaufman, M. J. (1996). Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *Journal of Emotional and Behavioral Disorders, 4,* 194–209.

[31] National Academies of Sciences, Engineering, and Medicine 2019. *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25201/25201.

[32] Florida's Multi-tiered System of Supports (MTSS). (2012). *MTSS implementation components: Ensuring common language and understanding.* Retrieved from http://flpbs. fmhi.usf.edu/pdfs/MTSS%20Paper%20Impl%20Comp%20Dec%202011.pdf

[33] National Center on Response to Intervention (2010). *Essential components of RTI – A closer look at Response to Intervention.* Washington, DC: U.S. Department of Education, Office of Special Education Programs, National Center on Response to Intervention.

[34] OSEP Technical Assistance Center, Positive Behavioral Interventions & Supports. (2012). About us. Retrieved from https://www.pbis.org/about/about

[35] D'Ambrosio, R. (n.d.). *The Prevention and Intervention Services Program's link to academic improvement: Highlights.* Retrieved from http://citeseerx.ist.psu.edu/viewdoc/ download?doi=10.1.1.578.1759&rep=rep1&type=pdf

[36] Vincent, R. M. (2009). *A framework for integrated student assistance & behavioral health services* [PowerPoint slides]. Tumwater, WA: True North Student Assistance and Treatment Services.

[37] Center for Prevention Research and Development. (2005). *Background research: Student assistance programs.* Champaign, IL: Center for Prevention Research and Development, Institute of Government and Public Affairs, University of Illinois.

[38] Vincent, R. M. (2009). *A framework for integrated student assistance & behavioral health services* [PowerPoint slides]. Tumwater, WA: True North Student Assistance and Treatment Services.

[39] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/ sapispmanual2012.pdf

[40] Mandell, D., Hill, S., Carter, L., & Brandon, R. (2002). *The impact of substance use and violence/delinquency on academic achievement for groups of middle and high school students in Washington.* Seattle, WA: University of Washington.

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

[42] Prevention First. (2011). *Student assistance program guidebook: A resource for schools.* Springfield, IL: Prevention First.

[43] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[44] Fertman, C. I., Tarasevich, S. L., & Hepler, N. A. (2003). *Retrospective analysis of the Pennsylvania Student Assistance Program outcome data.* Washington, DC: Substance Abuse and Mental Health Services Administration.

[45] Ibid.

[46] Washington State Department of Education. (2012). *Addressing adolescent substance abuse: An evaluation of Washington's Prevention and Intervention Services Program. 2010–2011 Annual Report.* Olympia, WA: Office of Superintendent of Public Instruction.

[47] Williams, C. (2003). *Community-based TADPOLE control group study report: 2003* (Technical report prepared for STARS). Memphis, TN: University of Memphis.

[48] Hepler, N., & Williams, C. (2002). *Interpreting and applying the Community-based TADPOLE report: Fiscal year 2001–2002.* Memphis, TN: University of Memphis.

[49] Hepler, N., Williams, C., Butler, D., & Cook, P. (1998). *Community-based TADPOLE agency evaluations--Annual reports to agencies: Fiscal year 97/98.* Memphis, TN: University of Memphis.

[50] Student Assistance Center at Prevention First. (2017). *Student assistance program guidebook: A resource for schools.* Retrieved from https://www.prevention.org/Resources/c54b613c-d9d7-456d-99d2-2521e531e003/StudentAssistanceProgramGuidebook.pdf

[51] Evans-Whipp, T., Beyers, J. M., Lloyd, S., Lafazia, A. N., Toumborous, J. W., Arthur, M. W., & Catalano, R. F. (2004). A review of school drug policies and their impact on youth substance use. *Health Promotion International, 19,* 227–234. Pentz, M. A., et al. (1997). "The conflict between least harm and no-use tobacco policy for youth: ethical and policy implications." *Addiction, 92*(9), 1165–1174.

[52] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[53] Markle, B., Splett, J. W., Maras, M. A., & Weston, K. J. (2014). Effective school teams: Benefits, barriers, and best practices. In M. D. Weist, N. Lever, C. Bradshaw & J. Owens (Eds.), *Handbook of school mental health: Research, training, practice, and policy* (2nd ed.). New York: Springer.

[54] Center for Prevention Research and Development. (2005). *Background research: Student assistance programs.* Champaign, IL: Center for Prevention Research and Development, Institute of Government and Public Affairs, University of Illinois.

[55] True North Student Assistance and Treatment Services. (1995). *True North Program Model. A Cooperative of Educational Service District 113.* Tumwater, WA: Educational Service District 113.

[56] Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations* (HHS Publication No. SMA 12-4670). Rockville, MD: SAMHSA.

[57] Ibid.

[58] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[59] Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

[60] Ibid.

[61] Ibid.

[62] Ibid.

[63] Ibid.

[64] Allison, K. W., Edmonds, T., Wilson, K., Pope, M., & Farrell, A. D. (2011). Connecting youth violence prevention, positive youth development, and community mobilization. *American Journal of Community Psychology, 48*(1–2), 8–20.

[65] Williams, C. (2003). *Community-based TADPOLE control group study report: 2003* (Technical report prepared for STARS). Memphis, TN: University of Memphis.

[66] Hepler, N., & Williams, C. (2002). *Interpreting and applying the Community Based-TADPOLE report: Fiscal year 2001–2002.* Memphis, TN: University of Memphis.

[67] Hepler, N., Williams, C., Butler, D., & Cook, P. (1998, October). *Community Based-TADPOLE agency evaluations—Annual reports to agencies: Fiscal year 97/98*. Memphis, TN: University of Memphis.

[68] Student Assistance Center at Prevention First. (2017). *Student assistance program guidebook: A resource for schools.* Retrieved from https://www.prevention.org/Resources/c54b613c-d9d7-456d-99d2-2521e531e003/StudentAssistanceProgramGuidebook.pdf

[69] Way, N., Reddy, R., & Rhodes, J. (2007). Students' perceptions of school climate during the middle school years: Associations with trajectories of psychological and behavioral adjustment. *American Journal of Community Psychology, 40,* 194–213.

[70] Limber, S. P., Olweus, D., Wang, W., Masiello, M., & Breivik, K. (2018). Evaluation of the Olweus Bullying Prevention Program: A large scale study of U.S. students in grades 3–11. *Journal of School Psychology, 69*, 56-72. Retrieved from http://www.sciencedirect.com/science/article/pii/S0022440518300529. doi:https://doi.org/10.1016/j.jsp.2018.04.004

[71] Fein, R. A., Vossekuil, B., Pollack, W. S., Borum, R., Modzeleski, W., & Reddy, M. (2004). *Threat assessment in schools: A guide to managing threatening situations and to creating safe school climates*. U.S. Department of Education. Washington, DC: U.S. Government Printing Office.

[72] Interdisciplinary Group on Preventing School and Community Violence. (2012). A call for more effective prevention of violence. Retrieved from http://curry.virginia.edu/articles/sandyhookshooting

[73] U.S. Departments of Education, Homeland Security, Health and Human Services, and Justice. (2018). Final Report of the Federal Commission on School Safety. Retrieved from https://www2.ed.gov/documents/school-safety/school-safety-report.pdf

[74] Interdisciplinary Group on Preventing School and Community Violence. (2012). A call for more effective prevention of violence. Retrieved from http://curry.virginia.edu/articles/sandyhookshooting

[75] Ibid.

[76] StopBullying.gov. (n.d.). Community action toolkit. Retrieved from www.stopbullying.gov/prevention/training-center/community-action-toolkit.pdf

[77] Ibid.

[78] Dennis, M. L., Clark, H. W., & Huang, L. N. (2014). The need and opportunity to expand substance use disorder treatment in school-based settings. *Advances in School Mental Health Promotion, 7*(2), 75–87. Retrieved from http://dx.doi.org/10.1080/1754730X.2014.888221

79 Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

80 D'Ambrosio, R. (n.d.). *The Prevention and Intervention Services Program's link to academic improvement: Highlights.* Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.578.1759&rep=rep1&type=pdf

81 Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

82 Ibid.

83 Ibid.

84 Ibid.

85 Ibid.

86 Ibid.

87 D'Ambrosio, R. (n.d.). *The Prevention and Intervention Services Program's link to academic improvement: Highlights.* Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.578.1759&rep=rep1&type=pdf

88 Ibid.

89 Bond, L. A., & Carmola Huff, A. M. (2004). Taking stock and putting stock in primary prevention: Characteristics of effective programs. *The Journal of Primary Prevention, 24*(3), 199–221.

90 Liddle, H. A., & Rowe, C. L. (2006). *Adolescent substance abuse: Research and clinical advances.* New York: Cambridge University Press.

91 Springer, J. F., & Phillips, J. (2006). *The Institute of Medicine Framework and its implication for the advancement of prevention policy, programs and practice.* Sacramento, CA: Center for the Applied Research Solutions.

92 Carlson, K. A. (2001). *School-based outpatient treatment for adolescent substance abuse: A review of program models in Washington state.* Olympia, WA: Office of Superintendent of Public Instruction.

93 Wagner, E. F., & Macgowan, M. J. (2006). School-based treatment of adolescent substance abuse problems: Student Assistance Program group counseling. In H. A. Liddle & C. L. Rowe (Eds.), *Treating adolescent substance abuse: State of the science* (pp. 333–356). Cambridge, UK: Cambridge University Press.

94 U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health.* Washington, DC: HHS.

95 Dennis, M. L., Clark, H. W., & Huang, L. N. (2014). The need and opportunity to expand substance use disorder treatment in school-based settings. *Advances in School Mental Health Promotion, 7*(2): 75–87.

96 Belur, V., Dennis, M. L., Ives, M. L., Vincent, R. M., & Muck, R. (2014). Feasibility and impact of implementing motivational enhancement therapy– cognitive behavioral therapy as a substance use treatment intervention in school-based settings. *Advances in School Mental Health Promotion, 7*(2): 88–104.

97 Hunter, B. D., Godley, M. D., & Godley, S. H. (2014). Feasibility of implementing the Adolescent Community Reinforcement Approach in school settings for adolescents with substance use disorders. *Advances in School Mental Health Promotion, 7*(2): 105–122.

98 Rattermann, M. J. (2014). Measuring the impact of substance abuse on student academic achievement and academic growth. *Advances in School Mental Health Promotion, 7*(2): 123–135.

99 Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners. Retrieved from https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

100 Washington State Department of Education. (2012). *Addressing adolescent substance abuse: An evaluation of Washington's Prevention and Intervention Services Program. 2010–2011 Annual Report.* Olympia, WA: Office of Superintendent of Public Instruction.

101 O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* Washington, DC: National Academies Press.

102 Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

103 Ibid.

104 Ibid.

105 Ibid.

106 Vermont Agency of Human Services, Vermont Department of Health, Division of Alcohol and Drug Abuse Problems. (2011). Student Assistance Program Outcomes 2010. Retrieved from http://www.asap-vt.org/documents/Legislative/SAP_SummaryAndOutcomesFY10.pdf

[107] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[108] Burns, B. J., Howell, J. C., Wiig, J. K., Augimeri, L. K., Welsh, B. C., Loeber, R., & Petechuk, D. (2003). *Treatment, services, and intervention programs for child delinquents.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

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

[110] Burns, B. J., Howell, J. C., Wiig, J. K., Augimeri, L. K., Welsh, B. C., Loeber, R., & Petechuk, D. (2003). *Treatment, services, and intervention programs for child delinquents.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[111] Ibid.

[112] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[113] Taylor, L. K. (2013). Behavioral health: Middle school students. In D. Wiley & A. Cory (Eds.), *Encyclopedia of school health.* Thousand Oaks, CA: Sage Publications.

[114] Ibid.

[115] Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

[116] Wagner, M. Cameto, R., & Newman, L. (2003). *Youth with disabilities: A changing population. A report of the findings from the National Longitudinal Transition Study (NLTS) and the National Longitudinal Transition Study 2 (NLTS-2).* Menlo Park, CA: SRI International.

[117] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[118] Vincent, R. M., Belur, V. K., Ives, M. L., & Dennis, M. L. (April 2012). *Feasibility and impact of implementing MET/CBT as a substance use treatment intervention in school based settings.* Presentation at the Joint Meeting on Adolescent Treatment Effectiveness. Washington, DC.

[119] Vincent, R. M. (2009). *A framework for integrated student assistance & behavioral health services* [PowerPoint slides]. Tumwater, WA: True North Student Assistance and Treatment Services.

[120] Schutte, K., Maike, M. M., & Johnson, M. M. (2006). *Washington state Student Assistance Prevention-Intervention Services Program: Program manual.* Olympia, WA: Office of Superintendent of Public Instruction.

[121] Vincent, R. M. (2009). *A framework for integrated student assistance & behavioral health services* [PowerPoint slides]. Tumwater, WA: True North Student Assistance and Treatment Services.

[122] Vincent, R. M., & Thompson, J. (2007). *Brief intervention utilizing motivational enhancement therapy and cognitive behavioral therapy: Five sessions for adolescents.* Tumwater, WA: Washington Association of Student Assistance Professionals.

[123] Ibid.

[124] Vincent, R. M. (2009). *A framework for integrated student assistance & behavioral health services* [PowerPoint slides]. Tumwater, WA: True North Student Assistance and Treatment Services.

[125] Dennis, M. L., Clark, H. W., & Huang, L. N. (2014). The need and opportunity to expand substance use disorder treatment in school-based settings. *Advances in School Mental Health Promotion, 7*(2): 75–87.

[126] Winters, K. C., Leitten, W., Wagner, E., & O'Leary Tevyaw, T. (2007). Use of brief interventions in a middle and high school setting. *Journal of School Health, 77,* 196–206.

[127] Dennis, M. L., Clark, H. W., & Huang, L. N. (2014). The need and opportunity to expand substance use disorder treatment in school-based settings. *Advances in School Mental Health Promotion, 7*(2): 75–87.

[128] Prevention First. (2011). *Student assistance program guidebook: A resource for schools.* Springfield, IL: Prevention First.

[129] Grunenfelder, D., Johnson, M., Maike, M. M., & Schutte, K. (2012). *Washington's Student Assistance Prevention-Intervention Services Program: Program manual.* Retrieved from https://www.k12.wa.us/sites/default/files/public/preventionintervention/pubdocs/sapispmanual2012.pdf

[130] Fertman, C. I., Tarasevich, S. L., & Hepler, N. A. (2003). *Retrospective analysis of the Pennsylvania Student Assistance Program outcome data.* Washington, DC: Substance Abuse and Mental Health Services Administration (SAMHSA).

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